

Accessing Abortion
in Ireland:

Meeting the Needs of Every Woman



nwc

National Women's Council



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Acknowledgements

The National Women's Council (NWC) commissioned Dr Sinéad Kennedy to write this report. We would like to extend our sincere thanks to her for leading this project and providing such a cogent and robust analysis of the development of Ireland's abortion care since the introduction of the Health (Termination of Pregnancy) Act 2018.

NWC gratefully acknowledges the funding provided by the Centre for Reproductive Rights which has made this work possible.

Special thanks are also due to our members who supported this project, including those who sit on the Abortion Working Group. Some members and experts generously gave their time for interviews to inform this analysis. Their insights were integral to this work and are very much appreciated. We would also like to extend special thanks to Disabled Women Ireland, the Abortion Rights Campaign, Doctors for Choice, the Irish Family Planning Association and Mara Clarke from Abortion Support Network. In addition, the ongoing legal analysis work conducted by Lawyers for Choice, and in particular, Mairead Enright, was of specific importance to this project. A full list of contributors is available in Appendix 1.

Finally, we would like to acknowledge staff members, Alana Ryan and Mary Hayes, who worked with Sinéad in developing and disseminating this paper as part of the NWC's health policy and advocacy work.

Foreword

Central to all of NWC's advocacy and campaigning for women's reproductive health, is the experiences of women. We firmly believe that it is women who are best placed to make decisions regarding their health with the advice and support of their doctor.

In 2018, the people of Ireland voted overwhelmingly for a more compassionate country which respected women's experiences and doctors' clinical judgement, and enabled abortion care to be provided at home.

Three years on, it is very welcome to see that after years of secrecy and shame, exile and isolation, many can now access this vital healthcare here in their own country.

However, from listening to women since the introduction of the Health (Regulation of the Termination of Pregnancy) Act we know that not all those in need of support are able to access it.

The most recent available statistics show that in 2019, 375 Irish residents were forced to travel for abortion care in England and Wales, with most seeking assistance during the second trimester. Almost 20 per cent of those who had to travel were seeking care in the heart-breaking circumstance of foetal anomalies.

For these women and pregnant people, the Termination of Pregnancy Act did not provide access, demonstrating that there are still significant barriers in both the legal framework and its operation which are preventing abortion care at home.

The forthcoming Review of the Act is an essential opportunity to widen access and address these obstacles.

This is a critical moment for the Government to listen to women and act on the outcomes of NWC's research and the robust evidence gathered in the WHO Policy Implementation - Access to Safe Abortion Services in Ireland and the TCD Unplanned Pregnancy and Abortion Care Study (UnPAC) study.

Addressing obstacles means recognising that the restrictive nature of the Act, coupled with poor abortion care coverage and support pathways mean that for many, support at home remains out of reach.

In particular, aspects such as the medically unnecessary three-day waiting period, the 12-week cut off and the 28-day mortality clause for fatal foetal anomalies, all serve to impede doctors' abilities to provide urgent care when required while also placing additional stress on women during a challenging time.

Furthermore, despite abortion being recognised as an essential aspect of healthcare by the World Health Organisation, a doctor who provides abortion care outside the specific circumstances laid out in Irish law may face a prison sentence of up to 14 years. This criminalisation of healthcare has a chilling effect and undermines doctor's clinical judgement and professional expertise.

The Review gives us a precious chance to tackle these legal barriers to access, as well as a timely opportunity to consider how we can expand and enhance abortion care provision nationwide.

While Covid19 has led to some service innovations which are to be celebrated and built upon, for example, telemedicine for early abortion care, service coverage remains a pressing issue. At present, just one in ten GPs are providing early medical abortions while only half of maternity hospitals are providing surgical care. Aligned to this, there are problems in the pathway between community and hospital care which hinders deliver of joined-up, patient-centred care. Addressing these issues in access is imperative if we are to achieve better health outcomes for all.

This is our moment to further stand with women and pregnant people and ensure that at this critical time for reproductive health and rights in Ireland, their voices and experiences are central to the provision of abortion care.

Orla O'Connor

Director, National Women's Council

Introduction

This paper, commissioned by the National Women’s Council explores the provision of abortion services in Ireland under the Health (Regulation of Termination of Pregnancy) Act 2018 (ToP) since their introduction in January 2019. It explores women’s experience of abortion services as well as providers’ experience of service delivery, highlighting that there is still much more to be done to ensure all women and trans people¹ can access timely and appropriate reproductive healthcare. Through a series of interviews conducted with community and hospital-based care providers, as well as campaigners and activists, throughout November and December 2020, it explores women’s and pregnant people’s experience and access of abortion services as well as providers’ experience of service delivery with the aim of identifying barriers to access. The paper identifies key issues with regard to the ToP Act, particularly in terms of its limitations and equity of access. This analysis examines how access to and experience of abortion care are impacted by factors such as poverty, race and ethnicity, disability, and also looks specifically at the challenges of access during the Covid-19 pandemic. Looking forward to the three-year Review of the ToP Act, the paper concludes by identifying several recommendations designed to ensure the enhancement of abortion care policy, service delivery and equitable access.

¹ It is not only women who need access to abortion services; but members of the trans community too. Transgender men, intersex and non-binary or non-gender conforming people that have the physiology to become pregnant also require abortion services and experience significant obstacles in access the care that they require. I have attempted, throughout this paper to use inclusive language although sometimes it is necessary to focus on women’s experience of abortion services.

Section 1

Context: Repeal of the Eighth Amendment

It is estimated that at least **170,000** women living in Ireland have travelled to Britain to access abortion since the eighth amendment was introduced

The Eighth Amendment and the Long Road to Repeal

In order to understand the nature of Ireland's current abortion laws it is helpful if we begin by reflecting on the political context in which the law was introduced, and consider how Ireland transitioned from having one of the most restrictive abortion regimes in the world to a more liberal system, in terms of early pregnancy at least. Article 40.3.3, known as the Eighth Amendment, was voted by referendum into the Irish Constitution in September 1983. It stated: "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." The consequences of these forty-three words would have a profound effect on lives of women living in Ireland. The amendment effectively equated the life of a pregnant woman with that of an embryo or a foetus, creating an unworkable and dangerous distinction between a pregnant woman's life and her health. It was memorably characterised by Senator Ivana Bacik as "uniquely misogynistic, in that it expressly sets up the right to life of both the pregnant woman and the foetus that she carries in conflict – anticipating that a time would come when somebody would have to decide between them".² It banned abortion in all circumstances except when doctors believe the life of the pregnant woman was at risk, including the risk of suicide. The ban on abortion extended to pregnancies that were the result of rape and incest, cases of fatal foetal anomaly and where a pregnant woman's health was at risk. And yet, despite these restrictions, it failed to prevent significant numbers of women accessing abortions. It did however cause grave harm to many women living in Ireland, including death. It created a culture of shame and stigma around abortion and sexuality, as well as significant financial, practical

² Bacik, I. (2013), Legislating for Article 40.3.3, *Irish Journal of Legal Studies*. 3 (3): 22.

and psychological hardships for those seeking abortions, privations that were disproportionality experienced by the most excluded and vulnerable sections of society. Doctors spoke about the eighth amendment's 'chilling effect' on healthcare providers, deterring them from acting in the best interests of their patients. Having an abortion or helping a woman to have an abortion was a criminal offence in Ireland carrying a sentence of up to 14 years imprisonment. Criminalisation also applied to women who obtained abortion pills through the internet, and those who helped them.

Yet, every year, thousands of women travelled abroad to Britain and other European countries to access abortion care and many more took illegal abortion pills provided by groups like WomenHelp and Women on Web.³ It is estimated that at least 170,000 women living in Ireland have travelled to Britain to access abortion since the eighth amendment was introduced in 1983.⁴ Little, if any attention was given to the women⁵ who could not travel abroad, including those on low incomes; asylum-seeking or undocumented women; women with disabilities for whom travel may be difficult; women, girls, people in care or in abusive and coercive relationships. In other words, Irish law effectively facilitated unequal access to abortion as that access was dependent on the socio-economic circumstances of the pregnant woman. From 1992, better off women were constitutionally mandated to travel abroad and could avail of Government supported counselling services on their return, whereas women unable to travel abroad who terminated their pregnancies in Ireland, for example, with the abortion pill, faced a 14-year prison sentence and little or no professional support from a counsellor or doctor. Furthermore, there was always a deep hypocrisy inherent in the Irish State's so called 'pro-life' position. The State's commitment to supporting 'life' became far less absolute once that child was born with no constitutionally imposed protections, then or now, for children in need of healthcare, education or housing.

A central, though largely unexamined, feature of the Irish State's central maintenance and enforcement of Ireland's punitive abortion regime was the regulation and control of knowledge. Information about accessing abortion was strictly regulated by the State, although by the late 1990s abortion information was widely available on the internet.⁶ Yet, the State itself was inordinately interested in producing its own official narrative about abortion in Ireland. Between 1992 and 2017, seventeen separate reports have been commissioned by various apparatuses of the State under the auspices of the legislative, executive or judicial powers.⁷ With the exception of the 2017 Citizens Assembly Report the voices and experiences of women are

Irish law effectively facilitated unequal access to abortion as that access was dependent on the socio-economic circumstances of the pregnant woman

3 See Sheldon, S. (2016) "How can a state regulate swallowing? The home use of abortion pills in Ireland". *Reproductive Health Matters*. 24 (48): 90-101.

4 This is an estimated figure calculated using figures published by Department of Health in the UK from 1983-2018.

5 As outlined in footnote 1, we also recognise that as well as women, trans men, non-binary and intersex people may also have been in need of abortion care but unable to travel.

6 While the advent of the internet was a game changer for accessing abortion information internet, it should not be over-stated as there were many women still without a source of information e.g. women with literacy issues and rural women without internet access.

7 For more details and a list of these reports see Kennedy, S. (2020) 'The Right to Know: Gender, Power, Reproduction and Knowledge Regulation in Ireland', in Cullen, P., Corcoran, M. (ed.) *Producing Knowledge, Reproducing gender: Power, Production and Practice in Contemporary Ireland*. Ireland: UCD Press, pp. 110-129.

completely absent from these reports. It would not be until the emergence of the Repeal campaign, with its emphasis on women's experience as knowledge, that this strict dichotomy between public and private forms of gendered knowledge would begin to dissolve. Although as is evident from the publication of Mother and Baby Homes Commission Report (January 2021) the Irish State continues to be either unwilling or unable to recognise women's experience as a form of legitimate knowledge worthy of respect and inclusion.⁸

Feminist activists continued to campaign in different ways against the eighth amendment throughout the 1980s, 1990s and 2000s while supporting women's access to abortions. The NWC worked on the issue of abortion for over thirty years, with its position on abortion developing over time in recognition of the diversity of views and perspectives from women and members on the issue. In 2009 the members of the NWC overwhelmingly supported a motion for a policy seeking provision of safe, legal abortion for women in Ireland. This gave the organisation a stronger voice and enabled it to develop its own public campaign strategies calling for access to abortion.

Death of Savita Halappanavar

It was, however, the tragic death of Savita Halappanavar in 2012 that galvanised activists and organisations to begin working together to develop a campaign to remove the eighth amendment from the Constitution. Savita Halappanavar, an Indian woman living in Ireland, presented to a Galway Hospital miscarrying at 17 weeks in October 2012. Doctors felt that due to the presence of a foetal heartbeat they could not treat her, citing the eighth amendment. She repeatedly asked for a termination, but her requests were denied with one nurse telling her that "this is a Catholic country".⁹ This proved fatal and she died of septicaemia. In the aftermath of Savita Halappanavar's death a Health Service Executive (HSE) investigation was chaired by the British obstetrician and former president of the Royal College of Obstetricians and Gynaecologists, Sir Sabaratnam Arulkumaran. Addressing an All-Party Oireachtas Committee in October 2017 he stated unequivocally that the eighth amendment "played a major role" in her death.¹⁰ The State's response was to introduce the unworkable Protection of Life During Pregnancy Act 2013 (PLDPA) which permitted abortions where a woman's life is at risk, including the risk of suicide. However, this was placed within a highly complex regulatory and criminal legal framework and in the context of the eighth amendment the Act was effectively meaningless.

One year later, in the summer of 2014, a young migrant woman, Ms Y, pregnant as a result of rape, became suicidal after being denied an abortion. Begging for an abortion, the woman went on hunger strike but instead of acceding to her request for an abortion she was legally entitled to under Irish law, an order to force-feed her was obtained from the High Court

8 See Enright, M. (2021) 'Mother and baby home adoptions may have been legal but that does not make them right', *The Irish Times*, 16 January. <https://www.irishtimes.com/opinion/mother-and-baby-home-adoptions-may-have-been-legal-but-that-does-not-make-them-right-1.4459471#YALnPVVJ9YA.twitter>

9 Holland, K. (2013) *Savita: The tragedy that shook a nation*. Transworld Ireland, 81.

10 Holland, K. (2017) 'Eighth Amendment 'played major role in Savita's death'', *The Irish Times*, 19 October. <https://www.irishtimes.com/news/social-affairs/eighth-amendment-played-major-role-in-savita-s-death-1.3261037>

and she was effectively coerced into continuing her pregnancy until the foetus was viable.¹¹ Meanwhile, the Repeal campaign continued to gain momentum with activists determined to end the horror and hypocrisy of Ireland's abortion laws. In December 2012, the Abortion Rights Campaign (ARC) was established. On the 7th of October 2013, the thirtieth anniversary of signing the eighth amendment into the constitution, twelve women's and civil society organisations, including the NWC, released a joint statement highlighting the detrimental impact of Ireland's abortion ban. These organisations went on to form the Coalition to Repeal the Eighth Amendment later that year with the specific aim of removing the eighth amendment from the Constitution in order to protect and respect women's lives, health and choices.

Citizens' Assembly

By 2016 abortion had become a key political and election issue and the newly elected Government were under pressure to at least appear to be acting on the issue. So, in 2016, the Government established a Citizens' Assembly to consider the issue of abortion and to make a series of recommendations to the Oireachtas. Members of the public, representative groups and citizen organisations were invited to make a submission. The Assembly, a randomly selected group of 99 citizens, heard from a wide range of medical and legal experts, advocates from human rights groups, as well as campaigning and civil society organisations. Significantly, the Assembly also heard from women who had had abortions. This was the first time that an official State body incorporated the experiences of women who had had abortions into its findings. Following extensive discussions and deliberations the Assembly made the following recommendations:¹²

- that Article 40.3.3 of the Constitution should not be retained in full.
- that it would be a matter for the Oireachtas to decide how to legislate on these issues.

