The Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018

Report

Marie O'Shea, BL. (28th February, 2023)

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In this report, the term 'women' includes women, girls and all people who can become pregnant

Section 1: Executive Summary and Recommendations

1.1 Executive Summary

The research study is an independent review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018.

The findings of this report are informed by the Unplanned Pregnancy and Abortion Care (UnPAC) study commissioned by the HSE to get an in depth understanding of service users' experiences; a review of health providers' perspectives of termination of pregnancy service implementation, and a public consultation process, both of which were commissioned by the Department of Health; the Chair's meetings with service users and providers, and by the preliminary observations of an ongoing research project entitled "Conscientious Objection after Repeal: Abortion, Law and Ethics" (CORALE), which is being led by researchers at Trinity College Dublin and funded by the Irish Research Council.

This is a report of an independent Review commissioned by the Department of Health pursuant to the obligation in *section 7* of the Act that obliges the Minister shall, not later than three years after the commencement of this section, to carry out a review of the operation of the Act.

The main findings of the Review are set out below:

Service provision and geographic coverage

Section 3 of the report looks at statistical data, showing:

- the numbers of terminations of pregnancies performed in Ireland, between 2017 and 2021 (before and after commencement of the Health (Regulation of Termination of Pregnancy) Act 2018 and comparative statistical data from the UK and the Netherlands;

- the numbers of providers and geographic spread of providers in primary care, and

- the numbers and geographic spread of hospitals providing full services under the Act.

  The main findings are:

  - Between 1st January 2019 and 31st December 2022, approximately 17,820[1] terminations of pregnancy were carried out in this jurisdiction. Of these, 17,510 were performed under *section 12* (where the pregnancy did not exceed 12 weeks). The number of terminations of pregnancies under *sections 9, 10* and *11* (risk to life or health, risk to life or health in an emergency, and condition likely to lead to the death of the foetus), have remained relatively low and static.

  - The numbers of pregnancies terminated in Ireland in 2017 and 2018, under the Protection of Life During Pregnancy Act 2013, on the grounds that there was a risk to loss of life of the pregnant woman, were 15 and 32 respectively. The numbers of terminations performed under the comparable grounds of *sections 9* and *10* (risk to the life or health of the pregnant woman, and risk to life or health of the woman in an emergency) are within the same range (23 in 2019; 25 in 2020 and 11 in 2021).

  - The data indicates that there has been a decline in the number of women who have travelled abroad for abortion care since 1st January 2019, when services commenced in Ireland. Most of those who are travelling to the UK are in the later stages of gestation and the abortions are being provided under Ground C (where the pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical and mental health of pregnant person) and Ground E (where there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped). These figures indicate that not all needs are being met.

  - There are an estimated 422 providers of termination of pregnancy services in primary care. This has risen by 95 since 2019. There is uneven geographic coverage of primary care providers. Fewer contracts between the HSE and primary care providers are recorded in the south-east, north-west, midlands and border counties.

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[1] Based on notifications received by the Minister for Health, pursuant to *section 20* of the Act. The figures for 2021 may not be accurate as the number of notifications did not align with the numbers of claims for payment made by GPs.

- There is uneven geographic coverage of hospitals providing full services under the Act. Only 11 of 19 maternity units or hospitals provide full services. This figure has risen by one since 2019. It is expected that a further four hospitals will commence providing full services this year.

Factors that influence provision of services in primary care and hospital settings

Section 4 of the report looks at factors that influence provision of services in primary care and hospital settings. The main findings are:

- There is a dearth of information relating to GPs' reasons for not providing termination of pregnancy services. Research indicates that the main reason may be attributed to excessive workloads. A lack of hospital back up is also a relevant factor as is having access to peer support.

- The reason for non-participation by hospitals has been attributed by the HSE and the Department of Health to the prevalence of conscientious objection among medical practitioners.

- In some counties, service provision is reliant on a handful of providers across primary care and hospital setting. There is a potential risk that these staff may burnout. The service is untenable.

- Recruitment of willing providers in the hospital setting has been shown to be effective. However, the service is led by consultants and the recruitment process is slow. The Act restricts who can provide termination of pregnancy services and this in turn restricts the range of health workers who could potentially provide the service and make it less reliant on willing medical practitioners.

- Support by managerial staff and workforce engagement at providing hospitals varies and this impacts upon service provision and organisational culture.

Infrastructural challenges

Section 5 of the report looks at the infrastructural challenges that exist in termination of pregnancy services. The main findings of this section are:

- Hospital providers and service users have cited infrastructural challenges as affecting the provision of termination of pregnancy services. These include the lack of dedicated space (single rooms and theatre access).

- The HSE is aware of the infrastructural challenges and has informed the Chair that it has established a working group to address deficits in maternity services.

Choice of method of termination of pregnancy

Section 6 of the report addresses options available to women for termination of pregnancy. The main findings of this section are:

- Medical termination of pregnancy is the most predominant method utilised in delivering care to women under all grounds in the Act. For some women, this method may not align with their needs, choice, or priorities.

- In early termination of pregnancy, surgical abortion in the form of manual vacuum aspiration (MVA) can be more efficient timewise, and preferable to women. However, it is not routinely available. The HSE has confirmed that six of the 11 providing hospitals routinely provide this as an option to women whose pregnancies do not exceed 12 weeks. At least two of the six hospitals providing a surgical option for early termination of pregnancy, provide this in the gynecological setting.

- The provision of surgical termination of pregnancy is resource dependent and requires management support as well as training and education of providers.

Operation of *sections 9* and *10*

Section 7 examines the operation of *sections 9* (risk to life or health) and *section 10* (risk to life or health in an emergency). The main findings are:

- Both *sections 9* and *10* are perceived as lacking clarity. Medical practitioners find the wording of *sections 9* and *10* ambiguous. There is no guidance as to the threshold of "risk", "serious harm", or the extent to which the risk has to be averted.

- Medical practitioners report that the sections may be challenging to implement in clinical practice, particularly in the field of perinatal psychiatry, where the patient's condition may have been exacerbated by the pregnancy but it is difficult to determine whether the risk would be averted by termination.

- There is a lack of a standardised pathway and clinical guidance on how and when women may access care under these sections. This may lead to women who have a legitimate right to access care here due to, for example, mental health risk, cardiac risk, cancer care risk or teratogenic high-risk medication, travelling abroad to seek abortion.

- The subjective nature of interpretation, together with the prospect of criminal sanction and adverse media scrutiny, risks the practice of defensive medicine, which may lead to women being denied care in Ireland.

- Medical practitioners believe that some health workers conflate *sections 9* and *10* with the grounds for abortion contained in the Protection of Life During Pregnancy Act 2013, and do not realise that termination of pregnancy may be considered where there is a risk of serious harm to the health of the pregnant woman.

Operation of *section 11* (condition likely to lead to the death of the foetus)

The operation of *section 11* is examined in section 8 of the report. The main findings are:

- The literal interpretation of *subsection (1)* requires the pregnant woman to be physically examined by two medical practitioners. The second examination is regarded as generally being otiose to requirements as it does not aid diagnosis or assessment of prognosis. Opinion is formed on the basis of diagnostic testing, including imaging, invasive and non-invasive tests. (This may similarly apply in relation to *section 9(1) cases).*

- *Section 11* lacks clarity as to how and when it applies, save in straight-forward cases. It can be difficult to implement in practice, even in cases where the condition may be fatal and associated with severe morbidity and/or disability. "Fatal foetal anomaly" is not a medical term. There is not any definitive list of conditions where death occurs in utero or within 28 days of birth.

- The subjective nature of interpretation, together with the prospect of criminal sanction and adverse media scrutiny, risks the practice of defensive medicine, which has likely led to women being denied care to terminate their pregnancy in Ireland.

- The right to review a refusal to a request for a termination of pregnancy, contained in *section 13*, is rarely invoked[2]. The submission to the public consultation of the Termination for Medical Reasons group indicates that this may be attributed to the length of time that it has already taken to obtain the initial decision, throughout which women are extremely distressed, and their wish to avoid further delay; the statutory timelines for the review being too long, and their concern that they will time out of receiving care abroad if their pregnancy exceeds 24 weeks.

- Not all staff in providing hospitals felt prepared to deliver termination of pregnancy services under *section 11.* Some participants reported that they did not receive any additional training, education or supports prior to the commencement of services.

- Making diagnosis and assessing prognosis in complex cases requires the medical practitioners to feel supported by the multidisciplinary team (MDT) and to have access to expertise in relevant to prenatal screening services

- Concerns were expressed that some multidisciplinary teams were not functioning well. Lack of up-to-date knowledge, bias relating to attitudes to termination of pregnancy and lack of understanding and respect for each other's roles and expertise, were some of the reasons attributed to less-than-optimal performance.

- Screening for structural foetal abnormalities and genetic chromosomal anomalies is required to underpin the operation of *section 11.* The former is carried out by ultrasound and women are being offered scans at two points in time. Furthermore, earlier this year the HSE published the National Clinical Practice Guidelines on Fetal Anomaly Ultrasound, which if successfully implemented will result in a more equitable and better-quality service. MRI is used as an adjunct to ultrasound, if needed.

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[2] Notifications to the Minister for Health saw that no reviews were carried out in 2019, two were carried out in 2020 and 1 was carried out in 2021.

- Concerns were expressed that the State has failed to provide a perinatal clinical genetics/genomics service. This service is required to provide expert guidance to MDTs as regards appropriate testing and interpretation of test results, and to counsel parents on the associated outcomes, enabling them to get a better understanding of what special needs the baby will have and the risk of recurrence of the condition in future pregnancies. There is only one consultant in clinical and biochemical genetics with special interest in perinatal genomics, based at the National Maternity Hospital, on a fixed term contract, funded by the Hospital's own resources. It is government policy to develop perinatal genomics services and in December 2022, the HSE launched the first National Strategy for Accelerating Genetic and Genomic Medicine in Ireland, which is due to commence implementation this year.

Travel to other jurisdictions

Section 9 of the report looks at the challenges faced by women who seek termination of pregnancy services abroad. This may occur in circumstances where they are informed that they do not meet the statutory criteria in *sections 9-11,* or the decision was pending but they felt that they would time out of care abroad if they waited; they timed out of care under *section 12 (*their pregnancies exceed 12 weeks), or they were not aware of their legitimate right to have an abortion in Ireland and could not have been supported by their medical practitioners as they lacked appropriate clinical guidance to advise them. The main findings of this section are:

- There is a need for standardised pathways of continuous care between the Irish hospital, the facility abroad and follow up care on return.

- Some women are unaware that they may receive follow-up care, including bereavement counselling, on return to Ireland, and may only discover this if complications arise necessitating a hospital referral.

- Some women lack clarity as regards what to expect when they receive care abroad and as regards logistical issues, such as repatriation of foetal remains. This imposes additional stress on them at a time when they are already in a very sad and vulnerable state.

Palliative Care, Foeticide and Bereavement Support

Palliative care, foeticide and bereavement support are involved in the provision of termination of pregnancy care and are discussed in section 10 of this report. The main findings of this section are:

Palliative care (the provision of comfort care to babies born alive after termination of pregnancy):

- In Ireland the palliative care pathway is well developed for babies who are born pre-viable or in a condition where they are expected to die shortly after birth and extraordinary life supporting measures are not deemed appropriate.

- Paediatricians and neonatologists have a key role in the provision of comfort care to newborns. However, the extent to which they are prepared to become involved is described as differing across settings and differing across the circumstances of the birth, with some not being prepared to offer comfort care where the birth is a result of a termination of pregnancy.

- Where they are not prepared to provide comfort care, the role is assumed by other medical practitioners and midwives who lack their expertise.

- The findings raise ethical issues and indicate inequities in the system.

Foeticide:

- Foeticide is recommended[3] but is not mandatory for terminations of pregnancy over 21 weeks. It is possible that terminations in later stages of pregnancy (*sections 9-11)* may result in live births[4].

- It can be perceived as the only option in some circumstances including where palliative care is not going to be supported by neonatologists or paediatricians.

- It did not become available until June 2019. Upskilling was required. It is now available in three hospitals which necessitate some women having to travel to another unit to undergo the procedure. Lack of wider availability of practitioners has to be balanced against the need of those who do perform the procedure to maintain skill.

Bereavement support:

- Bereavement support services appear to be well-developed across hospitals. However, it would appear that in some settings, the staff providing the service may not have adequate support for their heavy workloads.

- In the main, the service is appreciated by parents who have suffered the loss of their pregnancy or baby.

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[3] Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. Report of Working Party (2010) Royal College of Obstetrics and Gynaecologists.

[4] Where the termination has occurred on the grounds of risk to life or health of the pregnant woman, babies born at a viable stage of gestation are provided with life-support.

Operation of *section 12 (*early pregnancy*)*

The operation of *section 12* is examined in section 11 of the report. The main findings of this section are:

- Early termination of pregnancy service has been successfully implemented save that there are still some challenges.

- Uneven distribution and shortage of services, particularly in the south-east, north-west, midlands and border counties, has required women in those areas to travel, sometimes long distances by public transport, at significant cost, to access a providing GP. The mandatory three day wait between the first and second appointment compounds this problem. Both issues also present logistical problems for women, particularly those who are time constrained.

- Challenges relating to uneven geographic access and the mandatory waiting period have to some extent been ameliorated by the introduction of remote or telemedicine medical termination of pregnancy model of care introduced in April 2020, in response to the Covid-19 pandemic. This model of care is viewed positively by service users and practitioners and is regarded as being safe.

- A lack of accurate knowledge by women of service providers has made navigating the service challenging for some women. Some have experienced delay and obstruction (including the provision of inaccurate and misleading information) through encounters with non-providing GPs, including conscientious objectors, who are not fulfilling their legal and ethical obligations to make arrangements for the transfer of the woman's care. Some have experienced rogue agencies purporting to be pro-choice and have felt their decision to terminate their pregnancy to be undermined.

- Not all GPs are aware of their legal and ethical obligations under the Act and under the Irish Medical Council Guide to Ethical Conduct and Behaviour to make arrangements for the transfer of the care of the pregnant woman so she may avail of termination of pregnancy services.

- The free of charge HSE My Options helpline is critical infrastructure to provide clear and accurate information on providers of abortion services, non-directive counselling and a 24-hour clinical advice service to support women post termination of pregnancy. Knowledge of the helpline mitigates against the risk that women will encounter non-providing GPs and rogue agencies. However, despite targeted media campaigns, this study found that there are still women and service providers who are unaware of My Options.

- The statutory requirement that informed consent may only be given after at least three days have elapsed from the date of the first consultation is a contentious issue. Whilst there is perceived benefit to having a period of reflection to ensure that the decision is not made in haste and later regretted, it is perceived by others as an infringement on their personal reproductive autonomy. As termination of pregnancy services are not configured to run 365 days a year, the three-day wait can extend to a four or five day wait for treatment, if the first visit takes place towards the end of the week, particularly if it coincides with public holidays.

