



TOO MANY BARRIERS: EXPERIENCES OF ABORTION IN IRELAND AFTER REPEAL

By ARC and Lorraine Grimes, PhD

Authorship and Acknowledgments

Between 2019 and 2021, the Abortion Access Research Working Group of the Abortion Rights Campaign (ARC) developed and conducted an extensive research project to evaluate individuals' experiences of Ireland's abortion services.

This research entailed an online survey with both quantitative and qualitative questions. After the data collection was completed, Dr. Lorraine Grimes acted as primary data analyst on this project. Dr. Grimes analysed the data collected and compiled a detailed report of the results. The following report is a co-production between ARC and Dr. Lorraine Grimes.

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List of Abbreviations

AIMS	Association for the Improvement of Maternity Services
ARC	Abortion Rights Campaign
ASN	Abortion Support Network
CSO	Central Statistics Office
D&C	Dilation and Curettage
EMA	Early Medical Abortion
FFA	Fatal Foetal Anomaly
GP	General Practitioner
HSE	Health Service Executive
IFPA	Irish Family Planning Clinic
IOG	Institute of Gynaecology
NWC	National Women's Council
PPSN	Personal Public Service Number
TMFR	Termination for Medical Reasons
WHO	World Health Organization

Executive Summary



The Abortion Rights Campaign (ARC) is a grassroots all-volunteer group dedicated to achieving free, safe, legal, and local abortion everywhere on the island of Ireland, for everyone who wants or needs it.

This report presents the findings of the evaluation by the ARC Abortion Access Research Group on individuals' experiences of abortion provision in Ireland since the introduction of the Health (Regulation of Termination of Pregnancy) Act 2018. The findings are based on data collected via an online survey and analysed by Dr. Lorraine Grimes. This report makes recommendations to inform the public, legislators, and policymakers about individuals' experiences with abortion care under the Health Act 2018.

Brief Overview of Respondents

In total, 402 people responded to this survey; 388 people took the survey in English, 5 in Irish, 6 in Arabic and 3 in Polish. Eighty-eight percent of respondents identified as White Irish and 89% identified as Irish citizens. Respondents lived in all but two counties in the Republic and provided good representation across cities, small towns, and rural areas. Nine respondents were resident in Northern Ireland. The largest single age cohort was 35+ years old. The majority of respondents had their abortion in the first 10 weeks of pregnancy.

Of those survey respondents who gave details of where or how they had an abortion: 124 said they had an abortion through the health system in Ireland; 30 outside Ireland; and 12 by importing pills or accessing abortion in some other way. Twenty-one tried to have an abortion but were refused care or couldn't obtain pills. Of those who had an abortion through the health system in Ireland, 59 respondents said they had an abortion through a GP surgery; 24 had an abortion through a health clinic; 25 had an abortion in a hospital; and 16 did not specify where they had their abortion.

Major Findings

Information and Access

- **More than half of respondents (54%)¹ did not know where to go to get an abortion. Nearly one third of respondents (32%) said they did not know where to find information on abortion.** Only 65% of respondents were aware that abortion is free, at the point when they sought to access care. These findings illustrate substantial problems regarding the accessibility of information on abortion in Ireland.
- Only **61%** of participants used the MyOptions helpline. **14% of participants reported that they had not heard of the MyOptions phone line or website.** Respondents noted that the helpline is not available on a 24/7 basis and does not provide any information about how to access an abortion after 12 weeks.
- The majority of respondents noted that it was "easy" to make an appointment. **Others experienced great difficulty making an appointment, however, particularly with a lack of local providers or having to travel far to access services.** Respondents noted that MyOptions does not advertise that it can give contact details for providers, and some only learned that after trying to find a provider on their own.
- Respondents typically travelled up to one hour to access abortion services. **30% travelled between 4 to 6 hours, and 57% of respondents stated that they had to spend longer travelling than they usually would to access medical care.**
- Many participants noted that the **introduction of telemedicine (telephone or video consultations) made access to abortion easier** for them as it has reduced the need for travel and increased individuals' privacy.

Experience with Providers

- Those who accessed abortion under 10 weeks did so through a GP or health clinic. Overall, **respondents reported positive experiences of accessing abortion care with the GP and in health clinic settings.**
- At the first appointment, **79%** felt that they were given the information they needed about the procedure. **16% felt that they were not provided with the necessary information during their first appointment.**
- A significant finding of this research is that patients felt they were **not properly informed about the level of pain or amount and duration of bleeding they might experience with an Early Medical Abortion, or how to manage these effects of the medication.**

¹All questions in the survey were optional, for ethical reasons, so all percentages are of those respondents who answered the specific question.

- Six respondents noted that they **required access to an interpreter** but only 4 were provided with this service, constituting a significant added barrier to care for those whose first language is not English.
- **31% of respondents were referred for an ultrasound scan.** After having the scan, more than half (**53%**) of participants waited more than three days to have the abortion.
- Respondents described problems with scanning services, **including inappropriate comments from the technicians and incorrect results.** One participant travelled to England on the basis of an incorrect dating scan that showed her to be over 12 weeks when in fact she was not.
- Waiting times to attend the first appointment with the doctor ranged between one day and one week. **26% waited more than the required three days for their second appointment.**
- The majority of respondents reported **negative effects of the mandatory three-day waiting period.** Participants described the mandatory delay as “demeaning” and as inducing “undue stress and anxiety”.
- After 10 weeks, patients have to go to one of 10 maternity hospitals providing abortion care. Patients’ experience of abortion care **in hospitals from 10 to 12 weeks varied but was overwhelmingly negative.** Respondents reported **insufficient facilities, lack of compassion from medical staff, and refusal of surgical procedures when requested.**
- Some participants noted **being pressured into contraceptive methods which they did not ask for or want.**
- Only **40% of respondents attended the optional two week follow-up appointment.** A small number reported not being offered any follow-up.

Refusal of Care, Disrespectful Treatment and Anti-Abortion Activity

- **Almost one in five respondents (19%) were refused care and refused a referral to another doctor.** Respondents noted that these GPs were often rude and unsympathetic. Being refused care caused ‘fear’ and ‘confusion’ for participants. Some noted calling other GPs before finally deciding to import pills instead of continuing to pursue an appointment.

- One participant reported that although she “would quite likely break [her] spine” if she continued the pregnancy, **doctors were reluctant to provide her with an abortion**. This participant’s experience resonates with official Irish government statistics showing that almost no abortions are being carried out for risk to health (Section 9 of Health Act 2018).
- **73%** of respondents said they felt they were treated with dignity and respect by healthcare providers and staff; however, **22% felt they were not treated with dignity and respect by providers**. Respondents noted judgemental treatment from some reception staff. Some respondents noted experiencing racism from providers and staff.
- **14% of participants in this study said they encountered anti-abortion activity** while attempting to access abortion care. Anti-abortion activity had a particularly negative impact on patients.

Travelling Abroad, Cases of Fatal Foetal Anomaly and the Effects of COVID-19

- **Fifteen respondents noted that they tried to get an abortion in Ireland but were refused care and ultimately had to travel abroad**. Reasons for travel included experiencing a failed medical abortion, a wildly incorrect dating scan, and being diagnosed with foetal anomaly that did not unambiguously fall within the restrictive bounds of the Health Act 2018.
- **The majority of respondents who travelled abroad had received a diagnosis of foetal anomaly which was “not fatal enough”** under Section 11.1 of the Health Act 2018, illustrating the negative impact on patients of conservative interpretations of the law.
- Participants reported that they **primarily used their own savings or borrowed from family to cover the cost related to abortion** (transportation, travel, accommodation, child care, lost wages etc). **22% spent up to €500** and one spent €2000 for travel abroad.
- Travelling abroad for abortion **during the pandemic** added significant stress to the journey, as well as risks to health from possible exposure to COVID-19.

Recommendations to Break Down Barriers

- This research demonstrates that **more information is needed about how and where to access an abortion in Ireland**. ARC recommends more advertising of the MyOptions helpline, and expanding the MyOptions service to include: advertisement in the ten most commonly spoken languages in addition to English; covering phone queries at a wider range of hours; providing information and guidance to cover a wider range of patient circumstances; booking appointments with GPs; providing more information about what to expect during an early medical abortion; and booking services with interpreters.
- **ARC recommends repealing the mandatory three-day waiting period and all gestational time limits**. The mandatory three-day waiting period and gestational time limits constitute arbitrary and undue barriers to access.
- Doctors refusing care or refusing to refer patients onwards currently constitute a substantial obstacle for abortion-seekers. **ARC recommends that a formal complaints procedure should be implemented for those who experience refusal of care and that a disciplinary procedure be introduced to redress harm to patients**.
- ARC recommends that **all early abortion care be provided in community settings**, including patient's choice of method, consistent with best international practice.
- ARC recommends **better quality and more accessible scanning services**. The Irish Health Services Executive should review its contracts with scanning providers, especially private companies, to ensure they are unbiased and accurate. Correct dating of pregnancy is paramount to ensure people's right to access an appropriate abortion. It is also crucial while the legislation includes restrictive gestational time limits.
- ARC recommends that **telemedicine services introduced as a result of the COVID-19 pandemic be made a permanent feature of abortion provision**.
- Many respondents noted having to travel long distances to access providers, spotlighting the need for **more providers in all areas of the country, particularly in rural locales, and also full participation in abortion provision by all 19 maternity hospitals**.
- ARC recommends that **values clarification and anti-racism training** be provided to medical practitioners, reception staff, and all other hospital staff whose work intersects with the provision of abortion care.
- ARC calls for the **introduction of legislation on Safe Access Zones**. Participants noted the negative effects of encountering anti-abortion activity outside clinics and hospitals.
- ARC recommends that the Irish government take urgent steps to close the gap between policy and practice so that **abortion is freely available to any individual resident in Ireland**. Participants reported being asked to pay for their abortion care where they could not provide evidence of a PPSN (Personal Public Services Number). This constitutes an additional barrier to access for some migrants.
- ARC strongly recommends the **decriminalisation of abortion** in order to support doctors to make patient-centred decisions without fear of prosecution.

Introduction

The Abortion Rights Campaign (ARC) is a grassroots all-volunteer organisation dedicated to achieving free, safe, legal, and local abortion everywhere on the island of Ireland, for everyone who wants or needs it. ARC challenges abortion stigma and recognises that many people, including girls, women, transgender people, non-binary, and intersex people, can become pregnant and need an abortion. ARC was one of the three core groups that formed the civil society organisation [Together for Yes](#), which successfully campaigned for a Yes vote in the referendum to repeal the 8th Amendment of the Irish constitution in May 2018.

In the 2018 referendum, 66.4% of voters chose to repeal the 8th Amendment of the Irish constitution, allowing the government to pass legislation on abortion. In December 2018, the Oireachtas (Irish parliament) passed the [Health \(Regulation of Termination of Pregnancy\) Act 2018](#), which legalised abortion "on request" up to 12 weeks, and only in very limited circumstances beyond this point (where there is a "serious risk to life, or of serious harm to the health," of a pregnant person, in cases of emergency where there is an immediate serious risk to life or of serious harm to the health of a pregnant person, or where two medical practitioners are of the opinion that there is a condition affecting the foetus likely to lead to the death of the foetus either before or within 28 days of birth).

On 27 September 2020, ARC launched its survey to evaluate Ireland's abortion services. The data collection period ran until 31 March 2021. This survey sought to elicit the experiences of those who accessed, or attempted to access, an abortion in Ireland since the 1st of January 2019, with the aim of better understanding the barriers to abortion in Ireland under the Health Act 2018.

Methodology

This research takes a person-centred approach, prioritising the experiences and testimony of those who successfully or unsuccessfully attempted to access an abortion in Ireland since 1st January 2019.

The aims of the evaluation are:

1. To collect data on the implementation of abortion services in Ireland
2. To identify specific barriers to abortion access and contributors to suboptimal standards of care
3. To assess whether particular groups face additional barriers to accessing abortion
4. To allow a comparative approach with international standards of abortion access
5. To identify areas for further research
6. To advocate for an accessible and high standard of patient-centred abortion care

From the outset of the study, the research team regularly consulted with various organisations to ensure an appropriate, accessible, and inclusive research focus. The team received feedback from groups including:

- Migrant Rights Centre Ireland (MRCI)
- Disabled Women Ireland (DWI)
- ShoutOut
- National Traveller Women's Forum (NTWF)
- Abortion Support Network (ASN)
- Lawyers for Choice (LFC)
- Association for Improvements in the Maternity Services - Ireland (AIMS)
- Abortion Network Amsterdam (ANA)

The research team first launched the survey in English and then in 10 additional languages: Irish, Polish, Romanian, Lithuanian, Arabic, French, German, Spanish, Italian and Portuguese. In the final month of the survey, ARC worked with an ISL interpreter to create a video explaining how to participate in this research through Irish Sign Language. There were no requests to take the survey in ISL. One hard of hearing and two deaf respondents did take the survey, as described in the Demographic Section of this report.

In addition to posting the survey online, ARC promoted the survey through social media and shared it with various stakeholder groups. These include grassroots and advocacy groups working with members of the disabled community, members of the Traveller community, asylum seekers, LGBTQ+ people, and others. These organisations were selected in an explicit effort to make the survey accessible to all those who have attempted to access an abortion in Ireland.

There were a total of 402 respondents: 388 respondents answered in English; 5 answered in Irish; 6 in Arabic; and 3 in Polish.

Research Ethics

The team sought and incorporated research and ethical advice from a number of academics and experts specialising in the areas of reproductive healthcare, policy evaluation, and research ethics. In addition, an expert panel was convened, and an ethics application was prepared using the Maynooth University Ethics Application as a template. This application was then reviewed by two volunteers of Maynooth University’s ethics panel.

When clicking onto the online survey, potential respondents first saw information on why the survey is being undertaken and what will happen to the findings. Each participant was asked to complete five tick-box statements giving consent to the project, confirming they understand the purpose of the study, what the information from the survey will be used for, that their participation was voluntary, and that they had the right to leave the survey at any stage without providing an explanation. Participants were offered the opportunity to have their survey response digitally archived with the Digital Repository of Ireland (DRI). Participants were asked for permission to have their responses quoted anonymously in the report. Those who did not tick this box have not been quoted in this report. The consent statements and answers were as follows:

Table I Consent

	%	Total
I have read and understand the information provided on the previous page	98.97	384
I understand that my participation is voluntary and I do not need to answer all the questions if I don't want to	91.24	354
I agree for my responses to the survey to be shared in the Digital Repository of Ireland	88.14	342
I agree for my responses to be quoted anonymously	89.69	348
I agree to take part in this study	90.98	353

Not everyone gave consent to take part in the study: 353 out of the 388 total respondents who completed the survey in English agreed to take part. Of the 35 applicants who did not tick this box, only three of the 35 continued to complete the survey in full. These were omitted from the reporting in this document.

There are some limitations to the survey. It was only made available online; therefore, only those with access to the internet and a computer or smart-phone and a basic level of comfort with technology could complete it. The survey had to be completed in one sitting as it was not possible to save answers and return to it later. While efforts were made to phrase questions in a simple and basic format, the survey required a certain degree of literacy skills. All participants were offered the opportunity to ask questions about the research by contacting ARC through email at surveyforchoice@gmail.com and survey@abortionrights.ie.

The ARC Research Team decided in the course of developing the survey that all questions would be completed by choice; in other words, respondents could move on to another question even if they left one or more blank. Throughout the survey, preceding the open-ended qualitative questions, the text stated that respondents should only answer questions if they were comfortable providing further information. Given the sensitive nature of the topic, it is understandable that many questions were skipped. Not responding to open-ended questions is common in questionnaires, given the respondent burden involved. This decision to maximise respondents' comfort may have resulted in a trade-off against obtaining more complete data. There were 72 questions in total including open qualitative questions after each section where participants could provide detail of their personal experience if they so wished. No one respondent would be required to answer all 72 questions as the questions addressed different scenarios, such as accessing abortion care in Ireland and accessing abortion care abroad.

Data protection and security is vital to this project. Survey Monkey is a respected and trusted survey platform. Data are protected and validated by Norton and TRUSTe, who verify the security of the system. Due to COVID-19 restrictions, the data was stored in an online format through means of a password protected file on a trusted filing storage database. Only the ARC Research Team and data analyst had access to the survey data. These were not shared in any other form or with any outside groups or individuals.

Interpreting the Findings

The survey was translated from English into ten different languages; therefore, the team created eleven different versions in Survey Monkey. Questionnaires were completed in four of the eleven languages – English, Irish, Polish and Arabic. Answers in Irish, Polish, and Arabic were translated for analysis. Among those who started surveys in these languages, the overall average completion rate was very low at 9%. The term ‘completion’ refers to those questionnaires where the respondent answered all questions relevant to them, while the term ‘partially completed’ is used for those where more than 50% of the questions were answered. ‘Incomplete’ refers to those questionnaires where fewer than 50% of questions were answered. Of the 353 respondents who gave consent to participate in English, 218 (56%) were incomplete, 135 (35%) were partially completed, and 35 (9%) were fully completed. The completion and partial completion rate for Arabic, Polish and Irish languages was very low at 0%. The table below presents these completion rates by survey language. Demographic details of survey respondents who took the survey in Arabic, Irish and Polish are in Appendix 1.

Table II Respondents by Language

	English n (%)	Arabic n (%)	Irish n (%)	Polish n (%)	Total n (%)
All started	388 (100)	6 (100)	5 (100)	3 (100)	402 (100%)
Incomplete (<50%)	217 (56)	6 (100)	5 (100)	3 (100)	231 (57%)
Partially complete (50%+)	135 (35)	0 (0)	0 (0)	0 (0)	135 (34%)
Completed (100%)	36 (9)	0 (0)	0 (0)	0 (0)	36 (9%)

Analysis of quantitative data was carried out using Survey Monkey’s analysis features and data was also exported to Excel to generate additional tables and charts. Qualitative analysis of the open ended questions was conducted using NVivo software. All qualitative answers were uploaded to NVivo and a codebook of themes was created and agreed with the Research Team. The coding process, identifying the themes in the data, followed the “dynamic and fluid process” of the grounded theory approach (Strauss & Corbin, 1998). Codes formed the basis of the analysis of themes throughout the report. It is important that the voices of those who experienced abortion services are at the forefront, and are central to this report. Respondents’ answers are quoted throughout this report. Quotations remain in the respondent’s own words, only edited for obvious typographic or spelling errors, punctuation, and confidentiality (identifying locations and providers are anonymised). Efforts were made to include as much qualitative data from respondents as possible; however, it was not possible to include all contributions. Two respondents indicated they were opposed to abortion and had not tried to access an abortion. These respondents answered questions with, for example: “Don’t agree with abortion. I love babies.” These survey responses were not included in the analysis.

Section 1 Demographics

The demographic section of this report is inclusive of all demographic answers provided despite low completion rates of subsequent survey items. Anyone who provided demographic data or other minimal data was included in the analysis. It is important to represent all of the data collected. Throughout the report, completion rates are given for each question.