The Assembly members then made a series of recommendations to the Oireachtas about what should be included in this legislation. They recommended that a woman shall be entitled to access an abortion in the following circumstances:

Up to 12 weeks

- Without restrictions as to reasons

Up to 22 weeks

- In cases where pregnancy is a result of rape
- On grounds of foetal diagnosis of serious disability
- Risk to health

11 Holland, K (2014), 'Timeline of Ms Y Case', *The Irish Times*, 4 October. <http://www.irishtimes.com/news/social-affairs/timeline-of-ms-y-case-1.1951699>

12 Citizens' Assembly (2017) *Final Report on the Eighth Amendment of the Constitution*. Citizens' Assembly, 2017. <https://www.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution.html>

After 22 weeks / no gestational limits

- On grounds of diagnosis of fatal foetal abnormality
- Serious risk to health
- Risk to life

Joint Oireachtas Committee

Following the Citizens' Assembly a 21-strong Oireachtas committee on the Eighth Amendment was tasked with examining their recommendations. The Committee heard additional evidence from medical, legal and human rights experts. In December 2017, the Committee made the following recommendations:¹³

- removing Article 40.3.3 (the eighth Amendment) from the Constitution
- that having an abortion in Ireland would no longer be a criminal offence
- allowing abortion without restriction as to reason up to 12 weeks
- allowing abortion with gestational limits set by medical best practice for reasons of fatal foetal abnormality or risk to health, including mental health.

Referendum

On the 29th January 2018, the Government approved the holding of a referendum to remove Article 40.3.3 (eighth amendment) from the Constitution before the end of May 2018 and to replace it with a Constitutional provision enabling the Oireachtas to legislate for abortion.¹⁴ On 9th March 2018 the then Minister for Health, Simon Harris, published a Policy Paper on the Regulation of Termination of Pregnancy¹⁵ and the General Scheme (Heads of a Bill) to Regulate Termination of Pregnancy on March 27th¹⁶ outlining how the Government intends to legislate if Article 40.3.3 is repealed. The key findings were as follows:

- Abortion would be legal on grounds of risk to the health of pregnant woman.
- No distinction would be made between a risk to the physical or mental health of a pregnant woman.
- Abortion would be permitted on the grounds of a foetal condition which is likely to lead to death before or shortly after birth.

13 Report of the Joint Oireachtas Committee on the Eighth Amendment (Oireachtas, 2018) <https://webarchive.oireachtas.ie/parliament/media/committees/eighthamendmentoftheconstitution/Report-of-the-Joint-Committee-on-the-Eighth-Amendment-web-version.pdf> (Accessed 30 November 2020)

14 Marie O'Halloran, "Abortion now in hands of the electorate, says Taoiseach" Irish Times, 30 January 2018 <https://www.irishtimes.com/news/politics/oireachtas/abortion-now-in-the-hands-of-irish-electorate-says-taoiseach-1.3373887> (Accessed 30 November 2020)

15 Joint Oireachtas Committee (2018) Policy Paper on the Regulation of Termination of Pregnancy. 09 March. <https://www.gov.ie/en/publication/82a29f-policy-paper-on-regulation-of-termination-of-pregnancy/>

16 General Scheme of a Bill to Regulate Termination of Pregnancy. Dublin: Department of Health; 2018.

- Abortion would be permitted up to 12 weeks of pregnancy on request.
- The Protection of Life During Pregnancy Act, 2013 would be repealed in full.

This General Scheme would become a key feature of the Government's case in support of the referendum. On 22 March 2018, Together for Yes, the national civil society campaign for a Yes vote in the referendum, was launched. Together for Yes brought together three national organisations to campaign for a Yes vote and was led by Orla O'Connor, from the National Women's Council, Gráinne Griffin from the Abortion Rights Campaign, and Ailbhe Smyth from the Coalition to Repeal the Eighth Amendment.

Repeal Campaign

The Repeal campaign was thirty years in the making and it is not possible to explore in detail the nature of campaign here.¹⁷ However, it is worth highlighting one of the most notable and deliberate features of the campaign; the inclusion of women's voices and experiences of pregnancy and abortion. For a country whose entire history around sex and sexuality has largely been characterised by silence and shame, this was remarkable.¹⁸

If, as Carol Sanger argues, citizens are not just subjects of the law, but

“are also supposed to make law, directly or indirectly” then “we cannot advance how we and our representatives think about something – and certainly not how it should be regulated – until we start talking about it.”

This conversation began with the X case in 1992 and was reignited around the tragic death of Savita Halappanavar. It started with what are sometimes known as the 'hard cases' cases involving rape, serious risk to health or cases of fatal foetal abnormality; but it also quickly became about the everyday experiences of women who travelled abroad or took the abortion pill because, given their own particular set of circumstances, they simply did not want to be pregnant. These stories moved debate away from abstract medical-legal questions and placed the focus where it belonged, on women's agency and decision-making ability.

¹⁷ For an overview of the Repeal Campaign and Together for Yes, in particular, see Griffin, G., O'Connor, O., Smyth, A., O'Connor, A. (2019) *It's a Yes! How Together for Yes repealed the Eighth and transformed Irish society*. Orpen Press.

¹⁸ Sanger, S. (2017) *About Abortion: Terminating Pregnancy in Twenty-First Century America*. Harvard University Press, p.xiii.

The referendum on the thirty-sixth Amendment to the Constitution was held on 25 May 2018. The electorate voted by a landslide in favour of repeal. The scale of victory was enormous, with 66.4% of the electorate voting 'yes' to replacing Article 40.3.3° of the Constitution ('the Eighth Amendment')

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The referendum on the thirty-sixth Amendment to the Constitution was held on 25 May 2018. The electorate voted by a landslide in favour of repeal. The scale of victory was enormous, with 66.4% of the electorate voting 'yes' to replacing Article 40.3.3° of the Constitution ('the Eighth Amendment') with an Article stating provision may be made by law for the regulation of termination of pregnancy. At 64.5%, the turnout was one of the highest ever recorded for a referendum in this country and the highest of any referendum since 1992. On the 18 September 2018, President Michael D Higgins signed the thirty-sixth Amendment of the Constitution Bill 2018 into law and the Government announced that legislation outlining the legal grounds on which abortion was now permissible in Ireland would be presented to the Oireachtas within weeks with the aim of making legal abortion services available on 1 January 2020.

Section 2

Implementation of abortion services in Ireland

The NWC contended that the effects of Ireland's new abortion law needed to be two-fold: Firstly, it must ensure safe, equitable, accessible and legal abortion for women, and, secondly, it must institutionalise women's autonomy over reproductive decision-making

Drafting Ireland's Abortion Law

Following the removal of the eighth amendment from the Constitution, the then Minister for Health Simon Harris published the Health (Regulation of Termination of Pregnancy) Bill 2018 on 1 October 2018, which closely resembled the General Scheme published during the referendum campaign. The bill proposed to provide a statutory basis for the regulation of the termination of pregnancy in Ireland. Although the Bill explicitly refers to women, under the Interpretation Act 2005, these provisions should also apply to the trans community.¹⁹ Less than three months later the Bill had passed all stages in the Oireachtas (13 December 2018) and was signed by the President of Ireland on 20 December 2018. The Act came into operation on 1 January 2019 by order of the Minister.

The NWC were broadly welcoming of the Bill, having played a major leadership role in the referendum campaign as part of Together for Yes, with the NWC's Director Orla O'Connor serving as one of the three co-directors of Together for Yes. However, after the publication of the Bill, alongside many of the organisations who campaigned for Repeal, the NWC expressed disappointment that decriminalisation and safety zones were not considered as part of the legislation²⁰ and suggested a series of amendments. All of NWC's amendments were based on extensive research born out of over thirty years of policy development in the area of women's reproductive health, and, crucially, the personal testimony of women that had so animated the debate during the referendum campaign. The NWC contended that the effects of Ireland's new abortion law needed to be two-fold: Firstly, it must ensure safe, equitable, accessible and legal abortion for women, and,

¹⁹ See Simon Harris, Select Committee on Health debate -Health (Regulation of Termination of Pregnancy) Bill 2018, 6 November 2018: https://www.oireachtas.ie/en/debates/debate/select_committee_on_health/2018-11-06/2/

²⁰ National Women's Council (2018) 'National Women's Council of Ireland welcomes passing of abortion legislation' https://www.nwci.ie/learn/article/national_womens_council_of_ireland_welcomes_passing_of_abortion_legislation accessed 20 April 2021

These proposals, along with other amendments aimed at improving access to and experience of abortion care, were submitted by a wide variety of activists and campaigning groups, all of whom had decades of experience in providing support and care for women in need of abortions. However, these were largely overlooked

secondly, it must institutionalise women's autonomy over reproductive decision-making. In order to achieve this, the NWC advocated for a number of amendments to be included in the final draft of the Bill.

Firstly, they advocated for the inclusion of a Preamble in the Bill that would serve as a reminder for future generations of the long fought for changes to protect women's health. This would further serve to reflect Ireland's past restrictive abortion laws and the legacy of how women have been treated in Ireland. They also made a series of recommendations to the substance of the bill that would ensure that women's experiences and decision-making abilities was prioritised.

- **Scope of Providers of Care:** Ensure a wider range of healthcare professionals can provide, or be involved in the provision of abortion care. The published Bill only enables service provision by doctors. Nurses and midwives provide highly skilled, complex care in other areas of Irish healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call.
- **Medical Decision-Making & Assessing Risk:** Ensure the legislation enables medical decision-making in the best interests of women. Doctors must be empowered to feel confident in their interpretation and application of the abortion law, so that they (or their legal advisers) do not adopt needlessly cautious interpretations of provisions.
- **Conscientious Objection:** Protection for women in the case of conscience-based refusals of care (so-called 'conscientious objection') requires a clear, legal and policy framework, governing the practice of conscientious objection by healthcare providers, coupled with an effective oversight and complaint mechanism for women.
- **Notification & Data Collection:** Data collection is necessary to ensure good quality care. Routine monitoring is essential to inform service development in the interests of women (numbers per region; gestation; method; location; etc.) In establishing a new system it is essential that data collected enables monitoring of national distribution of abortion provision and incidences of refusal of care.
- **Safety Zones:** Speedy introduction of legislation providing for safety zones which are necessary outside maternity hospitals and primary care centres to protect women and their healthcare providers.

These proposals, along with other amendments aimed at improving access to and experience of abortion care, were submitted by a wide variety of activists and campaigning groups, all of whom had decades of experience in providing support and care for women in need of abortions. However, these were largely overlooked. In the end, the only significant concession accepted was procedural: an amendment to review the operation of the Act within three years of commencement. The Government did agree that it would publish legislation regarding safety zones – although we are still awaiting this – and agreed to establish a central online / telephone hub which could direct women to available services.



Section 3

Provision of Abortion Services

Abortion services in Ireland began on 1 January 2019, seven months after the removal of the eighth amendment from the Constitution. By way of comparison, Portugal, which legalised abortion in 2007, took eighteen months to introduce services. The timely introduction was welcomed and reflected the huge desire for social change around abortion. However, while GPs and community-based providers adapted and responded quickly to the introduction of services, some smaller hospitals struggled to introduce service, with one hospital-based provider commenting: “hospitals are large, complex organisations with defined cultures. Education and training is needed to help change those cultures and introduce a new and potentially disruptive service.”²¹ While hospital-based provision continues to be uneven across Ireland, we can still conclude that the rapid and effective introduction of largely effective abortion services stands as a testimony to the dedication of a significant number of committed healthcare professionals who involved themselves in developing models of care, drafting of professional guidelines, researching abortion care as well as training and education within the profession.

Abortion in England and Wales is predominantly provided in the independent sector (in clinics run by providers such as the British Pregnancy Advisory Service (BPAS) and Marie Stopes). In contrast, Ireland introduced abortion services using established infrastructure, primarily through General Practitioner (GP) provision, an approach similar to that employed in Scotland. Service provision is not mandatory, GPs opt-in to provide services and there is no compulsory ultrasound. Women’s health clinics run by the Irish Family Planning Association and Dublin Well Woman are also significant providers of EMA services within the greater Dublin area.²² While this approach has led to uneven service provision due to

21 O’Donoghue, K. (2019) ‘Doctors left high and dry after repeal of Eighth Amendment’, *Sunday Business Post*, 07 July. <https://www.businesspost.ie/insight/doctors-left-high-and-dry-after-repeal-of-eighth-amendment-273f7225>

22 The Irish Family Planning Association have clinics in Dublin City Centre and Tallaght. Dublin Well Women have two clinics in Dublin City Centre and Coolock.

conscientious objection, the model has proved largely effective resulting in a service “that reflects the essence of Family Medicine – low tech, high complexity – and potentially a more person-centred service”.²³ Medical practitioners have developed their own independent support networks in order to provide backup for one another in the delivery of abortion services, to more effectively lobby for necessary improvements in services and support and to encourage colleagues to sign up as providers. For example, the Southern Taskgroup on Abortion and Reproductive Rights (START), which had its genesis in the Together for Yes campaign, was established in 2018. It is a growing group of over 250 doctors drawn from general practice, obstetrics, and gynaecology and psychiatry in the Munster area and beyond who lobby for optimal abortion care for women. START and other activist medical groups such as Doctors for Choice have also run training and information sessions for their colleagues who want to provide care. Reflecting on the experience, a number of leading Irish doctors involved in the implementation of the service wrote:

“Irish clinicians had to learn what it’s like to move from theory to real practice in provision of care. This was more intense than many of us clinicians would have predicted and having the support of others - international colleagues, management, administration and other clinicians - within the community and hospital setting has been incredible.

Although the referendum result in Ireland was overwhelmingly supportive, the road to abortion care provision in Ireland was paved with obstacles and barriers, including heterogeneity of opinion among healthcare providers. Nonetheless, the generosity of spirit and good will of many served to drive provision forward and ultimately allowed the service to begin.”²⁴

These positive sentiments were echoed by all of clinicians (community and hospital-based) who were consulted in the course this research; all felt grateful that they could, in most cases, offer their patients the care that needed while noting how normalised the service has become within their own practice. This was in spite of the daily pressures experienced by doctors working within HSE where maternity services are under severe pressure, gynaecology waiting lists are long, all of which has been compounded by the stresses of Covid-19, the problems with CervicalCheck and recruitment of doctors, nurses and midwives.