It is compounded by the need to complete terminations before the pregnancy exceeds 12 weeks. It can be particularly problematic for marginalized and vulnerable service users where organizing multiple appointments may be challenging. The mandatory waiting period can impose a physical and psychological burden on women.

- The mandatory three-day wait may cause women to time out of eligibility for care in Ireland (especially if the three days is extended). This disproportionately affects women who may not realise that they are pregnant until later in the first trimester or who may have delayed in seeking care, or who may have timed out due to failure of previous treatment to terminate the pregnancy. In the case of the latter, there is a risk that the pregnancy could be affected by foetal anomalies (such as limb defects) occurring due to the teratogenic effects of the abortifacient medication.

- Unreliable referral pathways for ultrasound scanning services feature as a challenge. Access to the service can vary significantly depending on geographic region. In some regions, arranging scans can be a protracted and frustrating process. The timeliness and cohesiveness of referral is impacted by the availability of staff. Staff at some ultrasound centres appear to be unaware of or not respectful to women's wishes to see the screen or not.

- Unreliable pathways for referral of women to hospitals for early termination of pregnancy also feature as a challenge. Primary care providers require reliable pathways of care and identifiable access points to the closest providing hospital. Access to hospital care is in part reliant on a small number of staff, including medical practitioners and nurse/midwife coordinators who are the point of contact between primary care providers and hospitals and who make arrangements for the woman's care within the hospital. When they are not there, it can result in unpredictable access as in some settings, cross-over from colleagues is not always facilitated.

- Not all GPs have engaged in education and training in termination of pregnancy care. Education and training are required by non-providing GPs as well as those who provide, as they may encounter patients with complications, post procedure. The National Clinical Guidelines for Investigation and Management of Complications of Early Termination of Pregnancy, have recently been produced by the Institute of Obstetricians and Gynaecologists in collaboration with the HSE National Women and Infant's Health Programme (NWIHP). This is a welcome development and should improve medical practitioners' knowledge in this area.

- Free of charge access to termination of pregnancy services is restricted to people who have a PPS number. This adversely affects access to the service by people who do not have a PPS number, such as asylum seekers, migrants, undocumented individuals and people living in Ireland on a temporary basis, who are obliged to pay for the service unless the cost is absorbed by the provider.

Operation of *section 22* (conscientious objection)

Section 12 of this report examines the operation of *section 22 (*conscientious objection). The main findings are:

- The wording of *subsections (1)* and *(3)* are ambiguous and lack clarity insofar as there is not any guidance as to what is involved in "*participating in carrying out"* and making *"such arrangements for the transfer of care of the pregnant woman"* respectively. Hence, *section 22* is open to subjective interpretation.

- Although *subsection 22(2)* purports to restrict the exercise of conscientious objection by a medical practitioner, nurse or midwife in circumstances where there is an immediate risk to the health or life of the pregnant woman, the Act fails to place a mandatory obligation on them to do so. This is due to the wording of *subsections 22(2) and 10(1).*

- Some non-providing GPs are directly contravening the law by not making arrangements for the transfer of the woman's care. This was shown to be the norm in the UnPAC study.

- Conscientious objection is a significant factor in the uneven geographic distribution and number of providers. The HSE has attributed conscientious objection as being a major factor in the roll-out and development of services in the hospital setting. There is a relationship between GPs' willingness to provide and lack of hospital support.

- Preliminary observations of the CORALE study indicate that where there is limited staffing to attend a patient, a person with a conscientious objection may feel under undue pressure to participate in care.

- There is an ongoing need for education and training on conscientious objection and termination of pregnancy for staff working in primary care and the hospital setting, including clerical and administrative staff and senior managers.

- Initiatives have been taken by the HSE to overcome barriers to access caused by conscientious objection. These include arranging values clarification sessions in hospital settings (which has been shown to be effective). The ICGP is planning to facilitate its members attending values clarification workshops.

- There is not any statutory prohibition or restriction on health care workers who abuse their right to conscientiously object by actively obstructing or delaying a woman's access to care by providing misleading information. It would appear that persons who engage in this conduct are able to do so with impunity.

Operation of *section 23* (criminalization)

The operation of *section 23* of the Act is examined in section 13 of this report. The main findings are:

- Criminalisation of abortion *per se* can be stigmatizing for women as it reinforces its social and cultural framing as an immoral and aberrant act.

- The potential for exposure to criminal liability (and adverse media scrutiny) is heightened by the uncertainty surrounding the operation of *sections 9 – 11*, which involve predicting whether termination of pregnancy will avert the risk to the health or life of the pregnant woman or whether the condition of the foetus will cause death in utero or within 28 days of birth.

- The positioning of abortion in criminal law may deter healthcare professionals from engaging in services, not because they do not want to provide but because they feel that the law does not protect them. It has also led to overly cautious, risk-adverse decision-making (defensive medicine) being practiced which has tended towards refusing the woman's request for an abortion.

- There is no legal framework to protect women from persons who purport to control their reproductive autonomy by attempting to exert pressure on them to continue their pregnancies, or who actively interfere with their access to termination of pregnancy services, for example by providing misleading information.

Training and education

Section 14 of this report looks at how training and education has been provided to health workers involved in termination of pregnancy care. The main findings are as follows:

- Training and education of health workers is a vital component for the provision of high-quality termination of pregnancy services under each of the grounds of the Act.

- Training and education of health workers commenced prior to the introduction of services on 1st January 2019, despite the relatively short preparation period of approximately seven months, from the referendum in May 2018. Primary care providers appear to have been well supported in the early stages of the roll-out. Not all hospital staff felt adequately prepared and raised concerns about lack of training and education from the offset.

- Training and education needs are ongoing and need to be identified and responded to by relevant stakeholders, including professional bodies, the HSE and senior managers at healthcare facility level.

- The HSE continues to invest in workforce training annually. However, it appears that due to workforce constraints, there are insufficient staff in hospital settings to enable engagement with continuous professional education, and staff are developing and delivering training sessions independently of HSE NWIHP and informally, during lunch breaks and peer support sessions.

- Training and education require management support. There have been different levels of involvement by hospital based senior managers. In some sites it has been initiated by individual staff, without management support.

- The ICGP has run introductory courses on medical termination of pregnancy, two of which have been online. Between December 2018 and January 2022, the courses were attended by 1,146 GPs[5], some of whom attended more than once to refresh their skills. This is indicative of the relatively low number of GPs who have undertaken formal training.

- Communication between primary care and hospital providers can be somewhat deficient in termination of pregnancy care. The lack of feedback to primary care providers, following referral of patients for management of complications, is a lost opportunity to improve GPs knowledge to inform future decision-making regarding appropriate referrals.

Safe access zones and protection from harassment

Part 15 of the report looks at safe access zones and protection from harassment. The key findings of this section of the report are as follows:

- Anti-abortion protests outside hospital and primary care settings and harassing forms of behaviour have been occurring since services commenced in January 2019.

- The ostensible aim of demonstrators and protestors is to dissuade women from having terminations of pregnancy and health workers from providing services.

- As a matter of human rights, States should ensure that individuals seeking termination of pregnancy services are not subject to humiliating and judgemental attitudes that could lead to the denial or delay of such services.

- It is equally important, in the interests of sustaining services, that health workers are not deterred from service provision by intimidating, threatening, harassing conduct intended to influence their decision to continue to provide the service.

- On 5th August, 2022, the government published the General Scheme of the Health (Regulation of Termination of Pregnancy (Safe Access Zones)) Bill 2022. This purports to strike a balance between the rights of people accessing termination of pregnancy services and the rights of people to engage in demonstrations and protests.

Service evaluation and data collection

Section 16 of this report examines the current status of and requirements for service evaluation and data collection. The main findings of this section are:

[5] Based on information provided in October 2022, by the ICGP to the Chair of the Review

- To date, there is no established monitoring and evaluation system for abortion services in Ireland. Effective monitoring and evaluation are essential to measure quality and trends, and to inform policy and decision-making to further improve service delivery and quality.

- Currently, the only requirement for data collection is limited to the notification provisions of *section 20*, which provide very limited information.

- The HSE National Women and Infants' Health Programme is working to establish a data collection framework. The Clinical Advisory Forum for termination of pregnancy has established a service evaluation steering group. It is in the process of defining quality measures and data collection mechanisms for termination of pregnancy across community and hospital settings. Basic data collection has commenced with a number of primary care and hospital providers.

- It is important that the experiences of service users and providers are regularly obtained as part of the evaluation process, especially as termination of pregnancy services are not yet fully established.

- It is important that the processes for data collection and evaluation do not place onerous administrative demands on healthcare facilities which might affect compliance. Collaborative input from stakeholders in development of the processes would be desirable.

Free contraception scheme

Section 17 of this report looks at the free contraception scheme in the context of provision of follow-up care to people who have undergone early medical termination of pregnancy. The main findings of this section are:

- The launch of the Government's free contraception scheme to women aged 17-26 years and its planned expansion to include those aged 27-30 years in September 2023 is welcome, as is the intention to include 16-year-olds, subject to detailed consultation and legal advice.

- Access to the scheme has enabled women to choose forms of contraception, including long-acting reversable contraception, that might otherwise be prohibitively expensive to them.

- However, the scheme is only free of charge to women with PPS numbers. Accordingly, those who do not have a PPS number are required to bear the cost themselves. This is potentially too onerous on women with low incomes.

Key findings from Discussion

Based on the research findings, it would appear that the legal framework governing termination of pregnancy services is not in alignment with Ireland's human rights obligations insofar as *sections 9 – 11* lack sufficient clarity as to when and how they apply, and application of the law under *sections 9-12, 22* and *23* potentially create barriers to access. Potentially, the production of Ministerial guidelines to accompany the Act would address some, but not all, of these issues.

The review of the operation of the Act should be an iterative process. Termination of pregnancy has yet to be fully established into the health service. There is a need to increase the numbers of providers across the community and hospital settings and put in place necessary supports to sustain the service. There is need for further policy considerations around the operation of *sections 9, 10, 11, 12, 22* and *23.*

1.2 Recommendations

To address barriers to access of termination of pregnancy services by women due to the uneven geographic distribution and low number of primary care providers, the following recommendations should be considered:

- The HSE should consider undertaking a mapping exercise to ascertain the precise number of medical practitioners providing the service in each county or CHO.

- The HSE should conduct a geospatial mapping exercise to measure the furthest distance a woman of reproductive age must travel to access a providing medical practitioner. In areas where there is low coverage and consequently women must travel longer distances to access care, the Department of Health and the HSE should consider supporting the establishment of local women's health centres, providing comprehensive women's healthcare services. These could be led by an obstetrician/gynaecologist or a GP with special interest in women's health. Such a model would enable GPs who are interested in providing the service (but are unable to do so due to lack of peer support from practice colleagues) carry out sessions at a different location.

- To inform future policy formation and implementation relating to increasing the numbers and distribution of providers in primary care, the HSE should undertake research to improve its understanding of the barriers and enablers of service provision in primary care. This would require a collaborative approach with the ICGP, as the organisation that has contact details of all GPs.

- To address barriers associated with GPs' excessive workload responsibilities that impacts their capacity to become involved in termination of pregnancy services, the Department of Health should support ICGP initiatives to achieve their target of increasing the number of GPs by 1,800 by 2028, to take the national target to 6,000, which would represent 4,000 GPs.

To address the barriers to access caused by the uneven geographic spread of providing hospitals and low numbers of health workers being willing to lead and/or provide termination of pregnancy services, the following recommendations should be considered:

- The HSE should continue its current policy to fund additional consultant posts in obstetrics and gynaecology to support commencement of services. This has been shown to be effective.

- The HSE Clinical Lead for Termination of Pregnancy should continue to liaise with hospitals as regards their personnel needs to achieve the appropriate skills mix and mass to deliver a quality service, and the HSE should respond to these needs.

- To support the recruitment process to positively discriminate in favour of persons willing to provide termination of pregnancy services in settings where there are no providers or the numbers are so low that the service is untenable, the Department of Health should consider amending *section 22* of the 2018 Act to include a provision similar to *section 15* Contraception, Sterilisation and Abortion Act 1977 (New Zealand) which sets out in statutory form the employer's obligations to accommodate the rights of conscientious objectors except in circumstances when it is necessary to uphold the right to health care.

- All job specifications for staff required to run the service in hospitals where there are insufficient numbers to sustain the service, should feature provision of termination of pregnancy services as mandatory requirement as should the contract of employment. Candidates should be informed at interview of the contractual obligations and of the legal consequences of breaching the condition, which could be termination of employment.

- The HSE should proactively monitor non-providing hospitals to ensure that they are prioritising the recruitment process for consultant obstetricians and gynaecologists. If the targeted dates for commencement of service contained in the HSE's implementation plan are not met, special measures should be introduced and these could include, as appropriate:

  - The HSE directly involving itself in recruitment where there has been a demonstrable lack of initiative to expedite the recruitment process by local managers;

  - If, despite advertisement of the post, or it is known that there may be less interest in applying for positions at particular hospitals, further incentives to recruitment should be considered, such as the provision of protected time for research or other educational endeavours, such as post-graduate study.

  - Diversion of funding (on the basis of a fixed sum per patient) from the non-providing hospital to the hospital providing care for women who were unable access services at their local unit (unless this was due to the woman's personal choice or the need to access specialist care).

To address barriers to service delivery by the low numbers of medical practitioners willing to provide the service, and to ensure that service is not dependent on a handful of health workers operating in small teams across the primary and hospital setting, the following recommendation is made:

- The Department of Health should consider amending the legislation to expand the range of health professionals who may provide termination of pregnancy services and should liaise with the professional bodies in relation to provision of training and education.

To sustain and develop good quality services, it is recommended that:

- The HSE and senior hospital management should support the appointment of dedicated service coordinators and clinical leads. These can be new or existing staff. Where consultant hours are restricted, consideration should be given to involving non-consultant hospital doctors (NCHDs) to oversee care.

- Senior managers (across both primary care and hospital settings) should provide a forum, such as an all-staff meeting, where staff (providers and those interested in providing) may discuss the implications of the service, share staff concerns and receive responses from managers, outline the responsibilities of staff, clarify roles, and facilitate staff who wish to provide the service to identify themselves to managers.

- Senior managers should support staff providing termination of pregnancy services and ensure that they are not assigned excessive workloads, which may lead to burnout.

- All sites should have access to appropriately resourced bereavement support teams and medical social workers to support patients, and senior managers should ensure that they do not carry excessive workloads.