The demographic section sought answers on age, gender, county of residence, ethnicity, citizen status and whether respondents live in an urban, rural or town setting. It was agreed by the ARC Research Team that information on income or socio-economic status would not be gathered as it was felt that respondents could share this information in the open-ended questions if they wished. Questions regarding housing, such as whether respondents were homeless, living in Direct Provision, couch-surfing or in other temporary living conditions were posed, to test the theory that insecure housing could be a barrier to accessing abortion. 'Direct Provision' is Ireland's system of accommodation for people seeking international protection, who are also known as asylum seekers. Most Direct Provision Centres are outside urban areas with limited public transit to healthcare providers.²

Age

In the survey, 348 respondents reported their age when they accessed abortion; this is disaggregated in Table 1.1.

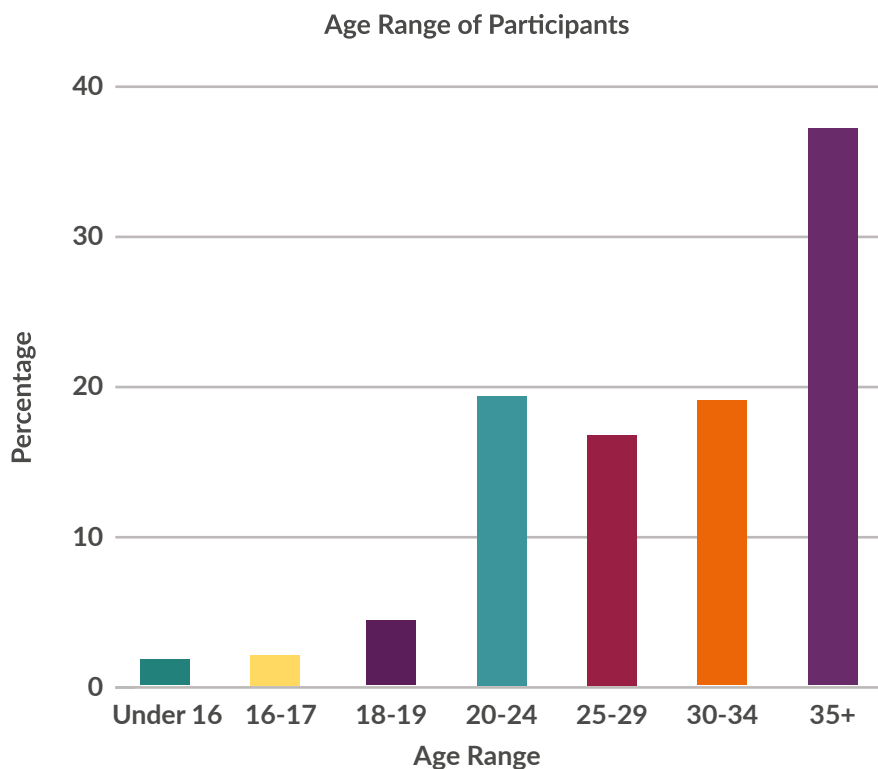
Table 1.1 Age of Participants

	number of respondents (n)	percentage of respondents
Under 16	6	1.72%
16-17	7	2.01%
18-19	15	4.31%
20-24	67	19.25%
25-29	58	16.67%
30-34	66	18.96%
35+	129	37.07%

² For more information see: <https://www.irishrefugeecouncil.ie/Listing/Category/direct-provision>

³ The annual report on abortion access from the Department of Health in Ireland does not provide a breakdown by age. It provides only the number of abortions carried out by county per month.

Figure 1.1 Age Range



The largest cohort of respondents was the 35+ age group (Figure 1.1). According to statistics from England and Wales in 2019, there has been an increase in the rate of abortion for all aged 25 and above. The largest increases in abortion rates by age there are amongst those aged 30-34, which have increased from 15.7 per 1000 in 2009 to 20.9 per 1000 in 2019.⁴ One explanation for the large proportion in the 35+ category could be that people are choosing to have children later in life and are choosing to have a smaller number of children than in previous decades.⁵

Six participants in this study were under the age of 16. According to the state-funded MyOptions webpage, those aged 16-17 do not need parental consent for an abortion, but the GP can report the case to Tusla – Ireland’s Child and Family Agency – if they believe there is a risk to the welfare of the child. Those under the age of 16 need permission from a parent or guardian.⁶ In this study, only one patient under the age of 16 was asked to get the consent of a parent or guardian in order to obtain abortion care, while five reported that they were not required to do so. The participant who was asked to provide consent from an adult was granted the consent needed.⁷

⁴Abortion Statistics, England and Wales: 2019 Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales, January to December 2019, Published 11 June 2020

⁵Wiebe, E., Chalmers, A., Yager, H. (2012):‘Delayed motherhood: understanding the experiences of women older than age 33 who are having abortions but plan to become mothers later’, Canadian Family Physician Medecin de Famille Canadien, 58(10), 588-95.

⁶ <https://www2.hse.ie/conditions/abortion/how-to-get-an-abortion/where-to-go-for-an-abortion.html> Accessed 7 June 2021

⁷There is very little research on access to abortion in Ireland for those under age 16.

Gender Identity

In terms of gender identity, the majority of respondents identified as female, others represented as male, transgender, non-binary, intersex, and other.⁸ See table 1.2 below.

Table 1.2 Gender Identity

	n	%
Female	309	83.51%
Male	21	5.68%
Non-binary	8	2.16%
Transgender	7	1.89%
Intersex	5	1.35%
Prefer not to say	10	2.70%
Other (please specify)	10	2.70%

Ethnicity and Nationality

In terms of ethnicity, a total of 337 respondents answered the question, the majority of whom identified as White Irish. One person identified as both White Irish and Black Irish-African. This data was excluded from the ethnicity table below, in order to enable statistical comparisons with Central Statistics Office (CSO) classifications.

Table 1.3 Ethnicity

	n	%
White - Irish	297	88.13%
White - Irish Traveller	4	1.19%
White - Any other white background	19	5.64%
Black or Black Irish - African	6	2.07%
Black or Black Irish - Any other Black background	3	0.89%
Asian or Asian Irish - Chinese	2	0.59%
Asian or Asian Irish - Any other Asian background	4	1.19%

⁸Transgender people's access to abortion is an underexplored area and further research is needed. See: Rachel K. Jones, Elizabeth Witwer, Jenna Jerman. (2020). 'Transgender abortion patients and the provision of transgender-specific care at non-hospital facilities that provide abortions', *Contraception*, 102, 100019. <https://doi.org/10.1016/j.conx.2020.100019>

According to the CSO, in 2016, 82.2% of the population were White Irish.⁹ The 88% figure in this study is a slightly higher proportion.¹⁰ The representation of those from other backgrounds is similar to their CSO representation in 2016; in 2016, 5.87% of the population in Ireland were from "Any other White background", 0.4% were Chinese and 1.7% were "Any other Asian background". Irish Travellers were 0.7% of the population in Ireland in 2016, in this study 1.19% of participants identified as "White – Irish Traveller".¹¹

The majority of respondents in the study, 88.56% (n=302), were Irish citizens, with 5.87% (n=20) legal residents, and a small numbers of participants who were students from outside Ireland or asylum seekers, refugees or undocumented. See Table 1.4 for more detail.

Table 1.4 Residency

	n	%
Irish citizen	302	88.56%
Legal resident	20	5.87%
Student from outside Ireland	6	1.76%
Asylum seeker or international protection applicant	6	1.76%
Refugee	4	1.17%
Undocumented	3	0.88%

⁹<https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8e/> Accessed on 30 June 2021.

¹⁰ It is worth noting that the demographics of the age and gender profile of those who might need an abortion may not be the same as that of the overall Irish population.

¹¹<https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itd/> Accessed on 30 June 2021.

Respondents were asked to express their nationality by selecting a tick-box, and could elaborate on this with a free text option. Three hundred and forty respondents answered this question. Below were the responses (the free text responses have been incorporated into the table):

Table 1.5 Nationality

	n
Irish	313
American	4
British	3
French	1
Spanish	1
Irish-Italian	1
Swedish	1
Dutch	1
Prefer not to say - EU	1
Hungary	1
U.K. and Australian	1
British/New Zealand	1
British/Canadian	1
Hispanic	1
Caucasian	1
China	1
Egyptian	1
Brazilian	1
Nigerian	1
South African	1
African	1
Zimbabwe	1

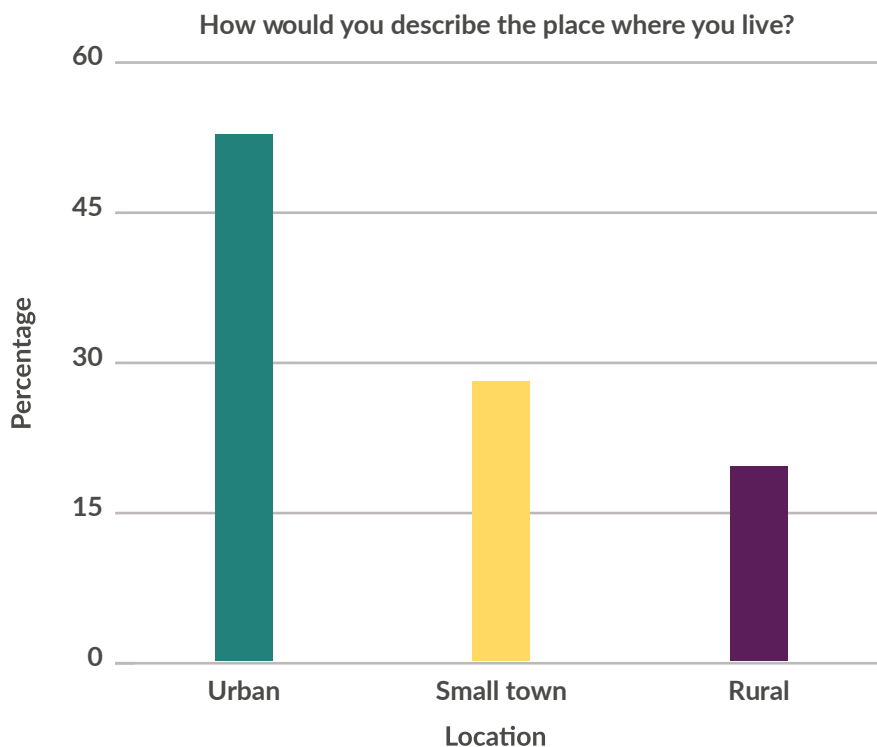
Participants were asked which county in Ireland they were resident. The largest proportion 35.82% (n=120) were located in the county of Dublin, somewhat over-representative of the national composition. According to CSO figures, in 2016 Dublin city and county made up 28.3% of the population.¹² There was a balanced representation of participants by county. There were no participants from counties Longford or Roscommon; however, all other counties are represented.

Table 1.6 Resident by County

County	n	%
Dublin	120	35.82%
Cork	46	13.73%
Galway	21	6.27%
Kildare	19	5.67%
Limerick	14	4.18%
Wicklow	12	3.58%
Clare	11	3.28%
Resident in Northern Ireland	9	2.69%
Donegal	7	2.09%
Wexford	7	2.09%
Kerry	6	1.80%
Laois	6	1.80%
Meath	6	1.80%
Waterford	6	1.80%
Kilkenny	5	1.50%
Leitrim	5	1.50%
Tipperary	5	1.50%
Not normally resident in Ireland	5	1.50%
Carlow	4	1.19%
Offaly	4	1.19%
Louth	3	0.90%
Mayo	3	0.90%
Monaghan	3	0.90%
Sligo	3	0.90%
Westmeath	3	0.90%
Cavan	2	0.60%
Longford	0	0.00%
Roscommon	0	0.00%

¹²Population by County 2016, Central Statistics Office, https://www.cso.ie/en/releasesandpublications/ep/p-rsdgi/regionalsdgsireland2017/nt/#indicatorTitle_175170 Accessed 11 May 2021

Figure 1.4 Urban-Rural Setting



There was good representation across urban, rural and small town settings. Three hundred and twenty nine of 404 respondents completed this question. In total, 52.58% (n=173) of participants were located in an urban setting, 27.96% (n=92) were situated in a small town, and 19.45% (n=64) were based in a rural location. Those located in rural Ireland and those whose first language is not English face additional barriers to abortion in Ireland. Some participants in the survey noted how difficult it was to find a provider in rural Ireland. They said:

“It is still very difficult for rural women to access abortion or even information about abortion. It would be so much harder if I didn't speak English... Some women I know in my rural area don't have access to that support. We are very isolated without local contacts or language or transport or information.”

“I ended up with an infection but had moved to a remote location during lockdown and could not get a doctor to see me... Eventually I had to meet a doctor in a petrol station in the west of Ireland to hand me this test in an envelope without any check or anything. Between taking rejection calls from GPs surgeries making me feel like I wasn't human, then meeting in a petrol station, it was just a dehumanising experience [that] has caused huge trauma along with the actual termination.”

Insecure Housing

Participants were asked: “Were you homeless or in an insecure housing situation at the time of your abortion? This could include sleeping rough, emergency accommodation, living in a domestic violence shelter or homeless shelter, couch surfing, living in a hotel/hostel, etc.” Eight participants answered yes (2.84%). In addition, seven participants stated that they lived in a Direct Provision Centre or emergency accommodation. Of the seven, five answered “no” to the question, “Did living in a direct provision centre or emergency accommodation affect your experience of getting an abortion?”. None answered yes. It is notable that none of the participants stated that their living situation in a Direct Provision Centre or emergency accommodation affected their experience of abortion. Given the nature of Direct Provision Centres as confined and often cramped living, with entire families in one room or with single individuals sharing a room or bathroom with strangers, this would suggest that a person’s experience would be affected, and the typical rural location of Direct Provision Centres could make access to abortion more difficult. Since the pandemic, some residents living in cramped Direct Provision Centres have been moved to private hotel rooms in order to provide for better isolation and safety. It could be that the temporary move to more private settings has allowed for more privacy to phone MyOptions and doctors, and to undergo an abortion at home. However, this is unclear. It may also have been that none of the respondents felt comfortable expanding on this question. A follow up question asked, “Did being homeless or in insecure housing at the time of your abortion affect your experience of getting an abortion?” Four answered yes, and five answered no. The reality of insecure housing and its impact on security, safety and decision making is brought to the fore by participants’ qualitative answers quoted below.

“Limited bus times and options, and having to walk around the city afterwards waiting for my return bus, as I could not afford to go to a hotel or be somewhere private while I processed and the pill kicked in.”

“Children need security and safety. If I couldn’t provide that for myself then how could I provide that for them?”

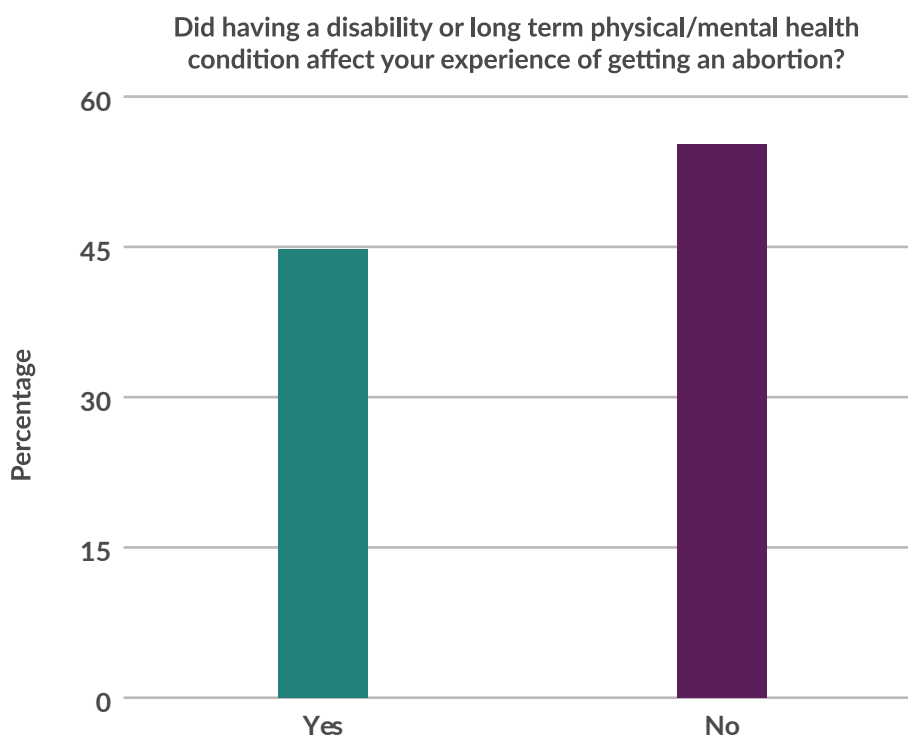
“There was no viable way for the housing situation to improve... Knowing that if I continued [with the pregnancy] and my mental health suffered, [it] is unlikely I would receive any sort of adequate help... I might have continued my pregnancy. But Ireland, in policy and action, does not care for the homeless, or the mentally ill.”

These three respondents outline the difficulties in continuing a pregnancy without adequate accommodation and the difficulties in having an abortion without a private space to return home to.

Disability, Long-term Physical Illness or Mental Health Condition

Respondents were asked if they had a disability, long-term physical illness or mental health condition. In total, 64 participants stated that they had a disability. Of these, 44.74% (n=17) of respondents stated that having a disability, long-term physical or mental health condition affected their experience of getting an abortion, while 55.26% (n=21) felt it did not.

Figure 1.6 Disability



According to a report by ARC and Disabled Women Ireland, in 2019 there were over 100,000 women with disabilities of childbearing age living in Ireland.¹³ The overall percentage of disabled respondents in this study is 21.19%, compared to 13.5% of the general population in 2016.¹⁴ This difference may be due to any of several factors: the narrow way in which "disability" is interpreted in national census records; higher levels of poverty among disabled people, meaning they may be more likely to seek abortion for socioeconomic reasons; higher numbers of females than males having a disability; and high levels of interest in this survey among disabled people who circulated it among their networks.¹⁵ In this survey, 29 participants reported having a mental health or psychological illness. The disabilities stated are listed in the Table 1.6.

¹³<https://www.cso.ie/en/releasesandpublications/ep/p-cp9hdc/p8hdc/p9d/> Accessed on 30 June.

¹⁴Abortion Rights Campaign & Disabled Women Ireland (2019) Submission to the United Nations Special Rapporteur on Violence against Women on mistreatment and violence against women during reproductive healthcare in Ireland and Northern Ireland. <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/ARC%20DWI.pdf>.