23 Mullaly, A. et al. (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(2020): 306 [https://www.contraceptionjournal.org/article/S0010-7824\(20\)30189-X/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(20)30189-X/fulltext)

24 Ibid. 305.

Accessing an abortion in Ireland

The legal provision of abortion in Ireland is regulated by the Health (Regulation of Termination of Pregnancy) Act 2018 and determines the conditions under which abortion services can lawfully be provided for in Ireland. Essentially, women and pregnant people are permitted to access abortion services under four conditions:

1. In early pregnancy where the pregnancy is less than 12 weeks (Section 12)
2. In cases where there is a risk to life, or of serious harm to the health of the pregnant woman and the foetus has not reached viability (Section 9) In cases of emergency where there is an imminent risk to the life or of serious harm to the health of the pregnant woman or person (Section 10) In cases where a condition is present that is likely to lead to the death of the foetus either before or within 28 days of birth (Section 11) Under each criterion, one, or depending on the circumstances, two doctors must certify that the criteria of the Act have been satisfied. This means that doctors essentially perform the role of gatekeeper, determining when and whether the statutory criteria for access to care have been met. They play this role under the threat of criminalisation: Section 23 of the Act makes them potentially criminally liable where they could be subject to a prison sentence of up to 14 years for performing an abortion outside the proscribed parameters.

Access

Abortion services in Ireland are free at the point of delivery. Ireland does not have a universal health care system and offers limited universal health benefits, so the Government's decision to make abortion free, is notable and welcome. However, there are some provisos: you must be resident in Ireland and possess a PPS number, which not every person requiring an abortion has. Women from Northern Ireland can access abortion services in the South but they have to pay a fee, up to €450 plus travel and, in some cases, accommodation.²⁵

In order to facilitate access to abortion services a HSE freephone line 'My Options' was established to provide free and confidential information and counselling to people experiencing an unplanned pregnancy.²⁶ The My Options counselling service is provided on behalf of the HSE by experienced pregnancy counsellors from One Family, a national organisation for one-parent families. Women and pregnant people seeking advice will be able to request the name of the nearest GP who can provide abortion services if they are up to nine weeks pregnant. After nine weeks, women are referred by their doctor to the nearest hospital providing abortion services. People experiencing an unplanned pregnancy are also

25 See Alliance for Choice (2020) 'Up to 12 weeks access in Ireland'. <https://www.alliance4choice.com/up-to-12-weeks-access-in-ireland>

26 See HSE My Options (2021) 'Unplanned pregnancy support services' <https://www2.hse.ie/services/unplanned-pregnancy-support-services/my-options-freephone-line.html>

able to access non-directive counselling via My Options. During the initial rollout of the My Options service it was briefly not accessible to people who are deaf or hard-of-hearing and this meant that a deaf or hard-of-hearing person would have had to rely on a friend, family member or voice-into-text relay service to access the support, undermining their right to privacy and autonomy. This was in spite of the fact that several disability groups had submitted a 27-page document to the Department of Health detailing problems the abortion legislation will create for disabled people, three months in advance of the introduction of services. Services for people who were deaf or hard of hearing were introduced one month into the period of service provision and were in place by the end of January 2019. My Options currently provides translation services and offer interpreters for 240 different languages. A person or someone on their behalf calls My Options who, after securing a translator, will call back on a 3-way call. However, provision of translation services is uneven in Ireland and accessing this service can create further delays to accessing services and put many women at risk of exceeding the 12 week cut-off point.

1. Abortion in Ireland under 12 weeks

The majority of abortions in Ireland are early medical abortions (EMA)²⁷ performed under Section 12 of the legislation which states: “A termination of pregnancy may be carried out in accordance with this section by a medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy”. The Chief Medical Officer has confirmed that the 12 week limit is to be strictly interpreted: “Twelve weeks plus 1 day exceeds 12 weeks. Therefore, 12 weeks is 12 weeks plus 0 days”.²⁸ There is no flexibility around this cut-off point and no recognition that there may be challenging circumstances beyond the control of the woman or pregnant person, which may have delayed them accessing the procedure within 12 weeks.

²⁷ An EMA involves taking two medicines, mifepristone and misoprostol. The first medicine, Mifepristone, ends the pregnancy. It works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down and the pregnancy cannot continue. The second medicine, misoprostol, makes the womb contract causing cramping, bleeding and loss of the pregnancy similar to a miscarriage.

²⁸ The Chief Medical Officer, Dr Tony Holohan, confirmed this in a letter dated 27 November 2018 which was sent to the Dr Cliona Murphy; Chair of Institute of Obstetricians and Gynaecologists, RCPI and Dr John O'Brien, President of Irish College General Practitioners. See: Crowley, P. (2019) Letter to Minister for Health, Simon Harris T.D. re. Report on Health (Regulation of Termination of Pregnancy) Act 2018 Reviews sought in 2019. <https://www.hse.ie/eng/about/who/qid/resourcespublications/annual-report-on-notifications-under-the-health-regulation-of-termination-of-pregnancy-act-2018.pdf> ; See also Institute of Obstetricians and Gynaecologists (2018) *Interim Clinical Guidelines: Termination of pregnancy under 12 weeks*. December 2018. <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2018/12/FINAL-INTERIM-CLINICAL-GUIDANCE-TOP-12WEEKS.pdf>

In order for a woman or a pregnant person to obtain an abortion a medical practitioner must certify that they have examined the pregnant woman or person and confirmed that they are of a “reasonable opinion” that the pregnancy has not exceeded 12 weeks. Pregnancy is dated from the first day of a woman’s or pregnant person’s last menstrual period (LMP). A three-day waiting period must elapse before the abortion can take place. The second consultation must take place a minimum of three days after the first visit:

If first visit is on:	Procedure may commence on the following:
Monday	Thursday
Tuesday	Friday
Wednesday	Saturday
Thursday	Sunday
Friday	Monday
Saturday	Tuesday
Sunday	Wednesday



There is no provision for cases where EMA fails and pregnancy continues past 12 weeks. If the woman is under 12 weeks they may undergo the procedure again but they must also begin the process again, be recertified and wait a further three days. If they are over 12 weeks they will be refused an abortion. We do not know how many of these cases have occurred as failed medical abortions are not reported to the Department of Health, but the issue was highlighted by all of the providers who were interviewed for this paper (the Abortion Support Network has also encountered a number of cases which are discussed below). The Irish Family Planning Association (IFPA) Medical Director Dr Caitriona Henchion noted how the issue was consistently raised with the Department of Health during the drafting stage of the Act, but to little avail.²⁹

²⁹ See Reilly, C. (2019) ‘Introducing Abortion: the Story so Far’, *Medical Independent*, 25 March. <https://www.medicalindependent.ie/introducing-abortion-the-story-so-far/>

EMAs under 10 weeks are provided within the community by a GP, unless, in a small number of cases, there is a medical reason for more specialised care within a hospital or where initial GP management failed. EMA is also provided by two Dublin-based women and sexual health clinics: the IFPA and Dublin Well Woman. In cases where a woman is unsure of her dates and could be close to 9 weeks gestation, they are referred for an ultrasound to determine gestation. If the pregnancy is over 10 weeks the person is then referred to a maternity hospital to have the abortion where the same legal conditions apply (certification and a three-day waiting period). There are nineteen maternity units in Ireland and yet, only ten of these are currently providing abortion services.³⁰ The maternity hospitals providing abortion services in Ireland are:

- National Maternity Hospital, Holles Street, Dublin
- Rotunda Hospital, Dublin
- Coombe Women & Infants University Hospital, Dublin
- Midland Regional Hospital Mullingar, Co. Westmeath
- Our Lady of Lourdes Hospital Drogheda, Co. Louth
- University Hospital Galway, Galway
- Mayo University Hospital, Castlebar, Co Mayo
- University Maternity Hospital Limerick, Limerick
- Cork University Maternity Hospital, Cork
- University Hospital Waterford

Hospital provision of abortion services reaching just over 50% more than two years after services were introduced suggests that institutional conscientious objection may be a significant factor in the failure to ensure adequate geographical provision of services.³¹

30 See Health Services Executive, "Hospitals providing abortion services" <https://www2.hse.ie/conditions/abortion/how-to-get-an-abortion/hospitals-providing-services.html> accessed 23 April 2021. Accessed 23 April 2021. The Department of Health had hoped to visit hospitals still not offering the service late in 2020 but stated that this engagement was cancelled due to Covid-19. See Loughlin, E. (2021) 'Half of the country's maternity hospitals do not offer full abortion services', *Irish Examiner*, 25 March. <https://www.irishexaminer.com/news/arid-40250726.html>

31 See Ní Aodha, G. (2019) 'Conscientious objection prevents full rollout of abortion services in several maternity hospitals', *The Journal*, 16 July. <https://www.thejournal.ie/conscientious-objection-abortion-hospital-4725826-Jul2019/> ; See also, for example, the Irish Catholic Bishops' Code of Ethical Standards for Health Care (July 2018): "No healthcare facility or practitioner should provide, or refer a patient for, an abortion, i.e. any procedure, treatment or medication whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation. Such procedures, treatments and medications are morally wrong because they involve the direct and deliberate killing of, or a direct lethal assault on, an innocent human life in the earliest stages of development". (2.24).

There are

19

maternity
units in Ireland

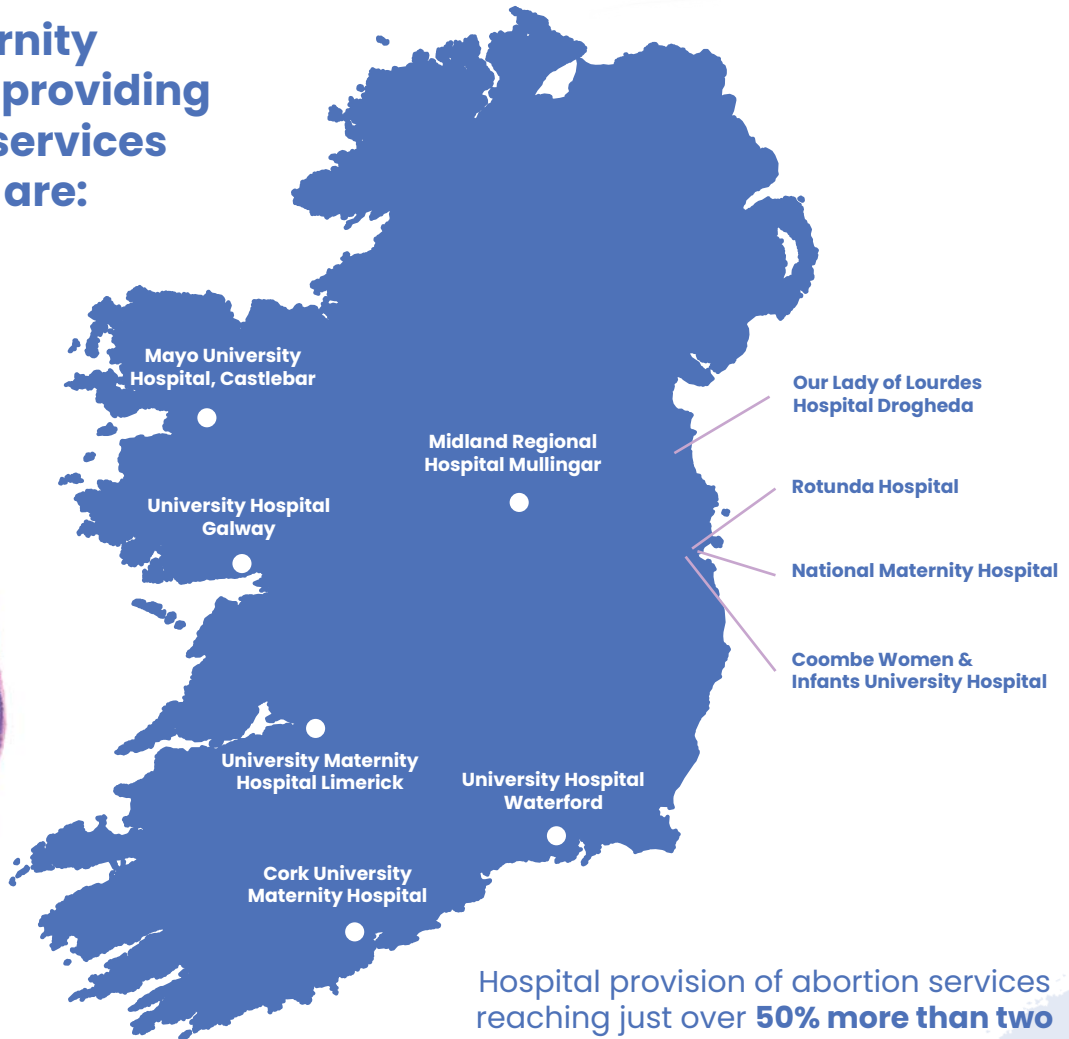


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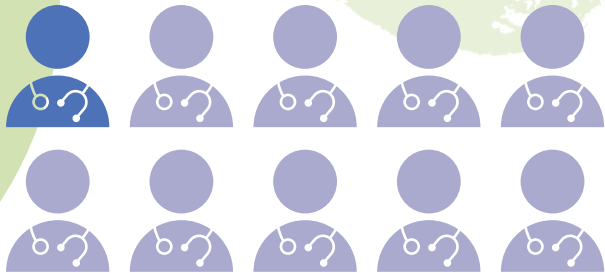
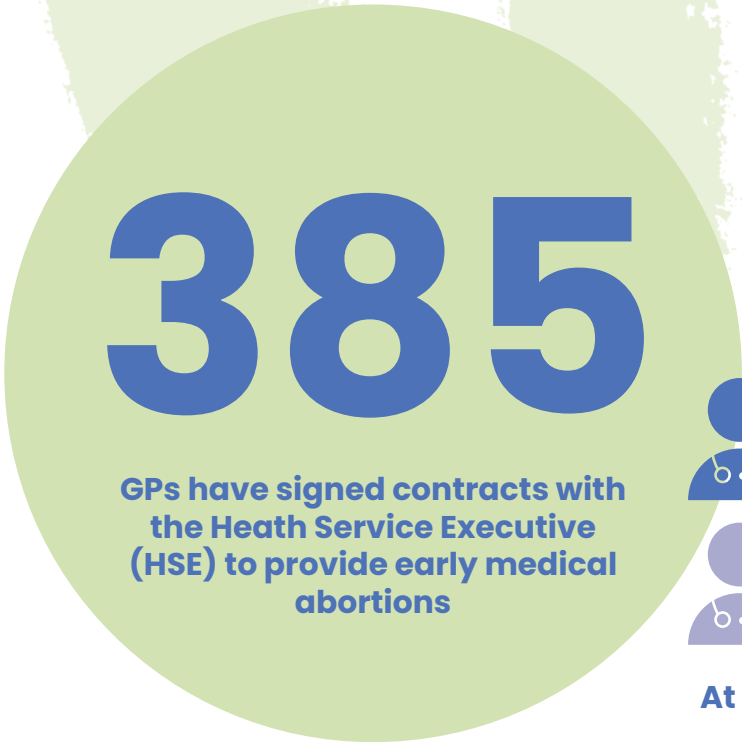
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Hospital provision of abortion services reaching just over **50% more than two years after services were introduced** suggests that institutional conscientious objection may be a significant factor in the failure to ensure adequate geographical provision of services.