- The Department of Health should engage with relevant stakeholders, including universities and professional bodies, in sustainability planning, including training and education of undergraduates and newly qualified health professionals in termination of pregnancy.

- The Department of Health and the HSE should consider supporting providers' by creating a national peer-to-peer support and advocacy network. Existing networks, including the variety of specialties that care for women seeking abortion, should be amalgamated to form an Irish Abortion Provider Network. This will require support from the Department of Health and the HSE in terms of funding, governance, educational development and administration. It would be important that support provided would not be on terms that would compromise its ability to be an effective advocate.

To improve access to surgical termination of pregnancy, particularly in circumstances where the needs of the pregnant woman are not being met by the medical method, the following recommendations should be considered:

- HSE should continue efforts to make surgical option of termination of pregnancy more routinely available, particularly in pregnancies that do not exceed 12 weeks.

- Managers in primary care and hospital settings should be supportive of medical practitioners and other professionals who wish to engage in competency-based training and demonstrate practical support such as providing protected time to attend courses and to gain experience at other sites.

- Ambulatory gynaecology units should be assessed by the HSE to ascertain whether they are appropriate to provide surgical termination of pregnancy (where pregnancy does not exceed 12 weeks), using manual evacuation aspiration (MVA).

- The Department of Health and the HSE should consider making MVA for early termination of pregnancy available in the community settings. This may require development and support of appropriate facilities. These facilities could potentially be used to provide end to end women's health services.

To address the barriers to access to termination of pregnancy services arising from the operation of *sections 9* and *10 (*risk to the life or health of the pregnant woman, including in emergency situations) the following recommendations should be considered:

- To assist medical practitioners implementing of *sections* 9 and 10 in clinical practice, Ministerial guidelines to accompany the Act should be developed to provide clarity as to the threshold of "risk" to the life of the or of serious harm to the pregnant woman, the threshold of "serious harm", and the extent to which the risk has to be averted. A collaborative or collective leadership approach, involving service providers, should be taken to developing the guidelines to ensure they meet their needs in implementing the law in clinical practice.

- The Department of Health should amend *subsection 9(1)* and *10(1)* to reflect that it may be very challenging in clinical practice to predict whether a termination of pregnancy would avert the risk to the woman's life or health, based on the knowledge available at the time the determination is made. This is particularly relevant to perinatal psychiatry. The Department of Health should aim to support medical practitioners from the risk of future challenges by considering amending these *subsections* to include the following underlined text

  > *"A termination of pregnancy may be carried out in accordance with this section where … medical practitioner(s), having examined the pregnant woman", are of the reasonable opinion formed good faith* <u>*on knowledge available to them at the time of making the determination*</u> *that - ….*

- The HSE should work with and support the relevant professional stakeholders (the Institute of Obstetricians and Gynaecologists, the ICGP, the RCSI, the RCPI and the Midwifery and Nursing Board of Ireland) to provide training and education on the operation of *sections 9* and *10* to address any barriers to care emerging from lack of knowledge and understanding of how they apply in clinical practice.

- The HSE should work with and support the relevant professional stakeholders (mentioned above) to develop clear and accessible clinical interpretations and guidance of how women access care under *sections 9* and *10,* for example, to improve understanding of a woman's eligibility to access a termination of pregnancy if she presents with mental health risk, cardiac risk, cancer care and teratogenic high-risk medications, to be able to counsel her on her options.

- The HSE should develop standardized reliable pathways of care for women seeking termination of pregnancy under *sections 9* and *10* of the Act, and providers should be informed of the point of entry to those pathways.

To avoid delay in accessing care due to the requirement for both medical practitioners tasked with forming the requisite opinions under *sections 9(1)* and *section 11(1),* to examine the pregnant woman, the following recommendations should be considered:

- Ministerial guidance is required on the interpretation of "*examination of the pregnant woman*", to clarify whether it may be interpreted to permit the second medical practitioner's opinion to be based on examination her case notes including test results, as opposed to a physical examination in circumstances where this would not assist in making diagnosis or assessing prognosis.

- If necessary, subsections *9(1)* and *11(1)* should be amended to replace the necessity for two medical practitioners to conduct a physical examination of the pregnant woman with a requirement on them to consult with each other, having regard to the woman's case notes, in forming their opinions in good faith.

To address the challenges in clinical practice and the potentially unfair outcomes on parents arising from implementing *section 11* (condition likely to lead to the death of a foetus), and noting that there is not a universal agreed list of conditions where death in utero or within 28 days of birth is guaranteed for many foetal conditions, the following recommendations should be considered:

- Department of Health should review the legislation and in doing so convene stakeholders including medical practitioners and other relevant healthcare professionals, patient representatives, lawyers and ethicists, to obtain a better understanding of the difficulties in making diagnosis and assessing prognosis in relation to whether the condition of the foetus will lead to its death in utero or within 28 days of being born, and the consequential effects this has on parents, where it is acknowledged that their baby's health will be severely compromised and its length of life will be very short (possibly less than 28 days), but cannot be definitively determined to satisfy the legal criteria. The Department of Health should engage the relevant stakeholders to consider alternative grounds that would be clear to apply in practice and would be in keeping with the spirit of the legislation.

- To support healthcare professionals in counselling parents following a diagnosis of a fatal foetal anomaly, the Department of Health and the HSE should support the establishment of a national database to collect essential epidemiological information on congenital foetal anomalies within this jurisdiction, over an agreed period of time. This service could be provided by the National Perinatal Epidemiology Centre (NPEC).

- To support medical practitioners tasked with forming the requisite opinions required by law as to whether the person seeking a termination of pregnancy fulfils the *section 11* criteria, the HSE should conduct research investigating how multi-disciplinary teams are functioning across the six fetal medicine centres. It is recommended that would improve knowledge as to,

- whether the multidisciplinary team has the right skills mix of disciplines for its caseload, whether it has timely access to expertise in perinatal genetics, perinatal cardiology and perinatal paediatrics;
- whether its members have requisite up-to-date knowledge to underpin their opinions;
- its members' education and training needs and how effectively these are being met, and
- the culture of the team and whether it is conducive to functioning well and if not what evidence-based interventions would be desirable and practical to effect improvement.

To reduce delays in the process to review refusals to requests for termination of pregnancy, it is recommended that:

- The Department of Health and the HSE should take steps to ensure that the procedures to review a refusal to a request for a termination of pregnancy are patient-centered and aim to reduce time between initiation of the review and its completion to three days.

Pending implementation of the National Strategy for Accelerating Genetic and Genomic Medicine in Ireland, the HSE should address the State's failure to provide a clinical perinatal genomics/genetics service to underpin the operation of *section 11*, by providing support to the National Maternity Hospital to support the position of Dr. Sam Doyle, who is the only consultant in this jurisdiction specialising in clinical and biochemical genetics with special interest in perinatal genomics. A perinatal genetics/genomics service is urgently required to:

- guide multi-disciplinary teams towards appropriate testing and interpretation of test results, to improve diagnosis and assessment of prognosis, including likely length of life; to place fetal medicine teams in a better position to counsel parents about their options to continue or discontinue the pregnancy, including educating them on the special needs of the child and signposting them to supports available;

- diagnose and provide follow-up care to babies born unwell where nothing was suspected during pregnancy and to babies where an anomaly was detected but could not be diagnosed prior to birth, and

- provide pre-conception services to parents whose pregnancies have been affected by a genetic fetal anomaly or the mother's genetic condition (or whose close relatives' pregnancies were) and those who have undergone several miscarriages which may be due to a genetic factor.

To improve the care pathway for women who have to travel to procure termination of pregnancy, in later stages of gestation, it is recommended that,

- The HSE to collaborate with all relevant stakeholders, including service users who have experienced travelling abroad for termination of pregnancy in later stages of gestation, to develop a pathway of care that would provide a continuum of service including follow up care with her treating consultant on her return.

To emotionally support women who are terminating their pregnancy at a later stage, due to a risk to her life or health, or due to the pregnancy being affected by a fatal foetal anomaly, it is recommended that:

- The HSE and senior hospital managers should ensure that the parents are able to avail of perinatal palliative care.

- The HSE, in collaboration with relevant stakeholders, including the RCPI, should develop specific guidelines for comfort (hospice) care for the short duration of the life of babies who survive birth following a termination of pregnancy. The guidelines should be informed by the multiple stakeholders, including neonatologists, paediatricians, nurses, midwives, foetal medicine specialists and obstetricians, and, if required by lawyers who would be able to clarify the legal rights of the babies, if this were an issue, and by ethicists. The production of guidelines and their implementation would ensure that all survivors have access to the same high-quality standard of care.

- The HSE should conduct a mapping exercise of maternity hospitals to ascertain the level of engagement of neonatologists and paediatricians to the provision of comfort care and identify hospitals where the lack of engagement is a major issue, and respond accordingly.

To ensure that accurate information on termination of pregnancy services is easily accessible by women and medical practitioners, and to mitigate against the risk of women encountering misinformation which may delay or preclude access, it is recommended that:

- The HSE should continue to resource the My Options helpline. Sustained efforts should be made to increase public awareness of its services. This should include ongoing efforts to reach women in rural areas and marginalized groups.

- The HSE, in developing data sets and frameworks for monitoring and evaluating termination of pregnancy services, should include mechanisms for monitoring the quality of information provided by medical practitioners and counsellors.

To increase the number of medical practitioners on the My Options helpline open list (GPs who are willing for their contact details to be provided to any women seeking termination of pregnancy services), it is recommended that:

- The ICGP should continue to remind its members (especially non-providers) of the My Options helpline and its role and should encourage GPs to register on My Options “open list”.

To remove barriers to access caused by delay attributed to operation of *subsection 12(3)* (mandatory three-day wait), it is recommended that:

- The section be amended to substitute the mandatory three-day waiting period with a mandatory obligation on medical practitioners to advise the pregnant woman that she has a statutory right to a reflection period, which she may exercise, at her own discretion.

To overcome barriers associated with timing out of access to early termination of pregnancy (pregnancies not exceeding 12 weeks), that are attributable to the mandatory three-day waiting period, delays in the health system or failed medical termination of pregnancy, it is recommended that:

- *subsection 12(4)* be amended to provide that the current limitation period (pregnancy not exceeding 12 weeks) be extended for a specified period in circumstances where the operation of the three-day waiting period and/or the inability to make arrangements for termination of pregnancy within 12 weeks, leads to the pregnant woman becoming ineligible to access an early termination of pregnancy, and to enable women who have commenced but not completed the termination of pregnancy within that period (due to failed medical termination of pregnancy), to complete the termination.

To create a more reliable pathway of care including equitable access to dating ultrasound services in early pregnancy, it is recommended that:

- The HSE collaborate with relevant stakeholders to develop and support reliable standardized pathways of care identifying access points to hospital services to facilitate patient referrals from the community to the hospital setting.

- The HSE should consider conducting a primary care providers' satisfaction survey of private ultrasound services and consider reviewing contractual arrangement with providers if problems are identified.

- The HSE and relevant stakeholders, should conduct a national audit of waiting times between referrals and scanning appointments, and receipt of scan results by GP or women's health centres.

- The HSE and senior managers in hospitals should support the appointment of dedicated service coordinators and clinical leads for termination of pregnancy services. These may be new or existing staff.

To achieve equitable access by all women to termination of pregnancy services, the remaining financial barriers to access of early termination of pregnancy services and contraception should be removed, and it is recommended that:

- The Department of Health should consider providing these services on the basis of residence in Ireland, thereby including people who do not have a PPS number, such as undocumented migrants and foreign students.

To ensure that the legislation provides clarity as to the obligations of conscientious objectors, it is recommended that:

- The Department of Health to provide Ministerial guidelines to accompany the Act on the interpretation of "*participate in*" and *"making arrangements to transfer*", as per *subsections 22(1)* and *22(3)* respectively.

To mitigate against the risk that a conscientious objector would not provide a termination of pregnancy where there is a risk to the life or health of the pregnant woman in an emergency, it is recommended that:

- *Section 22* be amended to include a provision obliging suitably qualified medical practitioners to perform a termination of pregnancy in emergency situations where there is an immediate risk to the pregnant woman's life or health.

To improve organizational culture around termination of pregnancy and to enable inclusive open discussion about the service, it is recommended that:

- Senior managers across primary and hospital settings should provide a forum, such as all-staff meetings, where providers and non-providers of services may meet to discuss the implications of service, share staff concerns and receive clear responses from managers, outline the responsibilities of staff and clarify their roles and enable opportunities to staff to identify themselves to managers as being willing or not willing to become involved in the termination of pregnancy service.

- Senior managers across both settings should operate an open-door policy where providers and non-providers may meet with them in a more private setting to raise issues regarding the service, including reporting adverse reactions from colleagues, and their willingness to become involved or not in service provision.

- The HSE, professional bodies and senior management should provide opportunities and facilitate staff attending education on the operation of the law on termination of pregnancy and values clarification.

- The professional bodies, the Irish Medical Council and the Nursing and Midwifery Board of Ireland, the RCPI, the RCSI and the ICGP, should ensure that their members are aware of their legal and ethical obligations relating to conscientious objection and should monitor members' adherence.

- Hospital induction programmes for nurses, midwives and NCHDs who will be working in obstetrics and gynaecology should include training on conscientious objection and values clarification.

- Universities and professional bodies should provide training in conscientious objection and values clarification to students and trainees in courses relevant to termination of pregnancy. Notably, this is broader than obstetrics, nursing and midwifery, as assessment of risk to life or health may require determinations to be made by medical practitioners in the fields of, *inter alia,* psychiatry, rheumatology, cardiology and respiratory medicine.

- At individual healthcare facility level, values clarification workshops should be conducted with all staff, including managers involved in maternity and gynaecology service delivery and receptionists, who might encounter a person seeking abortion services to mitigate the effects of abortion stigma and increase the provision of, and access to, care.

To remove barriers to access to termination of pregnancy services caused by the prospect of criminal charges being brought against medical practitioners which is a deterrent to becoming involved in service provision and which causes the practice of defensive medicine that may lead to unfair outcomes for service users, it is recommended that:

- *Section 23* be amended to remove medical practitioners from its scope.

- Furthermore, consideration should be given to decriminalizing medical practitioners for failure to comply with request of the review committee as set out in *section 17(7)*, and removing the criminal offence against a body corporate, contained in *section 24,* and, in the alternative, introduce a statutory obligation.

To protect women from the effects of conduct by medical practitioners and other healthcare professionals designed to delay or prevent a woman accessing termination of pregnancy services, the following recommendations should be considered:

- The Department of Health should consider introducing a statutory obligation on healthcare workers to refrain from providing misleading information or otherwise engaging in conduct that is designed to (or which could reasonably be considered as being designed to) prevent or delay a woman's access to termination of pregnancy.