¹⁵See the NUI Galway Centre for Disability Law and Policy and the Re(a)lproductive Justice project websites for forthcoming reports; <http://realproductivejustice.com/> and <http://www.nuigalway.ie/centre-disability-law-policy/research/publications/>

Table 1.6 Type of Disability

Disability	n	%
Mental health / psychological health	29	74.36%
Chronic illness	10	25.64%
Neurodiverse (ADHD, autism)	7	17.95%
Physical disability	6	15.38%
Specific learning disability	4	10.26%
Deaf	2	5.13%
Intellectual disability	2	5.13%
Blind or visually impaired	1	2.56%
Hard of hearing	1	2.56%
Acquired brain injury	1	2.56%
Other	1	2.56%

Some respondents provided details on the effect of having a physical or mental health condition on their access to abortion. One respondent said, “I have depression and anxiety so the lead up to it worsened it”. Other participants stated:

“Taking the first step took me weeks longer than it should have as I have anxiety and depression, medicated for both, but no counselling [sic] or other supports are available unless I go private and I can't afford to.”

“I have borderline personality disorder and the ordeal was extremely stressful and I had to go to hospital at one stage because my mental health was so poor.”

The negative impact on mental health was usually caused by trying to secure appointments or waiting for appointments. The mandatory three-day waiting period between first consultation and provision of abortion services caused particular anxiety; this will be further explored in Section 3 of this report.

In terms of physical health, one participant stated that “any pregnancy for me is extremely high risk with real risk of organ failure and death”. Another respondent noted that although it was dangerous for her to continue with the pregnancy, doctors were reluctant to provide an abortion.

“So much harder to access - even though I was told that I would quite likely break my spine if my pregnancy continues - they didn't want to touch me because of my disability.”

Section 9 of the Health Act 2018 permits abortion if there is "risk to the life, or of serious harm to the health, of the pregnant woman".¹⁶ A total of 21 abortions were carried out under Section 9 in 2019, a very small number.¹⁷ Abortion is still criminalised under the Health Act 2018 unless abortion is carried out under specific criteria. It may be that doctors are not comfortable working within the parameters of the Act because of the possibility of a 14-year prison sentence, and are therefore hesitant to perform abortion even if the patient's health is at risk.¹⁸ This hesitancy could have devastating consequences for that patient's health. Decriminalisation of abortion would remove this chilling effect and ensure that doctors can use their clinical judgment to care for their patients.

Eligibility of Respondents for Abortion

Under the Health Act 2018, access to abortion is permitted under the following criteria: under 12 weeks; or after 12 weeks in an emergency; if there is "risk to the life, or of serious harm to the health, of the pregnant [person]," or if the foetus is likely to die before or within 28 days of birth.¹⁹ The medical practitioner can be arrested and prosecuted if an abortion is carried out that does not fall within one of the above criteria.

In this study, 124 respondents said they had an abortion through the health system in Ireland.²⁰ Of these, 59 respondents said they had an abortion at the GP surgery, 24 said they had an abortion in a health clinic and 25 stated that they had an abortion in a hospital. Thirty had an abortion outside of Ireland. Twenty-one tried to have an abortion but were refused care or couldn't obtain pills. Twelve had an abortion by importing pills or accessing abortion in some other way. Self-managed abortion is not criminalised under the Health Act 2018, but anyone who assists an individual in "procuring an abortion" outside the bounds of the Act is subject to criminal penalties, and the importation of prescription drugs is illegal.²¹

Table 1.7 lists the gestational age at which respondents had their abortions. A total of 140 participants completed this question.

Table 1.7 Gestational Age

Gestational Age	Total
Under 10 weeks	89
10 to 12 Weeks	12
12 Weeks +	24
20 Weeks +	15

¹⁶Health (Regulation of Termination of Pregnancy) Act 2018, <http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html> Accessed on 30 June 2021.

¹⁷Annual Report 2019, Notifications in Accordance with Section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018, Department of Health, June 2020.

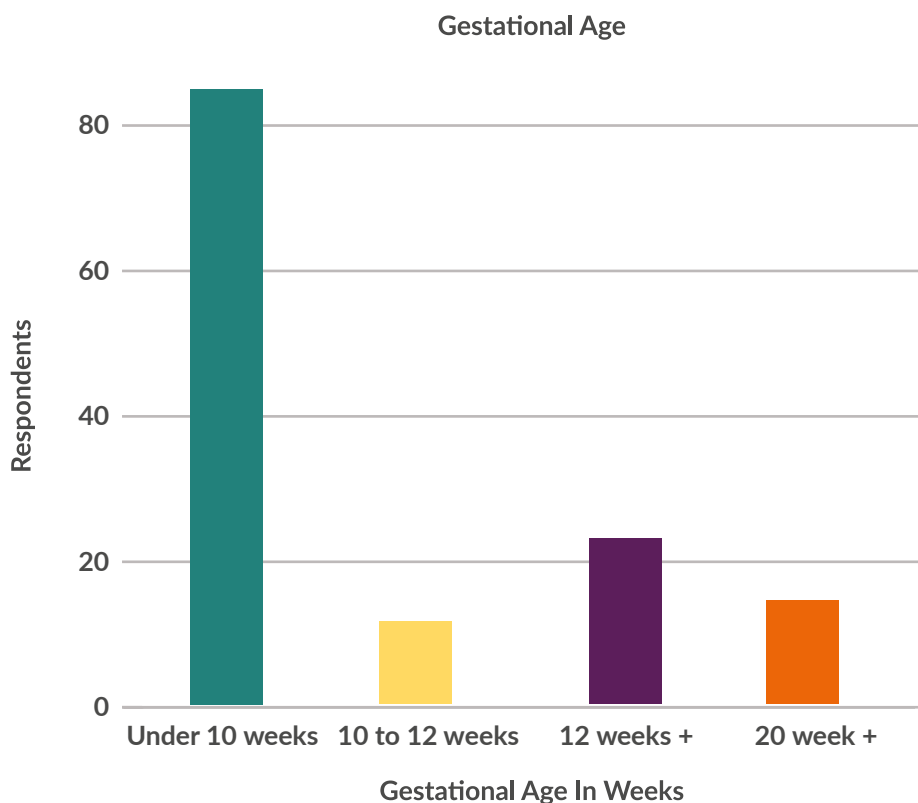
¹⁸Duffy, Deirdre and Pierson, Claire and Myerscough, Caroline and Urquhart, Diane and Earner-Byrne, Lindsey (2018) 'Abortion, emotions, and health provision: Explaining health care professionals' willingness to provide abortion care using affect theory.' *Women's Studies International Forum*, 71. pp. 12-18.

¹⁹Health (Regulation for Termination of Pregnancy) Act 2018, <http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html> Accessed 7 June 2021

²⁰Note that just 124 respondents completed this question out of 353 who consented to take part in the project. 2021

²¹The chilling effect of criminalisation is likely to be more keenly felt by migrants whose status within Ireland may depend on not breaking the law

Figure 1.9 Weeks' Gestation



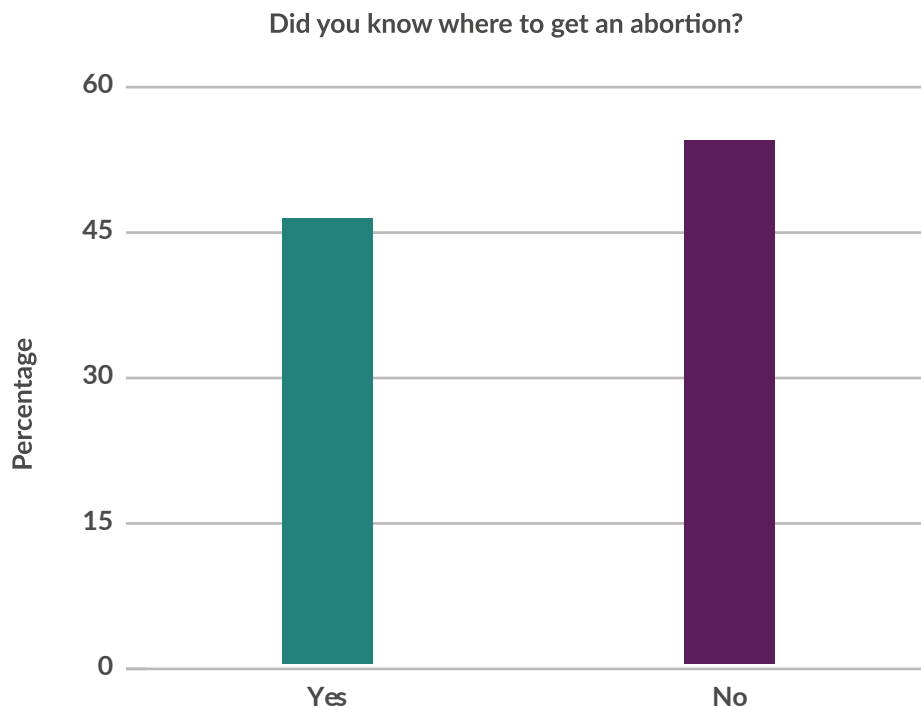
Abortions carried out later in the pregnancy are usually cases of fatal foetal anomaly (FFA). Cases of FFA will be discussed further in Section 4 of this report.

Section 2: Information and Barriers to Access

Information

More than half of respondents, 54% (158), said they did not know where to go to get an abortion. This research found that there is a significant gap in terms of information on how to access an abortion.

Figure 2.1 Information on Abortion



Over 87% of respondents (n=206) said they knew abortion was free, but only 65% (n=153) were aware of this when they sought care. **Nearly one-third of respondents, 32% (n=76) said they did not know where to find information on abortion.** The majority of respondents stated that 'Google' or 'the internet' was where they sought information. MyOptions and the Irish Family Planning Association (IFPA) were the most frequent websites named. Two participants stated that they contacted someone they knew had been "active in the repeal campaign." Three respondents stated that they attended their GP who referred them to MyOptions.

Eight percent (n=12) of participants in this study said they encountered rogue organisations which claimed to provide abortion but instead delayed access.

"Online there were sites that were... masquerading as abortion help. These people are sad and calculating."

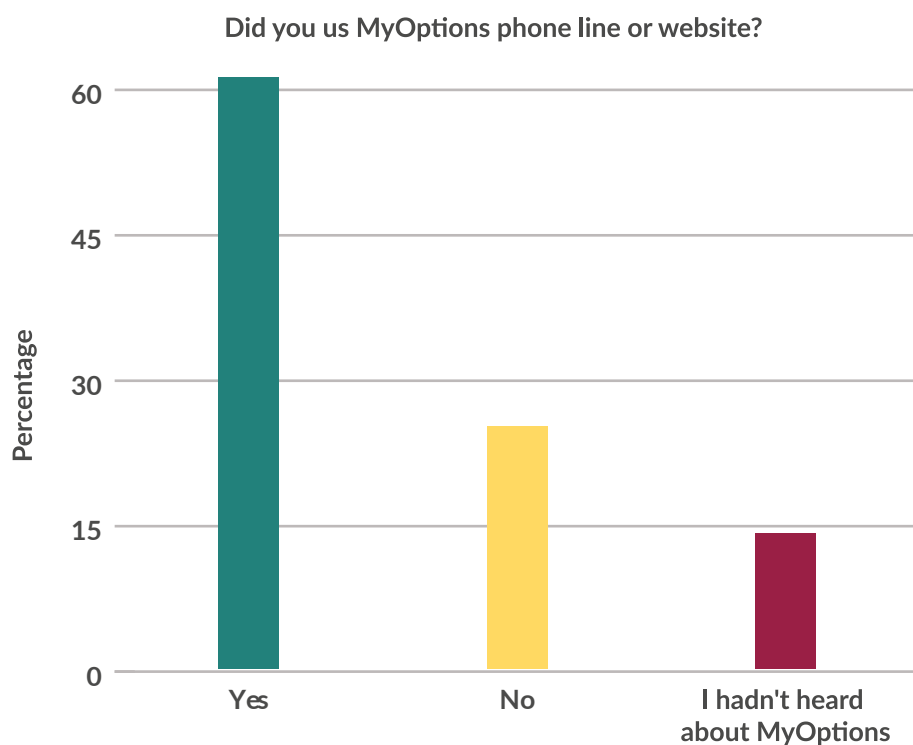
"I went to get a pregnancy test and look at options but they only tried to talk me out of abortion and toward adoption."

"I did have an issue accessing as false one [website] was the first thing on google list."

Patient Experience of MyOptions

[MyOptions](#) is the Irish Health Service Executive (HSE) national helpline "that provides free and confidential information and counselling to people experiencing an unplanned pregnancy."²² However, MyOptions is not just a counselling service: it provides essential information to those seeking an abortion on who their nearest provider is. This information is not explicitly stated on the website. Similar to other studies, this research study found that people are not always aware that MyOptions provides this information.²³ In this survey, 61% (n=141) of participants eventually used the MyOptions helpline, while 25% (n=59) said they did not.

Figure 2.2 MyOptions



²²<https://www2.hse.ie/services/unplanned-pregnancy-support-services/my-options-freephone-line.html> Accessed 19 May 2021.

²³Mishtal, 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-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, Switzerland.

Those who did not contact MyOptions may have accessed abortion through their own GPs, a specialised health clinic such as IFPA or Well Woman, or online through [Women on Web](#), [Women Help Women](#) or some other agency which provides a global telehealth service. In addition, those who experience a fatal foetal anomaly or those needing an abortion if there is risk to their health or life may not contact MyOptions, as they would typically be attending a hospital for diagnosis. Almost 14% (n=32) of respondents had not heard about the MyOptions phone line or website. **Clearly more advertising is needed to ensure that those needing to access abortion are aware that the first step is to contact MyOptions.** One respondent stated:

“I knew immediately I wanted an abortion and I spent a long time googling where to get one. I had seen MyOptions helplines several times, but it was not immediately obvious to me you had to ring them to get the numbers of participating GPs - I imagined MyOptions was going to give me different options available to me rather than an abortion, which I was not interested in. After having no luck finding any info on GPs that would give abortions online, I then rang MyOptions and was surprised that they gave me numbers immediately of GPs in my area and to say ‘My Options’ referred when calling the GP, as I was worried about having to say to a GP’s secretary that I wanted an abortion! I really wish it had been more obvious online that you just need to call MyOptions to get a list of GPs!...I think it should be more explicit online to call MyOptions if you want an abortion!”

Respondents’ overall experience with MyOptions was mixed. While participants mostly commended the counsellors as supportive and non-judgemental, there were issues with some counsellors being rude or “cold”. There were also issues accessing the helpline which is not available 24/7 for information services.

MyOptions was described as “supportive”; “helpful”; “compassionate” and “non-judgemental”. One respondent said “It is such an efficient service, once you know to ring MyOptions.” Positive responses of MyOptions included:

“Woman on end of the line was very caring and responsive, made sure to give me multiple opportunities to talk with her if I wanted to offload.”

“The best thing about it was that it was free and I had the option of speaking with a nurse through the helpline at any point if needed. That helped a lot.”

“I rang the MyOptions help line as the bleeding was quite heavy and I was experiencing some symptoms of low blood pressure, the lady I spoke with was very helpful and reassuring. Excellent service, couldn’t praise them enough.”

“The woman that I spoke to on the phone was so kind and helpful. She could tell I was in distress and experiencing a crisis pregnancy. She remained so calm throughout the call and explained everything to me very carefully. She gave me a list of GP clinics in my area to call and I honestly felt like she was a beacon of light in a very dark time for me.”

"The Counsellors and nurses were absolutely amazing, between advice and calming anxieties and making me feel heard and not alone. I know they had limits but they did everything they could and I will always be grateful for their kindness."

"They were so professional and so very kind to me. I was so lost and alone and they helped me so much with no judgement."

"Lots of information, non-judgemental, [but] a little too clinical."

"Great. Really helpful. Didn't try to persuade me to do anything. Just gave impartial information and offered supports."

"I chatted with MyOptions twice and I can't commend them enough for their empathetic approach. They went above and beyond to make me aware of my options in a non-judgemental way."

"The woman on the line was the first person I told I was pregnant, even before my partner. She was incredibly helpful and empathetic, and very focused on my emotional well being, and offering a space for me to voice my options and arrive at my own decisions. She was helpful in giving me the information I required and encouraged me to use the phone line again if I needed someone to talk to."

Some participants were critical of their experience and noted a lack of compassion from staff on the helpline. There were issues with not being able to contact the helpline. The information and counselling phone line operates from 9am to 5pm Monday to Friday. Some respondents left voice messages and had to wait up to two days for a call back. There is a 24-hour line but this is for medical advice only, for those going through the early medical abortion process.

"I would say cold on the phone."

"The my options first phone call was ok. A little distant/lacking compassion."

"The first time I called the lady on the phone she couldn't have been more helpful and understanding. I rang a second time and the lady I got I felt was a bit cold. It put me off ringing again."

“Helpful but faced an obstacle in getting information about local GPs providing this service as they don't pass it out on online chat so I had to get someone to ring up for me. Can be intimidating to place that call.”

“Not great, very long waiting time before I could speak to anyone. Their webchat service essentially doesn't work.”

“At first I left a message, no one called me back. After two days I rang again and got an answer. The person was very helpful and didn't seem judgemental at all.”

MyOptions helpline is limited in terms of the information it provides, as it only provides information on those accessing abortion under 12 weeks. It does not provide information on how to access abortion in cases of Fatal Foetal Anomaly (FFA), or where there is a risk to health including the mental health of the pregnant person. Some respondents experiencing an FFA contacted MyOptions but were disappointed with the lack of information provided. One participant stated that she was not referred on to the mental health support she needed. The HSE funds a number of agencies to provide counselling throughout the country, and MyOptions should have provided a referral.

“MyOptions staff were thorough, helpful, friendly and very informative... but they had no way to refer me on to get mental health supports and this was something I badly needed- not counselling but medical assistance.”

“Very good but my termination was for medical reasons at 23 weeks so they couldn't help.”

“I had a question about time limits for fatal fetal anomalies – as I was waiting for amniocentesis test results that wouldn't be back until, I was wondering [possibly] weeks. I was worried that there might be a 24 week time limit. The girl on the phone didn't know the answer. She looked up the legislation for me (Which I had done before the call) and she read it to me. But the wording is hard to understand. I was disappointed that she didn't know the answer to this important question.”

MyOptions is also limited in the service it provides. One participant noted disappointment that she had to arrange the appointment with the GP herself. She thought she could be referred from MyOptions without having to make that call herself. Placing a call to ask for abortion care may be intimidating for many. Some participants noted privacy issues when ringing to make an appointment. One respondent said it was “Easy enough but [I was] concerned about privacy.” Another said it was “difficult, I had to lie, pretend I couldn't access my usual doctor to get an appointment.” Others also noted difficulties asking the receptionist for an appointment and used the term “MyOptions” rather than saying the word “abortion”. One participant said they did not want to access an abortion in their local area. “I had to call a few places before getting access as some places were booked up and my options only give you GP services in your local area.”

“I wish I had have known to use the term “MyOptions” when on the phone but it was easy otherwise.”

“It was okay. I was given the information but I had to make all the arrangements myself. I could have done with some help.”

“Hard with COVID as you have to explain what you want to the receptionist before the GP will agree to call you back.”