At present, just one in every ten GPs is an abortion care provider

Although, as we will see below, there are a number of significant barriers to accessing EMA, the first year of provision has been largely effective with 6,542 abortions performed under 12 weeks.³² As of April 2020, 373 GPs had signed contracts with the Health Service Executive (HSE) to provide EMA,³³ and medical professionals who took part in this research suggest this has increased slightly to approximately 385 providers. The Irish College of General Practitioners (ICGP), estimates that 3496 GPs are actively practising in Ireland,³⁴ meaning that at present, just one in every ten GPs is an abortion care provider. It is also worth noting that due to the doctors' availability and capacity to take additional patients, not all are available at any one time. In consultation with GPs, a decision was made to make participating doctors' details only available by calling the My Options helpline, rather than publishing a list of their names in order to minimise the targeting of individual doctors by anti-abortion activists. My Options is also available 24 hours and is clinically staffed and can advise appropriate secondary care if required out of surgery hours to support women taking EMA medication.

32 Department of Health (2020) Notifications in accordance with Section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018 – Annual Report 2019. <https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/>

33 Ryan, V. (2020) "All GPs signed-up for abortion services not constantly available" *Irish Medical Times*. 1 April 2020. <https://www.imt.ie/uncategorised/gps-signed-abortion-services-not-constantly-available-01-04-2020/>

34 Collins, C., Homeniuk, R. (2021) How many general practice consultations occur in Ireland annually? Cross-sectional data from a survey of general practices. *BMC Family Practice* 22, 40

All of the medical practitioners interviewed for this paper enthusiastically supported the continuation of a telemedicine option post-pandemic in order to ensure a better more patient centre care model for EMA.

Early Medical Abortion under Covid-19

From the beginning of the Covid-19 restrictions in March 2020, doctors and women's groups voiced serious concerns to the Minister of Health that timely access to abortion services could be compromised by the restrictions. They argued that the legal requirement requiring a woman seeking an early medical abortion (before 12 weeks) to make two GP visits, three days apart, was "irreconcilable" with current public health advice to avoid all but essential travel.³⁵ In a letter to the Minister, six organisations, including the NWC, stated: "Mandating two face-to-face appointments is not in alignment with Government policy to restrict travel and social interactions... It poses risks to patients and staff of transmitting Covid and reduces availability of providers, as it precludes those providers who are self-isolating but well from providing the service whilst working remotely." The letter called for "legislative or other measures to enable abortion services to continue during the Covid-19 outbreak" and to "make provision for remote consultation in accordance with public health guidance and home administration of both abortion medications (mifepristone and misoprostol)". The then Minister for Health, Simon Harris later clarified that based on the legal advice he had received he was satisfied that remote consultation for EMA (under 12 weeks) was possible and did not require addition legislation. Section 12 of the 2018 Act included the phrase "having examined" and this the Minister stated did not exclude the possibility of the examination being carried out by other means, for example, by telemedicine or video conference. He also stated that Section 12 provided for a termination of pregnancy to be carried out "where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy".³⁶ The new guidelines provided for remote consultation with a medical practitioner for the purposes of accessing termination in early pregnancy. Where a medical practitioner judges it to be clinically necessary, a face-to-face consultation may be held with the patient; however, the document states that such consultations should be kept to a minimum during the Covid-19 public health emergency.³⁷

35 Holland, K (2020) 'Coronavirus: Concern crisis could prevent timely access to abortion services', *The Irish Times*, 27 March, <https://www.irishtimes.com/news/social-affairs/coronavirus-concern-crisis-could-prevent-timely-access-to-abortion-services-1.4213703>

36 Simon Harris cited in Ryan, V. (2020) 'Telemedicine abortion consultations permitted — Health Minister'. *Irish Medical Times*. 26 March. Available at <https://www.imt.ie/uncategorised/telemedicine-abortion-consultations-permitted-health-minister-27-03-2020/>

37 Institute of Obstetricians and Gynaecologists (2020) *COVID-19 infection Guidance for Maternity Services*. <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/05/COVID19-pregnancy-Version-4-D2-final.pdf>

The introduction of a telemedicine model for early medical abortions should be welcomed. There is a robust body of international peer-reviewed research confirming that this is a safe and effective approach to health care that is highly acceptable to women who require abortion.



The introduction of a telemedicine model for EMA should be welcomed. There is a robust body of international peer-reviewed research confirming that this is a safe and effective approach to health care that is highly acceptable to women who require abortion.³⁸ It has allowed medical practitioners to continue to deliver a safe service reflecting international best practice,³⁹ while reducing social contact, the risk to a woman's health, her doctor and other patients, as well as reducing the burden on medical practitioners at an extraordinarily busy time. All of GPs consulted for this paper were extremely positive about the model with one doctor commenting on how the introduction of telemedicine "mitigated the worst effects of the three-day waiting period. I can phone a patient back on the days she requests an appointment and then schedule the second visit for three days later".⁴⁰ GPs also noted that while the majority of women are happy for the first consultation to take place remotely, most choose an in-person meeting for the second consultation. All of the medical practitioners interviewed for this paper enthusiastically supported the continuation of a telemedicine option post-pandemic in order to ensure a better more patient centred care model for EMA.

38 For example, see Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., Gemzell-Danielsson, K. (2019) "Telemedicine for medical abortion: a systematic review" *BJOG: An International Journal of Obstetrics and Gynaecology* 126 (9) 2019: 1194-1102. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684> and public health guidance Institute of Obstetricians and Gynaecologists (2020) COVID-19 infection Guidance for Maternity Services. <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/05/COVID19-pregnancy-Version-4-D2-final.pdf>

39 See Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., Gemzell-Danielsson, K. (2019) "Telemedicine for medical abortion: a systematic review" *BJOG: An International Journal of Obstetrics and Gynaecology*. 126 (9) 2019: 1194-1102. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684>

40 Source: Author interview with GP, November 2020.

2 Abortion in Ireland after 12 weeks

Abortions after 12 weeks are tightly regulated and may only be carried out in a number of specific circumstances under sections 9 and 10 of the legislation, without a three day wait period. The grounds set out in the legislation are:

1. An abortion may be carried out where 2 medical practitioners, after examining the pregnant woman, are of the reasonable opinion formed in good faith that there is a risk to the life, or of serious harm to the health, of the pregnant woman, the foetus has not reached viability, and it is appropriate to carry out the termination of pregnancy in order to avert the risk.
2. An abortion may be carried out by one medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that there is an immediate risk to the life, or of serious harm to the health and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

These grounds provide the only viable care pathway for the majority of women and pregnant people who are unable to access abortion care within the 12 week limit, and who may include victims of sexual violence, minors, people living in coercive relationships, migrants and those living in Direct Provision, people who have recently experienced a crisis such as bereavement, or those who were unable to access a GP provider locally. Therefore, the notably low numbers of abortions performed post-12 weeks under section is deeply concerning and suggests that not all those in need of abortion services are able to access them in Ireland. Only 24 individuals (21 under Section 9 and 3 under Section 10) obtained abortions because of a medical emergency or risk to their life or health; that figure closely mirrors the number of abortions performed under highly restrictive Protection of Life During Pregnancy Act (PLDPA).⁴¹

⁴¹ Sections 7 and 8 of the Protection of Life During pregnancy Act 2013 provided for legal termination of pregnancies in cases of a risk of loss of life from physical illness; Section 9 provided for legal termination of pregnancies in cases of a risk of loss of life from suicide. <http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/pdf>

Notifications 2014–18 from Protection Of Life During Pregnancy Act 2013:⁴²

Year	Number of abortions
2014	26
2015	26
2016	25
2017	15
2018	32

These figures suggest that “risk to the life, or of serious harm to the health” are being interpreted in clinical practice within the same restrictive framework as under the PLDPA. The clinical guidelines that inform medical practice in this area reflect this:

“Risk to the life, or serious risk to the health of the mother may arise in a number of scenarios. Such risk may occur due to a pre-existing condition, such as chronic renal disease or cardiac disease; may become apparent for the first time in the first or second trimester of pregnancy (cancer or cardiomyopathy); or may be as a result of a sudden deterioration during the first half of pregnancy (chorioamnionitis or severe early onset pre-eclampsia). These cases pose a unique challenge for the clinician with regard to estimation of risk and where a decision is to perform a termination of pregnancy, the timing, mode and place of the procedure in order to best deliver optimal care for the woman.”⁴³

The Guidelines also stress that the legal framework that doctors must work within and the criminal consequences involved if they fail to satisfy the requirements of the Act. There is limited information in the public domain about the specific nature of cases where abortions were performed after 12 weeks, but the Rotunda Hospital’s 2019 Annual Report does state that five abortions were performed there under Sections 9 and 10 of the Act and that the majority of these involved cases of “previable preterm rupture of the membranes in which chorioamnionitis had developed”.⁴⁴

42 Sources: Department of Health (2014) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2013*; Department of Health (2015) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2014*; Department of Health (2016) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2015*; Department of Health (2017) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2016, 2013*; Department of Health (2018) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2017, 29 June 2017*. Department of Health (2019) *Notifications in accordance with Section 20 of the Protection of Life During Pregnancy Act 2013 – Annual Report 2018*.

43 Institute of Obstetricians and Gynaecologists (2019) *Interim Clinical Guidelines: Risk to life or Health of a Pregnant Woman in Relation to Termination of Pregnancy*. May 2019. p.12. <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/05/FINAL-DRAFT-TOP-GUIDANCE-RISK-TO-LIFE-OR-HEALTH-OF-A-PREGNANT-WOMAN-220519-FOR-CIRCULATION.pdf>

44 The Rotunda Hospital Dublin (2020) *The Rotunda Hospital Annual Report 2019*. Dublin, p13. <https://rotunda.ie/rotunda-pdfs/Clinical%20Reports/Rotunda%20Annual%20Report%202019.pdf>

The legislation also reflects a failure to acknowledge the widely accepted definition of health, defined by the World Health Organisation (WHO), unchanged since 1948, as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

This again would suggest that “risk to the life, or of serious harm to the health” is interpreted within a highly conservative framework that denies women a role in reproductive decision-making and prevents medical professions from exercising clinical judgement in the best interests of their patients. The legislation also reflects a failure to acknowledge the widely accepted definition of health, defined by the World Health Organisation (WHO), unchanged since 1948, as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁴⁵

A separate issue relates to how post-12-week abortion care is provided for those who do meet the narrow eligibility criteria. A recent abortion policy implementation study supported by the WHO suggests that there are significant challenges in accessing surgical abortion care due, in part, to infrastructural limitations including difficulties in accessing hospital operating theatres, shortage of providers, and objections raised by theatre staff.⁴⁶ Covid-19 has compounded these challenges and created an additional barrier to scheduling procedures. The WHO research team recommends that uncomplicated procedures in the late first and second trimester can be more safely provided in ambulatory outpatient settings.⁴⁷ Moving abortion care to outpatient gynaecological settings would reduce pressure on acute services and may make the service more accessible to patients.

45 World Health Organisation “What is Health?” <https://www.who.int/about/who-we-are/frequently-asked-questions>

46 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, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37.

47 *ibid.*

3 Abortion in Ireland in cases of fatal foetal anomaly

Abortions in cases of fatal foetal anomaly (FFA) are carried out under Section 11 of the legislation. A termination of pregnancy may be carried out in accordance with this section where two medical practitioners, having examined the pregnant woman, are 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. Both medical practitioners must certify his/her own opinions. The termination of pregnancy is to be carried out by an obstetrician who certified the termination. In 2019, 100 terminations were carried out under Section 11.⁴⁸

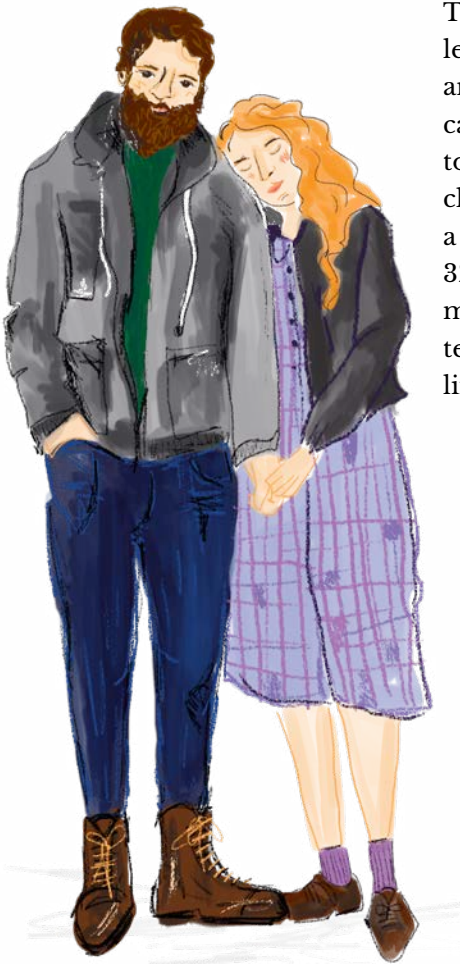
The inclusion of the 28-day time limit in the definition of ‘condition likely to lead to the death of the foetus’ was not included in the draft General Scheme and has created two difficulties in clinical practice. Firstly, while in some cases of FFA it is possible to predict death soon after birth, it is not possible to predict the exact time-frame within which it will occur. Secondly, the Act clearly excludes cases where the foetus’ life expectancy after birth is short – a matter of months or years – but not as short as 28 days. Approximately 3% of pregnancies receive a diagnosis of a major congenital anomaly but more women receiving a diagnosis as a result of advancements in prenatal testing.⁴⁹ According to Clinical Guidelines, Fatal foetal anomalies and life-limiting conditions “may include but are not limited to” the following:⁵⁰

- 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

48 Department of Health (2020) Notifications in accordance with Section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018 – Annual Report 2019. <https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/>

49 Power, S., Meaney, S., O’Donoghue, K (2020). “Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study”. *BJOG: An International Journal of Obstetrics & Gynaecology* 15 September 2020: 1 <https://doi.org/10.1111/1471-0528.16502>

50 Institute of Obstetricians and Gynaecologists (2020) *Interim Clinical Guidelines: Pathway For Management Of Fatal Fetal Anomalies And/Or Life-Limiting Conditions Diagnosed During Pregnancy: Termination Of Pregnancy*. Revised January 2020. <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/01/IOG-TOPFA-PATHWAY-FINAL-180119.pdf>



- Congenital severe hydrocephalus with absent or minimal brain growth
- Non-immune hydrops with major cardiac defect
- Inoperable conjoined twins
- Craniorachischisis / Exencephaly/ Iniencephaly

As the Clinical Guidelines acknowledge, this list is not meant to be exhaustive but it is indicative of how the legislation is interpreted in terms of clinical practice.⁵¹ In a revealing study conducted in Cork during the first six months of 2019 when abortion services were in the process of being introduced, foetal medicine specialists discussed their experiences of diagnosing and providing care to people with a FFA pregnancy:

“Half of the FMSs [foetal medicine specialists] expressed ‘uncertainty’ regarding a diagnosis being fatal as it ‘depends’ on an individual’s ‘definition’ of what is fatal. Relating to prognosis, participants identified that ‘there is never any certainty’ when death will occur, and that there is always an ‘outlier’ (i.e. a baby that will live longer than expected). A couple of FMSs commented on the relief experienced when the baby dies, confirming that their diagnosis was ‘right’. Their fear of getting it wrong is associated with the ‘difficult’ legislation, and that ‘under the legislation, [they] can’t have babies who survive for a long period of time’, i.e. beyond the 28 days referenced within the legislation.