To ensure that training and education needs of current and future service providers are met,

- Periodically, the HSE with the support relevant professional bodies, such as the ICGP, the Institute of Obstetricians and Gynaecologists, and the Nursing and Midwifery Board of Ireland, should assess members' knowledge of their obligations under the Act and professional codes of practice and their knowledge of guidelines, and should respond to their needs in an appropriate manner.

- The HSE should engage with relevant stakeholders and support the development of a protocol requiring medical practitioners in hospital settings to communicate to GPs the treatment and outcome of patients referred by them to manage complications. This would facilitate GPs to provide better care to the particular patient and would also improve their knowledge on managing future complications and making appropriate referrals.

- The HSE and professional training bodies should consider developing and supporting at national and regional level, regular multidisciplinary educational discussion groups where complex cases and management of complications may be discussed, to improve learning. Regular multidisciplinary meetings could also be an intervention for practitioners to obtain a better understanding of each other's roles, challenges in service delivery at healthcare facility level, pathways of care, and other areas that impact upon service provision. The meetings could vary in duration and could be online to facilitate participation. They could be

recorded and available as podcasts to disseminate education to a wider audience. They would require a facilitator. Attendance could be on a voluntary basis and practitioners could be involved in proposing topics for discussion at future meetings, thereby responding to their needs. Support by management at individual healthcare facility level would be required to enable practitioners to attend.

To remove any barriers to access by women to termination of pregnancy services caused by conduct intended to influence a person's decision to have a termination of pregnancy or a health worker's decision to provide the service, it is recommended that:

- Legislation should be enacted to provide for safe access zones and protection of service users and providers by criminalisation of conduct which intentionally or would reasonably be regarded as having the effect of influencing a person's decision to have a termination of pregnancy or provide the service.

To provide an evidence-base to inform future policymaking and implementation to improve the quality of termination of pregnancy services, it is recommended that:

- The Department of Health and HSE should resource research programmes to build evidence around the operation of the Act from the perspectives of service users and service providers (including but not limited to relevant stakeholders in the Department of Health, the HSE, CHOs, individual healthcare facility managers and healthcare practitioners).

- The Department of Health and the HSE should continue to support the development of a national data framework and indicator set on termination of pregnancy services, which should integrate continuous review. This includes, continuous support, including resources, to enable CAF to develop and roll out its monitoring and evaluation programme across primary and secondary care.

- The HSE should liaise with individual healthcare facilities to understand resources required to implement data collection and respond to their needs in a timely manner.

- The HSE should liaise with individual healthcare facilities to understand resources required to achieve standards set out in National Clinical Practice Guidelines relating to termination of pregnancy and respond to their needs in a timely manner.

As part of the Government's commitment to improving women's sexual and reproduction health, and to help women avoid unplanned pregnancies, it is recommended that:

- The government continue to support the free contraception scheme and expanded it to all women of reproductive age.

To develop and sustain an excellent quality termination of pregnancy service, it is recommended that:

- A multi-agency collaborative approach involving, *inter alia,* the Department of Health, the HSE, professional training bodies, service users, service providers, is required to develop and sustain excellent quality services. It will require ongoing commitment and leadership from the highest level, the Minister for Health.

- The review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018 should be an Iterative process. Services yet to be fully embedded across all counties / CHOs and there is need to address issues pertaining to the operation of *sections 9, 10, 11, 12, 13, 22* and *23* of the Act. A further independent review should occur in three years' time.

Section 2: Background

On 25th May, 2018, the Eighth Amendment to the Irish Constitution, which had acknowledged the right to life of the unborn child with due regard to the equal right to life of the mother, was repealed, and the Constitution was amended to enable the State to make provision by law for the regulation of termination of pregnancy.

The Health (Regulation of Termination of Pregnancy) Act 2018 was signed into law in September 2018 and termination of pregnancy services commenced on 1st January, 2019. The Act broadened the grounds upon which termination of pregnancy could be provided, permitting it to be carried out where there is a risk to life or of serious harm to the health of the pregnant woman, including in an emergency; where there is a condition present which is likely to lead to the death of the foetus either before or within 28 days of birth; and without restriction where the pregnancy does not exceed 12 weeks. Prior to the 1st January, 2018, termination of pregnancy could only be performed where there was a risk to life of the mother, pursuant to the Protection of Life During Pregnancy Act 2013. Accordingly, the health service had to respond to ensure that the services could be provided across primary care and hospital settings.

Section 7 of the Act provides that a review of the operation of the Act be carried out by the Minister for Health no later than three years after service commencement. The Review commenced in 2022.

Section 2.1: Terms of Reference

The Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018 was commissioned by the Department of Health in order to facilitate the monitoring of the impact, operation and effectiveness of the legislation in practice, as well as he delivery of services in the area.

The terms of reference provided that the Review would:

- assess the extent to which the objectives of the Act have been achieved, analysing in that regard the outcomes of the three strands of evidence on the operation of the Act. The three key streams of information informing the Review are service users, service providers and the public;

- assess the extent to which the Act's objectives have not been achieved and make recommendations to address the barriers, if any, uncovered in that regard;

- assess the impact of the Act's operation on access to termination of pregnancy services in the State, taking into account the level of service provision before commencement of the Act, figures on Irish women accessing termination in this country and in other jurisdictions, and any other factors which may be relevant;

- examine the arrangements put in place to implement the Act including, but not confined to service provision in the community setting, and service provision in the hospital setting, and to provide a final Review report with recommendations as appropriate.

Section 2.2: Methodology

The Review was informed by three key information strands:

- the Unplanned Pregnancy and Abortion Care (UnPAC) study
- the Review of Health Providers' Perspectives of Termination of Pregnancy (ToP) Service Implementation, and
- the public consultation process.

Details of the methodologies utilised in these three reports appear in Appendix A (Research Methods).

Separately, to improve the Chair's understanding of the operation of the Act and challenges and enablers of service provision, she interviewed three service users, six service providers in the primary care setting, 16 service providers in the hospital setting as well as nine key senior personnel in the HSE and the Department of Health. The Chair attended the annual conference of the Southern Taskforce for Abortion and Reproductive Topics (START) which is an organisation comprising approximately 300 service providers across different disciplines.

The Chair interviewed senior management figures, including two consultants and a director of midwifery at a non-providing unit, with the aim of obtaining a better understanding of their challenges to service implementation.

The Chair reviewed literature (peer reviewed and grey) and received the preliminary observations of the "Conscientious Objection after Repeal, Abortion, Law and Ethics" (CORALE) study, in January 2023. The primary objective of the CORALE Study is to investigate, for the first time, the operation of the right to conscientious objection in Termination of Pregnancy (TOP) services in Ireland.

Section 3: Service provision and geographic coverage

Section 3.1: Service use in Ireland since 1st January, 2019

Pursuant to *section 20*, medical practitioners are obliged to notify the Minister for Health about all terminations carried out under the Act. From these notifications it is possible to ascertain the following information about service use since 1st January, 2019 – 31st. December, 2021, with the caveat that notifications in respect of the year 2021 may not be accurate. In 2021, the number of claims for payment for services exceeded the number of notifications received by the Minister. The discrepancy may potentially be explained by the effects of Covid-19 and the HSE cyber-attack.

Terminations by section of the Act

Section	2019	2020	2021
9 – Risk to life or health	21	20	9
10 – Risk to life or health in an emergency	3	5	2
11 – Condition likely to lead to death of foetus	100	97	53
12 – Early pregnancy	6542	6455	4513
Total	6666	6577	4577

Terminations by month of the year

Month	2019	2020	2021
January	625	709	628
February	490	552	493
March	508	654	405
April	538	639	289
May	580	520	100
June	533	510	103
July	602	605	157
August	530	516	142
September	506	541	488
October	545	490	521
November	548	456	630
December	592	327	559
No date received	69	58	62
Total	6,666	6577	4577

Terminations by county

County	2019	2020	2021
Carlow	74	56	46
Cavan	77	107	70
Clare	73	83	82
Cork	606	645	408
Donegal	127	128	90
Dublin	2493	2414	1618
Galway	280	274	206
Kerry	48	110	103
Kildare	295	264	165
Kilkenny	96	83	64
Laois	79	60	46
Leitrim	27	28	22
Limerick	226	278	186
Longford	47	52	41
Louth	213	220	160
Mayo	111	105	83
Meath	252	240	168
Monaghan	36	54	46
Offaly	67	67	49
Roscommon	43	53	38
Sligo	59	60	54
Tipperary	174	161	128
Waterford	149	158	124
Westmeath	104	108	76
Wexford	165	159	147
Wicklow	138	141	145
Northern Ireland	67	36	5
Other	15	8	2
No address given	525	425	204
Total	6666	6577	4577

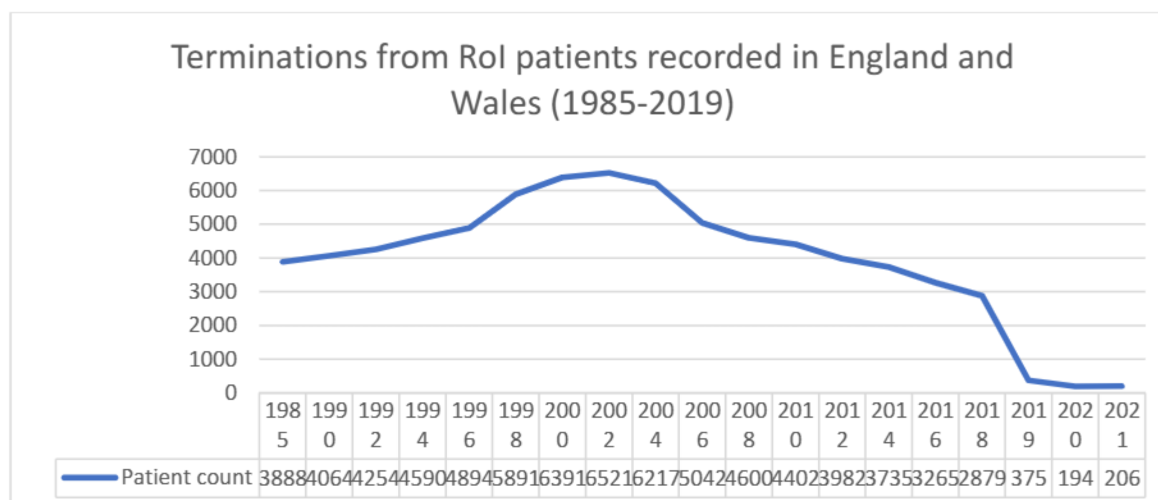
Comparison with terminations of pregnancy carried out in Ireland under the Protection of Life During Pregnancy Act 2013

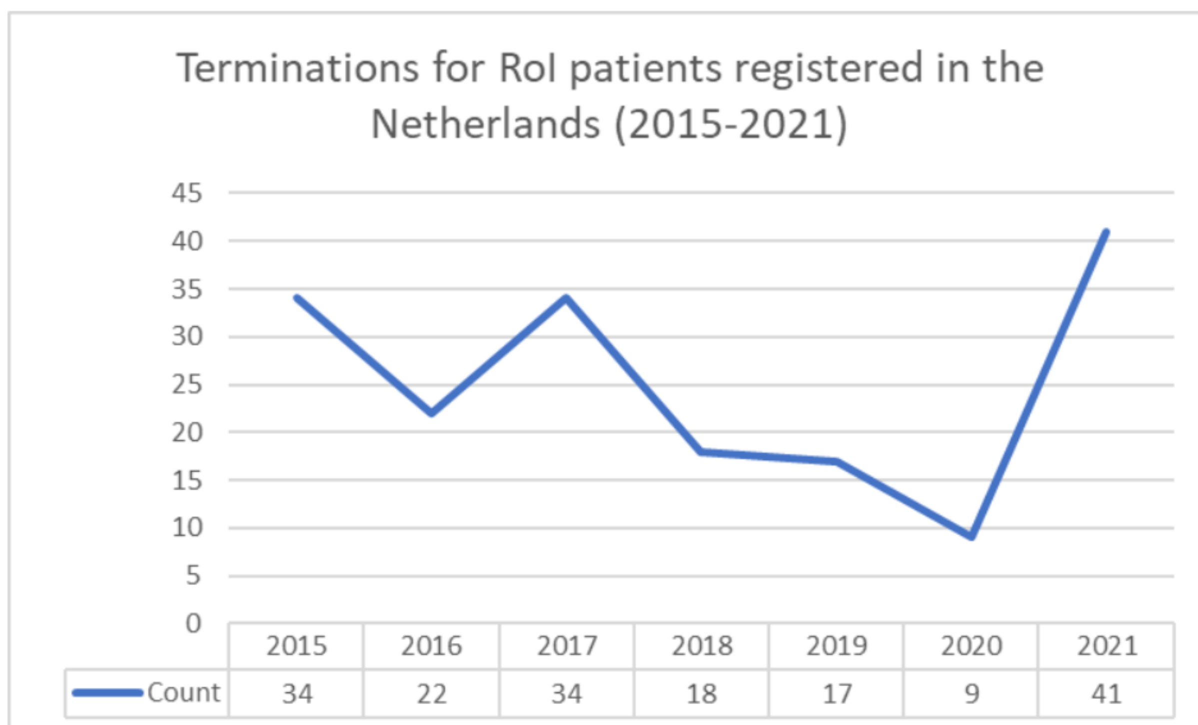
Information released under the Protection of Life During Pregnancy Act 2013 (which permitted termination of pregnancy to be carried out when there was a risk of loss of life of the pregnant woman) when compared with figures for terminations on comparable grounds under *sections 9* and *10* of the 2018 Act (which permit termination of pregnancy to avert a serious risk to the mother's life or health) indicates that there has not been much change in the numbers of abortions carried out in these situations.

	Protection of Life During Pregnancy Act 2013		Health (Regulation of Termination of Pregnancy) Act 2018					
	2017	2018	2019		2020		2021	
			s.9	s.10	s.9	s.10	s.9	s.10
Abortions carried out	15	32	21	3	20	5	9	2

Section 3.2 Comparison with terminations of pregnancy carried out abroad

There has been a significant downward trend in numbers of women seeking abortions outside of the State since the commencement of the 2018 Act. Overall, figures appear to have declined since 2019, with data from England and Wales showing the number of people providing Irish addresses at abortion clinics to have reduced. In contrast, the number of Irish addresses registered at clinics in the Netherlands in 2021 increased significantly and is reported to be at its highest rate since Dutch authorities started recording Irish service users. The reason for this is not known. Spain is also known to be a destination for Irish women seeking termination of pregnancy. However, Spain does not disaggregate its data by country. It is possible that women are also travelling from Ireland to other parts of Europe for the purpose of procuring abortion services.