“When I called the MyOptions line I asked if my own GP provided abortion services. They told me she wasn’t listed, meaning she doesn’t take new patients, but that she might provide services for existing patients. The only way to find out if she would provide me with care was to call my doctors office and ask. I really didn’t want to ask and have them say no and then have to go back there in future, so I went to a stranger GP for my abortion. I was lucky the new GP was great but would really have liked to have my own doctor treat me. I think MyOptions should be able to tell you if your GP provides services for existing patients and not have patients have to ask their own GP’s receptionist a potentially difficult question at a stressful time.”

MyOptions should have a list of all GPs who provide any level of abortion care, and if they do not know this information then the onus should be on MyOptions to ring the GP for the patient and find this information for them. **Currently, the burden of ringing the GP is on the patient. A service in which the appointment is arranged by MyOptions with a willing provider, in consultation with the patient, could eliminate the burden from the patient themselves and help minimise delays.**

The majority of respondents noted that it was “easy” or “surprisingly easy” to make an appointment with the doctor. One respondent said it was the “Easiest appointment I’ve ever been able to make.” One person noted that even with the pandemic, it was “very easy considering the height of lockdown.”

However, others experienced great difficulties when making appointments. Many noted a lack of providers locally and having to travel far for appointments. One respondent said it was “pretty easy once I found the only doctor’s surgery in my county that would do an abortion.” Some participants noted a long wait in order to get an appointment. One respondent had to wait for two weeks. Another said, “I first called [2 health clinics], as I felt more comfortable going to them. Unfortunately, the wait would be 3 weeks.” Many noted having to contact several GP surgeries before finding a provider to see them. Those who rang several clinics may not have rung MyOptions, who would have given them the phone number of providers. Nevertheless, one respondent had to ring MyOptions twice as none of the GPs provided would see them. Some also encountered hostile receptionists which can be very distressing when trying to seek care.

"Very easy to speak to someone on the MyOptions helpline however, it was very difficult to make an appointment with a GP who was willing to provide abortion care."

"I had to ring the helpline again because the first 3 numbers I was given didn't have any availability."

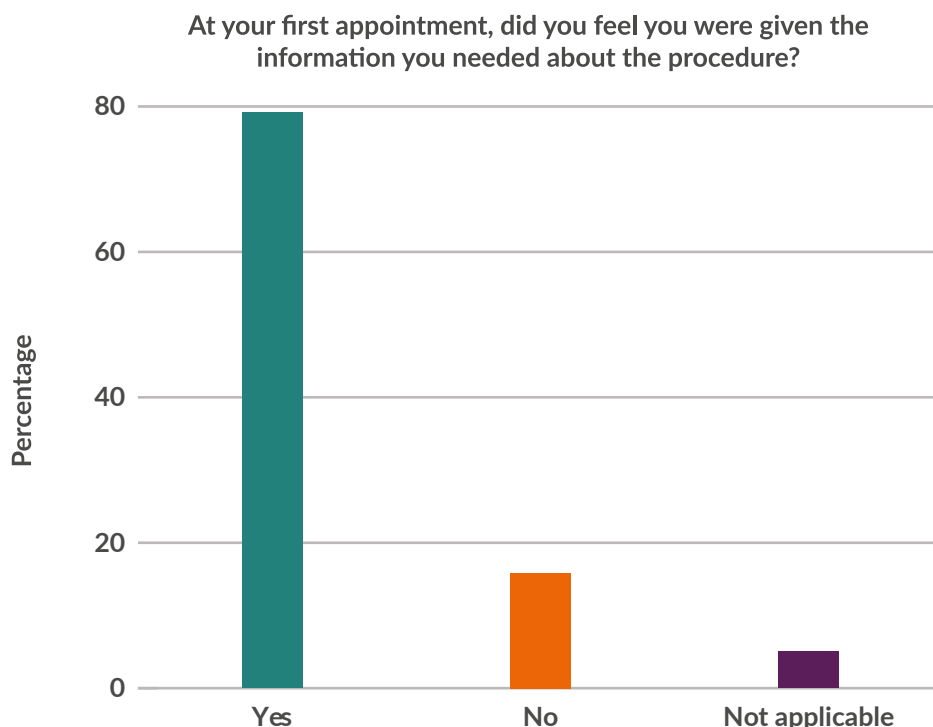
"I found it quite difficult to book an appointment. Two receptionists were very rude to me and hung up very abruptly. I ended up having to go all the way into [town] which is a 45 minute drive from where I live."

"Difficult. Nearest doctor was almost an hour drive away. I hadn't envisioned this."

"Very difficult - I rang 9 GP clinics before getting an appointment. This may not seem like a lot but when you are distressed and panicking, it is a lot...One clinic I called said "You want a what?!" quite loudly down the phone. I was shocked at the varying responses I was receiving. Finally I got an appointment and was booked in by a very kind and informative receptionist who sympathised with my situation and got me an appointment the next day."

One participant stated that she rang looking for counselling on unplanned pregnancy. She said she was not provided with this. Others stated that they would have liked more information from MyOptions on the abortion experience itself. One respondent said they "would like more in depth information about taking pills and more about the side effects."

Figure 2.3 Information from Provider



At the first appointment, 79% (n=109) felt they were given the information they needed about the procedure; however, 16% (n=22) felt they were not. One participant said: "Information provided by doctor was vague leaving me scared and nervous something would go wrong. [I was] not offered a follow up or any sort of scan/blood work." Six respondents stated that they needed an interpreter at their appointments. Four were provided access to an interpreter, but two were not. Other respondents said they were provided with sufficient information and expressed gratitude for the thoroughness of the healthcare provider as well as MyOptions.

"The [reproductive health clinic] were really great. The counsellor provided a range of pamphlets for me to collect and read (but there were some outdated ones about adoption where the organisation doesn't exist anymore). Everyone who helped me was really supportive, from reception to the nurse to the two doctors I spoke to. I saw a different doctor at each visit, and the Dr at the second visit (where you receive the first pill) was really honest and open about what I would experience, so I felt really prepared. A few weeks after the abortion I bled really heavily and they were really supportive and helpful about this also. They made a difficult experience a lot easier."

"I checked the HSE website and was relieved to see the webpage with contact details for support and for information I knew I could trust. I kept thinking about how bizarre it was that this website page must have only been months old. The woman on the MyOptions helpline was exceptional, friendly professional and judgement-free"

"Overall I felt well informed once the process began. I felt I was treated respectfully and not judged at any point. I'm so grateful this country has advanced to the point where my life isn't going to be ruined because a condom broke and my birth control failed."

"It's not something I ever expected to need. The information was hard to find but I felt reassured that if I needed medical help it was there. I have never been more scared and I can't imagine how women done [sic] this when it was a illegal. I'm so grateful for those who fought to change the system. I made my decision for my and my families benefit it was personal. The GP I attended was [...] a GP who [I usually] dealt with was nothing but reassuring and kind. I did have an issue with a phone call asking for my name when was I trying to access abortion services. I'm not sure if it was legitimate but I didn't respond. The GPs surgery confirmed it wasn't them. I'm unsure of how anyone would have got this info about me."

"I wish I had known someone else who had been through the procedure and could have advised me... I wish I could have practical advice from a friend/person who'd been through it...'If you think those extra strength paracetamol are any use, get yourself some adult diapers etc.' It just would have normalised the whole process and I'[d] have been better prepared for the realities of the procedure. As good as a doctor is at explaining the medical details, a real lived experience is different."

Despite the high percentage of respondents who said they got the information they needed, one gap stood out in the analysis: **a failure to properly inform patients on the level of pain with an early medical abortion (EMA)**. One participant said, "I wasn't expecting the level of pain I experienced and was alone in my house which was scary at times." If patients were better informed of the realities of the pain, then they would be able to prepare better for the process and this would reduce the shock and fear experienced during the process. Some participants said:

"I was really shocked at how horrific the actual experience of the termination was. The doc said panadol would be enough. But I couldn't keep water down. Vomiting, diarrhea, shaking, excruciating pain which all lasted 6 hours. I'm not sure if this is normal but it's not what was talked about."

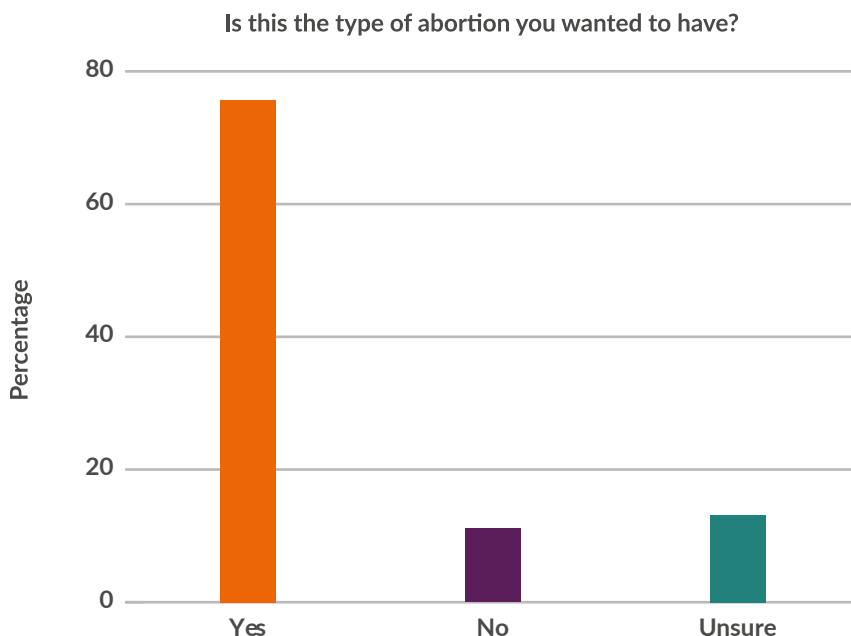
"The only thing that is positive is that we can access it, but the support and information, along with no proper pain relief, the entire thing was traumatising...The aftercare needs to be way better, and the information about what will happen before you decide."

"I don't think they really explained how painful it would be after taking the pills. I was lucky to have my partner with me but I can imagine taking them alone would be so scary. There should be support available in that instance."

"I didn't feel like I was fully made aware of the pain and amount of bleeding. I was told 'mild cramping' - which was most definitely not the case... I was told to take 3 days max off work, and it actually took me 2 and a half weeks to recover, even then I still had heavy bleeding."

"The second pills that cause bleeding were much stronger than I thought. I had read the info packet that came with them and I had googled the effects but I wasn't prepared for the pain. My BP dropped and my whole body cramped, I needed help getting off the floor to get my blood flowing again and it terrified me. I tried to ring the phone services and was on hold for a while due to it being the Christmas period, but when I did get through the person advised me and I felt comfortable with their info."

Figure 2.4 Type of Abortion



Abortions before 12 weeks can be induced with medication or by a medic carrying out a procedure. It should be the patient’s choice which method they want to avail of. However, recent studies have found a lack of information on these choices and a lack of availability of choice in practice. This report complements the research findings of the World Health Organization (WHO) which found there was a lack of choice in relation to surgical abortion in Ireland.²⁴ One respondent in the current study explained the difficulty in arranging an appointment when they opted for a surgical rather than a medical abortion. They said: “Arranging the hospital appointment was fiddly – apparently not many people opt for surgical”. Another participant said, “medical is pushed as the best option -why? Surgical is immediate and more economic, less visceral.” One participant said that if they had the choice again, they would request a surgical abortion: “The pills were sold to me as the easier option but I was not prepared for the length of bleeding afterwards. If I was to get another abortion I would opt for a surgical one with D&C just to speed up the process.” In contrast, one participant wanted a medical abortion and feared going over the time limit for a medical abortion with a GP and having to enter hospital. They said they had “anxiety and fear of not being able to meet the time for medical abortion at home.” While another respondent stated, there should be “more options other than the pill.” One respondent was eligible but said that practically, it was easier to order pills online:

“Technically, I was absolutely eligible. The problem I had was it was just too far to travel for me and not twice in one week. We only have one car, I would have to take time off work, how would we get the kids to school, everybody would know, even if I left early I had all the stress of what if the car breaks down, on my own, terrible navigator, what if I missed the school pick up, what if the traffic is bad, I had a million things to think about on top of being pregnant with four kids and having the worst pregnancy sickness ever. So then I had to stress about where I would get the pill myself, what if it got stopped at customs, the scenarios that you create in your head are terrible and its hormones and just the whole not being in control of your own life with a small family was very unsettling.”

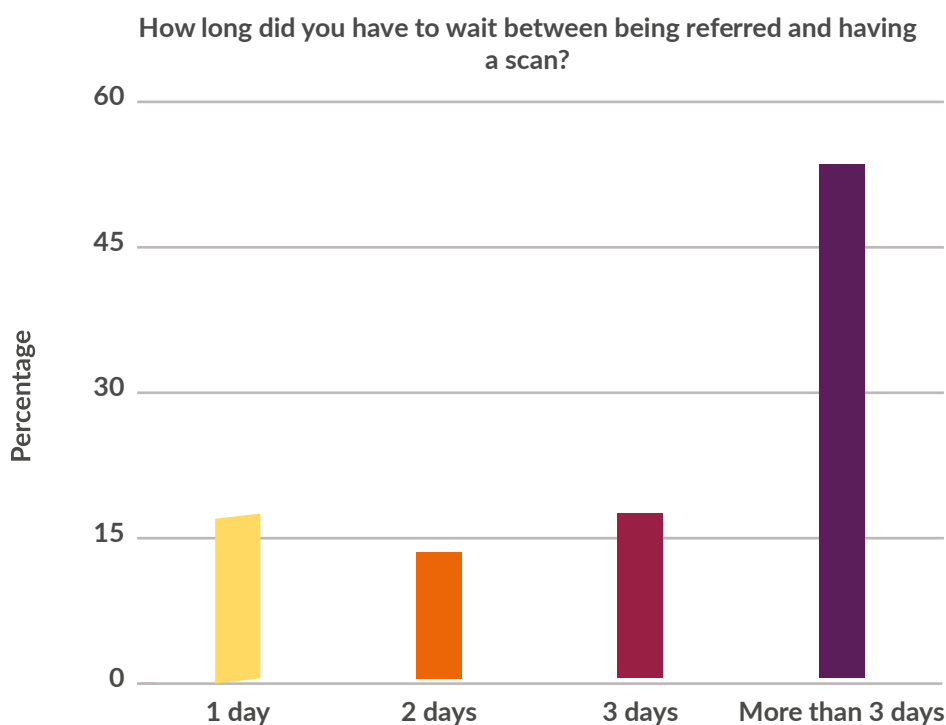
²⁴Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. “Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report,” April 23. UNDP-UNFPA-UNICEF-WHO World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, Switzerland.

Section 3: Experience of Abortion Access in Ireland

Scanning and Delays in Access to Care

Almost one-third (31%) (n=108) of respondents in this survey were referred for an ultrasound scan. After having the scan, 53% (n=28) of participants waited more than three days before having the abortion; 17% (n=9) of participants waited three days; 13% (n=7) waited two days; and 17% (n=9) waited one day before having the abortion.

Figure 3.1 Scanning Waiting Times and Incorrect Scans



Scanning delays can create knock-on problems for people whose abortions fail, and can have a significant impact on mental health, which will be discussed below. One participant's pregnancy was dated incorrectly, and they unnecessarily travelled to the UK as a result, adding great financial pressure to their abortion experience. Reporting from Abortion Support Network (ASN) makes clear that this participant's experience is not unique; ASN has helped numerous clients from Ireland who were given incorrect dating scans that led them to make unnecessary journeys abroad.²⁵ This mistake is extremely troubling as correct dating of gestational age is paramount in terms of patients' right to access abortion. As this participant wrote:

"I was renting a room and was told I was over 12 weeks and had to travel and pay around 600 euro, turns out I was 8 weeks and was told 12 weeks incorrectly by the doctor and didn't have to travel or spend all my savings and end up losing my room...It's just upsetting knowing I could have accessed the service for free but was sent away due to a simple error that would have been easy to fix."

²⁵See Abortion Support Network social media posts and newsletters.

Waiting times to attend the first appointment with the doctor ranged from one day to one week. After this preliminary wait, 60% (n=67) then waited the required three days between the first appointment and second appointment; 26% 13 (n=29) waited more than three days; and a small number of respondents (n=13) were seen within one or two days. Major structural delays impede timely access. Weekends and holiday periods were the primary causes of delay for the initial appointment with the doctor. Reliance on public transport was also noted as a cause for delay. One respondent stated “[I] had to travel from [isolated rural area] to [city in next county] because [home county] has limited options”. Managing childcare was also noted as a reason for delay in attending appointments. One respondent noted a delay because “my doctor wouldn't sign documents, I had to attend a different GP.” Others said that they waited several days because of privacy issues: “I needed privacy and had to wait so I could be alone when taking the pills.” Two respondents noted that they took more time themselves to think about their decision. Other respondents stated:

“I had to ring a GP first then be referred to the hospital to meet a consultant as I was over 9 weeks. there was 6 days between the GP appointment and the Consultant in [hospital].”

“The reason was unspecified to me, I was just given these dates and had no option but to wait.”

“The only reason was that ridiculous law making me wait three days. It would have been physically safer and less painful if I hadn't been forced to wait.”

“I first went to a doctors surgery that didn't provide abortion service (Mon eve) Called My Options after recommendation by that doctor Mon eve. Called recommended GP Tues am - got appt for Fri. Follow up appt scheduled for Mon, ultrasound showed 11 weeks. Referred to [hospital]. Called Wednesday by [hospital] to come in Friday. Took first pull [sic] Friday at appt and attended for medical abortion Sunday 14 days after first doctors appointment but 2 days after first hospital appointment.”

While a small number of respondents reported that the delay in scanning and appointments had no effect on them, others said the delay had a significant impact on their mental health. One respondent noted “Severe distress and trauma resulting in mental health issues”; another stated “I couldn't sleep, very anxious”. One participant said that they “wished the days away”.

“My mental health suffered greatly and my hyperemesis made it almost impossible for me to eat or work or study as it worsened over this waiting time.”

“It made the experience more stressful. I was hiding it from my partner at the time so the multiple appointments and delay while having to lie was extremely difficult for me.”

“Scheduling three separate appointments around a full time job wasn’t easy. Thankfully I work in [city] centre and was in close to the clinics.”

“There was a delay between calling and getting the first appointment with a clinic and that pushed me over the time limit [for an Early Medical Abortion] that meant I had to have a hospital abortion.”

“I found out I was pregnant on Friday evening and could not contact a GP until Monday. When I tried ringing the [reproductive health clinic] over the weekend they told me they had no availability and could not see me, and advised I wait and speak to a GP. It was a very stressful weekend as I had no idea how many weeks pregnant I was, and being aware of how time sensitive the situation was, I worried the delay of waiting the weekend and the three days mandatory waiting period might put me over 12 weeks and mean I would be unable to have an abortion. I had also been told by MyOptions that there was no abortion provider in my county, and I was afraid that I might experience a delay in trying to find a GP near me.”

“Being made to go for a scan even though I was very certain with dates. This caused delays and too much time for me to fret over the decision when I was very confident for one week but this changed when I had to go for a scan.”