Legislative challenges were identified by most participants, primarily ambiguity, ‘understanding what the legislation allows for’ and which conditions are deemed fatal and can therefore be terminated legally. Over half of the participants referenced the legislation as ‘restrictive’ and argued that it was forcing them to travel for a TOP [termination of pregnancy] for conditions that are not ‘quite fatal enough but are absolutely not going to survive.’⁵²

The study questioned the suitability of Irish legislation for providing suitable abortion care in cases of FFA and highlights the problems and anxieties created by retention of criminal liability for clinicians practising in this field.

Cases of FFA featured prominently in the Repeal referendum with many parents bravely coming forward to tell their painful stories of experiencing a pregnancy with a fatal foetal anomaly, being denied care in Ireland and then being forced to travel; these cases resonated deeply with the electorate who clearly wanted to see people experiencing these difficult pregnancies cared for in Ireland. The failure of the HSE to introduce a clear standardised system of healthcare across all the maternity hospitals in the country for women and pregnant people who are given a diagnosis of severe or fatal foetal anomaly means that experiences of care are uneven, especially in cases where they do not qualify for treatment in Ireland. Organisations like Termination for Medical Reasons Ireland which provide support to parents

51 Potentially fatal fetal anomalies/ life-limiting conditions (PFFA/PLLC) include diagnoses where there is a significant chance of death in utero or in the newborn period. Prognosis may not always be clear at the time of diagnosis, and it may not be apparent until after birth whether or not active intervention is indicated.

52 Power (2020) et al. p. 3

who experience an FFA pregnancy report that many women continue to be denied care in Ireland because of the 28-day guidelines and are forced to travel to Britain and elsewhere to access care there.⁵³ Differences in the application of law around FFA between Britain and Ireland creates confusion and problems in accessing care. British law does not require that the foetus will die either before, or within 28 days of, birth. Therefore, when women arrive in Britain seeking an abortion, medical staff who are not familiar with the exactitude of Irish law, question their need for care telling them they can access services in Ireland, when they clearly cannot. This adds to the pain and stigma to women and families already experiencing a heart-breaking situation.



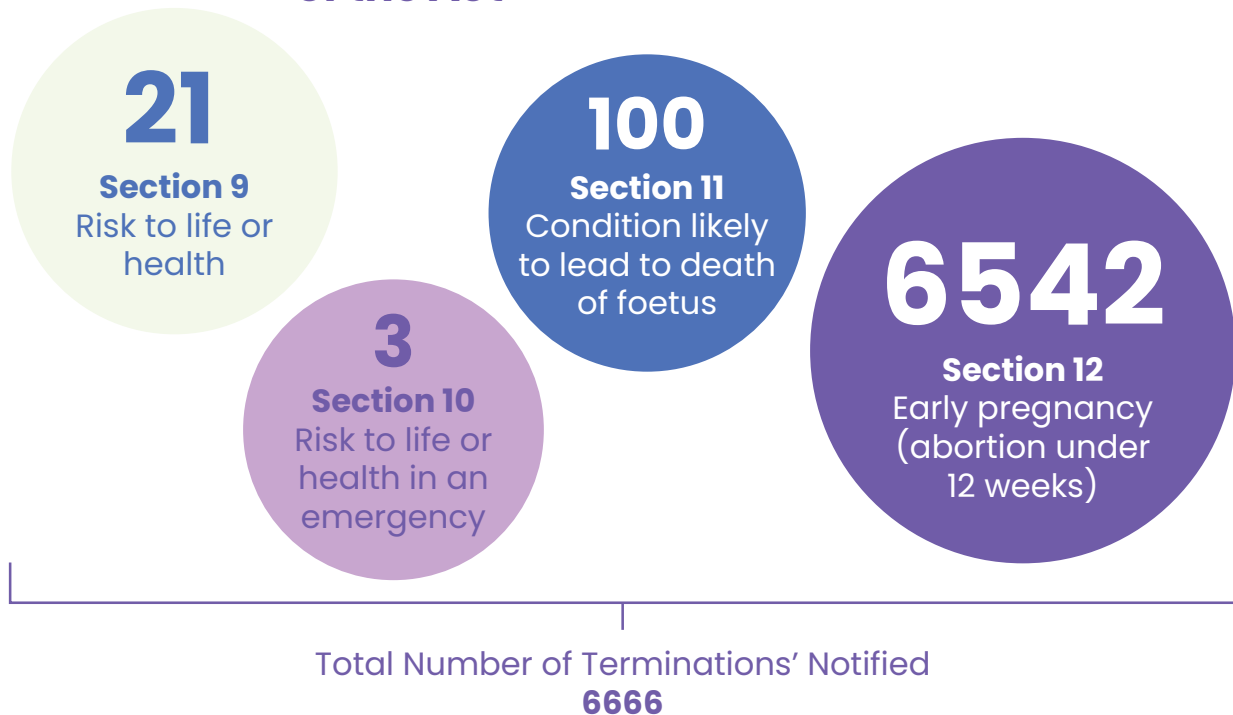
⁵³ See Terminations for Medical Reasons Ireland <http://tfmireland.com>

Section 4

Assessment of Provision of Abortion Services in Ireland

The Health (Regulation of Termination of Pregnancy) Act 2018 has now been operational for two years. The figures for 2020 will not be published until later in 2021. Figures for 2019 show that 6,666 terminations were carried out under the legislation in Ireland.

Terminations of pregnancy by section of the Act⁵⁴



⁵⁴ Department of Health (2020) *Notifications in accordance with Section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018 – Annual Report 2019*. <https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/>

These figures represent an important achievement demonstrating that abortion care has been provided in Ireland to a significant number of women and pregnant people. In previous years these women would have either had to travel abroad for abortions, would have accessed the abortion pill online and self-administered without localised medical support or, would have been forced to continue their pregnancy against their will. However, we do not know the number of people who have been unable to access abortion, have been refused treatment because they did not satisfy the legal criteria, or who have fallen outside the legislation and have illegally taken abortion pills at home.

Statistics published by the UK Department of Health and Social Care (2019) reveal that 375 women and pregnant people travelled for abortions to England and Wales.⁵⁵

While it represent a dramatic decrease of 87% from the previous year (2018) when 2,879 Irish residents travelled, it nevertheless reveals that at least one person had to travel abroad every day in order to access an abortion.

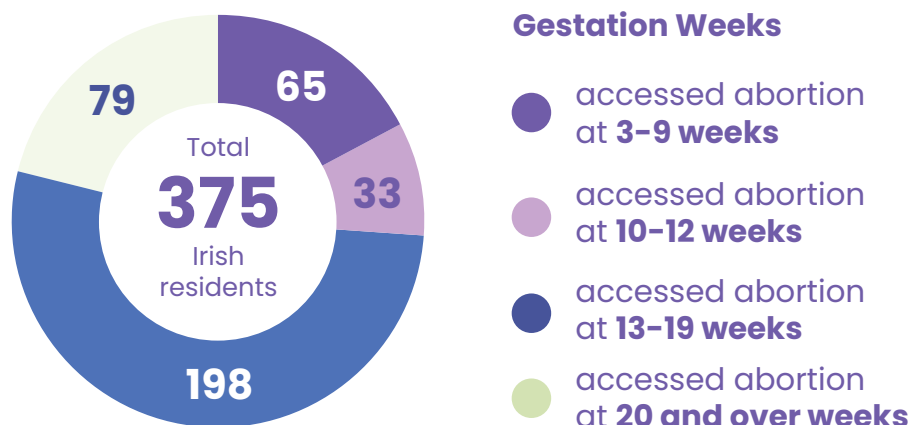


At least one person had to travel abroad every day in order to access an abortion

The background of this section features a light purple silhouette of the United Kingdom. A dashed purple line starts from the top right of the map, loops around the top, and ends with a small airplane icon flying towards the bottom left of the map.

⁵⁵ 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/abortion-statistics-for-england-and-wales-2019>

Gestation in weeks of women giving Irish addresses who accessed abortion services in England and Wales in 2019



Given the highly restrictive nature of Ireland’s post-12 week abortion laws, it is not surprising that the majority, approximately 75% of abortions took place after the first trimester. However, it is surprising that over 20% took place under 12 weeks and almost 17% occurred under 9 weeks when Ireland is supposed to have universal provision. We do not know the reasons why women travelled in these situations and there is currently no published research available. However, information shared by the Abortion Support Network (ASN) provides an important overview and insight into the gaps in service provision in Ireland and some of reason why people travel. ASN, a charity which helps women and pregnant people living in Ireland who are forced to travel access abortion services abroad, received calls and emails from 235 people resident in the Republic of Ireland, asking about abortion services between 2 January 2019 and 30 June 2020.⁵⁶

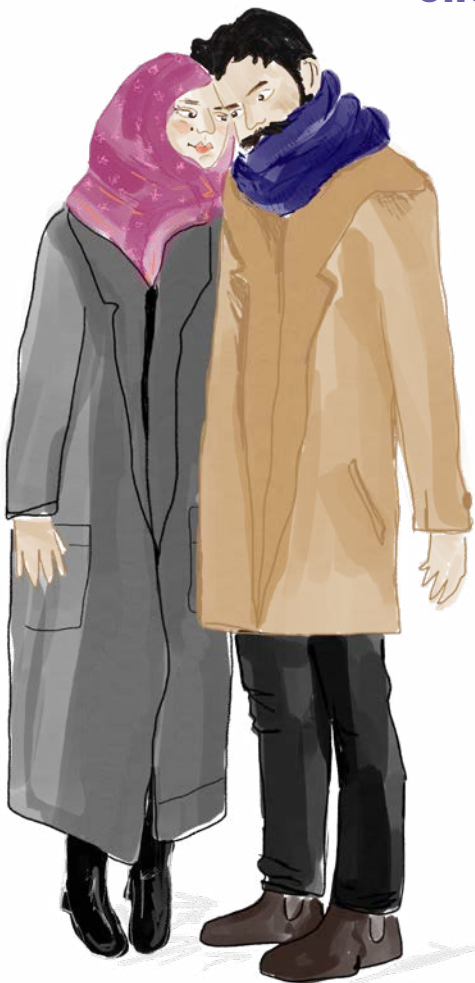
Overview of Abortion Support Network clients between 10 weeks and 11 weeks 6 days gestation

- A person called for information before making a decision. The person was unsure if they would have the decision made before they ran out of time.
- A number of people contacted ASN at 11 weeks 4 days, 11 weeks 5 days and 11 weeks 6 days having been told that they were “too far” to get treatment in Ireland.

⁵⁶ Figures supplied by Mara Clarke from Abortion Support Network. We are very grateful to Mara Clarke for sharing these figures and information with me and for her insights and advice on this paper.

- Two people were told there were no appointments before they ran out of time/hit 12 weeks due to an upcoming nurses strike.
- A person with a history of genetic disorders who wanted to find out options for termination if test results occur after 12 weeks.
- At least 5 women who believed they were under 12 weeks (10 weeks 5 days, 11 weeks 2 days, 11 weeks 4 days, etc) based on Last Menstrual Period but who scanned over 12 weeks at appointments in Ireland.

Overview of Abortion Support Network clients post-12 weeks



- ASN report encountering many cases of women whose pregnancies had medical indications, but the abnormalities did not fit within the restrictive criteria for termination for medical reasons under Section 11. Last Menstrual Period in these cases ranged from just over 12 to 28 weeks.
- Dozens of women who were within three days of the legal limit, meaning they were prevented from accessing care due to the medically unnecessary three-day wait limit.
- Several cases where people were delayed while waiting for scan results (reported delays varied from two days to over two and a half weeks).
- ASN encountered many cases where women did not realise they were pregnant until they were at or over 12 weeks. In some cases, there were other issues in the woman's life, such as domestic abuse; a young woman who did not realise she was pregnant; an older woman who thought her symptoms were a result of the menopause; a person with health issues that masked pregnancy symptoms; several women with no pregnancy symptoms.
- ASN encountered a number of cases where the woman knew she was pregnant but her life circumstances changed and so keeping the pregnancy was no longer viable.
- Several women who were delayed in coming due to misinformation given to them by anti-choice GPs (including two who told women they were not pregnant when they were) and rogue crisis pregnancy centres.
- ASN encountered two women pregnant as result of sexual assault who thought the 12 week limit did not apply in their cases.
- More than 25 clients had an EMA in Ireland, it failed and they were then over the 12 weeks. (Note: this is not something ASN would ask, so this figure only represents the number who have disclosed).

We know from many years of research and experience in Ireland how the distress and anxiety of an unintended pregnancy is compounded by the need to access abortion care in another state, in an unfamiliar city and often without family support.⁵⁷ The requirement to travel abroad means women's access to care is delayed, and that they must cover all the costs involved and organise the logistics of the trip, arrange childcare and time off work. There is no continuity of care for those who travel. Care delivered between jurisdictions does increase risk, including inability to access timely care and the potential risks to physical health when travelling. Women's decision-making is pressured due to the burden of travel. Not all women are able to exercise the freedom to travel. Disabled women, marginalised women such as asylum-seekers, migrants, undocumented women, those living in poverty and those living in abusive relationships may find themselves trapped in Ireland and unable to travel.