Abortion travel (Netherlands) 2015-2021

Data from the UK Department of Health and Social Care provides figures on the gestational age of pregnancies at time of abortion. Women, who travelled to the UK for abortion services since 2019, were at the following gestational stages of their pregnancies:

Gestation(weeks)	2019	2020	2021
3 – 9	65	11	7
10 – 12	33	7	2
13 – 19	198	134	137
20 and over	79	42	60

Gestational age of Republic of Ireland ToP service users England and Wales (2019-2021)

The data shows that for early termination of pregnancy (not exceeding 12 weeks gestation) there appears to be a significant downward trend in the numbers of people travelling from Ireland to seek this service. This is indicative of successful implementation of the early termination of pregnancy services in this jurisdiction.

The slight decline and relatively static numbers of women travelling to the UK for abortion services at later stages of gestation since 2019 is potentially due to women timing out of eligibility to obtain an early medical termination in Ireland; women seeking abortion on grounds not available under Irish law, and women who may have been eligible for termination of pregnancy services under *sections 9 -11,* but were refused by their medical practitioners due to challenges associated with operating these sections or were unaware of their legitimate right to access care under grounds under *sections 9* and *10* . Further discussion on timing out of services for early medical abortion, and the challenges operating *sections 9 – 12,* appear in this report under the headings of "*Section 9 and 10*", "*Section 11*", and "*Section 12*".

The data also records the grounds on which the abortion was performed. There are seven grounds upon which abortion is legal pursuant to the Abortion Act 1967 (England and Wales).

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Grounds for provision of termination [Abortion Act (1967), England, Wales and Scotland]	
A	That the continuance of the pregnancy would involve risk to the life of the pregnant person greater than if the pregnancy were terminated
B	That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant person
C	That the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant person
D	That the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant person
E	That there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped
F	To save the life of the pregnant person
G	To prevent grave permanent injury to the physical or mental health of the pregnant person

Between 2019 and 2021 the grounds cited for performing abortions on women who provided Irish addresses are:

Grounds	2019	2020	2021
A (alone or with B, C or D)	0	0	0
B (alone)	0	0	0
B (with C or D)	0	0	0
C (alone)	311	131	103
D (alone or with C)	0	0	0
E (alone or with A, B, C or D)	64	63	103
F or G	0	0	0

Grounds for Termination of Pregnancy Recorded (England and Wales), 2019-2021

Since 2019, most of the abortions were performed underground C (alone). The other ground upon which abortions were performed for these women was ground E (alone or with A, B, C or D). Terminations under this ground increased in 2021.

The Abortion Support Network (ASN) who provide financial and logistical support for Irish abortion travel provided a synthesis of data relating to Irish residents following implementation of the 2018 Act. The following table shows the numbers of contacts made by Irish residents to the ASN and the number of people that it provided financial support for travel to:

Detail	2019	2020	2021	2022 (to June)	Total
Number Contacts	159	158	175	116	609
Number Funded	69	51	59	50	229

Abortion Support Network data 2019-2021

Section 4: Factors influencing provision of services in primary care and hospital settings

Section 4.1: Numbers of providers in primary care

The vast majority of terminations of pregnancy services are performed under *section 12* (pregnancy not exceeding 12 weeks). For the most part, this service is provided in the primary care setting by GPs and medical practitioners in entities such as women's health clinics

There is not any accurate data on the precise number of primary care providers of termination of pregnancy services. Based on the number of contractual agreements between the HSE and GPs and women's health clinics, it is possible to estimate that has been an increase in the numbers since 2019:

Year	Number of contracts between HSE and Primary Care Providers
2019	325
2023 (as of 16th February)	422

As of 16th February 2023, 412 of the contracts are held in the name of individual GPs. However, other GPs may provide locum services under these contracts if in a practice setting. 10 of the contracts are held in the names of "entity providers" (a company type situation, for example women's health centres and student union medical facilities). Therefore, it is likely 422 is likely an understatement of the number of individual providers.

The number of contract holders in primary care has increased by 10 since May 2022. The Chair was unable to ascertain the location of the additional 10 contract holders. However, there is known to be an uneven geographic coverage of primary care providers. Fewer GP contracts are recorded in the south-east, north-west, midlands and border counties than elsewhere. This is illustrated by the following diagram that represents the situation in May 2022:

GP ToP contracts May 2022 (total = 412)

GP Contracts for Termination of Pregnancy by county (2022)

The data provided by the HSE to inform this Review did not include sub-national population data for each of the community health organisations (CHOs) that the contracts fell in. The CHOs were established by the HSE as a means of ensuring that provision matched population-level need. Some CHOs match on to counties and others cut across county borders. Accordingly, without the precise location of contract holders or details of the number of individual GPs at contract holding surgeries, it was impossible for the researchers to gauge whether there is sufficient coverage to meet local demand.

In counties with poor coverage, service users have limited choice as to GP provider in their area. As one GP who participated in the providers' perspectives study commented,

> *"so whilst there is a geographic spread to a degree and the numbers have increased somewhat, there is still a lack of services, particularly in some counties where you may only have one or two GPs providing so that's certainly an issue in terms of giving somebody choice I suppose and lots of choice around providing GPs"* (R215)

Another GP, who participated in the World Health Organisation (WHO) study[6] referred to the particular problems with uneven distribution as opposed to the numbers of providers, stating that 80-90% of patients seeking services at his rural clinic had travelled from more populated parts of the country that lack a provider.

Section 4.2: Factors influencing GP provision

There is a dearth of information regarding GPs' reasons for not providing termination of pregnancy services. As non-providers of the early medical abortion service make up the vast majority of GPs (nearly 90%), a survey was commissioned as part of this Review by the Department of Health to try to get a better understanding of factors influencing GPs' willingness or ability to provide services.

The sample included providers and non-providers to identify the different factors involved. Due to the low response rate 6% (n=188) of returned surveys that could be analysed, the data of itself cannot be said to be representative of all GPs, but in conjunction with qualitative data gathered in the service providers' research (primary and secondary data), it could be used to establish if there is evidence of,

A. Lack of engagement in professional development and training by non-providing GPs
B. A connection between individual GPs providing and their colleagues in surgeries providing;
C. A connection between local hospital provision, and
D. A relationship between non-provision and workload.

Section 4.2.1: Indications from survey results

Excessive workloads

The most relevant factor influencing GPs decisions to provide emerged as their workload responsibilities with 41.3% (n=38 / 92) stating this to be very relevant, 6.5% (n=6 / 92) as stating it to be quite relevant, and 7.6% (n=7 / 92) stating it to be somewhat relevant to their decision. This supports qualitative data gathered as part of the service providers' perspectives study that indicates that the decision to provide services is influenced by workload capacity.

The model of care for early medical termination of pregnancy service is resource intensive. For pregnancies not exceeding ten weeks, two consultations are required before the abortifacient medication can be dispensed, a third follow-up visit is optional. In complicated cases, the GP may also be required to make referrals for ultrasound scans, manage complications where the woman continues to be pregnant requiring ongoing monitoring of her pregnancy hormones, which involves multiple visits or manage excessive bleeding. Referrals to hospital for terminations of pregnancies exceeding nine weeks may also be very time-consuming, particularly if the care pathway is unreliable and multiple follow-up calls are required to make arrangements.

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[6] Mishtal J, Reeves , Chakravarty D, Grimes L, Stifani B, Chavkin W *et al* Abortion policy implementation in Ireland: Lessons from the community of care. PLoS ONE 17(5) e0264494

The providers' research revealed that the additional resources required to deliver termination of pregnancy services could be perceived as a deterrent to involvement in the service. As two GPs explained,

> *"I think it's just the thought of trying to add another service to what you're already doing when you're barely keeping your head above water with the amount of work that's coming in. I think that's probably a big thing" (R201)*
>
> *"So, I have a colleague who isn't involved in the service, not because (they were not) interested. Just, like, (they) don't want to do all that extra work, (they) have enough to be doing". (R108)*

The WHO study by Mishtal J *et al* captured excessive workloads as a deterrent for GPs, particularly in rural areas, taking on provision of abortion services. It refers to a recent study by Crosbie B *et al*[7] measuring GPs' real-time workload that shows that GPs work very long hours, one-third of their workload is non-remunerative and that their pay had been cut by approximately 40% as part of the 2008 austerity measures and has yet to recover. These factors are believed to be a disincentive to doctors entering the profession in Ireland. ICGP representatives, attending the Oireachtas Health Committee on 14th December, 2022, stated that around 1,800 more GPs are required within the system, to take the total to roughly 6,000, to provide the equivalent of 4,000 full-time roles, and that currently, there are 4,250 GPs representing 2,800 full-time roles[8].

Allowing practice midwives and nurses and other health care professionals to become more involved in the provision of abortion services in the community setting would positively impact upon easing GPs' workload burdens. Currently, *section 12* restricts provision of abortion services to medical practitioners. The WHO guidelines[9] recommend against regulation on who can provide and manage abortion as this can result in delays and burdens in accessing care.

Lack of hospital back-up

The relationship between whether a GP provides and whether a local hospital provides is complex. The WHO study by Mishtal J *et al*[10] refers to lack of hospital-back up as being a relevant factor, quoting one informant in the medical community stating that the two-hour journey from the nearest hospital provider as, *"a huge deterrent to providing the service".*

Most of the survey respondents reported that proximity of a local hospital unit was not a relevant factor to their decision, with 72.1% (n=67 / 188) stating that it was not that relevant or not relevant at all, as against 22.6% stating that it was either very relevant (n=9/188), quite relevant (n=12/188)

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[7] Crosbie B, O'Callaghan ME, O'Flanagan *model* S, Brennan D, Keane G, Behan W. A real-time measurement of general practice workload in the Republic of Ireland: a prospective study. British Journal of General Practice 2020; 70(696): e489-e96

[8] Emmet Malone, "Longer GP waiting times inevitable from April, health committee hears". Irish Times, Thursday, 15th December, 2022, page 3.

[9] Abortion care guideline. WHO (2022)

[10] Mishtal J, Reeves , Chakravarty D, Grimes L, Stifani B, Chavkin W *et al* Abortion policy implementation in Ireland: Lessons from the community model of care. PLoS ONE 17(5) e0264494

or somewhat relevant (n=5/188). Most of the survey respondents who identified as providers worked near a providing hospital, as did many of the non-providing GPs.

Conscientious objection

The survey also identified that conscientious objection would not appear to be a major factor influencing GPs decisions about provision of the service. Just over half of the survey respondents, 52.7% (n=99) stated that they did not provide early medical termination of pregnancy services. Not all non-providers identified themselves as having a conscientious objection. Of the 123 respondents who responded to the question on conscientious objection, only 26% (n=32) put themselves into that category, and 28 of these respondents said that they would not provide termination of pregnancy services in any circumstances, with some including comments that they did not believe the service should be included in medical practice at all. 64.2% (n=79) of non-providers claimed not to have a conscientious objection, and 9.8% (n=12) stated that they preferred not to say. Conscientious objection is discussed in a separate section of this report.

Training and professional development

Engagement in training and professional development is potentially connected to whether a GP is a provider or a non-provider. Many of the non-providers who engaged with the survey had not engaged in training or sought it out, despite 67 respondents who identified as non-participants stating that they did not feel they had requisite skills to provide early medical termination of pregnancy services. Training and education are necessary to inform them of the legal framework, the limits of conscientious objection, responsibilities around referrals and patient handovers and management of complications. Training and education are discussed in a separate section of this report.

The ICGP has rolled out training courses to its members. As of October 2022, 672 GPs had attended in person training sessions and 474 had participated in online training. However, these numbers do not accurately represent the numbers of GPs who have undergone training through ICGP programmes, as they include GPs who had attended more than once, to refresh their skills.

Criminal sanctions

Interestingly, 67.8% of respondents stated that the existence of criminal sanctions within the Act were not that relevant (n=53/90) or not relevant at all (n=8/90) to their decision whether to provide services[11]. The operation of *section 23 (criminal offences)* is discussed in a separate section of this report.

Peer support

Having access to experienced colleagues for support was relevant to 45.2% (42/93) of respondents' decision-making, illustrating the importance of supporting peer networks.

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[11] In contrast to the challenges faced by medical practitioners applying the regulations in *sections 9 – 11,* where the prospect of criminal sanctions and adverse media scrutiny are significant considerations for service providers, the application of *section 12* is based on assessment of the gestation period, which is relatively straightforward, with less risk of operating outside the legal regulations and less prospect of criminal charges being brought.

The WHO study by Mishtal J[12] refers to the important role that voluntary peer support groups, such as Doctors for Choice and the Southern Taskforce on Abortion and Reproductive Topics (START) group played in preparing for the introduction of services in the community. It specifically mentions START, which includes mainly GPs, but also hospital-based providers, and its role as a central support network, running an extensive WhatsApp network, with a smaller "train the trainer" group to help train new providers. It refers to its ongoing role in providing support to providers, and describes this as, *"vital"*, and that, *"the strong peer support provided by START was also linked to feelings that the work was rewarding".*

Voluntary peer support groups have also been active advocates for policy reform. They have been part of the collaborative approach in developing services, working with the Department of Health, the HSE and professional training organisations.

Section 4.2.2: Unreliable or unclear referral pathways to hospital care

Outside of the survey, the providers' research and the WHO study[13] refer to unreliable pathways from primary to secondary care for abortion services as also discouraging some GPs from becoming abortion providers. Both studies refer to unclear and slow referral pathways, with GPs not having sufficient knowledge of the abortion services available in each hospital, and knowledge having been acquired informally, through word of mouth.

According to the WHO study which focused on community provision, in 2020 the HSE took steps to improve the pathway to hospital by requesting each hospital to provide details of their nurse midwife coordinator and the email addresses that the referral needs to be sent to. However, the findings of this Review, show that the referral pathways are still problematic. There may be delays in responding to emailed referrals, particularly if the nurse/midwife coordinator works part-time, is on leave or otherwise not available and adequate cover is not in place. GPs still seem to be relying on informal relationships with consultants to arrange medical care.

Sections 4.3: Factors influencing hospital provision

The hospital termination of pregnancy services are consultant led. Women's access to services is therefore dependent upon their willingness to provide care.

There are 19 maternity hospitals in Ireland. The Department of Health has confirmed that to some extent, all 19 hospitals offer some aspects of services in relation to termination of pregnancy, including supporting women with post termination complications; providing ultrasound scanning; providing appropriate care and supervision in some cases where the health or life of the mother is at risk, and referral to a tertiary hospital, as appropriate, and providing appropriate care and supervision for women following a diagnosis of fatal fetal anomaly, and referral to appropriate care.