“The only issues I had were in the [provider] clinic where the scanner kept referring to my 'baby' and asking if it was my first. I was also a bit taken aback to have the ultrasound images appear in the [provider] app when I had an MRI later in 2020.”

As the last example shows, issues with inappropriate language from sonographers were reported. Sonographers should be informed that the patient is seeking an abortion. In addition, the feature of the provider app which shows previous scans, as reported above, should be removed.

Mandatory Three Day Wait

The mandatory three day wait is a significant cause of delay, especially for those who are close to the 12-week limit. The majority of respondents noted the negative effects of the three day wait. Some found it demeaning to have to wait for care, while many explained the negative impact it had on their mental health, increasing anxiety, stress and worry. Some who suffered greatly from morning sickness were made to suffer for longer when they were already sure of their choice. Many respondents noted the fact that the mandatory delay was unnecessary, such as this participant who said, "No effect, I knew my decision from the beginning." A small number of respondents noted that the mandatory delay had "no effect" on them as they were very early in the pregnancy. Of these, some said they used the time to reflect on their decision, with one participant stating, "None... it was positive and gave me time to be sure"; another said "Between the consultation and the actual appointment the waiting period was good as it gave me time to think and accept my decision."

"It caused more stress and was rather demeaning for me and my partner as we already considered our decision extensively before initiating the process."

"Severe distress and resulting mental health issues."

"My mental health and physical health suffered."

"It was very difficult to arrange transport from my rural location to the GP. I arranged for a friend to accompany me on the first visit because the secretary had been so hostile, but my friend could not come with me the second time because she must work."

"More time to sit with the situation which was not helpful, decision had been made at that stage, my mental health was severely affected by the wait time. I felt everyone could hear my thoughts and I was hiding a massive secret while trying to act normal. I also felt that I was making a responsible decision to have the termination early but the wait time just added time to the gestation."

"Negatively- increase anxiety and worry. Impeded daily living."

"It felt unnecessary, unreasonable and was upsetting."

"It made me feel like I was not trusted to make my own decision and caused me a great deal of mental and physical distress."

"Stress and anxiety, it never made me second guess my decision but I was having a difficult early pregnancy with a lot of nausea and it just prolonged my pain."

"Extremely stressful and unnecessary."

"I had to spend three days waiting for care, which in the grand scheme of things may not seem to be significant, especially because I was under 6 weeks pregnant. However, I was exhausted and suffering from morning sickness. At no point was I hesitant in my decision, and the waiting period prolonged my discomfort. It also felt so patronizing and condescending. It's my choice, and I should be able to execute it without delay."

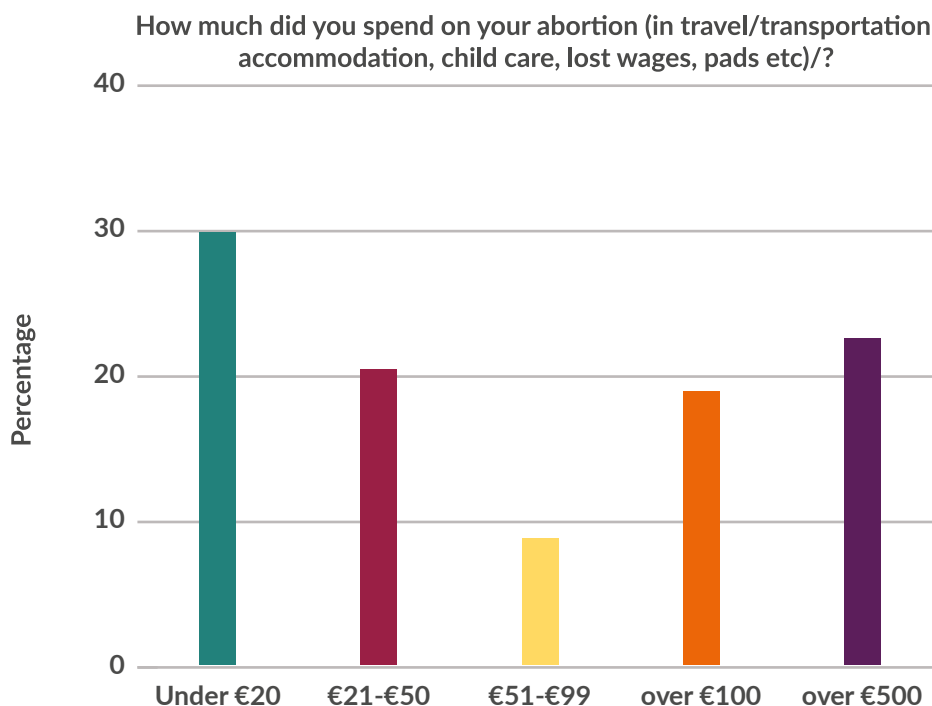
"The waiting period caused undue stress and anxiety as it made the time between having the scan and waiting for the Doctor's appointment an agonizing wait, where I felt powerless in my own body. On a practical level, it was difficult trying to plan the time off work. It was not feasible for me to take extended leave, and I did not want to discuss my circumstance with my employer, so I left early to go to my scan, then had to work during the waiting period and take two days off when having the abortion. Working during those days was a horrible experience."

This research finds that the mandatory three day wait negatively impacts people's health and wellbeing. The experiences outlined above show that the mandatory delay is a barrier to access.

Abortion Related Costs and Travel

The majority of respondents stated that they used their salary or savings to cover the costs related to abortion care. There are many hidden costs to abortion care, such as transport to and from appointments and childcare.

Figure 3.3 Cost of Abortion



Some participants stated that they borrowed money from friends or family: “Borrowing money and working as much as I could but I’m disabled so it was very hard. I hate that I owe my friends now.” Some respondents noted taking uncertified sick leave or taking several days off of work and therefore losing out on their salary. One participant said:

“Work asked me to see a company doctor as I missed time in work. I missed longer than I should’ve as I had retained products [of conception] so I ended up getting a D&C a month after the termination. I was out of work two months in total.”

One participant noted that they had just lost their job due to COVID-19 and therefore were thankful that their abortion was free. Although abortion is a free health service, one participant noted that they had to pay for the GP visits and pay privately for a scan. The Health Act 2018 states that abortion care is free for anyone resident in Ireland. However, in practice, those without a PPSN (Personal Public Services Number) are often obligated to pay for abortion care themselves. Some GPs will provide care at no cost, or provide care and then seek reimbursement from the HSE. This gap between the law and practice can prevent people without PPSNs from accessing abortion care free of cost, especially asylum seekers who have recently arrived in Ireland, undocumented migrants, and international students.

One respondent noted that while she had the number, she did not bring her ID card with her and this delayed her access:

“I didn’t realise I needed to bring a photo ID along with official document showing my PPSN. This meant the doctor wouldn’t proceed and receptionist advised me to come back next day with photo ID but it just freaked me out.”

Another participant noted having to pay privately for care in order to make sure she did not go past the 12-week cut-off:

“I had to pay two separate GP fees 60each and a 90euro ultrasound fee... Then was advised I had to be referred to hospital. I could have waited for a public ultrasound but the wait was unknown and I was able to book with the GP straightaway. As soon as I decided my course of action all I wanted was to have the procedure as soon as possible, but at every stage I felt I was delayed by 1/2 days - time between first appointment and second appt, between doctor ultrasound and referral. It just kept stretching. At a certain point I was nervous that I would be out of eligibility if there were any more delays. I don’t know what I would have done then.”

Respondents typically travelled up to one hour to access abortion services. Thirty percent travelled between 4 to 6 hours. Fifty-seven percent (n=78) stated that they had to travel longer than they usually would for medical care.

Figure 3.3 Travel for Abortion



People diagnosed with fatal foetal anomaly may have to travel repeatedly to Dublin or another major city for scans and then again for an abortion, if deemed to meet the requirements. Travel abroad added significantly to the travel time and the financial burden involved, which will be further discussed in Section 4.

A number of respondents spoke of cramping while they were travelling home from their appointments. A reliance on public transport left people in difficult situations waiting for a bus while in pain. One participant noted that there was more privacy in travelling out of her town to access care. They stated, "I was happier to travel as it gave me a feeling of anonymity." Overall, however, having to travel had a negative effect on patients both mentally and physically. Long-distance travel for abortion care is also against best practice.

"I had to travel during lockdown and get a lift into town. Being stopped by the police was uncomfortable. I suffered terribly from morning sickness so we had to stop the car for me to be sick on the street multiple times."

"Was definitely more difficult to not be able just to go to my local GP especially because I was incredibly nauseous at the time so travelling was difficult."

"It made things significantly more difficult as I had to rely on public transport and being from a rural isolated place this was extremely difficult for me."

"It was very stressful for me. I don't like driving long distances, and given my vulnerable state at the time it was even more difficult."

"I live in a very rural area so we are used to travelling for healthcare but I have a car and my husband drove me. I was aware that many had to travel abroad so I was grateful to be able to stay relatively close to home."

"I felt very fortunate to have a car otherwise it would have been totally unattainable for me to have had the procedure at the Surgery I attended, due to non-existent public transport between the two towns. Due to Covid-19, it wouldn't have been appropriate for me to request a lift from a friend, and I would have felt uncomfortable using public transport to travel to somewhere like [large city]"

"It was difficult to arrange transport. I live in a different town to the GP who provides abortion services. I could not go to my regular doctor. There is no public transport between our towns. I had to arrange childcare for my other children because my partner had to work. It was very stressful."

"Having to travel from [West of Ireland] to [large Eastern city] for an ultrasound scan was horrendous, as I don't drive I had to rely on public transport in the middle of the pandemic and do a solo trip. It also cost 50€, then an additional €20 to get to the surgery each time as no surger[ie]s in my town provide abortions."

Of particular concern is respondents' reports of cramping or being sick on the journey home from the doctor's office after taking the first pill. According to the HSE guide to medical abortion, "the first medication is taken with the doctor and the second is taken at home 24-48 hours later."²⁶ This requirement was changed with the introduction of COVID-19 protocols, meaning the patient is no longer obliged to take the pill in front of the GP. They are allowed to bring it home (or have someone else pick it up on their behalf) and start the abortion when it is best for them. Describing an abortion before the COVID-19 pandemic, one respondent said, "I had already thrown up my first pill before I got home." Others stated:

"I would have been more comfortable if I could have done it at home and not spent 4 hours wandering around [city] and then 3 hours on 2 buses bleeding and feeling emotional."

"I was cramping as I drove home. It was painful but I managed."

"Getting to take the second pill at home helped me feel far more in control of the experience and more comfortable and dignified. The symptoms came on so soon and violently, that had I taken the second pill in the GP surgery, I would have started to experience them while driving home."

"It made making extra arrangements for childcare and the drive home was very difficult, mentally and physically."

²⁶ <https://www2.hse.ie/file-library/unplanned-pregnancy/guide-to-medical-abortion.pdf> Accessed 30 June 2021

One respondent who shared that they were in an abusive relationship at the time of their abortion said having to travel for care made the situation extremely difficult for them.²⁷ They said it was “distressing, I felt added shame. I was in an abusive relationship and had to do this alone while ensuring other children were cared for. It made a traumatic experience even more so...The travel put my safety at risk as I was hiding the abortion to protect myself & my children.” Another participant stated that the abortion helped her escape a difficult relationship: “The abortion helped me to escape what would have turned out to be a very distressing and disturbing relationship with the father, in this sense I feel like I had to save my life. I stand with every woman who has made this decision.”

Experiences of Abortion Care with the GP and Health Clinics

Those who accessed abortion under 10 weeks did so through a GP or health clinic. Those over 10 weeks accessed an abortion in one of the 10 maternity hospitals providing abortion care (only 10 of the 19 maternity hospitals provide abortion care, even as late as summer 2021).²⁸ Respondents reported mostly positive experiences of accessing abortion care with the GP and health clinics. The comments below showcase some of the positives noted by participants:

“My doctor was so clear and supportive. She is now my GP. My partner was able to come to all of the appointments- this was crucial. I had the abortion at home and my partner had been told the step by step support I would need on the day. This was important. I rang the my options phone-in post abortion with questions and they were very helpful. If everyone had the experience I had I think it would be great. I hope others did. I was lucky to have noticed I was pregnant very early and exactly when I got pregnant. This also meant to process was easier. I have no idea what I would have done if I had to leave [the] country.”

“In what was a very distressing time the GP took time to answer questions honestly and without judgement. Her professionalism and kindness will not be forgotten.”

“My GP was phenomenal. She was non-judgemental, open, kind and helpful.”

“The staff at the women’s clinic were brilliant. Non-judgemental, informative, gentle and efficient.”

“The doctor that treated me was very kind and non-judgemental. He offered his phone number and told me to ring at any time if any complications occurred or anything felt wrong.”

²⁷ For more on abortion and domestic violence see: Christina C. Pallitto, Claudia García-Moreno, Henrica A.F.M. Jansen, Lori Heise, Mary Ellsberg, Charlotte Watts, 'Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence', *International Journal of Gynecology & Obstetrics*, 120 (1), (2013), 3-9 <https://doi.org/10.1016/j.jjgo.2012.07.003>

²⁸ The ten hospitals providing abortion care in Ireland are: National Maternity Hospital, Rotunda Hospital, Coombe Women & Infants University Hospital, Our Lady of Lourdes Hospital Drogheda, Cork University Maternity Hospital, University Maternity Hospital Limerick, University Hospital Galway, Midland Regional Hospital Mullingar, University Hospital Waterford, Mayo University Hospital, Castlebar.

"The doctor was very professional. He listened to me and discussed with interest the natural herbal medicines I had taken to try and end the pregnancy. He was very open and professional. I was very happy with the care he provided."

"I went to a women's health clinic and the staff were brilliant, I felt like I was in very good hands."

"The GP doing the 1st phone consultation with me was very nice respectful informative and made me feel at ease even though I didn't go through with the abortion."

"I had my abortion in January 2019 just after the service became available and, though I realise it is not the case for everyone, I was struck by how we had gone from a situation of no access to one where access was easy, normalised in a GP setting, and without any cost."

"I went to a [reproductive health clinic] and the staff were amazing and so supportive. At no point did I feel judged, they treated me like I was just a patient getting healthcare - as it should be. I was so so grateful for that."

"The GP arranged a scan in a private clinic in my town for the same day I contacted her. This was all done without me having to arrange anything, and took a huge weight off my mind having to contact another person. The nurse who did the scan was incredibly sensitive and well informed - I worried she might not know I was having the scan with the intent of having an abortion, and I was so afraid that I would be in an awkward situation, but she was so incredibly judgement free and caring. Similarly, the GP was also so sensitive and concerned for my emotional well-being, even giving me her own mobile number that I could contact her out of hours if I had any concerns. Being able to take the second pill in my own home, in my own time afforded me a great amount of dignity and allowed me to navigate the experience with a greater sense of autonomy. All in all, I had a very positive experience with the Irish healthcare system, but I was also so acutely aware at each step how different my experience would have been if my own personal experiences had been something else - for example, accessing the surgery I attended would have been unattainable without a car due to lack of public transport. I have worked jobs previously that I was unable to take two days off together so that would have been difficult to navigate the time off without having compromised my privacy and share the experience with my employer. I am lucky to live in a private residence with my partner, so the experience of taking the pills at home was a controlled one, but if I lived with family members or housemates, it would have been considerably more traumatic."

These types of experiences are contingent on meeting a helpful, pro-active GP. Not all participants were equally fortunate. Some reported issues with GPs charging for the consultation even though the HSE covers up to three appointments for abortion (the initial consultation, the second appointment to get the medication three days later, and an aftercare visit). Respondents also described negative experiences with GPs who were not abortion providers, as will be discussed below in 'Refusal of Care'. One case involved clear obstruction of care from a GP who refused to prescribe pills or refer the patient to another doctor.

"My GP refused to carry the abortion or refer me to another doctor, which delayed my abortion by two weeks. I found out quite early on, and had to drag a pregnancy on for an excruciatingly long two extra weeks without any need, simply because my GP did not want to prescribe the pills."

"The initial GP I went to informed me that they 'do not do that here' and then considered charging me €60 for a 2 minute consult."

"Clinic was very unprepared. They told me I would be fine to work the following day and I was in agony and losing so much blood. They didn't give me much details to prepare me for what my body was going to go through. I had no follow up appointment. They gave me a prescription for paracetamol which barely touched the intense pain I was in. There was nothing positive about the experience they put me through."

"The first doctor immediately congratulated me when I told him I was pregnant and straight away asked if I was taking folic acid and vitamin D! He assumed it was a wanted pregnancy which made it difficult for me to ask for information about abortion. Furthermore, I was charged €50 for the consultation (but I requested a refund later)."

Follow-up Care

Only 40% (n=55) of respondents attended the optional follow-up appointment two weeks after the abortion. After the onset of COVID-19, the follow up appointment usually took place over the phone. A small number reported not being offered any follow up. One respondent said, "I didn't know I could have a follow up appointment". Others mentioned having to follow up with the GP for a prescription for pain relief.

"The doctor said they would contact me but never did. They also never sent me an email hospital referral or sick certificate as they said they would. I had to follow up with them on the day to ask for the pain medicine prescription to be sent to the pharmacy."

"My abortion in Ireland was unsuccessful, I had to travel to England. I was never given any option of a follow up appointment in Ireland even though I did go through the abortion process it just wasn't successful."

The follow up appointment is also important to answer any questions and check any symptoms that concern the patient. One participant said, “The GP caught some early signs that it had been incomplete and referred me to hospital”. However, others noted that they found this appointment emotionally difficult. Some said “It was hard” and “very uncomfortable”. One respondent stated that their GP did not believe them when they thought they had an incomplete abortion:

“At the follow-up I already knew I was still pregnant. However my GP didn't seem to trust my judgement on that even though I am a sonographer. I found this part very stressful and messy. Trying to get the appointment in the [hospital], the [hospital] then had problems securing documentation needed to book in the appointment off the GP. So I had to collect it myself and basically harass the surgery. There was a problem with my bloods also the GP didn't fill out the blood forms correctly which pushed on my time even more.”

For those who did avail of follow-up care, the majority responded that it was a positive experience. Some noted that they had the chance to talk about contraception. One participant said, “The doctor was incredibly supportive, understanding and compassionate.” Others stated:

“Excellent. The doctor was professional and empathetic at every stage of medical care, as was the staff.”

“My experience was a positive one. I had a really nice GP taking care of me, I felt supported and it definitely made the whole process a lot easier. I was treated with kindness and respect when I needed it the most.”

Impact of COVID-19

Since the COVID-19 pandemic, access to abortion in Ireland has changed. Early medical abortion before 10 weeks through a GP or health clinic is now carried out via telemedicine, or sometimes a telephone consultation followed by an in-person consultation. The first visit is usually over the phone, and then following the mandatory three day wait, the second appointment can be either in person or over the phone followed by collection of the pills. This is usually discussed with the patient and the doctor recommends either an in-person consultation or telephone consultation depending on the person's situation. **Many participants noted that the introduction of telemedicine made access to abortion easier for them as it has reduced the need for travel.** They also noted that there was more privacy with fewer in-person visits to attend and no other patients in the waiting room. However, one person noted that “both of my doctor appointments and the one counselling session I had were over the phone. It would have been nicer to meet them in person.” COVID-19 restrictions also meant that this was a very isolating time, some participants found it more difficult in terms of getting support from friends and family.