Abortion, travel restrictions and Covid-19

All of these issues have been compounded by the Covid-19 pandemic and the resulting travel restrictions, exacerbating many of the barriers that women and pregnant people experience in accessing abortion in Ireland, especially after 10 weeks. Official figures for 2020 are not yet available but *The Irish Times*, under a freedom of information legislation to the British Department of Health and Social Care, found that the number of women travelling to Britain for abortions more than halved in the first six months of 2020, compared with the same period in 2019: 101 Irish women travelled for abortions between January and June 2020 compared with 215 during these months in 2019.⁵⁸ Level 5 restrictions were also imposed again in the second half 2020 so we expected that these reduced figures will be mirrored for the second half of the year, and the first half of 2021, as may will find it impossible to travel due to Level 5 restrictions.

57 For overview, see Joint Committee on the Eighth Amendment of the Constitution (2017) Debate: *Health Care Issues Arising from the Citizens' Assembly Recommendations: Masters of the National Maternity Hospital, Holles Street and the Rotunda Hospital*. 11 October 2017. https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-10-11/3/

58 Holland, K. (2020) 'Coronavirus: GP visits regarding abortions to take place remotely', *The Irish Times*, 08 April. <https://www.irishtimes.com/news/social-affairs/coronavirus-gp-visits-regarding-abortions-to-take-place-remotely-1.4223488>

International research and best practice has consistently shown that waiting periods disproportionately effect women who are most vulnerable.

Gaps in Access and Provision

1. **Three-Day Waiting Period:** The ability to obtain abortion care without delay is critically important to reproductive health, and waiting periods create an unacceptable barrier to care. The three-day waiting period was presented by the Government during the referendum campaign as a period of reflection. However, this makes little sense given that the ‘reflection’ only begins after they request the abortion and has their pregnancy certified by a doctor that it is under 12 weeks. Women who present towards the end of the 12 weeks may be denied a termination of pregnancy simply because of the waiting period. The three-day waiting period holds no medical purpose or value and only serves to create an unnecessary obstacle to obtaining medical care.⁵⁹ It means that a woman must make two visits in order to obtain an abortion creating additional burden for those who need to arrange for time off from work or caretaking duties. International research and best practice has consistently shown that waiting periods disproportionately effect women who are most vulnerable.⁶⁰ Due to the inadequate provision of care in some parts of the country many women have to make two journeys over long distances to access care creating additional burdens that are once again more acutely experienced by the poorer and vulnerable women, migrants, asylum seekers and traveller women, disabled women.
2. **Time Limits:** The ToP Act requires pregnancy to be dated from the first day of a woman’s or pregnant person’s last menstrual period (LMP). Most women tend to date their pregnancy from conception but LMP means that many are at least two weeks further along in their pregnancy than they thought. This adds to the pressure of accessing abortion services within the legal timeframe. All of the doctors interviewed reported encountering patients in state of panic after realising they were approaching

59 See WHO (2012) *Safe Abortion Guidance: Technical and Policy Guidance for Health Systems*, 78. https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=111076120923E146C492CC58950C3D93?sequence=1

60 See Guttmacher Institute (2020) ‘Waiting Periods for Abortions’. <https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion>

All of the doctors interviewed reported encountering patients in state of panic after realising they were approaching the 12 week limit. One doctor commented:

“While the hospitals are extremely helpful they only have a certain number of appointments on certain days of the week. So you find yourself desperately ringing around trying to find your patient an appointment before it’s too late and they have to travel”

the 12 week limit. One doctor commented: “While the hospitals are extremely helpful they only have a certain number of appointments on certain days of the week. So you find yourself desperately ringing around trying to find your patient an appointment before it’s too late and they have to travel”.

- 3. Post-12 Week Provision:** The lack of post-12 week provision is deeply concerning and combined with the lack of requested Reviews under Section 9 of the ToP Act, suggests that women do not see this as a viable option to securing an abortion.⁶¹ Given the fact that numbers of abortions performed after 12 weeks (excluding grounds of FFA) is almost identical to the numbers performed under the highly restrictive PLDPA, it appears that doctors are only willing to perform abortions on this ground in exceptional circumstances. If the law could be amended to include the WHO definition of health which understand it as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This would allow ‘health’ to be interpreted contextually and to take account of the person’s wider circumstances and social well-being, and of their own perceptions of the risks to their health.
- 4. Standardised Pathways to Care:** One of the most important barriers to expanding GP abortion provision in Ireland is the lack of standardised national referral pathways into hospital provision. Across Ireland, experiences of pathways into hospital care are mixed with some GPs expressing extreme frustration at the lack of a clear pathway for women requiring hospital-based care under 12 weeks. There appears to be no pathway to care

61 Crowley, P. (2019) Letter to Minister for Health, Simon Harris T.D. re. Report on Health (Regulation of Termination of Pregnancy) Act 2018 Reviews sought in 2019. <https://www.hse.ie/eng/about/who/qid/resourcespublications/annual-report-on-notifications-under-the-health-regulation-of-termination-of-pregnancy-act-2018.pdf>

for a patient post-12 weeks requiring an abortion. If a woman is entitled to an abortion under Section 9 of the ToP Act, who is responsible for ensuring that she accesses one?

5. **Fatal Foetal Anomaly:** A national care pathway for cases of fatal foetal anomaly would ensure that the patient's choices and options are explained clearly and in an unbiased manner. Patients should be transferred to a specialist foetal medicine unit in Dublin, Cork, Galway or Limerick within seven days and offered all pre-natal screening and diagnostic tests if a problem is indicated. If a patient diagnosis is such that they cannot be looked after under existing legislation and need to travel to access healthcare, the HSE should have a formal referral pathway with an appropriate hospital in the UK, like Liverpool Women's Hospital, Guys Hospital in London or Mary's Hospital in London.
6. **Service Deficiencies:** Access to abortion services is uneven across the country both in terms of community-based GP care and hospital-based abortion care. Abortion services are orientated around urban centres where people may have more than one option to access abortion services. Outside of urban centres options are more limited, especially in the North West. At present, there is no provision in county Sligo and women and pregnant people may have to travel a round trip of up to 100 km, to Donegal or Roscommon, to access a GP twice, three days apart with the possibility of a third visit if a scan is required.
7. **Hospital Provision:** One additional maternity hospital is expected to begin providing abortion services in 2021 but hospital provision remains just over 50%. This creates a situation of significant geographical inequity and means that some women, especially for those based in the North West of the country, must travel significant distances if they require hospital treatment or scans. Many maternity hospitals also refuse to provide early pregnancy scans to date pregnancies under 12 weeks. One doctor interviewed reported that a Donegal-based woman, in need of a scan, endured a 10-hour return journey to a Dublin hospital on public transport in the same day. The HSE contracted a private provider, Affidea, to provide early pregnancy ultrasounds in the community. However, many GPs interviewed reported poor levels of service in many parts of the country. Staff shortages meant that the service was intermittently unavailable. Given that the majority of women who are referred for scans to date their pregnancy are presenting towards the end of the first trimester, even a 24-hour delay could result in them exceeding the 12 week limit and being refused an abortion. The limits on hospital provision also means that surgical abortions under 10 weeks are rarely possible and women's choice of abortion method is curtailed.

8. **Criminalisation:** Abortion is recognised as an essential aspect of healthcare by the WHO, yet a doctor who provides abortion care outside of the circumstances specified in the ToP Act is potentially criminally liable and could be subject to a prison sentence of up to 14 years (Section 23). This sets abortion care apart from other forms of healthcare and suggests that doctors providing abortion care are in some way “inherently less conscientious than other professionals and that the usual regulatory mechanisms of (general) criminal and civil sanctions and professional/fitness to practise oversight are insufficient for these professionals. In this way, the Irish law perpetuates the stigmatisation of both the care provider and the recipient of abortion care.”⁶² All doctors interviewed remarked on the “chilling effect” of criminalisation in their practice with one doctor commenting: “In no other area of my practice could I go to prison for filling out a form incorrectly”.
9. **Conscientious Objection:** The issue of Conscientious Objection (CO) and the role that it plays in restricting access to and provision of abortion services requires more attention. CO is only legitimate in circumstances where it does not impose an unreasonable burden on the patient, in terms of delay or distress or health consequences and no person should be faced with refusal of lawful abortion care. In other words, there must be a guarantee of access. Thus far the community-based model where GPs opt-in to provide services has resulted in significant geographical inequity in abortion services, especially in rural areas. The HSE needs to do more to ensure that all women have access to abortion services within their own community. With only half of all maternity hospitals in the State providing abortion services, conscientious objection is clearly operating at an institutional level, despite this being unlawful. There is also a need to protect healthcare providers who provide termination services. Respect for self-determination and integrity are applicable not only to providers who decide that their belief precludes them but also to those who decide to provide termination.⁶³ It should also be noted that for all the medical practitioners interviewed for this paper, the delivery of abortion care is an ethical choice; a choice they make because of their conscientious commitment to women’s autonomy, health and wellbeing.

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

63 For a detailed discussion see Chavkin, W., Swerdlow, L., Fifield, J. (2019) ‘Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study’. *Health and Human Rights*. 2017;19(1):55-68

10. **Exclusion Zones:** Following the referendum to repeal the eighth amendment and the subsequent enactment of legislation to regulate the termination of pregnancy in Ireland, there have been calls to enact further legislation which would create protest exclusion zones within a defined radius of a facility where terminations of pregnancy are to take place. The then Minister for Health, Simon Harris committed to drafting such legislation and a 'Safe Access Zones' Bill for this purpose. The Minister has been reported as saying that he had planned to include these provisions in the 2018 Bill, however he was concerned it would slow the Bill down. The legislation was due to be published in the summer of 2019 but to date no Bill has been produced. GPs interviewed for this paper argued that the threat of protests is potentially the biggest impediment to a new provider in areas which do not yet have adequate provision as it is in those areas that protests have had a disproportionately significant impact.

Section 5

Abortion access and equality

Abortion laws are, by their very nature, designed to determine who can and cannot access care and under what circumstances. Restrictive laws always disproportionately affect the most marginalised and vulnerable sections of society. Access to abortion needs to be understood and placed within the overall context of gender equality, including the context of human rights and social justice as it intersects with other structural and systemic forms of discrimination (race, class, gender and sexuality, disability).

The NWC has consistently emphasised the way in which abortion is too often isolated from issues such as socio-economic inequalities, health inequalities, barriers to active participation and inequality of opportunities and of outcomes - matters which directly affect an individual woman's decision-making process and are inextricably linked to gender equality.⁶⁴ We need to think about abortion and reproductive healthcare more generally within a social justice framework that is connected to other fundamental human rights such as the right to decent housing, the right to access good education, the right to live free from violence and the right to have access to healthcare. For example, access to an early medical abortion is of little help if you are homeless or live in a direct provision centre and do not have the resources to access your treatment or a safe, private place to recover. Furthermore, as Paola Rivetti argues: "questions of economic exclusion and race are rarely disjointed".⁶⁵

64 National Women's Council of Ireland (2013) *Abortion - Policy Position Paper of the National Women's Council of Ireland*. March 2013. https://www.nwci.ie/learn/publication/abortion_policy_position_paper_of_the_national_womens_council_of_ireland

65 Rivetti, P. (2019). "Race, identity and the state after the Irish abortion referendum" *Feminist Review*, 122(1), 185. <http://dx.doi.org.jproxy.nuim.ie/10.1177/0141778919845881>

Reflecting on the post-referendum legal scenario, Senator Eileen Flynn, a pro-choice Traveller activist asks:

“So who is going to support us, is [...] everyone going to have the same access to abortion? Because from today, [...] us, women here today have a hell of a long way to go in Ireland.”

Reflecting on the post-referendum legal scenario, Senator Eileen Flynn, a pro-choice Traveller activist asks:

“So who is going to support us, is [...] everyone going to have the same access to abortion? Because from today, [...] us, women here today have a hell of a long way to go in Ireland. [...] at the moment I’ve learned a lot about history at the conferences I’m going to and [...] thinking where is the history of the women from ethnic minorities, we’re not even in history books. And we’re the ones who are making history.”⁶⁶

Restrictions and obstacles created either by the law or uneven provision of services always disproportionately effect the most marginalised and vulnerable sections of society. People with financial means can usually navigate around restrictions and have a number of alternative options open to them. Traveller women are one of the most at risk groups of poverty in Ireland. 81.2% Traveller women are without work and one in three Irish Traveller women (32.7%) are looking after the home and family, nearly twice the rate of the general population (17.5%).⁶⁷ Traveller women experience particular obstacles in accessing healthcare and reproductive healthcare in particular. Again, Senator Eileen Flynn spoke about her own experiences of Irish maternity system as a Traveller woman:

“I went in there openly as a Traveller woman and straight away I was undermined in the maternity hospital. I wasn’t undermined by the midwives, I was undermined by the consultant, the one consultant. I didn’t have any choice or any say over anything. I felt angry as a pro-choice activist, not having the choice, not feeling heard, not feeling my baby mattered. I suffered with my sodium levels. I had numerous admissions. I felt a nuisance any time I went to the hospital.”⁶⁸

66 Eileen Flynn cited in Rivetti (2019) p.185.

67 National Traveller Women’s Forum Ireland (2013) *National Traveller Women’s Forum Health Position Paper*. <https://www.ntwf.net/resources/publications/>

68 Hogan, J. (2020) ‘Eileen Flynn: “As a Traveller woman, I was undermined in the maternity hospital”’. *The Irish Times*, 22 September 2020. <https://www.irishtimes.com/life-and-style/health-family/parenting/eileen-flynn-as-a-traveller-woman-i-was-undermined-in-the-maternity-hospital-1.4354484>

Research by the National Traveller Women's Forum shows that Traveller women experience discrimination in the health services with 66.7% of service providers agreeing that discrimination against Travellers occurs sometimes in their use of health services. The level of complete trust by Travellers in health care professionals is just 41% in comparison to 82% by the general population.⁶⁹ This suggests that Traveller women's experiences and their lack of trust in health care providers mean they are unlikely to seek support in relation to their reproductive health and may be unable to access abortion services in a timely manner.