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[12] Mishtal J, Reeves , Chakravarty D, Grimes L, Stifani B, Chavkin W *et al* Abortion policy implementation in Ireland: Lessons from the community model of care. PLoS ONE 17(5) e0264494

[13] Mishtal J, Reeves K, Chakravarty D, Grimes, L, Stifani B, Chabkin W, et al. (2022) Abortion policy implementation in Ireland. Lessons from the community model of care. PLoS OEN 17(5) e 0264494

According to the HSE, 18 of the 19 hospitals offer some aspects of care to women who choose termination of pregnancy for *section 11* (fatal foetal anomaly). Due to the complexity of termination for fatal foetal anomaly, the referring hospital may not take back patients from the tertiary centre. For some women, it may be more appropriate for her to have the termination at the tertiary centre, if there is a maternal health issue or if there is a possibility that the foetus will survive birth and the referring hospital is not equipped to provide appropriate care. The woman herself may prefer to stay at the tertiary referral centre rather than return to the referring unit and this preference is accommodated.

The providers' research identified resistance by hospital level senior management to late-term termination of pregnancy as being a barrier to service delivery. The research shows that not all 19 hospitals are willing to provide termination of pregnancy services in all cases where the life of health of the mother is at risk (*section 9)* and prefer to abdicate their responsibility to larger maternity hospitals. As articulated by a perinatal psychiatrist,

> *[The hospital] don't like doing terminations. They don't feel trained and set up for it. There's a lot of moral objection to it, certainly at quite senior level is the feeling I get. So that's a definite barrier to people getting late-stage terminations. They want to just be able to refer it up because they refer their high-risk stuff to Dublin anyway. They want to refer it up. They see Dublin, it's more acceptable to staff so they just don't bother to get themselves trained up because they don't want to anyway because they don't want to deliver these terminations.* (R203)

Section 4.3.1: Numbers providing full services and uneven geographic coverage

As of February 2023, the numbers of providing hospitals fully engaged with termination of pregnancy services (and providing abortion services for pregnancy not exceeding 12 weeks) has increased by one only since February 2019, one month after services commenced.

Date	Number of hospitals providing
1st January 2019	7
8th January 2019	8
28th February, 2019	10
11th April 2022	11

There is uneven geographic coverage of hospitals providing full services under the Act. The 11 providing hospitals are located in Dublin, Cork, Drogheda, Galway, Limerick, Mayo, Mullingar, Sligo and Waterford.

Last year, the government set an initial target that all maternity units would be providing the full range of services by the end of 2022. However, the target was not reached with only one hospital, University Hospital Sligo, commencing services.

It remains government policy that termination of pregnancy services should be provided in all 19 maternity hospitals. HSE NWIHP is working towards having 17 hospitals providing by quarter 2 2023. Service commencement in all but one of these hospitals is dependent on recruitment. The following recruitment update was provided to the Chair by the Department of Health in January 2023,

Site	Recruitment status
University Hospital Kerry	Applications closed – Interviews scheduled Jan '23
Midland Regional Hospital Portlaois	Applications closed – candidate appointed – start date agreed
St. Luke's General Hospital Kilkenny	Advertised – Closing Feb '23
Cavan General Hospital	Applications closed – candidates shortlisted Dec '22 – Interviews scheduled Jan '23
Sligo University Hospital	Update pending – TOP service has commenced

On the basis that lead time to recruitment of medical practitioners is approximately one year, this information indicates that an additional four units will come on board in 2023 (as Sligo University Hospital is already providing), bringing the total number of providing units to 15, which is unsatisfactory, particularly considering the length of time that has passed since service planning commenced in 2018. The post of national clinical lead on termination of pregnancy services was vacant between March 2019 and January 2020 and restrictions relating to Covid 19 may have been temporary disruptive factors.

The current status of provision is being attributed by the HSE and the Department of Health to the lack of consultant obstetricians and gynaecologists willing to provide the service, mostly on the grounds of conscientious objection, or of not being willing to lead and provide the service alone, without peer support.

Whilst medical practitioners, nurses and midwives may exercise a right to conscientious objection to provision of abortion services, it may not be exercised by other senior management employees responsible for running services at hospital level. Funding has been available for recruitment of additional staff to enable services to commence. However, it may be inferred from the information provided that the recruitment process in Kerry, Portlaois, Kilkenny and Cavan did not occur until 2022. Further delays may be expected if the medical practitioner awarded the contract does not take up the post for several months due to outstanding contractual obligations or logistical reasons associated with moving back to Ireland from abroad.

The net effect of failure to provide full services is to move the workload to another maternity hospital and to cause women to have to travel greater distances (in some cases taking several hours) to receive care that should be available to them in their nearest maternity hospital.

Senior hospital management and the HSE NWIHP are responsible for identifying service needs and responding to them. It is encouraging that four additional hospitals have progressed recruitment.

However, it is important that strong political will at the highest level is sustained to maintain progress.

Section 4.3.2: Conscientious objection and recruitment challenges

Reluctance to include the provision of abortion service as a condition of funding and/or employment has led to at least two positions funded by HSE NWIHP being filled by consultants who subsequently declared holding conscientious objection to abortion. To try to prevent this recurring, the HSE NWIHP Director confirmed that in 2022, the provision of funding approval for five additional posts was conditional upon the recruiting hospitals making it clear through advertising that candidates would be expected to contribute to elective termination of pregnancy as part of their practice.

The Review revealed that there has been uncertainty among those involved in the recruitment process as regards the lawfulness of making the provision of termination of pregnancy services a condition of the employment contract or to enquire of candidates at interview whether they are willing to provide and/or lead on the provision of services. However, whilst freedom of conscience, thought and religion are internationally protected human rights, it should be noted that the rights are not absolute. Of note, Article 9 of the European Convention on Human Rights which protects people from being unfairly discriminated against on the basis of their thought, conscience and religion[14]. is subject to such limitations as may be prescribed by law and are necessary in a democratic society in the interests of, *inter alia,* health, of for the protection of rights and freedoms of others.

Arguably, the State could, by amending *section 22*, place on a statutory basis the employing hospital's obligation to accommodate conscientious objection except in circumstances where it is necessary to uphold the right to healthcare. This would require the hospital employer to be cognizant of the need to balance both rights in the recruitment process. The hospital would have to be able to show that it did not have the critical mass of existing employees to perform the duties and sustain the service.

In New Zealand, where legislation allows conscientious objection by providers, the legislature has included in *section 15* Contraception, Sterilisation and Abortion Act 1977, the obligations upon employers in protecting a person's freedom of religion and belief and sets out when it is appropriate to not accommodate them. The section precludes an employer from *inter alia* refusing or omitting to employ an applicant for available work or affording an applicant or employee less favorable terms of employment or from terminating a contract of employment, on the basis of the person having a conscientious objection, unless accommodating that objection would unreasonably disrupt the employer's provision of health services, in which case the employer can take any of the aforementioned actions. The section affirms the aggrieved person's right to make a complaint under New Zealand's Human Rights Act 1993 or Employment Relations Act 2000.

[14] Article 9 protects a person's right to freedom of thought, conscience and religion.

Section 4.4: Restrictions on who can provide services

Under the 2018 Act, the service may only be performed by medical practitioners, which due to the low numbers providing and their geographic distribution, can result in delays and burdens to women accessing abortion services. Expanding the range of healthcare workers to include, for example midwives and nurses across both settings, and non-consultant hospital doctors (NCHDs) in the hospital setting, would potentially increase the numbers and improve the geographic distribution of providers.

The WHO recommends against regulation on who can provide and manage medical and surgical abortion services. It points to the benefits of expanding the workforce including timely access to medical and surgical care, reduced costs, travel and waiting time, shifting components of care away from physicians and making abortion more available in rural areas and at primary care level. It points to provider restrictions reducing efficiencies, administrative burdens and workload burdens within health systems, and reduction in the number of available providers. The WHO's 2022 Abortion Care Guidelines provides guidance as to how to involve a wider range of health workers.

If the statutory restrictions were amended to enable service delivery by other health care professionals, it would be important that GPs and other medical practitioners providing the service would continue to see a critical mass of patients to retain and develop their skills. Accordingly, the overall numbers of providers would need to be monitored to ensure this can be achieved.

Expanding the range of health workers who can provide care would require training and education of nurses and midwives and amendment of the 2018 Act.

Section 4.5: Financial provision for staffing

In 2019, €12 million in development funding was released to support the workforce and infrastructure investment for the introduction and further roll-out of termination of pregnancy services in hospitals.

The number of whole-time equivalent posts funded for termination of pregnancy care by HSE NWIHP since 2019 appears in the table below. Regarding the conditions of workforce and infrastructure, the NWHIP Director explained:

> *"the posts listed below were approved to support the development and roll out of termination of pregnancy services as part of the various hospitals suite of maternity and gynaecology services. Prior to approving these posts, NWIHP engaged at hospital group, maternity network and local levels to identify key opportunities and challenges with regard to TOP service provision and to determine how best to proceed with the advancement of TOP services. These engagements also enabled NWIHP to establish what resource/skill mix was required to facilitate commencement of TOP services. (Statement from NWHIP Director, September 2022 to Dr Deirdre Duffy, principal investigator of the providers' research*

Posts	Filled	Filled (Temp. Basis)	Vacant	Grand Total
Consultants/Medics	17	4	6	27
Midwives/Nurses	21	1	2	24
Health and Social Care Professionals	11	0	3	14
Administrative Posts	6	1	1	8
Grand Total	55	6	12	73

Foundation funding also supported the establishment of the post of Clinical Lead for Termination of Pregnancy Services, the development and delivery of a national training programme and funding for an initiative at the National Maternity Hospital to provide national fetal and neonatal MRI services.

The HSE NWIHP Director has confirmed to the chair that, "*dedicated funding of €26 million across 2021 and 2022 in broader women's health services and initiatives including gynaecology and the implementation of the National Maternity Strategy is supporting recruitment across a broad range of healthcare professionals across different disciplines and staffing cohorts*".

Recruitment for support of provision of termination of pregnancy services is vitally important not only to commence but to sustain services in existing provider sites where, in the main, the service is reliant on a small number of consultants. There is no data as to the specific numbers of consultants providing the service in each hospital. However, both the Chief Clinical Officer and the HSE NWIHP Director described service provision across providing hospitals as being tenuous. Over-reliance on a small number of people (including consultants, nurses, midwives and other healthcare professions) may potentially lead to burnout if the additional responsibilities of providing the service leads to unsustainable workload burdens. This is potentially an unsafe system of work, not only unsafe for the staff involved, but also for patients due to the well documented adverse effects that burnout may have on patient care. The providers' research stresses the need for management to consistently monitor the distribution of staff responsibilities to ensure that staff do not become over-burdened by their workload.

The providers' research also revealed that in addition to the risk of burnout, in units where the dominant culture is against service provision and is dependent on a small number of consultants, this creates an unsupportive environment, feelings of being unable to ask for help and burden of increased workload.

Section 4.6: Need for dedicated clinical leads, service coordinators and medical social worker input

The providers' research refers to the need for dedicated clinical leads in each hospital to oversee and develop termination of pregnancy services. The providers' research study refers to the important role of nurse/midwife service coordinators that are present in all providing units[15] (albeit that in some sites the role is not sufficiently resourced to ensure a reliable pathway). It also refers to the vital role that medical social workers have in supporting the provision of all services under the 2018 Act.

[15] Confirmed by HSE NWIHP Director

The extent of a social worker's contribution involves seeing people who present for early termination of pregnancy where they have social issues such as housing, domestic abuse or addiction, where they are unsure of whether to have a termination or continue the pregnancy, seeing people who are seeking abortion in later stages of pregnancy and providing them with support and information.

Not every maternity unit has access to a medical social worker. The Chair met with a consultant working in a small hospital who explained that he felt that they needed a social worker, especially to provide support and information to patients who were considering abortion because of a perceived lack of social supports being available.

Section 4.7: Importance of good managerial support

The providers' research shows that where there is good managerial support and workforce engagement, hospital staff have been able to ensure that services are not being developed or negotiated by individuals or small teams. However, in some units, senior managers (both clinical and non-clinical) have taken an apathetic approach, tolerating rather than encouraging the development and running of the service.

Senior management (clinical and non-clinical) and consultants have a significant role in setting the culture of the workplace. Where the dominant culture is against service provision, whether due to conscientious objection or other factors, it can be difficult for staff to become involved. Junior doctors may feel reluctant to show interest in the provision of abortion services if their consultant is anti-abortion as they may fear that this would impact upon their future careers[16].

Stifani *et al's* study[17] of non-consultant hospital doctors (NCHDs) indicates that there is interest for training to expand their knowledge of and participation in termination of pregnancy services. In that study, 61.8% reported participation in termination of pregnancy care with 25.5% reporting that they had been involved in performing surgical procedures.

Staff, including junior doctors, must be provided with an opening to become involved in the provision of termination of pregnancy care if they wish to do so. Open discussions and training need to be facilitated by senior management on the limits of conscientious objection and how staff who wish to do so, might become involved in supporting or providing the termination of pregnancy service.

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[16] This finding in the providers' research study is supported by the preliminary observations of the CORALE study that indicate that attitudes of the consultant team or GP principals towards provision of the service may present challenges to others, primarily more junior members of staff (trainees/NCHDs), asserting their own views. Leaders / senior managers influence how comfortable more junior colleagues are to speak up about their own views on termination of pregnancy. Furthermore, it indicates that in smaller, non-providing hospitals, healthcare professionals who would be interested in providing the service would welcome an open discussion about the feasibility of service provision.

[17] Stifani BM, Mishtal J, Chavkin W, Reeves K, Grimes L, Chakravarty D, Duffy D, Murphy M, Horgan T, Favier M and Lavelanet A (2022) Abortion policy implementation in Ireland: successes and challenges in the establishment of hospital-based services. SSM – Qualitative Research in Health. 2 December, p 1000090

It is important that all staff feel respected and psychologically safe in the workplace and that a supportive environment is promoted by senior managers. Whilst research informing this Review reports providers of abortion services feeling varying degrees of disapproval or ostracism from non-providing colleagues, it would appear from the preliminary observations of the CORALE study that non-providers also describe experiencing stigmatization in the workplace if they were perceived as being out of step with the dominant ethos. In some instances, hospital staff with conscientious objections perceived that they were being accused of "not caring about women" by colleagues because it was known that they were not willing to provide the service.

Clear signals are needed to show that staff will be emotionally supported. This may involve senior managers directly addressing staff who are not behaving appropriately. The providers' research indicates that it can be difficult for managers to challenge inappropriate conduct in the context of broader issues relating to recruiting and retaining staff in the health sector.

Good leadership inspires confidence in staff to become involved. Where staff have a good relationship with providers and trust them, they may be more inclined to listen to their views. One example that was provided to the chair was by a midwife coordinator working in a small maternity unit where the nurses and midwives were hesitant to care for patients who were attending for termination of pregnancy services came on board after she spoke to them about how the service was protecting women from the potential harm of unsafe abortion.