“It helped in a way to anonym[ise] my experience. The first appointment with the GP was carried out over the phone, so it saved a lot of hassle of trying to arrange time off to travel there. When in the surgery, patients were required to wait in their cars until called and wear masks inside so it felt more discreet, particularly getting to avoid the long wait in a public waiting room.”

“I was stopped by Gardaí on the way which panicked me a little however medical appointments are essential journeys.”

“I really appreciated the fact there was no one in the waiting room- just me- it gave me much more privacy.”

“I felt extremely isolated and alone during the waiting period, as we were under level 5 restrictions.”

“It felt that covid made things easier with the restrictions, I'd have hated to attend to an in person counselling session that took 5 minutes and did nothing for my mental health.”

COVID-19 made access to abortion much more difficult and distressing for those who had to travel abroad for care. One participant said, “It was horrible. The added stress, worry, cost and isolation of going through having to travel for care in a covid world. Horrible.” The challenge of travelling abroad is discussed further in Section 4 below.

Experience of Abortion Care at 10-12 Weeks' Gestational Age

In Ireland, clinical guidelines dictate that abortion at or after 10 weeks be provided only in the hospital setting. The patient is supposed to have a choice between medical abortion and surgical abortion. As previously stated in Section 1, however, there is a lack of choice because so few hospitals provide surgical abortion.

Patients' experience of abortion care in hospital from 10 to 12 weeks was overwhelmingly negative. Medical abortion in the hospital entails taking pills and spending 24 to 48 hours in the hospital with cramps, bleeding, and in some cases vomiting or diarrhoea, until the pregnancy is completely expelled - all without the comforts of home. **Respondents reported insufficient facilities, lack of compassion from medical staff and refusal of surgical procedure when requested.** One participant said, “in [hospital]... I felt like the dirty secret t[h]rusted away in a room not to be cared about.” Another stated, “They spoke about the details of my file, of my life, to one another in front of me, they were careless, fake, judgemental, unprofessional.”

“The experience in the hospital could be better. The nurse was very rude. She might have been busy but your [sic] there for something emotional and in agony. It could be a bit better done.”

“I was referred to [hospital] as it emerged that my pregnancy had been ectopic. Here for most of the part I was treated with respect. However there were times when I was on the ward where nurses SHOUTED across a ward of women who were pregnant/experiencing miscarriage, asking me what date I took the abortion pill, what I was here for etc. I was absolutely disgusted and shocked by this not only from a privacy stance but out of respect for the other women going through their own nightmares beside me.”

Not only do Irish hospitals provide little choice of surgical abortion, but they primarily perform Dilation and Curettage (D&C) instead of vacuum aspiration, the method recommended by WHO.²⁹ **Training is needed in order for healthcare providers to be able to carry out the safest procedure for patients, as well as values clarification and education in patient-centred care to support the full range of abortion options.**³⁰

Some patients were repeatedly given rounds of pills rather than being given a simple safe procedure which would have been best for the patient. Staff also appeared to be unprepared and disorganised. In one case, the patient was told the hospital did not have the second set of pills in stock after they had taken the first round of medication.

“The legislation in Ireland had just passed and they honestly didn't know how to behave. I didn't receive any compassion for my situation, the treatment was very cold. One doctor in an Irish hospital made me listen to her opinion of how horrific she thought abortion was and how she voted against it before she reluctantly prescribed the 2nd round of pills to me. She made me feel worthless. When that round didn't work I asked the next doctor I met why I couldn't have a D&C and she admitted ‘the legislation is new and we're being very cautious to protect ourselves.’”

²⁹ World Health Organization and Department of Reproductive Health and Research, ‘Safe Abortion: Technical and policy guidance for health systems’, 2nd ed., World Health Organization, Geneva, 2012

³⁰Mishtal, 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-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, Switzerland.

“Even though I was so early (5 weeks) I had to go through two rounds of misoprostol with two trips to the [hospital] pregnancy options clinic to which I was referred by my GP after the first failed attempt. The second attempt also failed and I had to undergo a D&C to remove the last parts of tissues that were left. Despite all this the level of care and compassion I received from all the healthcare providers I met through this process was incredible and made the horrendous experience much easier as a result. I am heartened by the strength of support that was shown to me during the process.”

“After I had swallowed the first pill they then told me they didn't have the second pill in stock. There was a lot of silences and they were generally very unprepared. She asked me about adoption after I took the first pill which was very insensitive and also obviously too late.”

“Even though the legislation passed it was a few weeks before it was enacted and therefore not available to me. It wasn't successful abroad and I required help from the Irish system on my return...I attended the Irish health system who prescribed another 2 sets of pills which was horrific and was not working. I requested a D&C and was refused, now 12 weeks after my return from the UK and at high risk of infection. I got an infection and was still refused a D&C. A 4th round of pills would've ripped my insides out. I requested my medical file to obtain treatment elsewhere (ideally back in the UK). They tried to prevent me accessing my medical file and removing it to gain treatment elsewhere until I threatened to take legal action to get my file, then they relinquished it reluctantly... They left me 12 weeks until an infection formed. They offered me pills only and after 2 more attempts under the Irish system I requested more help but was denied a D&C. I could've died but they were more concerned about their protection than my health as the legislation was new.”

Participants noted poor facilities in the hospital: lack of toilet facilities, unclean and unsanitary bathroom conditions, and undergoing abortion in over-crowded hospital wards alongside patients suffering miscarriages or continuing pregnancies.

“In the hospital I was on a 6 bedded public ward with other people who were pregnant and having a baby that day and I was aborting mine. I felt very sad about that and ashamed that they might know. I thought I was going to be able to go to a private room. I had bad reaction to the tablets and had very bad diarrhoea. I had to do all this in a public toilet on the ward with other people in the cubicles beside me. That was horrific.”

“I had to wait in the antenatal clinic, surrounded by heavily pregnant women, to go for a scan to confirm a heartbeat” [after a failed abortion].”

“The facilities in hospital were awful. One toilet for 5 women which was covered in blood.”

“The ward was near a baby ward. Had to walk around pregnant women and sit with them for bloods/scan waiting area etc.”

“In the hospital you have to go to pregnancy ward, I needed an abortion for health reasons, otherwise I would have made it work. However unfortunately, you get put in same area as pregnant woman. It’s a bit in your face.”

To achieve compliance with best international practice and WHO recommendations, all early abortion care should be moved out of hospital settings. To the greatest extent possible, abortion care should be delivered by GPs, in health clinics, and in ambulatory gynaecology settings.³¹ Unless a patient has a specific medical need to be attended in hospital, there is no evidence supporting the routine restriction of abortion at or after 10 weeks to hospitals. This research provides evidence that patients have better experiences with community-based healthcare providers.

³¹ 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-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, Switzerland.

Despite lack of choice of procedure, lack of facilities and staff being unprepared, some respondents still noted empathy and support from staff in the hospital which they appreciated.

“The staff in the [reproductive health clinic] and the [hospital], they were exceptional. Crying now thinking of the nurse in the [hospital] who was with me that day, she treated it like any other normal medical treatment and it was a huge relief.”

“The doctors and nurses and receptionists in the [hospital] are the most kindest caring people I have ever met. I honestly would not be here without them all they saved my life.”

“Met such a kind empathetic midwife in the clinic who was supportive in my decision.”

“Treated with dignity and respect by most health care workers throughout.”

“The abortion hadn't completed fully and I was referred to Gynae ward in hospital and then had a D&C but I felt well looked after at all times by the people providing the service.”

“When I did go to [hospital] the staff were the most caring, kind, considerate people, they took my bloods and put me on antibiotics just to be sure there was no infection, they brought me through quickly and dealt with me in such a respectful manner at a time I was very scared, I'm forever thankful to the kind people on this planet, they have no idea how much there [sic] kindness helps.”

Refusal of Referrals and Abortion Care before and after 12 Weeks

Almost one in five respondents (19%) (n=26) said they were refused a referral to another doctor. Being denied a referral had a significant impact on patients. "Fear", "confusion" and "scared" were the feelings described. "Unnecessary stress" was also noted by a number of participants. Some reported calling several other GPs before finally finding a provider and others noted they imported pills instead of continuing to pursue an appointment. While the Health Act 2018 does permit physicians to refuse to provide abortion care (often referred to as "conscientious objection"), the Act and Irish Medical Council ethical guidelines require any such physician to transfer the care of the patient to a willing provider. Patients should be able to file complaints against non-complying physicians and the Medical Council and the HSE should take steps to monitor refusal of care and discipline physicians who fail in their ethical duties.

"My GP would not treat me or advise me where I could procure an abortion and just told me I could find information on the HSE website myself."

"We had to keep calling GP surgeries until we found one with a doctor who was willing to provide abortion care."

"Importing pills was terrifying."

"Initially I went to my GP who refused to help me. Gave me no information other than a phone number and just told me to call the HSE. No alternative referral offered. Rang [a reproductive health clinic] immediately after and they gave me the next available appointment."

"I was terrified. When I took the pills I was in so much pain. There was so much blood and I was scared I was going to die but I felt I couldn't go to the hospital I case I got in trouble because I did not meet the criteria for a legal abortion."

"I visited my GP first, assuming she could prescribe the necessary medication, she refused treatment. I had to call MyOptions to find GPs in my area that perform abortions, I rang three different practices and two of the receptionists were very rude on the phone to me. One hung up on me before I even had a chance to say thank you or goodbye. It was very distressing. At this point I had to call MyOptions for a second time, I was extremely upset because I wanted to have the abortion ASAP. She gave me numbers for doctors outside of my county."

One participant said, “I just decided not to proceed with it because it seemed to be so much hassle.” Finding a provider should not be so difficult. As recommended in Section 2 above, the **MyOptions webpage should explicitly state that the phone line provides the contact details of providers, and the State should not tolerate refusal of care.**

Section 9.1 of the Health Act 2018 states that an abortion after 12 weeks is permissible where two medical practitioners are of the opinion that “there is a risk to the life, or of serious harm to the health, of the pregnant woman” and so long as “the foetus has not reached viability”.³² WHO defines health as “a state of physical, mental and social well-being”.³³ The small number of abortions carried out under Section 9 of the Act - 24 in 2019 and 25 in 2020 - suggests that “risk” and “serious harm” are very high thresholds to meet, and that risks to a patient’s mental health may not be getting the consideration they deserve. In just one case in our study, a participant said that their mental health was taken into consideration:

“Was refused termination in [hospital 1] based on consultants opinion. Time wait for Amnio results, and had washed their hands of me. Went to see Peri-natal psychiatrist and they still refused me assistance. Was sent to [hospital 2] by my consultant in [another county]. On the way to the airport going to the UK for a termination, was turned down by one abortion clinic in the UK due to possible complications... I was lucky [hospital 2] were able to come to diagnosis...without an amnio and took psych report into account.”

As outlined above, a respondent also explained they risked organ failure and a broken spine if they could not obtain an abortion. Section 9 of the Health Act 2018, on risk to health, should be interpreted to understand health in the robust human rights-informed definition and should always include consideration of a patient’s mental health.

³²Health (Regulation for Termination of Pregnancy) Act 2018, <http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html> Accessed 9 June 2021

³³ World Health Organization and Department of Reproductive Health and Research, ‘Safe Abortion: Technical and policy guidance for health systems’, 2nd ed., World Health Organization, Geneva, 2012

Treatment from Medical Practitioners and Staff

Overall, 73% (n=114) of respondents answered that they felt that they were treated with dignity and respect by healthcare providers and staff, **however 22% (n=35) said they were not.** Those who were refused care by non-providing GPs noted that those doctors were often rude and unsympathetic. One participant said, “The actual doctor who provided me with my abortion was brilliant but I felt horribly degraded by the GP who refused the procedure.” Some respondents noted experiencing racism by providers and staff.

“Very shallow meeting and the staff are very rude towards migrants. I felt unsafe and ashamed for being a migrant and rely on their kindness.”

“Irish healthcare workers tend to be very racist and treat migrants, especially people of colour, very badly. I felt humiliated and talked down upon by the staff at the reception... felt infantilised and judged by the doctor at [reproductive health clinic] and sincerely felt that the counsellor could not care less about my situation and was simply ticking boxes. Having a counsellor or a blank wall to talk to would be the same for me at the time. I went through one of the most painful periods of my life alone and carrying the shame of being a migrant in Ireland knowing I'm not welcome here.”

Some providing GPs were also criticised for lack of follow up care, being disorganised and trying to dissuade the patient from having an abortion.

“They were good at the first appointment but then no follow up as promised, no referral letter sent in case I bled out, no sick note provided for my employer as they said they would and I had to follow up with them to send the prescription to the pharmacy so that I'd have the pain medication they provided on the day I HAD to take the second pills - this made that day so much more stressful.”

“The doctor was a young man. He seemed like a nice person and he did treat me with respect, but at the first appointment, he suggested I might regret going through with it. I had to sort of assert myself and when going in for the second appointment, I was worried he might try to put me off. I don't think it was at all intentional on his part and I don't think he was being judgmental exactly though I got the impression he found it regrettable. It's a delicate thing I suppose, because he wanted to make sure I wasn't making a mistake, but he did not understand my personal circumstances at all, I had explained briefly to him but I don't think he really understood. This all made the whole experience even more difficult.”

One respondent experiencing a fatal foetal anomaly stated, "Their hands were tied, they couldn't help us any more than they did." Similarly, another participant identified restrictions in the Health Act 2018 as the problem, stating, "I felt very supported in Ireland other than they couldn't provide me care I felt they wanted to. I know their hands were tied." One participant who was provided an abortion after a fatal foetal anomaly diagnosis said, "I was lucky my consultant was compassionate and understood." However, some participants felt that when they were diagnosed with an FFA, there was little follow up support and others reported staff deliberately trying to delay the process.

"I was told there were brain and bone issues and then ushered out of the room as the staff were clearly uncomfortable. They were aware that I was on my own yet I was given this bombshell diagnosis without being offered any follow up support whatsoever."

"Some staff deliberately tried to delay scans and put us off asking for harmony tests saying we didn't need it and then tried to delay amniocentesis."

Many participants noted that while the GP who provided the abortion care may have been supportive and non-judgemental, they experienced poor treatment from receptionist staff.

"The surgery secretary was hostile. The doctor could not have been better though. He was reassuring and professional. I felt very safe with him."

"The doctor was exceptional, she was compassionate and understanding. I did not feel that from the reception staff, I felt like they knew why I was there and I did not feel the same care from them that I saw them show to other patients."

"Doctor was great. When I asked receptionist for a sick note the doctor said just put something else on it. The receptionist made a judgemental comment."

“It was not a nice experience...The secretary kept trying to get me to see a different doctor. I finally had to explain why I needed that specific doctor and she was very abrupt and almost aggressive with me, as if she did not know how to deal with my call.”

“Felt shamed, judged, less than. Like a bad smell who had walked into the room, from the receptionist to the actual doctor, nothing but judgement.”

In contrast, two respondents noted how welcoming the reception staff were and how this eased their experience. **Values clarification training, including anti-racism training, should be provided to all staff including reception staff and other staff whose work intersects with abortion care in any way.**

“The GP and the receptionist in the practice were so brilliant, comprehensive and understanding, really made me feel comfortable in a non-judgemental way and helped me in every way possible.”

“There were a number of small gestures made by the staff at the doctor's surgery that made me feel welcomed and supportive. I remember when I rang the surgery to make the appointment, and the receptionists tone changed from one of detachment to one of comfort and support. She told me not to worry about anything, that it was free of charge, and that she would get me the earliest appointment available. She smiled at me when I arrived in the surgery, and when I left the appointment she just said to me, ‘That's you sorted now, all settled up. Be well.’ I knew I was in a safe place.”

Anti-Abortion Encounters and Refusal of Care

Overall, 14% (n=22) of participants in this study said they encountered anti-abortion activity while attempting to access abortion care. One participant said they experienced, “protests, verbal abuse, posters” outside a clinic. There were “people doing rosaries and saying hurtful things about going to hell and punishment.” One recalled “people with coffins outside praying”, while another respondent said “there was an anti-choice sign (maybe a picture of a foetus) outside the private ultrasound clinic where I had to go to ensure I was within the 12 weeks.”

Anti-abortion activity had a particularly negative impact on patients: “It was shocking. [They were] waving [a] photo of dead babies.” Another respondent said, “It made my experience a lot harder as I was alone.” And, “It was awful. I felt sick when I saw them. I just wanted to be left alone.”

One participant in this research said, “This should be illegal, they have no idea what I’ve been through.” Reflecting on her experience of protests, another respondent said, “It was horrendous, they don’t care about women.” Given the experiences of pregnant people outlined in this research, it is clear that anti-abortion activity has a significant impact on those seeking care. Legislation is needed to ensure that patients are no longer in fear of anti-abortion encounters outside of healthcare facilities.

Refusal of care as well as judgment, dissuasion, obstruction, and disrespectful treatment were all experienced by participants in this research from healthcare professionals and/or staff.

“I felt the consultant was anti-abortion and was trying to sway us from inducing our baby early despite her having Edwards syndrome. Every meeting with them was traumatic and I didn’t trust what he said early on as I felt he had his own agenda (telling me she would need a needle to stop her heart and that parents who continue pregnancy are always glad they did and so many other hurtful and not helpful things).”

“Midwife that scanned me post abortion back in Ireland was clearly not pro-choice and made me feel very bad about my decision.”

“I had a negative experience with my GP... She made it clear to me that she didn’t agree with my choice as she was Catholic.”

“The questions being asked [b]y a social worker at the time were biased against abortions.”

“There was a doctor on duty who would not see me as they did not agree with what I was doing which was fair enough but still made me feel upset.”

“Only indication was the consultant in [hospital] felt he was trying to dissuade us and made clear they could not help even though it turns out he could have. Asked did we want to hear the heartbeat.”

“A doctor in an Irish hospital withheld a prescription she was advised by another doctors to issue me until she told me how horrific abortion was in her opinion and how she voted against it and absolutely did not agree with what I had done.”

“Made me angry, confused, upset. I felt judged and back to being 19 and pregnant the first time. Conscientious objectors need to be removed.”

“I actually said at my scan at 7 weeks that I don't want the baby and I feel the doctor talked me out of it. Told me to go home and think about it. I wish I had been offered a counselling appointment at the time or some information. I left in tears.”

“After my initial failed abortion the doctor...proceeded to say continue with the most ridiculous thing and say well you might be able to continue with the pregnancy but because I had taken the full medication, it may have genetic implications to the foetus. At this stage I replied clearly I am here because I don't want to continue with the pregnancy.”