Migrant women and asylum seekers are particularly disadvantaged by Ireland's abortion laws; they experience multiple barriers to accessing care and are therefore disproportionately affected by obstacles such as the three-day waiting period and the strict 12 week limit. An Irish address and PPS number is required by everyone seeking to access an abortion which results in barriers in treating asylum seekers and women temporarily resident in Ireland.⁷⁰ One doctor interviewed spoke about the difficulties securing translation services from the HSE for a patient which delayed her procedure for an additional four days on top of the three-day waiting period. If unable to access an abortion in Ireland, not all women are able to exercise the freedom to travel due to the significant financial burden of travelling, or they may be prohibited from travelling due to their immigration or dependent status.

Figures released from the Department of Health in Britain show that black, Asian and Chinese women with Irish addresses are significantly represented (almost 9%) in the figures for women travelling abroad for abortion, suggesting that they face particular barriers to accessing abortion care in Ireland.⁷¹ This is reflective of the more generalised experiences of discrimination and inequality that migrants and people from ethnic minority backgrounds experience within the Irish healthcare system. For example, in the 2013-15 period some 40% of maternal deaths were among migrants, despite the fact that this group only accounts for 17% of the general population.⁷²

Disabled people are often denied the right to make reproductive decisions, including decisions about abortion, contraception, pregnancy, and childbirth. There are over 100,000 women with disabilities of childbearing age living in Ireland and women with pre-existing medical conditions accounted for 68% of maternal deaths in the 2013-2015 period.⁷³

69 Ibid 60.

70 See Health Service Executive, "Before Having an Abortion" <https://www2.hse.ie/conditions/abortion/abortion-methods/before-having-an-abortion.html> accessed 23 April 2021.

71 See 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/abortion-statistics-for-england-and-wales-2019>

72 University College Cork (2015) *Maternal death enquiry report 2013-15*. Cork: University College Cork.

73 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>



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Disabled Women Ireland:

“In addition to financial barriers, prejudicial attitudes, inaccessible information, physical and communication barriers and an inaccessible transportation infrastructure impedes disabled women’s and pregnant people’s sexual and reproductive rights and freedom”

Disabled women and pregnant people face numerous barriers to adequate maternity, sexual, and reproductive health services, barriers which endanger their lives and increase their risk of mistreatment within healthcare services. They experience significant obstacles to accessing abortion care and their specific needs are rarely, if ever, given consideration when designing service provision. Disabled people in Ireland are twice as likely to experience basic deprivation and consistent poverty affecting their ability to access basic health services on an equal basis as their non-disabled peers. Some sections of the populations have a higher-than-average experience of disability. Pauline Conroy notes that this is the case for Irish Travellers; almost one in five Irish Travellers had a disability in 2016.⁷⁴ Disabled Women Ireland argue: “In addition to financial barriers, prejudicial attitudes, inaccessible information, physical and communication barriers and an inaccessible transportation infrastructure impedes disabled women’s and pregnant people’s sexual and reproductive rights and freedoms.”⁷⁵ Therefore, while a community-based model may be suitable for needs of disabled people, many GP surgeries are not accessible.⁷⁶ As discussed above, abortion provision outside of urban centres is uneven and when combined with the three-day waiting period, many disabled women will struggle to access services without support which may undermine their autonomy and independence. Disabled women often have more complex medical needs and may realise they are pregnant later and are therefore disproportionately affected by restrictive times limits. Furthermore, too often in discussions, disabled women access to abortion services is viewed as a medical problem rather than a rights-based issue. Article 25 of the UN Convention on the Rights of Persons with Disabilities reinforces the right of persons with a disability to attain the highest standard of healthcare, without discrimination. Designing a better, more inclusive form of service provision must include direct input from the disabled women who are the service users.

Transgender, intersex, non-binary and gender non-conforming people can also become pregnant and may face additional specific barriers in accessing abortion services.⁷⁷ While the Interpretation Act 2005 extends provision of abortion under the Health (Termination of Pregnancy) Act 2018 to these groups, the original language of the Act can inadvertently instantiate the erroneous idea that abortion care is only for women and this should be addressed as part of the forthcoming Review process. There is an absence of available comprehensive research on individual experiences of trans people’s access to abortion services, but it is widely accepted that they experience major disparities in accessing health care compared to the

74 Ibid. p.5. See also Conroy, P. (2018) *A Bit Different: Disability in Ireland*. Orhen Press, p.11f

75 Abortion Rights Campaign & Disabled Women Ireland (2019), p.6

76 Bruton, L. (2018) “Sexual health, if you are living with a disability, is not a level playing field,” Irish Times. 6th March. <https://www.irishtimes.com/life-and-style/health-family/sexual-health-if-you-are-living-with-a-disability-is-not-a-level-playing-field-1.3406100>

77 From here on, we use the term ‘trans’ as an umbrella term to refer to these groups.

overall population.⁷⁸ Research⁷⁹ has shown that when using health services trans people are subject to barriers⁸⁰ and discrimination including but not limited to: inappropriate curiosity about their gender identity and sexuality; healthcare providers using inappropriate pronouns and old names; offering inappropriate services; providing inaccurate advice; refusing service provision; discrimination; stigma; heteronormativity; and a general lack of understanding and knowledge amongst healthcare staff about the specific health needs of LGBTQ+ people. These barriers can also be exacerbated by racism and intersecting oppressions.⁸¹ As a result of these experiences, many trans people do not seek necessary health care and may leave it later to attend health services because of these negative experiences. The 3-day wait and the 12 week cut off might therefore have a particular adverse impact on trans people and further exacerbate the barriers they face in accessing healthcare.

The geographer Sydney Calkin argues that we should design abortion provision by starting with the most marginalised in our society and ask ourselves: What kind of barriers do they face: to transport, to visas, to health systems, to systems of support? She argues that “a system designed by thinking about those least able to access care would certainly result in a system that decriminalised abortion and centred on the autonomy of pregnant people” rather than a system that requires multiple points of contact to ensure medical oversight over an individual’s decision making.⁸²

78 Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current opinion in endocrinology, diabetes, and obesity*, 23(2), 168–171. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4802845/>

79 See: Heng, A., Heal, C., Banks, J., & Preston, R. (2018). Transgender peoples’ experiences and perspectives about general healthcare: A systematic review. *International Journal of Transgenderism*, 19(4), 359–378; Howell, J., Maguire, R. (2019) Seeking help when transgender: Exploring the difference in mental and physical health seeking behaviors between transgender and cisgender individuals in Ireland, *International Journal of Transgenderism*, 20:4, 421–433; Moseson, H., Zazanis, N., Goldberg, E., Fix, L., Durden, M., Stoeffler, A., Hastings, J., Cudlitz, L., Lesser-Lee, B., Letcher, L., Reyes, A., & Obedin-Maliver, J. (2020). The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women’s Health. *Obstetrics and gynecology*, 135(5), 1059–1068; and Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current opinion in endocrinology, diabetes, and obesity*, 23(2), 168–171.

80 Other reported barriers include: health systems barriers (inappropriate records, forms, clinic facilities), socioeconomic barriers (transportation, housing, mental health), lack of cultural competence by health care providers, and financial barriers.

81 For example, disability and socio-economic status.

82 Calkin, S. (2020) ‘One year on, it’s clear that the new Irish abortion services have serious limitations’, *The Conversation*, 15 January. <https://theconversation.com/one-year-on-its-clear-that-the-new-irish-abortion-services-have-serious-limitations-129491>

Section 6

Outstanding issues on reproductive and sexual health

The National Women's Council *Every Woman* framework for reproductive healthcare services highlights that comprehensive pregnancy and abortion care is just one aspect of a holistic reproductive health model.⁸³ Reproductive healthcare begins before adolescence and continues after the menopause, and all women and girls growing up in Ireland should be able to access person-centred support in line with five key principles:

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

⁸³ National Women's Council (2017) *Every Woman: Affordable, accessible healthcare options for women and girls in Ireland* <https://everywoman.nwci.ie/our-model-for-reproductive-healthcare-services/>

Universal access to contraception and the development of a modern Relationships and Sexuality Education (RSE) curriculum are key gaps in our reproductive healthcare which continue to impact on abortion care in Ireland. To realise the reproductive and sexual health rights of all, these two related issues must be addressed.

1 Contraception

Access to safe and effective contraception is key to sexual health and wellbeing. A key recommendation of the Report of the Joint Committee on the Eighth Amendment of the Constitution (2017) was that free contraception be rolled out in Ireland recommending “the introduction of a scheme for the provision of the most effective method of contraception, free of charge and having regard to personal circumstances, to all people who wish to avail of them within the State”. Three years later and this key recommendation has yet to be implemented, despite a commitment by Government to introduce this during the 2018 referendum campaign. The IFPA found that the majority of patients (68.4%) who attended their clinics for an EMA were not using a method of contraception when they became pregnant.⁸⁴ These findings were also reflected in a major piece of research from the Dublin Well Woman Centre (November 2020) which found that the majority of women in Ireland are using ineffective contraception to prevent pregnancy and that there are many misunderstandings around contraception for pregnancy prevention amongst women in Ireland.⁸⁵ While access to contraception is part of the Programme for Government 2020⁸⁶ it needs to be prioritised and realistically resourced, ensuring that all forms of contraception available, especially Long Acting Reversible Contraceptives (LARC) which are the most effective form of contraception for preventing pregnancy⁸⁷ but are prohibitively expensive for many women. It must, as advocated by Dublin Well Woman, be supported by a comprehensive education and awareness programme, with age-appropriate information targeted at women and girls.

2 Relationships and Sexuality Education (RSE)

Comprehensive school-based sexuality education provides young people with the knowledge and skills to navigate the world around them, ensuring they have access to accurate information and a platform for discussing key issues in a safe and supportive environment. Along with access to affordable and accessible contraception, inclusive and rights-based sex education is a core element of reproductive and sexual healthcare. This is an area which Ireland needs to significantly develop, not least because of the bearing this can have on understandings of active consent and bodily autonomy. International evidence suggests that adolescent girls

84 Irish Family Planning Association (2020) *Clinical Focus: Early Abortion Care. Annual Report 2019*: 10. <https://www.ifpa.ie/resources/submissions/>

85 Dublin Well Woman Centre (2020) ‘New research shows majority of women in Ireland are using ineffective contraception to prevent pregnancy’, 24 November. <https://wellwomancentre.ie/new-research-shows-majority-of-women-in-ireland-are-using-ineffective-contraception-to-prevent-pregnancy/>

86 Government of Ireland (2020) *Programme for Government: Our Shared Future*. 29 October 2020. <https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/>

87 NICE Guideline (2005) ‘Long-acting reversible contraception’. Updated 2019. <https://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-pdf-975379839685>



are more likely than older women to self-induce an abortion or seek abortion services from untrained providers, they are less knowledgeable about their rights concerning abortion and post-abortion care, and can take longer than adult women to realise they are pregnant, leading to later term abortions which carry more risk.⁸⁸ These adverse outcomes could be mitigated through provision of better education on reproductive and sexual health, given that curriculum-based programmes are associated with increased knowledge of one's rights in a sexual relationship, increased communication with parents and greater use of contraception.⁸⁹ Recognising the relationship between effective sex education and lower rates of crisis pregnancies, the Joint Committee on the Eighth Amendment of the Constitution (2017) recommended a thorough review of sexual health and relationships education, including the areas of contraception and consent, and highlighted the need for this education to be delivered in designated curriculum time by qualified professionals. Positively, the Government has pledged to develop inclusive and age-appropriate primary and post-primary curricula⁹⁰ and the National Council for Curriculum and Assessment is currently in the process of developing new specifications for Social Personal Health Education (SPHE) and RSE, following their Report on the Review of RSE.⁹¹ It is critical that this opportunity for reform is fully realised given the centrality of evidence-based education to reproductive and sexual health policy.

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

89 UNESCO (2018) International technical guidance on sexuality education - An evidence-informed approach, p.29

90 Government of Ireland (2020) *Programme for Government: Our Shared Future*. 29 October 2020. <https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/>

91 See: National Council for Curriculum and Assessment, 'Social, Personal and Health Education (SPHE) / Relationships and Sexuality Education (RSE)' <https://ncca.ie/en/primary/primary-developments/social-personal-and-health-education-sphe-relationships-and-sexuality-education-rse> accessed 19 April 2021

Section 7

Recommendations

The introduction of abortion service provision in Ireland is to be celebrated. In 2019, over six and a half thousand termination were provided to women and pregnant people in 2019 in Ireland; these women would have been forced to travel or take abortion pills without medical support and under the risk of prison sentence. However, much needs to be done to remove barriers, guarantee and protect free access and expand service provision. As Mary Donnelly and Claire Murray remind us “legal change does not assure the provision of appropriate abortion care, nor does it guarantee a shift in the dominant narratives around pregnancy and abortion”.⁹² These are things that we need to continue to campaign and organise around.

Minister Simon Harris:

“It would be wholly irresponsible for us as legislators to pass legislation on such an important issue to do with women’s health and not keep it under review on the basis that our job is done.”

Section 7 of the Health (Regulation of Termination of Pregnancy) Act 2018 requires the Minister for Health to “not later than 3 years after the commencement of this section, carry out a Review of the operation of this Act”. In the Oireachtas debate on the ToP bill, the then Minister Simon Harris repeatedly advocated for the necessity of a review clause in the

⁹² Donnelly, M. and Murray, C. (2019) “Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision”. *Ethical and Legal issues in Reproductive Health*. November 2019. Pg 127. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.13025?af=R>

As abortion care is a new and multifaceted area of service provision, the Review must be evidence-based, grounded in the lived experience of women

legislation, contending that it would “be wholly irresponsible for us as legislators to pass legislation on such an important issue to do with women’s health and not keep it under review on the basis that our job is done.” He noted that it was important that Ireland not replicate the mistakes of other countries and “just pass legislation and leave it sitting on the Statute Book for years” ignoring changes in international best practice.⁹³ In making the case for the inclusion of review the Minister stated: “I am purposely seeking a review clause in the legislation as a result of looking at other jurisdictions where legislators thought all they needed to do was pass a Bill and that they had dealt with the issue forever. For us to do that would be a dereliction of our duty. It is appropriate that we return to the issue and make sure the legislation continues to be in line with best international practice. That is what a review clause will accomplish.”⁹⁴

At the second stage reading, he clarified that his commitment was to “a full, *external* Review of the Act”.⁹⁵ The Review is scheduled to be progressed in 2021 and offers a unique and important opportunity for independent oversight of how the Act is working, particularly in terms of user experience and service provision, however it is unclear if the Government will honour the external process that the then Minister pledged to commission.