Enabling staff and students to encounter patients on the ward who have had their pregnancies terminated and hearing their stories has been reported to the Chair as being effective in rousing interest in getting involved in supporting the service.

The providers' research highlights the benefits of having all-staff meetings where health workers may discuss the implications of the service, share staff concerns, outline responsibilities for staff and clarify roles. These meetings provided staff interested in providing the service with an opportunity to identify themselves to managers. They also offered space for health workers to ask questions, air concerns, and receive clear responses from managers. It recommends that all-staff meetings should take place in primary and secondary care.

Section 5: Infrastructural challenges

Hospital-based termination of pregnancy requires a single room where women are not in close proximity to other pregnant women. However, due to the configuration of hospitals, many single rooms are located in labour wards. The UnPAC study reveals that this can be very distressing for service users.

Theatre access, particularly in general hospitals where maternity services are required to share facilities with other services, can be challenging. Theatre access may be necessary where women are undergoing surgical termination of pregnancy.

Whilst MVA may be performed in gynaecology settings, the gynaecology service is under a lot of pressure and may not be able to easily accommodate termination of pregnancy services in addition to its other workload.

The HSE is aware of the infrastructural challenges and has informed the Chair that it has established a working group to address deficits in maternity services.

Section 6: Choice of method of termination

Section 6.1: Pregnancies not exceeding 12 weeks

There are three methods of termination of pregnancies that do not exceed 12 weeks, medical, manual vacuum aspiration (MVA) and electric vacuum aspiration (EVA). The Interim Guidance for Termination of Pregnancy Under 12 Weeks describes the three methods,

- *"A medical termination at less than 9 weeks, in primary care, involving the patient taking the abortifacient medication, mifepristone, at the surgery, and being given misoprostal to take at home to get rid of the products of pregnancy. After 9 weeks, the mifepristone is taken in the outpatient department and arrangements are made to admit them to complete the termination by administration of misoprostol".*

- *"Manual vacuum aspiration (MVA), a surgical option in secondary care without an anaesthetic, under paracervical block)"*

- *"Electric vacuum aspiration (EVA) in secondary care, usually with a general anaesthetic"*

The Interim Guidance on Termination of Pregnancy Under 12 weeks acknowledges that MVA can be more efficient, timewise, and preferable to a woman. It states that "*MVA combines the advantages of a surgical procedure with lower cost than EVA. MVA has the advantage that the patient may eat or drink as normal prior to having the procedure performed (Milingos et al. 2009, Kumar et al. 2013). The mean and median time from arrival to discharge with MVA in a recent study was 2.5 and 2.57 hours respectively (Pillai et al. 2015)"*. It further states that there are limited complications associated with MVA.

Section 6.1.1: Limited choice of methods available

In early termination of pregnancy most patients are not generally offered a choice of medical or surgical termination. In nearly all cases, women have a medical termination of pregnancy.

Medical termination of pregnancy that does not exceed ten weeks, are self-managed at home under the supervision of the primary care medical practitioner. The HSE has confirmed that in some circumstances, following a needs and risk assessment, women in this category may be offered a surgical method.

For some women, medical termination of pregnancy may not accord with their needs, choice or priorities. It may be very difficult for a homeless person or a person living in shared accommodation lacking privacy to manage the bleeding that follows a medical termination. Others might prefer a surgical option for work, family or other logistical reasons.

For those who attend hospital services from the 10th week of pregnancy, six hospitals currently routinely offer a surgical option to women[18]. It is not clear whether it is being utilised in all these units as the first line or treatment or only after several rounds of administration of misoprostol has failed. Being administered several rounds of misoprostol may be very stressful for the women concerned and can result in extended hospital stays. This was articulated very well by Victoria and Jade, respondents in the UnPAC study,

> *"It really felt like that at least for me individually, like it took a really long time for the cramping to come on, it wasn't as intense as you were warned it would be by the nurses and the doctors ….. They give you like a little cardboard tray thing to catch the material and then some nurse will inspect it to ensure that the material is there. So, the nurse would look at it and be like, "no that's not it, it's just blood clots, just blood clots" …. After the fourth dose of the second medication, like they were still telling me that I hadn't expelled the material. So, I was like really super stressed and by that point my body had stopped cramping. Like I had this feeling of like physical, like my body was telling me you're done, you know…. Whereas the nurses and doctors were saying, "no, you're not done, that's not it. Here, we'll give you, this is the last dose of medication and you know if nothing happens by tomorrow, then we'll start again"* (Victoria)

Jade recounted the stress related to being prescribed multiple rounds of medication to expel the products of pregnancy,

> *"And they eventually gave the first round of it, thank God, like it was getting a bit ridiculous now. So I took the pills and nothing happened. Four hours later another set of pills…. Nothing happened ….. and this went on 'til midnight" [interviewer asks, "so how many sets of pills did they give you then?], "I don't remember, I think it was between every four or five hours, but they came in to say, just to check blood pressure. And then I don't think I seen anybody ….. 'til the next morning. They said they're very busy and they'll talk to me in the morning. And if nothing was happening then they might have to go for a surgical end of things".*

The lack of routine surgical options for women for early termination of pregnancy has been ascribed by the HSE NWIHP Director to resources, particularly theatre space. It would appear from the providers' research that the lack of choice of a surgical termination of pregnancy is multi factorial and includes staff resistance to providing the service whether on grounds of conscientious objection or otherwise. It refers to the experience of a consultant obstetrician and coordinating midwife at one setting being informed that colleagues in the maternity unit were not comfortable with surgical terminations of pregnancy being carried out in the same labour ward theatre used for surgery on miscarriage patients. Over time, after the consultant and midwife made efforts to engage in dialogue with their colleagues, limited surgical options have become available.

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[18] Termination of Pregnancy Services – Implementation Progress Update. The National Women and Infants Health Programme (HSE). 30th June, 2022 Draft 1.0.

The providers' research also reported on providers encountering resistance from theatre staff, including anaesthesiologists, to supporting the provision of surgical termination of pregnancy.

Section 6.1.2: Improving access to surgical options (for pregnancies not exceeding 12 weeks)

The Chair interviewed a medical practitioner who routinely offers patients MVA to terminate pregnancies in a gynaecological unit of a hospital. The practitioner stated that the procedure (inclusive of preparation and recovery) took approximately 4 hours. This is consistent with the Interim Clinical Guidance that states that, *"The mean and median time from arrival to discharge with MVA in a recent study was 2.5 and 2.57 hours".*

As surgical (MVA) termination of pregnancy appears to operate so successfully in the gynaecology unit referred to above, the Chair enquired of the Department of Health and HSE NWIHP as to whether the service it could be provided the new ambulatory gynaecology clinics which are being established across the country to ameliorate the significant demand for gynaecology services. The model of care in these centres is described as "see and treat", a patient is triaged and if deemed appropriate, is referred on the same day to the ambulatory care unit for investigations and minor procedures, involving a relatively short recovery time. The Chair was informed that these clinics would not be deemed appropriate for termination of pregnancy due to the length of time from arrival to discharge that may be involved, citing it to be 6 – 8 hours. However, this time period seems to be over-stated, based on the Interim Clinical Guidance and the account provided to the Chair by the consultant referred to above.

Clinical leadership is particularly important to develop a surgical termination of pregnancy service, to increase capacity for EMA and MVA and provide training to healthcare professionals. According to the HSE NWIHP Director, it is striving to make surgical termination of pregnancy more routinely available. Incorporation of the MVA service into gynaecology units would likely improve access. In addition, internationally, in the UK and many other countries, including Australia and parts of the US, surgical termination of pregnancy is available in specialist clinics in the community setting, nearer to the woman's home. This model does not put pressure on hospital resources. It enables women to avail of their preferred option. Further consideration might be given to establishing the service in primary care in the context of women's health clinics.

As surgical options become more routinely available, it will be important to keep providers in primary care informed, so that they may advise their patients when discussing care.

Section 6.3: Choice of method of termination in later stages of pregnancy

The HSE NWIHP Director has confirmed that medical termination of pregnancy is also standard practice for termination of pregnancy beyond 12 weeks gestation. The Chair learned that provision of surgical methods of termination of pregnancy in the later stages is dependent on resources available at local level, including theatre space and anaesthetists, and medical practitioners and other healthcare professionals' willingness to provide the service. It is understood that at least one obstetrician is undertaking training.

Section 7: Operation of *sections 9* and *10*

Section 9 Risk to life or health

9 (1) 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 –

(a) there is a risk to the life, or of serious harm to the health, of the pregnant woman,
(b) the foetus has not reached viability, and
(c) it is appropriate to carry out the termination of pregnancy in order to avert the risk referred to in paragraph (a)

(2) Of the 2 medical practitioners referred to in subsection (1) –

(a) one shall be an obstetrician, and
(b) the other shall be an appropriate medical practitioner

(3) A termination of pregnancy shall not be carried out under this section unless each of the medical practitioners referred to in subsection (1) has certified his or her opinion as to the matters referred to in that section.

(4) The termination of pregnancy to which the certification referred to in subsection (3) relates shall be carried out –

(a) by the obstetrician referred to in subsection (2)(a), or

(b) where the medical practitioner referred to in subsection (2)(b) is also an obstetrician, by that obstetrician or the obstetrician referred to in subsection (2)(a).

Section 10 (Risk to life or health in an emergency)

10 (1) Notwithstanding the generality of section 9, or any determination made or pending pursuant to section 16 of an application under section 13(2), 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-

(a) there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and

(b) it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

(2) Where a medical practitioner proposes to carry out a termination of pregnancy under this section, he or she shall certify his or her opinion as to the matters referred to in subsection (1) –

(a) before carrying out the termination of pregnancy concerned, or
(b) where it is not practicable to do so before carrying out the termination of pregnancy, as soon as may be but, in any event, not later than 3 days after the carrying out of the termination of pregnancy concerned.

There are relatively few terminations of pregnancy performed under *section 9* and even fewer under *section 10*. Notifications to the Minister for Health for the years 2019 – 2021 show,

Year	Number of notifications received (*section 9)*	Number of notifications received (*section 10*)
2019	21	3
2020	20	5
2021	9 (unreliable data)	2 (unreliable data)

Section 7.1: Challenges to implementation

Three main challenges emerged in respect of implementation of *section 9* (which are likely also applicable to *section 10).* These are:

I. Ambiguity that arises from the wording of the sections;
II. Lack of clinical guidance, and
III. Lack of standardized pathways

There is a lack of clarity among medical practitioners as to when and how *section 9* applies. This places women in a great deal of uncertainty regarding their eligibility to have an abortion under this ground. It may lead to denial of or delay in access to care.

Section 7.1.1: Ambiguous wording of *sections 9* and *10*

Medical practitioners report that there is,

i. a lack of guidance as to the threshold of the "risk" to life, or of serious harm to the health, of the pregnant woman,
ii. a lack of guidance as the threshold of "serious harm", and
iii. a lack of guidance as to the extent to which the risk has to be averted.

The ambiguity was regarded positively by one medical practitioner as enabling greater clinical discretion, but others felt that it created uncertainty and presented a barrier to providing care, particularly in the context of the presence of criminal sanction in the Act.

The lack of clarity in the law makes it challenging for medical practitioners to determine whether the pregnant woman meets statutory criteria, particularly if she presents with a condition related to her mental health, where it may not be certain that terminating the pregnancy would avert the risk or the extent to which it would avert the risk to her mental health.

As one perinatal psychiatrist who participated in the providers' research study explained in relation to the challenges of operating this section,

> *"[The pregnancy] might have exacerbated it [the condition] but in good faith, I can't say that if you terminated, that you would feel better and in someone like her, she has a personality disorder as well, so very poor distress tolerance, she could very well get worse"* (R115)

This position clearly presents a dilemma where potentially it may be impossible for a clinician to make such a determination and yet unintentionally, failure to do so could result in significant harm to the pregnant woman. Certainty as to knowledge of whether a termination has averted the risk may only become apparent post-event.

The issue around lack of clarity is not peculiar to perinatal psychiatry but extends to other fields of medicine. The Chair heard from providers how the uncertainty around the interpretation of the "risk" and "serious harm" thresholds in other areas could lead to practice of defensive medicine, potentially leading to services being denied, or delayed.

Section 7.1.2: Lack of clinical guidance, education and training on application of *sections 9* and *10*

GPs reported that they require clear and accessible interpretations and clinical guidance of how women may access care under *sections 9* and *10.* For example, in cases of mental health risk, cardiac risk, cancer care and teratogenic[19] high-risk medications. They express concern that it is not known how many women have a legislative right to access termination of pregnancy care through these grounds and are travelling to procure an abortion abroad due to the lack of clinical guidance and pathway development.

Clearer clinical guidance is also required by health care professionals working in the hospital setting, as is further education and training on the law and its application. An issue arose during the Review indicated that some healthcare professionals do not appreciate that *sections 9* and *10* provided for termination of pregnancy where there was a risk to a person's health and may be conflating the legislation with the narrower provisions of the Protection of Life During Pregnancy Act 2013, that restricted abortion to risk to the woman's life. Due to this ignorance, they may not be considering the woman's options in the context of risk to her health.

A perinatal psychiatrist interviewed as part of the providers' research study, also highlighted colleagues' lack of knowledge of the law as a problem,

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[19] Teratogenic medications are associated with foetal abnormalities including mobius syndrome (limb reduction deficits) (source: medical practitioner participating in the Review)

> *"There is an element of luck. The luck goes all the way up. We've talked to obstetricians who are like, "but the person is not suicidal", and we're like, "that's not part of the Act". There's a lack of knowledge amongst obstetricians about the Act. So your obstetrician can be poorly informed. Your GP can be ideologically opposed to termination. Your psychiatrist can just be not sure what to do and not sure who to contact. There's just so many different areas where it can go a bit wrong that it is a bit worrying"* (R107).

A lack of understanding of the law and its application to terminations under *section 9* for risks arising to health from medical reasons is evident from GPs spoken to by the Chair who referred to the need for training, education and guidance to be able to advise patients as to whether their condition would come within the scope of the Act.

Section 7.1.3: Need for standardized pathways

The need for standardized pathways for termination of pregnancy on mental health and medical grounds under *sections 9* and *10* were raised by medical practitioners. These were described as being unclear and potentially leading to delays in accessing care. As highlighted by one perinatal psychiatrist,

> *"There's no standardized formal way … it's slightly disturbing. There's no formal clear pathway and sometimes it's GPs ringing us, sometimes there are people in the clinic[who] will contact us. Occasionally, it's women themselves contacting us. There isn't a clear pathway for how somebody should come for a termination on mental health grounds……. We're aware that this needs to be standardized, but we're not sure how to standardize it. We're probably a little afraid to drive that too hard in case that actually creates a barrier"* (R107)

The lack of standardized pathways for termination of pregnancy care for medical reasons as well as psychiatric reasons was also raised by community providers. From their perspective, the pathways for women to access abortion care under both *sections 9* and *10* (risk to life in an emergency) have not been established. From their experience, women who may be eligible to access termination of pregnancy under these sections are opting to travel abroad for termination rather than embark on a pathway that is not clear and could potentially delay treatment. In these cases, women are over 12 weeks pregnant.