Biased anti-abortion treatment, as well as outright refusal of care, had a significant impact on patients' experiences. In some instances doctors or others tried to dissuade patients, block access to treatment or make them feel guilty about their decision. One participant noted that she was “given incorrect information as to what week I was, meaning I couldn't access a free abortion in Ireland even though I was eligible.” **No one should have their right to abortion care in Ireland violated by doctors. No one should be allowed to impose their opinion on patients and there should be professional consequences for those who do.**

Contraception

Contraception should be freely available to anyone who wants it and it should be free of charge, as the Government promised in 2018.³⁴ However, regardless of whether it is free or not, contraception is a choice, and some participants noted being pressured into contraceptive methods which they did not ask for or want.

"Birth control pill was pushed on me straight after and it drove me crazy...since gone off of it."

"I was urged to accept a coil during the procedure. I refused."

"There was a presumption the pregnancy was unwanted. It was planned. Our circumstances changed and made it an unviable choice. That assumption by gynae who performed abortion and tried to convince me to have a coil put in was a little distressing as I didn't have the inclination to correct her."

"The first doctor I saw tried to force contraception on me, she wanted to give me the depo injection on the spot, I told her that I wanted to deal with the situation I was in and then I would think further on my contraception options. She kept bringing it up to the point of bullying. I had to be quite forceful to get her to drop it. If I was younger or perhaps a bit vulnerable I would have ended up taking it because of the way she was going on and on about it. I have heard others complain about this particular doctors manner with patients so I don't think it was due to the service she was providing at the time but she made me feel very uncomfortable and that I was stupid for getting myself pregnant. That was the first appointment, I saw a different doctor who actually gave me the medication who was very nice and [...] went through all the information in a neutral way."

³⁴ 'Women to have access to free contraception from 2021', Irish Times, 10 October 2019. <https://www.irishtimes.com/news/politics/oireachtas/women-to-have-access-to-free-contraception-from-2021-minister-1.4046712>

The HSE compensates abortion providers for a follow up appointment, and clinical guidelines encourage discussion of contraception at that appointment. However, under no circumstances should a patient be pressured by their doctor or healthcare worker into a contraceptive method they do not want.

Section 4: Travel Abroad for Abortion Care

In our survey, 15 respondents reported that they had tried to get an abortion in Ireland but were refused care, forcing them to travel. Of these, 11 participants said they were not told about organisations outside of Ireland who could help them to access an abortion abroad. Only two participants were told about [Abortion Support Network](#), two were told about [Marie Stopes](#), and four were told about [BPAS](#). These services provide vital information, logistical support, and financial support. **More information on services supporting patients to access abortion abroad is needed. This information should be shared by hospitals, health clinics, and by GPs.**

Reasons for Travel Abroad

Participants noted a range of reasons for travelling, including passing the 12-week limit, being diagnosed with a fatal foetal anomaly that did not unambiguously fall within the restrictive bounds of the Health Act 2018, experiencing a failed early medical abortion, or being given inaccurate information about her pregnancy. As noted earlier, one respondent travelled abroad for care on the basis of an incorrect dating scan: “Even though I was actually eligible and at 8 weeks, whoever read my scan read it wrong and said I was 12 weeks.” Another participant chose to travel because they felt they would have more anonymity, writing, “I was more comfortable going to Holland as I know people there and work in a healthcare field here so was worried someone might find out.”

Clinical guidelines cut off the period of abortion on request at 12 weeks + zero days. Even if a patient took abortion pills earlier in the pregnancy, the guidelines state that such patients are not able to access further abortion care unless they meet the limited criteria for an abortion after 12 weeks. This rigid and conservative interpretation of the Health Act 2018 has led to some Irish residents having to travel to England or even having to continue a pregnancy. **These clinical guidelines must be changed to make sure those who experience a failed abortion can obtain follow-up care in Ireland.**

One respondent described how after her abortion failed she was told “there was nothing more to be done”.

“I received all abortion tablets but unfortunately nothing happened. The abortion was unsuccessful and had not worked. There was nothing more could be done for me in the Irish system. I had taken the pills so there was a risk if I was to continue with the pregnancy. They were facial [sic] abnormalities or 50% chance of miscarrying at some stage in the pregnancy. I would not have been able to live with myself if I had continued with the pregnancy and a baby was born with abnormalities caused by me. I decided the best thing was I travel to England to get an abortion.”

The majority of respondents who travelled abroad did so because their foetal anomaly diagnosis was not “fatal enough” to qualify for an abortion in Ireland. Section 11.1 of the Health Act 2018 states that two medical practitioners, one being an obstetrician, must be “of the reasonable opinion formed in good faith that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth”.³⁵ One respondent said, “[You] still have to stay pregnant if diagnosis ‘not fatal enough’ and some staff won’t deal with you because they won’t discuss abortion and can opt out of having to provide care.” Another reported “having to travel to the UK because my situation did not tick the correct legal boxes.” Hospitals appear to be using a very conservative interpretation of Section 11.1.³⁶ The Institute of Obstetrics and Gynaecology (IOG) guidelines provide a list of recognised fatal foetal anomalies. The list includes, but importantly, is **not limited to**, these diagnoses:

- Severe multicystic dysplastic kidneys and oligohydramnios
- Holoprosencephaly
- Severe hydrocephalus
- Hydrops fetalis
- Life limiting complex cardiac defects as agreed by the paediatric cardiology MDT
- Bilateral renal agenesis
- Severe skeletal dysplasia
- Anencephaly/acrania
- Thanatophoric dysplasia
- Trisomy 13 or Trisomy 18
- Triploidy
- Hydranencephaly
- Severe osteogenesis imperfecta
- Multicystic/dysplastic kidneys with early onset anhydramnios
- Infantile polycystic kidney disease with early onset anhydramnios
- Congenital severe hydrocephalus with absent or minimal brain growth
- Non-immune hydrops with major cardiac defect
- Inoperable conjoined twins
- Craniorachischisis / Exencephaly/ Iniencephaly

³⁵Health (Regulation for Termination of Pregnancy) Act 2018, <http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html> Accessed 9 June 2021

³⁶Interim Clinical Guidance Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed during Pregnancy, Institute of Obstetrics and Gynaecology, Revised January 2020, <https://www.rcpi.ie/news/publication/interim-clinical-guidance-on-pathway-for-management-of-fatal-fetal-anomalies-and-or-life-limiting-conditions-during-pregnancy-termination-of-pregnancy/>

The conservative interpretation of “fatal” anomaly has left hundreds of pregnant people having to travel abroad for abortion care.³⁷ At least 375 Irish residents travelled to England and Wales for an abortion in 2019, the majority of whom travelled because they were refused treatment in Ireland.³⁸ Some respondents in our survey explained:

“Although my baby would not survive, the multidisciplinary team at my hospital gave examples of situations like mine when a baby did survive past 28 days, although with huge defects.”

“The condition was seen as non-fatal - but it was a life limiting condition.”

“I had to terminate for medical reasons. Our consultant said our case 100% warranted a termination and we also got a second opinion from [hospital] but the consultant here said he couldn’t be sure our baby would die within 28 days of birth and because I was 15 weeks he couldn’t help us.”

“I had to have CVS testing at 10 weeks for a genetic condition, the results take over two weeks and therefore I was over the 12 week cut off point in Ireland.”

³⁷See <http://tfmireland.com/> Accessed 1 July 2021

³⁸Department of Health and Social Care UK (2020) National Statistics: Abortion statistics for England and Wales: 2019. Published 11 June 2020. <https://www.gov.uk/government/statistics/abortionstatistics-for-england-and-wales-2019>

“The doctors said that under the laws I wasn't allowed an abortion in Ireland, even though two separate consultants told me I would eventually miscarry.”

“I fell outside of the Irish legislation because my son had multiple, severe, very serious abnormalities but they weren't sure if he would die within 28 days of birth. They only discovered this at 25 weeks gestation despite 4 previous ultrasound scans where not one issue was raised. Due to all of this, I was ineligible for an abortion in Ireland and had to go to the UK.”

“We got to meet our little girl after being induced at 24 weeks. It was a calm and controlled situation where the staff were very kind to us and I got to bring her home with us for a night. If I had not had a termination I was a high risk for miscarriage and I was worried my partner who works away wouldn't have been there to support me or meet our daughter and it would have been rushed and a stressed situation.”

“It is not fair that there is a window of about 2 days between finding out your child has a terminal medical condition and being able to access an abortion. I fell into this trap whereby I found out my child had a terminal illness but it wasn't enough to get an abortion in Ireland. In some cases you only are able to access the diagnosis at 11 weeks and then you get another test at 12 weeks and then you are too late to access services in Ireland. This is really hard on mothers we should be given the choice to be able to decide what we want to do for us.”

Cases of Fatal Foetal Anomaly: Experience of Care

The majority of respondents who travelled abroad had received a diagnosis of foetal anomaly which was “not fatal enough” under hospitals’ interpretation of Section 11.1 of the Health Act 2018, illustrating the negative impact on patients of conservative interpretations of the law. One respondent said, “before the fatal foetal abnormality was confirmed I was told I was in no man’s land, ‘grey area’ and no one in Ireland could help me.” Another said “The [hospital] foetal abnormalities clinic were so kind and informative, doing all they could for me with the very restrictive parameters of the law.” The experience of travelling abroad was traumatic, yet respondents appreciated and complimented the care by medical professionals abroad. Respondents stated:

“The staff in [UK hospital] were amazing, the little nursery that they have allowed me to spend some with my son in a beautiful environment where he was treated with dignity and respect. I’m not sure I would have received such fantastic care if I had the abortion in Ireland.”

“Staff in UK abortion clinic treated me with nothing but kindness, compassion, care. Hospital in Dublin were very wary giving me any info on abortions in UK.”

“I am scarred for life. I will never be able to get on a flight without thinking of having to travel for termination for medical reasons. We had to do all of this during the pandemic and didn’t know if my husband could be with me for support. The staff at [UK hospital] were amazing considering the circumstances. We also had to stay in a hotel away from family and our dog at the worst time in our lives.”

“I had my abortion in Liverpool and I believe we would not have gotten the same level of treatment in Ireland. I regret that we had to travel but I do not regret anything about our experience in the [UK hospital]. All TFMRS [Termination for Medical Reasons] and late term TFMRS should be available in Ireland and the [UK hospital] should be looked on as the model approach on how to do it well under such devastating circumstances for the patients.”

Some respondents also noted positive treatment from healthcare staff in Ireland. Even in cases where respondents were not able to receive an abortion, some still noted invaluable support from staff in the hospital.

“My baby had Edwards syndrome and was not going to survive due to a number of significant defects. The dignity, respect, support and care was outstanding and I was so grateful to be able to get the care I deserved in this country. I will never be able to thank the staff in the [hospital] enough.”

“The treatment I received in [hospital] was second to none. Compassion and support through everything from the scan to labour and delivery to bringing my baby home and giving me the cold cot to take with me. From taking hand and foot prints to just the general behaviour of everyone around me the nurses doctors could not have been more amazing. Name at reception so they knew I was coming etc. Follow up with Bereavement midwife and perinatal psychiatrist. Time with my little girl. This is what all women should have access to and is not being provided in every hospital.”

“I never wanted to have an abortion. My baby had fatal foetal abnormalities, trisomy 13. I was treated so well and with such great care throughout the process in the [hospital]. I have had a few miscarriages in the [hospital] but the treatment that I received during my abortion was actually a lot better than the miscarriages and I also received much better support and counselling but maybe that’s because I was further along in the pregnancy.”

But other respondents were critical of the care they received in Ireland.

“The nurses in the UK were very compassionate...Due to the Irish health system my abortion was very traumatic and it didn't need to be. There is nothing positive on how they treated me. They admitted to protecting their interests above my health even when I got an infection and could have died having decaying tissue in my body for an additional 12 weeks after the initial termination.”

"[Hospital] were not helpful. I had to walk by baby cots after hearing my awful news regarding baby chromosome problem. So upsetting. One Irish midwife told me 'I think you will regret an abortion for the rest of your life'."

"Women should have more say in their options and be offered abortion in cases of non-fatal foetal abnormalities which will have profound effects in their baby."

The reports of Irish hospital staff being "wary" of providing information about how to access care in England, and of "protecting their interests above" the patient's health, even when the patient has an infection, are disturbing.

Participants in our survey wrote about having to travel home without their baby's remains. One participant said they "had to leave baby behind. Wasn't able to have any ceremony to say good bye here with friends and family around." Another participant said they "never got to bring our baby home, not even as ashes. Never spoken to about being able to bring the remains home. Haunts me to this day and will forever [regret] that we had to leave our baby behind in the UK."

"I was away from my home, my family and my friends... Less than 24 hours after giving birth, I had to take an hour's train, an hour's flight and a two hour drive to get back home which was physically difficult at that stage. That all paled in comparison to the hardest thing of all where I had to leave my son in another country to have a post mortem while I flew home. I travelled back 2 weeks later for his cremation."

"Extremely traumatic experience. Scan in [hospital 1] diagnosed possible Thanatophoric Dysplasia. Consultant said 'no consultant in the country will touch you', this was a Tuesday. We left thinking we would have to travel to the UK in a panic as I was already 21 weeks. Made calls and had consultations in UK clinics no hospitals would take us due to pandemic. Had to get COVID tests to fly. Made a will, to take care of my other daughter in case I died, as there was a possibility of complications and possibility of getting COVID. Rang airline re repatriation 15 people hung up on me and would not give me information re repatriation. One abortion clinic in the UK refused to take me in case of rupture. Told me, when I asked could I hold my baby after, 'no, as she would not be on one piece'. Didn't know how I would bring her home or go back to get her. Sent for psychiatric assessment. Board meeting in [hospital 1] still no even with psychiatric report. Only [hospital 2] would look at me on the way to the airport. When asked for full obstetrics report from [hospital 1] for UK was refused my information."

Funding Travel Abroad

Most respondents used their own savings or borrowed from family in order to cover the cost of travel abroad for abortion care. As one respondent said, “We used our savings, it cost over €2000 for procedure, travel and accommodation.”

Abortion Support Network (ASN) offer financial support to those who have been refused treatment in Ireland or who wish to travel abroad for abortion care. A few participants in this research sought financial assistance from ASN. One participant said, “Abortion Support Network provided a grant to cover some of the treatment costs, we used savings to pay for the remainder of the treatment costs and hotel. A family member paid for our flights.” Another participant noted, “We were very lucky our family were supportive and gave us money. We were aware there was a charity fund but decided we could fund it ourselves and wanted to leave money for women who needed it more.”

Travelling abroad for abortion healthcare is extremely expensive. COVID-19 restrictions and self-isolation after travel increased the financial cost and distress for patients. One participant said:

“We are in the lucky position to be able to afford the abortion. I know many are not. In total, it cost over 1,000 euro including hotel, flights, car rental, the procedure itself. We had to pay for someone to mind our son at home while we travelled. We had creche costs as we had to isolate for 14 days with our son when we returned home and couldn't have any family support due to having to isolate.”

Travelling for Care during COVID-19

Travelling abroad for abortion healthcare during the pandemic added significant stress and isolation. Participants stated that it was “tiring, more expensive, and [they] felt let down, lonely, and isolated”. Another participant said travel “made it much more difficult and extremely traumatic.”

“Felt like an outcast criminal. It was horrible. Being in a strange place far from my home and family.”

“Caused a massive mental health issue for me. Travelling for care when you've been told your very wanted baby is sick is horrific. Then add in covid.”

“It caused an almost unbearable level of stress, particularly because we had entered Lockdown 1 and we needed to borrow a car from extremely anti-choice family members - thereby needing to lie, hide emotions etc.”

"It wasn't about the length of time or travel distance what I member most is breaking down in the car look at the ferry wondering how many women have done this before me and also how many people would see a visibly pregnant Irish woman on a ferry to the UK and know what we were doing."

"COVID-19 added more stress - re isolating after traveling & the added stress of picking up the virus due to having to travel."

"It was extra worrisome wondering if we could travel and if we would be stopped at the hospital in the UK following a COVID test. We were negative but could have caught it in transit and then we would have been in serious trouble."

"It made it much more difficult. We had to pretend we were not out of country and had to take our toddler with us. We didn't tell anyone we were travelling. Also having to be in a hospital on my own was awful. I still suffer from the trauma of it. In the end I delivered my baby on my own as the medical team didn't believe I was in labour when I knew I was. As my first baby had arrived very fast."

"It added to the trauma, I felt like a criminal given that I lived a few miles from [hospital] and there was no one there who could help me. I was also worried about flying so soon after surgery."

"It made it extremely traumatic. Felt terrible shame and with COVID I was so worried about travelling and bringing back something to my family."

"It has had a horrific impact on myself, mentally and physically. My partner and I are still devastated that we had to travel in the middle of a pandemic too. It was a terrifying experience."

"Added to anxiety having to go to another country. I feared flights would be cancelled/delayed. I feared I wouldn't be looked after as well in another country."

"Days of worry and trauma highlighted earlier. How to get there, how to get COVID tests, what would happen if I tested positive, who would take care of my other child, money involved, trying to book flights and organise repatriation, doing 3 consultations, meetings with my consultant who was afraid for my life due to possible complications, having to make a will so my daughter would be taken care of if anything happened, spent over 500 euro on phone bills calling hospitals in the UK to take me as they were refusing Irish women due to COVID."

The lockdown brought garda checkpoints and restrictions on inter-county travel and travel abroad, as well as shutting down much of the public transportation system, making travel especially difficult.

“We needed to travel from [home county] to [neighbouring county] to access abortion care in the middle of the first hard Lockdown. With no access to a car, the level of stress this caused was almost insurmountable. I can't imagine how anyone in the same situation but trying to do it totally alone would be able to cope.”

“No one wants to tell guards at a checkpoint that they are travelling for an abortion, nor should they have to. I think we need to look at the low uptake from GPs in rural areas.”

Another difficulty stems from some hospitals' decision to stop allowing partners to attend appointments, scans, and in some cases even labour, since the advent of COVID-19. Organisations such as the [Association for Improvements in Maternity Service](#) (AIMS) and the [National Women's Council](#) (NWC) have advocated for these restrictions to ease.³⁹ Respondents in this survey stated that not having partners with them added to stress and isolation. One participant said, “My husband was not allowed into all the appointments. Very difficult.” Others stated:

“It was hard at the reception area trying to explain to the staff why you were there. Partners should be allowed in for scans.”

“Allowing women to have their partner is essential. Not having my partner with me added to the trauma.”

“I had to attend all appointments on my own and I live 2 hours drive away. I didn't have access to childcare so I had to lie to my family as to why I was attending [large city] in the COVID pandemic - any other time I could have said I was at work and would have had childcare.”

“It was difficult. I didn't mind so much that my partner couldn't attend appointments, but the fear that I might have been refused treatment for a COVID symptom was terrifying.”