As abortion care is a new and multifaceted area of service provision, the Review must be evidence-based, grounded in the lived experience of women and pregnant people. The decision by the HSE Sexual Health and Crisis Pregnancy Programme to commission Dr Catherine Conlon of the School of Social Work and Social Policy at Trinity College Dublin to carry out research to understand people’s experiences of using abortion care services and unplanned pregnancy supports is most welcome, given good-quality data is essential to monitoring and evaluating service quality. This work, along with the WHO study *Policy Implementation – Access to Safe Abortion Services in the Republic of Ireland*, will provide valuable learnings to inform the Review.

The Review process itself must be centred around core principles that firstly ensure safe, equitable, accessible and legal abortion provision and secondly, to institutionalise women’s and pregnant people’s autonomy over reproductive decision-making. From the outset, we must be clear that the focus of this Review is to improve our abortion services in line with the HSE’s overarching strategic objectives and to bring it in line with WHO guidelines that seek to raise quality standards and provide measurably better and safer healthcare that is accessible to all.

To give the Review authority and credibility, it should be chaired by an independent person who is a specialist in reproductive rights and equality-based healthcare, and the Review group should be composed of a panel of experts, including service users, providers and reproductive rights advocates. This approach was adopted for the Review of the Gender Recognition Act

93 Minister Simon Harris, Health (Regulation of Termination of Pregnancy) Bill 2018: Committee Stage. https://www.oireachtas.ie/en/debates/debate/select_committee_on_health/2018-11-06/2/ accessed 23 April 2021.

94 Ibid. During this debate the current Minister for Health, Stephen Donnelly, also spoke strongly in support of a review of the legislation.

95 Minister Simon Harris, Health (Regulation of Termination of Pregnancy) Bill 2018: Second Stage. https://www.oireachtas.ie/en/debates/debate/seanad/2018-12-06/13/#spk_115 accessed 26 April 2021.

2015 and provides a model for effective partnership working between the State and experts from civil society to advance the rights of citizens and residents.

Finally, to ensure that abortion care providers are able to provide timely and person-centred support to all those in need, it is vital that the Review considers not just the operation of the Health (Regulation of the Termination of Pregnancy) Act 2018, but also the parameters of the legal framework. A comprehensive analysis of law, policy and practice, grounded in the lived experience of all women and pregnant people, is required if the Review is to meaningfully advance abortion care in Ireland. Within this analysis, particular focus must be given to addressing the difficulties in accessing abortion in the final stages of the first trimester and through the second trimester.

The following recommendations emerge from the analysis in this paper and are designed to enhance abortion care policy and service delivery.

Recommendations

Terms of Reference of Three-Year Review

- The Review process should be wholly independent of Government and chaired by a specialist in reproductive rights and equality-based healthcare, and the Review group should be composed of a panel of experts, including service users, providers and reproductive rights advocates.
- The Review should be expansive in scope, considering not just the operation of the Health (Regulation of the Termination of Pregnancy) Act 2018, but also the parameters of the legal framework.
- The Review should be conducted in line with international human rights standards, and the Terms of Reference and Review process should be public and transparent.
- As part of the Review process there should be a public consultation that is accessible to all, with a particular focus on ensuring marginalised communities are able to participate and share their views and experiences of abortion care in Ireland.

Abortion Provision

- Abortion is recognised as an essential aspect of healthcare and should therefore be fully decriminalised. To apply criminal law to abortion exclusively sets it apart from other forms of healthcare and suggests that doctors providing abortion care are in some way inherently less conscientious than other professionals.
- Abortion care, like all aspects of health care, should be decided in the context of a trusting and supportive doctor-patient relationship, whereby medical needs are met in line with clinical best practice and patient preferences. The evidence

highlights that the current twelve-week limit impedes doctors' ability to support patients in need of vital health care, with a disproportionate impact on marginalised communities. The 12 week limit must therefore be reviewed and extended into the second trimester.

- The ability to obtain abortion care without delay is critically important to women and pregnant people's reproductive health. Therefore, the three-day waiting period should be removed as a legal requirement to ensure timely access to abortion care under twelve weeks.
- In cases of EMA failure, women and pregnant people should continue to have access to abortion services under Section 12 of TOP, even if they exceed the 12 week.
- The option of remote consultation, introduced as an emergency measure during the Covid-19 pandemic should become a permanent feature of abortion healthcare in Ireland. Remote consultation should form part of a blended care offer, whereby women and pregnant people have the option to avail of either remote consultation or in person-care in line with their preference and where clinically appropriate. This, as confirmed by the Minister of Health in March 2020, requires no legislative changes.
- Clear standardised national referral pathways for all stages of abortion care must be developed. This should include explicit provision for a woman or pregnant person who decides against a community based EMA and elects for a surgical abortion.
- When determining risk to health, medical professionals should be empowered to apply the WHO's definition of 'health' which is understood as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This would allow 'health' to be interpreted contextually and to take account of the person's wider circumstances and social well-being, and would permit doctors to take account of the woman's or pregnant person's own assessment of relevant risks to their life/health, or of the severity of a foetal diagnosis.
- Exclusion zone legislation should be enacted as a matter of priority to create protest exclusion zones within a defined radius of a facility where abortions take place.

Coverage of Abortion Services

- Adequate early abortion care needs to be guaranteed in every county in Ireland. This should be understood as a core part of the primary care offer and therefore should be addressed as a key service priority with additional HSE resources deployed as required.
- Conscientious objection should not be permitted to obstruct access to abortion care. In cases of refusal of abortion care, a clear and timely pathway to an alternative provider must

be provided immediately. Healthcare institutions cannot be permitted to conscientiously object to providing services directly or indirectly through failure to provide services. Where necessary, new medical appointments should be fast-tracked to address any gaps in service provision

- The uneven provision of hospital-based abortion services must be addressed with abortion services being extended to all 19 maternity hospitals.
- Consideration should also be given to developing an outpatient ambulatory gynaecological model which could address some of the challenges in providing abortions in hospital theatre settings and enable greater access and patient-centred care.
- All maternity hospitals should be required to offer priority ultrasound access to women and pregnant people seeking abortions. Given that the majority of those who are referred for scans to date their pregnancy are presenting towards the end of the first trimester, even a 24-hour delay could result in them exceeding the 12 week limit and being refused an abortion.
- Robust data should be collected to inform service planning, this should include notification of refusals of abortion care, including refusals on the basis of conscientious objection and how women in these cases were referred on and ensured timely access to care elsewhere.

Training and Professional Development of Providers

- Termination of pregnancy should be fully integrated into all aspects of the medical, nursing and midwifery undergraduate curriculums.
- Advanced training should be provided to those who specialise as GPs delivered through GP training sites.

Abortion in cases of Fatal Foetal Anomaly

- A clear care pathway should be identified to ensure that the patient's choices and options are explained clearly and in an unbiased manner in cases of a diagnosis of severe or fatal anomaly. On receiving a diagnosis of severe or fatal anomaly all patients should be offered a referral to a qualified psychologist specialising in maternal health as standard.
- A patient should be offered all pre-natal screening and diagnostic tests if a problem is indicated. If a diagnosis of severe or fatal anomaly is indicated, the patient should be transferred to a specialist foetal medicine unit in Dublin, Cork, Galway or Limerick within seven days.
- Section 11 of ToP Act should be amended to exclude the reference to the death of foetus "within 28 days of birth". Instead, the professional judgement of clinician and the multidisciplinary teams involved in care should be trusted and respected in cases of fatal foetal anomalies.

- If a patient's diagnosis is such that they are not cared for under Section 11 of ToP Act and they need to travel abroad to access healthcare, all medical and travel costs, including assistance in bringing their remains back to Ireland, should be covered by the HSE. The HSE should establish formal links with hospitals in the UK, like Liverpool Women's Hospital, Guys Hospital in London or Mary's Hospital in London so that direct referrals are offered.

Equality Provisions

- The ToP Act should be equality proofed to ensure equality of access for all women pregnant people regardless of class, race or ethnicity, ability, gender or sexuality.
- The language of the Bill should be amended to ensure trans inclusivity. The bill should include gender inclusive language throughout, i.e. women and pregnant persons. This is important as non-binary people currently have no means of legally affirming their gender under Irish law.
- Abortion services should be free at the point of delivery for all users. In order to do this, the Government should remove the requirement for an Irish address and PPS number to access an abortion. This creates barriers for asylum-seekers, migrants, undocumented individuals and women and pregnant people from Northern Ireland and those temporarily resident in Ireland.
- If a woman or pregnant person is forced to travel in order to access an abortion that they are legally entitled to receive in Ireland, including in cases of fatal foetal diagnosis, the State should cover the cost of travel and treatment, and individuals should be entitled to claim expenses around the repatriation of remains and funeral arrangements.

Broader Reproductive and Sexual Health

- Universal access to contraception is a key aspect of reproductive healthcare. There should be immediate introduction of free, universal contraception as outlined in Report of the Joint Committee on the Eighth Amendment of the Constitution (2017) in line with the commitment in the Programme for Government (2020).
- A mandatory, comprehensive, rights-based relationships and sexuality education curriculum is urgently needed in Ireland. As the Joint Committee on the Eighth Amendment of the Constitution (2017) note, there is a relationship between effective sex education and lower rates of crisis pregnancies. The Programme for Government commitment to 'develop inclusive and age-appropriate RSE and SPHE curricula across primary and post-primary levels, including an inclusive programme on LGBTI+ relationships' should be implemented as a matter of priority.

Appendix 1

The interviews for this paper were conducted between 05 November 2020 and 18 December 2020. A number of experts, activists and professionals working in the field of abortion provision generously gave their time for interviews to inform this analysis. Their insights were integral to this work and greatly appreciated. They include:

- Mara Clarke, Abortion Support Network
- Roisin Dermody, Disabled Women Ireland
- Dr Marion Dyer, General Practitioner / Doctors for Choice
- Dr Mary Favier, Co-Founder of Doctors For Choice & START Doctors and former President of the Irish College of General Practitioners (ICGP)
- Lauren Foley, Fingal Feminist Network / Fingal Communities Against Racism.
- Professor Mary Higgins, Consultant Obstetrician and Gynaecologist, National Maternity Hospital.
- Dr Trish Horgan, General Practitioner / START Doctors
- Nem Kearns, Disabled Women Ireland
- Karen Kiernan, One Family
- Dr Mark Murphy, General Practitioner / Doctors for Choice
- Alison Spillane, Irish Family Planning Association
- Helen Stonehouse, Abortion Rights Campaign
- Amy Walsh, Termination for Medical Reasons
- Medical professional who wishes to remain anonymous.

Appendix 2

The Abortion Support Network (ASN) is a charity that provides information, financial assistance and, where needed and when possible, accommodation in volunteer homes to those forced to travel for abortion care from Ireland, Northern Ireland, the Isle of Man, Malta, Gibraltar and Poland. The people that ASN help tend to be those who are most marginalised and at risk – those in and escaping abusive relationships, people with insecure immigration status, families with pregnancies diagnosed with fatal foetal abnormalities, and people who are poor. Below are a selection of stories of people from the Republic of Ireland who were unable to access abortion services, needed to travel and were helped by ASN between October and December 2020.

A single mother who was in England having her termination when Ireland stopped allowing flights and ferries from the UK to arrive. ASN were able to get her on the last flight from England to Belfast, and on the last bus from Belfast to Dublin before they stopped running so she could get home to quarantine.

“Hi, I’m from Republic of Ireland, I am currently nearly 13 weeks pregnant, I am living at home I am unemployed I don’t even qualify for the dole, I am looking to get an abortion and am just wondering would I qualify for funding or anything towards it.”

“I am emailing from the Republic of Ireland because I need to go to England to have an abortion but I do not have the money to do so. I am really in need of some assistance as I am very stuck since I lost my job due to Covid and me and my partner are both struggling for money. My parents know but do not support what I am doing so they won’t help at all.”

A mother who had the difficulty of needing to travel to obtain an abortion for foetal abnormality compounded by her lack of a passport, limited flights to the place where the clinic is located, and the ferry company not taking foot passengers.

“Me and my wife are waiting for a prenatal genetic test results. Unfortunately, the doctors refused to do the tests for many weeks and there is a risk we will not get the results until after the 24th week of pregnancy. I am looking for an advice and information if the condition the foetus has qualifies us for an abortion after 24 weeks anywhere in Europe.”

A woman from Ireland had a pregnancy which was diagnosed with a foetal abnormality. She wanted to travel with her husband but he needed to stay home as they had no other childcare options. The woman was able to arrange her appointment and flights without our assistance, but was overwhelmed with the logistics required to travel - alone - during a pandemic. ASN were able to find her accommodation and also provide all the required letters to get across borders and into hotels.

A young Irish woman who was sent for a scan to confirm gestation and discovered she was 11 weeks, 6 days pregnant so had to travel at her own expense. ASN were able to buy her flights (she was worried she would book them incorrectly) as well as cover part of the procedure and accommodation costs.

“I had a termination in Ireland and thought all had gone to plan, but then didn't get my period. Now I am 20 weeks and they can't do anything to help me. I have been in contact with BPAS clinic and have an appointment for a procedure which is going to cost €1700. This does not include the cost of flights or accommodation. I am in dire straits as I don't have anything near that kind of money. I am asking for you to please help me in any way possible.”

A woman who had two failed early medical abortions in Ireland, who then, over the 12 week legal limit, was told her pregnancy had foetal anomaly indications (but apparently not serious enough to warrant an abortion in Ireland). She travelled to England to have an abortion, but was told she had a medical condition that required hospital treatment. The only hospital that was willing to provide her with care quoted charges of more than £2000. ASN was able to help them cover some of the costs as well as paying for accommodation for the six days she and her partner were required to stay in England.

“Hi, I need to travel to London next week for an abortion but I have problem with money. I took abortion pills in Ireland which didn't work and then I was 13 weeks so my GP said I have to go to England. The costs will be way more than I can afford so I was hoping you can help me. My passport expired so I have been waiting for the new one and I am now 16 weeks. Please help me.”

Another client had a medical abortion (in an Irish hospital) which failed, meaning she then had to travel to England at her own expense. When she asked about continuing the pregnancy, she was told that the foetus might have abnormalities from the medication she'd been given to cause an abortion. The initial clinic she booked into was in a city where there was an event that caused flight costs to soar.

A woman from Ireland was twice given early medical abortions in Ireland, and both times it failed. Since this brought her over 12 weeks into her pregnancy, Ireland turned its back on her and told her she had to travel abroad, at her own expense, to terminate the pregnancy. ASN were able to book her flights and accommodation, as well as provide a grant towards the cost of the procedure.

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