³⁹See: <http://aimsireland.ie/%ef%bb%bfmaternity-users-shocked-at-gross-misinterpretation-of-the-presence-of-partners-for-the-full-duration-of-labour-by-compliant-maternity-units/> Accessed 9 June 2021

“Nobody was allowed come into the hospital in Ireland with me. I had a scan on my own, I went through the emotions of a failed abortion on my own... I had to wait for the midwife to come back to work after the long weekend. I did this on my own as no one was allowed into me in the hospital and that was very hard. I then was faced with the difficulty of having to try organise getting to England during a lockdown. My brother came with me as he was the person with the least underlying conditions in my family to travel with me...When I was in the clinic in England my heart rate was so high they thought they would not be able to do the procedure. I was there all day, my heart rate never went down. I watched people come and go and I was still there waiting. Eventually they decided they would go ahead with the procedure. It was my last chance and I had travelled so far. My heart rate was so high because I was in a foreign country during a global pandemic and did not know what was about to face me. The procedure was finished in a matter of minutes and the women there were so lovely to me and held my hand. My brother was not allowed into the clinic with me due to restrictions. I had to pay 600 pounds...The girls on the desk were nearly embarrassed asking me for money as they couldn't understand why my home country could not help me...I could not help feeling disappointed and angry at the Irish system. My procedure was done at 6pm and I was on a flight back home at 10pm. It's not advised to fly that soon after but I had no choice as flights were limited. I also had that extra worry of something happening me on the flight but thank God I was okay...I never thought it would happen me.”

Endurance of Stigma

As many of the comments by survey respondents shared throughout this report show, individuals accessing abortion still feel stigma and shame, and still have stigma and shame imposed on them by others. Negative associations with abortion did not immediately dissolve upon Repeal or passage of the Health Act 2018. **Irish politicians, medical professionals, media, and others have more to do to ensure that all residents of Ireland can access the care they need with dignity and respect.**

Recommendations to Improve Abortion Access in Ireland

The recommendations below reflect the direct suggestions written by survey respondents and the overall findings of this research.

1. Better, More Widespread Information about Abortion in Ireland

Nearly one third of respondents, 32% (n=76), said they did not know where to find information on abortion. Respondents said that it must be clear that MyOptions provides the phone numbers of providers, and also that people need to ring for that information: “Be explicit that you must call MyOptions if you want an abortion i.e. don’t put people in a position where they think they need to ring random GPs offices and ask the secretary does that GP offer an abortion!!” A number of respondents suggested giving information about MyOptions in schools and colleges and for more advertisement of MyOptions: “Make it a part of the Secondary school curriculum. Let people know.” Participants also called for more advertising on “Instagram, Twitter, magazines” and also to encourage GP practices to state on their websites whether they are offering this health service. Respondents said “false services should be banned.” ARC also recommends advertising MyOptions in the ten most commonly spoken languages in Ireland in addition to English, and making MyOptions more easily accessible for those who speak a language other than English.

Many participants are still unaware that abortion care is free and that once a pregnancy is over 12 weeks, access to abortion is extremely limited. These basic facts also need more advertisement. More information on services assisting pregnant people who need to travel abroad is urgently needed from MyOptions.

Patients bear the burden of ringing the GP. A service in which the appointment is arranged by MyOptions with a provider, in consultation with the patient, could eliminate the burden from the patient themselves. One respondent said, “It should be made clear which GPs do/don’t provide the service or referral. Would save precious time and unnecessary anxiety and judgement.” A public list of those who do NOT provide abortion could counter the reluctance of GPs to be named on a public list of those who do.

Participants said they wanted more information on what to expect after taking the pills, and the reality of the pain and bleeding. One respondent stated, “I wish there was more information on what a normal abortion looks like, and how long it can last.” Another participant said, “reading people’s experiences gave me an incredible sense of not being alone.” She suggested “maybe a go to website with some kind of forum to ask questions when going through the abortion to clarify questions and just talk about what’s happening to someone who has been through.” Another participant suggested “there could be some FAQ or common experiences covered on the website.”

2. Repeal of the Mandatory Waiting Period and Extended Time to Access Abortion

Legislative change is needed to allow provision of abortion on request past 12 weeks. Many respondents called for legal and procedural changes: “Make it legal past 12 weeks” and “remove the three day waiting period.” One participant called on “less time waiting, [and an] increase time in which a woman may freely avail of an abortion from 12 to 24 weeks of pregnancy.” Another respondent said “make the latest date to get a legal abortion for any reason 20 weeks, in line with the U.K. and other liberal countries, Australia and Canada.” This report has found that the mandatory three day wait negatively impacts patients’ health. As one participant said, “the 3 day mandatory waiting period felt like punishment or a continuation of the absence of trust Irish reproductive laws had/have towards women.” The mandatory three-day wait and restrictive gestational time limits are arbitrary and undue barriers to access to abortion.

3. Better Accessibility of Abortion and Choice of Methods

Respondents reported having to travel long distances to reach providers. They stated that more engagement is needed with “local GPs, or even those in regional towns, to maybe increase the chances of them providing abortion care.” Many respondents stated their disappointment at the lack of providers even in urban areas. One respondent said, “make more hospitals do the procedure - it isn’t available in many hospitals still a year after it being legalised which is shocking.”

Respondents also wanted more choice of abortion method. Surgical procedures should be offered by all maternity hospitals, GPs and health clinics, in line with best international practice. One participant said, “I think the vacuum aspiration should be available in Ireland. If England can do it why can’t we. I was left with the thoughts after my failed abortion in Ireland that my baby could be born with abnormalities or i could miscarry. Nowhere in Ireland could help me and I don’t think anyone should be left in that state after a failed abortion. I was left on my own to figure out how to go to England to get one in the middle of a global pandemic.” Another participant asked “medical is pushed as the best option -why? Surgical is immediate and more economic, less visceral.” More training is needed in order for healthcare workers to be able to carry out the safest procedure for patients which, according to WHO, is vacuum aspiration.

4. Better Access to Abortion in Cases of Fatal Foetal Anomaly

One respondent pleaded, “let diagnosis of severe life limiting conditions be allowed to get abortions in this country. Improve the quality of diagnostic tools so decisions can be made in more time. And have consultants on hand to confirm negative diagnosis instead of having to wait weeks to confirm. The waiting is horrible.” Another stated that, “Consultants should be able to make a subjective decision based on their own opinion as to the need for a TFMR [termination for medical reasons] if over 12 weeks. My consultant absolutely believed we needed it and wanted to help us but said ‘his hands were tied’ by the legislation.” Another respondent pointed out:

“The system is letting women fall through the cracks. Women who want an abortion up to 12 weeks usually know by then but in the case of getting a Harmony test at 10 weeks by the time the result happens it’s too late for some women. A lot of these women are older and already have families or children and are then being forced to travel alone and to leave their babies behind in the UK. It’s still happening and needs to stop. They don’t get bereavement aftercare. We need free perinatal tests for women who want them on the public system. Termination needs to be increased to include the interim between 12 weeks and 24 weeks. There should be a list made of who is a conscientious objector as a consultant, they have too much power in board meetings one consultant was able to define my fate and wash his hands of me regardless of a perinatal psychiatrist report which was compelling in terms of my mental health. I should have been referred to another consultant for a second opinion and once a diagnosis of something serious is made a referral to a psychiatrist should be automatically made. A lab in this country to test amnio instead of shipping to UK. The wait was said to be nearly 6 weeks which wouldn’t give me any time.”

Another respondent wrote, “Change the law to allow for intervention when multiple foetal anomalies occur. Stop exporting tragedy and allow people to be cared for at home at the worst time of their life.”

5. Better Transport and Accommodation

Lack of public transport caused major problems in accessing to abortion services. One respondent suggested there could be a private taxi service: "A private service to drive people to appointments - I can't imagine the extra stress of having to navigate the poor public transport system here in order to get to and from appointments. A safe space where vulnerable people who have taken the pills and are miscarrying can stay. The miscarrying experience was truly harrowing, and I fear for anyone going through that in shared, overcrowded accommodation or lacking basic facilities." Another noted, "I would worry about women who like me live in small towns if they lack their own transport to get to a GP in another town for this service. Where I live, if I had to use public transport to get home it could take hours. It should really be available in more locations." A third participant suggested there should be "at least one provider in a town, a chemist, a GP, the hospital dispensary, it's wrong to make it so difficult to get an abortion."

Since the introduction of COVID-19 pandemic protocols, the patient is no longer obliged to take the pill in front of the GP. They are allowed to bring it home and start the procedure when it is best for them so they do not have to worry about beginning the abortion on their travel home from the clinic. This protocol should become a permanent part of abortion care

6. Better Counselling Support

Respondents recommended more counselling support. One participant suggested, "If you had a buddy system. Whoever answers the phone to you, plans a phone call follow up. More emotional support outside of the GP." For anyone dealing with a diagnosed FFA, access to bereavement counselling is important. One respondent said, "I feel that termination for medical reasons is a traumatic experience to go through and healthcare providers have to bear this in mind when breaking news to parents and treat them sensitively and with compassion. I strongly feel that some form of support should be offered during and after this process whether it be bereavement midwives, councillors, support groups or any support system that can help people going through this process. I was not offered any of this and felt that it would have helped me hugely." Another respondent suggested, "A counselling session perhaps set up by your GP before the procedure. Just to talk through all those feelings and take some advice. Sometimes people might not want this and I was fine without it but it also definitely would have helped but it is very hard to even consider talking to someone when your head has so many thoughts anyway but it would be helpful if an appointment was scheduled by the GP and you had the option to attend or not." The MyOptions service should ensure that everyone who wants counselling is connected with one of the free, HSE-funded services, and hospital services should book appointments for patients in their care.

7. Safe Access Zones

Participants called for the removal of anti-abortion activity from outside GP surgeries, health clinics and hospitals. One respondent said, "It's hard enough for people seeking abortions to make the decision and go through with it with the stigma that already exists. To subject these people to the vile verbal abuse and intimidation those who protest spew at them is untenable." Safe Access Zone legislation is long overdue.

8. Protect Patients from Refusal of Care

Refusal of care and the anti-abortion views of healthcare staff had a significantly negative impact on patients' experiences. Some anti-abortion GPs tried to dissuade patients, block access to treatment, or make them feel guilty about their decision. Those who do not wish to provide abortion care should not be allowed to impose their view on patients. Patients should be able to file complaints against non-complying physicians and the Medical Council and HSE should take steps to monitor refusal of care and discipline physicians who fail in their ethical duties to patients.

9. Better Quality and Availability of Scanning

Scanning caused significant delays for participants. In addition to any time patients had to wait for a scan, this survey found that after having the scan, 53% (n=28) of respondents said they waited over three days before having the abortion. Improved access to better scanning facilities and improved quality of scanning are both needed. One respondent said, "having everything in one place. Especially the ultrasound" would make it a lot easier for people to access.

Correct dating of pregnancy is paramount in terms of people's right to access an abortion. All sonographers should receive values clarification training and those who object to abortion should not be permitted to perform dating for patients planning to have an abortion. The HSE should review its contracts with scanning facilities to ensure they are unbiased, accurate, and provide value for money.

10. Move Early Medical Abortion out of Hospitals

Respondents reported insufficient facilities, lack of compassion from medical staff, and refusal of surgical procedure when requested. All forms of early medical abortion can be safely provided by GPs and health clinics, and ARC recommends that these healthcare providers be given the support they need to offer this essential medical service.

11. Maintain Telemedicine

Respondents noted that "Telemedicine was brilliant" and that it should be maintained after the pandemic. One respondent said, "Because of COVID-19 my first and second appointment were both via telephone which I find very comforting and relaxing." Telemedicine reduces travel, making access easier: "I was worried about having to travel to an appointment but the doctor did the first consult over the phone, which was really helpful and prevented me going to the clinic twice."

12. Provide Patient-Centred Contraception Care and Free Contraception

Respondents in this survey reported being pressured into contraception after having their abortion: "I felt like I was being coerced into going on the contraceptive pill or to get the Mirena coil. It made me very uncomfortable." All patients should have access to all methods of contraception, free of charge, and patients should access contraception only if it is their decision to do so.

13. Values Clarification for Staff

ARC recommends that **values clarification and anti-racism training** be provided to medical practitioners, reception staff, and any hospital staff whose work intersects with the provision of abortion care.

14. Guaranteed Interpretation for All who Need it

All patients need and deserve information in a language they understand, including Irish Sign Language (ISL) and first languages other than English. ARC recommends free, easy to access interpretation services for all healthcare appointments.

15. Guaranteed Free Abortion for All on Island of Ireland

ARC recommends that the Irish government take urgent steps to close the gap between policy and practice so that **abortion is freely available to any individual resident in Ireland**. Participants reported being asked to pay for their abortion care where they could not provide evidence of a PPSN (Personal Public Services Number). This constitutes an additional barrier to access for those who do not have PPSNs including recently arrived migrants and asylum seekers, Irish citizens coming to Ireland from abroad and undocumented migrants, among others, despite being guaranteed free abortion care in the Health Act 2018.

16. Decriminalisation

ARC strongly recommends the **decriminalisation of abortion** in order to support doctors to make patient-centred decisions without fear of prosecution.

Gratitude

Although many barriers impede access to abortion in Ireland, the introduction of the Health Act 2018 is an important milestone, particularly for anyone seeking an abortion under 10 weeks. Many respondents expressed their gratitude for the care they received and thanked those who fought for legislative change and worked to implement services. Respondents said:

“I was so incredibly thankful that I could be cared for at home. Something went wrong with the first round of pills and I was in a lot of pain. Knowing what I had done was legal and that I could get care at home here in Ireland by medical professionals meant a lot to me.”

“I am so grateful to have been able to safely avail of this service in my home country. For most of the part I was treated with dignity and respect and by very caring and empathetic staff.”

“I never thought I would appreciate Repeal in this way.”

“I’m eternally grateful that I didn’t have to travel abroad to gain access to abortion services. Instead I was able to attend a GP clinic a few miles from my house, and recover in the comfort of own home with the support of my family.”

“I feel so grateful to everyone who campaigned on repealing the eighth and who made it possible for someone like myself be able to have an abortion in this country. I can’t imagine how awful it was for women before 2019 who had to travel to the UK or try to get pills online. I also appreciated that I could go to a doctor outside my usual clinic, and that the doctor I saw asked if I wanted my own GP to be informed or not (I didn’t - I live in a rural area, and I feel here you never know people’s attitudes to abortion, so this was really important to me, the fact I could have it done without anyone knowing, even my own GP).”

“I had an illegal abortion with pills in Ireland in 2016. This experience was so much different. Thank you for all you’ve done.”

“Just my gratitude for your campaigning, without which I would not have had access to free, safe and legal abortion in Ireland. I think it is so important not only that abortion was legalised but that the campaign resulted in a situation where abortion is something that can happen in many cases in private in a person’s home, making it a normal, stigma-free experience. The campaign you ran in which experiences and sound rationale were openly aired and the eventual result also meant that when I had complications, I had somewhere to go without worrying that I would have to lie about the reasons or be ashamed or treated with hostility.”

Bibliography

Abortion Rights Campaign & Disabled Women Ireland (2019) Submission to the United Nations Special Rapporteur on Violence against Women on mistreatment and violence against women during reproductive healthcare in Ireland and Northern Ireland. <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/ARC%20DWI.pdf>

Department of Health and Social Care UK (2020) National Statistics: Abortion statistics for England and Wales: 2019. Published 11 June 2020. <https://www.gov.uk/government/statistics/abortionstatistics-for-england-and-wales-2019>

Duffy, Deirdre, Pierson, Claire, Myerscough, Caroline, Urquhart, Diane and Earner-Byrne, Lindsey (2018) 'Abortion, emotions, and health provision: Explaining health care professionals' willingness to provide abortion care using affect theory.' *Women's Studies International Forum*, 71. pp. 12-18.

Health (Regulation for Termination of Pregnancy) Act 2018, <http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html> Accessed 9 June 2021

Interim Clinical Guidance Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed during Pregnancy, Institute of Obstetrics and Gynaecology, Revised January 2020.

Interim Clinical Guidance Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed during Pregnancy, Institute of Obstetrics and Gynaecology, Revised January 2020.

Jones, Rachel K., Witwer, Elizabeth, and Jerman, Jenna. (2020). 'Transgender abortion patients and the provision of transgender-specific care at non-hospital facilities that provide abortions', *Contraception*, 102, 100019. <https://doi.org/10.1016/j.conx.2020.100019>

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-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, Switzerland.

Mullally, Aoife, Horgan, Trish, Thompson, Mike, Conlon, Catherine, Dempsey, Brendan, Higgins, Favier, Mary (2020). '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*, 102(5), 305-3017. <https://doi.org/10.1016/j.contraception.2020.07.003>

Pallitto, Christina C., García-Moreno, Claudia, Jansen, Henrica A. F. M., Heise, Lori, Ellsberg, Mary, and Watts, Charlotte, 'Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence', *International Journal of Gynecology & Obstetrics*, 120 (1), (2013), 3-9 <https://doi.org/10.1016/j.ijgo.2012.07.003>

Wiebe, E., Chalmers, A. and Yager, H. (2012): 'Delayed motherhood: understanding the experiences of women older than age 33 who are having abortions but plan to become mothers later', *Canadian Family Physician Medecin de Famille Canadien*, 58(10), 588-95.

World Health Organization and Department of Reproductive Health and Research, 'Safe Abortion: Technical and policy guidance for health systems', 2nd ed., World Health Organization, Geneva, 2012

Appendix 1: Non-English Language Respondents

Of the Arabic language survey, there were six respondents in total. However, three completed the first question only (the question on consent to participate in the survey). Two participants completed the demographic questions and did not answer any further questions in the survey. One completed the survey but skipped questions in relation to information and health service experience, a large proportion of the survey. The participant who completed the survey was refused care in Ireland and obtained pills over the internet. There is little additional detail completed by the participant. Of those who completed the demographic information in Arabic, all identified as female and were between the ages of 25-35+. All were based in small towns. One identified as Irish and an Irish citizen. One participant identified as from the North African/Middle Eastern region and undocumented. The third identified as a legal resident and Irish.

Of the Irish language respondents, five began the survey. One respondent completed just the first question. Two completed the demographic questions. Of these, one identified as male, Black African, and an Irish citizen. No other details were completed. The second identified as female, White Irish, in a rural location. No further details were provided. Of the remaining two respondents in the Irish language survey, one identified as Asian Irish and a person without immigration papers. They had accessed an abortion through the Irish healthcare system. No further details were noted. The other identified as White Irish, an Irish citizen and living in a city. This respondent gave inconsistent answers to the questions on whether they had accessed or tried to access abortion services. No further details were provided.

Of the Polish sample, one respondent was aged 16-17 and was a student from outside Ireland, based in a small town. No further details were provided. A second respondent identified as White Irish, based in Dublin. They reported that they were an "Asylum Seeker or international protection applicant" but were not living in a Direct Provision Centre or emergency accommodation. No further details were provided. The third Polish language respondent identified as White Irish, and was living in insecure housing or homeless. This respondent gave inconsistent answers to the questions on whether they had accessed or tried to access abortion services. No further details were provided.

Appendix 2: When Abortions Took Place

The HSE abortion statistics include the month in which abortions took place. The corresponding data for our participants is included below.