The Chair did discuss in general terms the issue of pathways with the Clinical Lead for Termination of Pregnancy services and was under the impression that pathways of care were in *situ.* If this were the case, then ignorance among providers of their existence of operation would need to be addressed. Otherwise, providers have recommended that the HSE should urgently establish pathways in each maternity unit catchment area for women who may be eligible under *sections 9* and *10* of the Act, and providers should be informed of the point of entry to those pathways.

The lack of universal provision of termination of pregnancy services across all maternity hospitals may be a contributing factor to lack of understanding or awareness of any existing pathways of care, as GPs may have to navigate their way through services in hospitals with which they are not familiar.

The infrequency of terminations under this section may also be a contributing factor to lack of knowledge of the law and the pathways to access care.

Section 7.2: Access by minors to perinatal psychiatry services for termination of pregnancy care

A concern was raised during the Review about the process involved for a minor seeking a termination of pregnancy to access perinatal psychiatry services. There is a difference between the age at which a person may consent for medical treatment and for which they may present for mental health treatment. The Mental Health Act 2001 defines childhood as under 18 years and consent of parents/guardians is required for treatment.

The Chair discussed minors' access to the specialist perinatal psychiatry team with the National Clinical Lead for the National Programme for Specialist Perinatal Mental Health Services. This clarified that,

- Generally, minors are referred to the perinatal psychiatry services by their obstetrician. Some of these minors are already linked with the CAMHs, and, where they are not and ongoing care is required, they are linked to that service.

- All of the maternity services have arrangements in place to support people under age 18 who are pregnant. The Rotunda has "Teen Midwife", the Coombe has "Teen Social Worker" and the National Maternity Hospital has "Daisy Clinic" for teenagers. The Clinical Lead stated that there are very few referrals to specialist perinatal psychiatry services of people under age 18 and that this may be due to the supports that are provided by these services.

- The usual practice is that the consent of the 16- and 17-year-olds is sought by the perinatal psychiatrists. Often parents are involved and very keen that the person is seen. Where they are not involved, the psychiatrists explains they need to contact parents.

- None of the psychiatrists have reported parents withholding consent.

- Some young people are under the care of Tusla and again no consent issues have arisen.

Whilst the need for parental consent to access perinatal psychiatry services differentiates from consent to other forms of medical treatment of persons under age 18 years, the issue stems from mental health legislation. This Review does not have the capacity to explore the issue in further detail. However, from a human rights' perspective, the right to non-discrimination and equality requires that States should remove all legal, procedural and social barriers that impede an individual's equal and non-discriminatory access to sexual and reproductive health, including abortion, and should repeal measures such as third-party authorization[20]. Third-party authorization is interpreted as including parental notification and parental involvement by the WHO who point to the effect of parental involvement mandating the disclosure of the pregnancy by the minor thus creating opportunities for parental veto. It refers to studies where parental involvement (including

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[20] General comment no. 22. The right to sexual and reproductive health (Article 12 International Covenant on Economic, Social and Cultural Rights. Geneva: UN Rights Committee (80th session); 2004 (CCPR/C/21/Rev.1/Add.13)

authorization) can act as a barrier to accessing services, by causing delay in receiving care, the continuation of the pregnancy and family disharmony.

The Clinical Lead commented that if the number of referrals of this age group justified it in future, consideration may be given to having a named Child and Adolescent Psychiatrist with special responsibility for pregnant and postnatal under 18-year-olds. Such a psychiatrist would need to have training in Perinatal Psychiatry. Since the implementation of the Specialist Perinatal Mental Health Model of Care Programme, funding has been provided for a higher training post in each of the six hub sites where supervision of the trainee is provided by an approved trainer, the perinatal psychiatrist. A Child and Adolescent Psychiatrist Trainee could apply for one of those posts through their training scheme or could ask to do special interest sessions in a hub site as an alternative route to getting experience in this area of practice.

Section 7.3: Requirement for two medical practitioners to examine the pregnant woman

The literal construction of *section 9(1)* requires two physical examinations of the pregnant woman to be carried out (one by each of the two medical practitioners). The extent to which this may contribute to diagnosis may differ according to the underlying condition. It may be that in some circumstances, the reasonable opinion may be informed by reviewing her case notes, thus not subjecting her to an unnecessary physical examination.

Section 8: Operation of *section 11* (condition likely to lead to the death of the foetus)

Section 11

11 (1) A termination of pregnancy may be carried out in accordance with this section where 2 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.

(2) Of the 2 medical practitioners referred to in subsection (1)-

(a) one shall be an obstetrician, and

(b) the other shall be a medical practitioner of a relevant specialty.

(3) A termination of pregnancy shall not be carried out under this section unless each of the medical practitioners referred to in subsection (1) has certified his or her opinion as to the matters referred to in that subsection.

(4) The termination of pregnancy to which the certification referred in subsection (3) relates shall be carried out by:

(a) the obstetrician referred to in subsection (2)(a), or

(b) where the medical practitioner referred to in subsection 2(b) is also an obstetrician, by that obstetrician or the obstetrician referred to in subsection (2)(a)

Notifications to the Minister for Health show that termination of pregnancy on grounds of *section 11* make up a small percentage (15% in 2019, 14% in 2020) of terminations conducted each year. The notifications show,

Year	Section 11 terminations of pregnancy in Ireland
2019	100
2020	97
2021	53 (unreliable)

The introduction of this service has enabled providers to discuss termination of pregnancy more openly and to support women who have had pregnancies affected by fetal anomaly. It has enabled women to access care in Ireland.

However, half of the people who travelled to the UK in 2021 to access termination of pregnancy services did so under ground E (alone or with grounds A, B, C, or D). Ground E provides for abortion where there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. It is likely that some of these women had pregnancies affected by fatal foetal anomalies and should have received care in Ireland.

This part of the Review looks at the challenges of operationalizing the section due to the law. It also looks at challenges that have arisen in service provision due to lack of resources required to support the service.

Contemporaneous to this Review, another review of the operation of *section 11,* was commissioned by the Chief Clinical Officer. That review is due to report in the first quarter of 2023.

Section 8.1: The requirement for examination of the pregnant woman by two medical practitioners

The literal construction of the wording of *Section 11(1)* requires two medical practitioners to physically examine the pregnant woman, for the purpose of forming their opinions as to whether there is present a condition affecting the foetus that is likely to lead to its either before, or within 28 days of birth.

The wording of the section acknowledges that under the current legal framework, the decision to perform a termination of pregnancy under *section 11* is not a sole endeavor, but should include input from other medical practitioners, of a relevant specialty, including the obstetrician who will carry out the procedure.

Second physical examination generally serves no purpose

The requirement for a second physical examination of the pregnant woman to enable the second medical practitioner to form his or her opinion was criticised by service providers who believe that in most cases, the second physical examination is generally otiose to requirements as diagnosis and assessment of prognosis of a Section 11 foetal anomaly requires diagnostic imaging (foetal ultrasound or MRI) and relevant invasive and/or non-invasive testing, the results of which are used in making a determination. A medical practitioner, applying the requisite standard of care, would in forming their opinion, review diagnostic images and reports of tests, case notes and, if necessary, participate in the multi-disciplinary team discussion about the case.

It was considered inappropriate to subject the pregnant woman to examinations that do not contribute to her care. Furthermore, particularly in smaller units, a second medical practitioner may not always be readily available to conduct a physical examination at the time the woman presents thereby necessitating another visit to the hospital causing her additional stress, inconvenience and delay.

The objective of the section could be achieved by the first medical practitioner consulting with the second one. This would enable the second medical practitioner to form the requisite opinion without conducting an unnecessary examination.

Such an amendment would not preclude both medical practitioners, where necessary, in particularly complex cases where the diagnostic tests are inconclusive, from meeting with the pregnant woman and performing further tests such as real-time ultrasound tests nor would it preclude obtaining further second opinions.

It may be desirable from an individual patient's perspective to meet (remotely or in person) both medical practitioners involved in the certification process to be able to discuss and obtain a better understanding of reasons for their opinions, particularly in circumstances where her request for an abortion has been denied.

Section 8.2: Challenges relating to diagnosis and assessment of prognosis

Patients who learn of serious fetal anomalies depend upon their medical practitioners to provide the information they need to navigate them when considering their options to proceed with the pregnancy or choose to have a termination.

Medical practitioners participating in this research reported that with the exception of a small number of very straightforward conditions such as anencephaly, the section is difficult to implement in practice even in cases where the condition of the foetus may be fatal and associated with severe morbidity and/or disability. They advise that the term, "fatal foetal anomaly", which became common parlance during the campaign to repeal the eighth amendment, is not a medical term and that there is not any definitive list of conditions where death occurs in utero or within 28 days of birth.

The Interim Clinical Guidance[21] acknowledges that *"lists of diagnoses or conditions are neither definitive nor static over time"* and that *"any list of eligible diagnoses may become outdated in a number of years. Similarly, combinations of fetal anomalies which by themselves may not be fatal, in combination with other anomalies could lead to a prognosis that is extremely poor".* It lists fatal foetal anomalies/life limiting conditions that are "highly likely" to qualify under *section 11*, and those that are potentially fatal fetal anomalies/life limiting conditions, where there is *"a significant chance of death in utero or in the newborn period"*[22].

This is acknowledged in the Institute of Obstetricians and Gynaecologists' Interim Clinical Guidance for the management of fatal foetal anomalies states that whilst a definitive diagnosis may follow early or mid-trimester ultrasound, *"prognosis may not always be clear at the time of diagnosis and may be influenced by a variety of factors including fetal growth restriction, fetal hydrops or multiple pregnancy. The prognosis may become clearer as the pregnancy progresses".*[23]

As a consultant neonatologist, who participated in the providers' research explained, even trying to predict whether the condition would likely lead to foetal demise or death within the prescribed timeframe is challenging,

> *I suppose in section 11(1), "likely" is the word I suppose there to lead to death of the foetus either before or within 28 days. That's a very hard thing to predict even if the condition is universally fatal, that they'll die within 28 days. It's a hard thing for a doctor to predict the timing of death"* (R124)

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[21] Interim Clinical Guidance Pathway for Management of Fatal Fetal Anomalies and/or Life Limiting Conditions Diagnosed During Pregnancy: Termination of Pregnancy. Version 1.0 published January 2019. Dublin. Institute of Obstetricians and Gynaecologists

[22] Interim Clinical Guidance Pathway for management of fatal fetal anomalies and/or life-limiting conditions diagnosed during pregnancy: termination of pregnancy. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland,Version 1.0 published January 2019 / Revision Date: January 2020.

[23] Interim Clinical Guidance Pathway for management of fatal fetal anomalies and/or life limiting conditions diagnosed during pregnancy: Termination of Pregnancy. Institute of Obstetricians and Gynaecologists Royal College of Physicians of Ireland, Version 1.0 published January 2019/Revison Date: January 2020. P.13

In a separate study of foetal medicine specialists by Power *et al*[24] challenges were identified with the interpretation of the legislation. In the study, half of the fetal medicine specialists expressed "uncertainty" regarding a diagnosis as fatal within the meaning of the Act. Participants identified that there is never any certainty when death will occur.

The results of another study[25] analysing NPEC data pertaining to all perinatal deaths (death occurring between 24 weeks gestation and seven days of birth) with congenital anomaly as a cause of death between 2011 and 2016, illustrates the complexity in practice of determining which anomalies or combinations of anomalies will lead to death in utero or within 28 days of birth. The study showed that 939 out of 2,638 perinatal deaths that had occurred in Ireland during 2011-2016, had an associated congenital anomaly. Nearly half of these were classified as chromosomal (43.2%, n=406), a quarter were classified as cardiovascular (23.1%, n=217) and 19.1% (n= 179) were classified as of the central nervous system. In 777 of the 939 perinatal deaths, the congenital anomaly was known. Of these 777, 42.1% (n=328), were considered a fatal foetal anomaly (a rate of 7.9% per 10,000 births) conclusively coming within the scope of *section 11*. In the views of the authors, the remaining cases although having died in the perinatal period, would not have been considered to conclusively fit the section's requirements.

Operationalising *section 11* can be tricky for those who try to predict in good faith whether particular cases come within its parameters. This also has implications when it comes to counselling parents about the prognoses and outcomes. The collection of epidemiological data to create a universal database of congenital abnormalities leading to perinatal / neonatal death occurring in Ireland over an agreed period could be of assistance to healthcare professionals in counselling parents following a diagnosis of complex fetal anomalies. This could be co-designed by NPEC, fetal medicine specialists and other relevant specialists to inform the data collection and timeframe.

Section 8.3: Overly cautious approach to decision-making (defensive medicine)

The onus in *subsection (1)* on medical practitioners does not require them to be absolutely certain but rather of the opinion formed in good faith that the condition is likely to lead to the death of the foetus either before, or within 28 days of birth. Applying this lower standard is still problematic, for the reasons outlined above. Participants in this Review, also spoke of colleagues' fear of adverse media scrutiny similar to that which surrounded earlier cases that went wrong, complaints to professional regulatory bodies and criminal prosecutions. They described this leading to "an overly cautious" approach to decision-making. One consultant at a large maternity hospital described being able to "*feel the tension at the MDT meeting*".

The overly cautious approach was attributed to excluding cases for termination under *section 11* where it was felt that the condition would likely lead to death in utero or within 28 days, but where there was fear that the foetus/baby in question could be "an outlier" in the sense that it could, contrary to all expectations, live for a short period beyond 28 days. In such cases parents are told that the condition is "not fatal enough" for termination to be provided in Ireland, but that the pregnant woman has a right to apply to review the decision or to travel to another jurisdiction with less restrictive regulations. There is not any data collected as to how many parents travel abroad upon receipt of this determination, nor the diagnosis or prognosis.

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[24] Power S, Meaney S, O'Donoghue K. Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study. BJOG: 2021; 128: 676-864

[25] Power S, Meaney S, O'Donoghue K. The incidence of fatal fetal anomalies associated with perinatal mortality in Ireland. Prenatal Diagnosis. 2020; 40:549-556.

It is highly likely from the findings of the study looking at the incidence of foetal anomalies associated with perinatal mortality[26] that feotal conditions that do qualify for termination on the *section* 11 criteria are being incorrectly refused, not because of medical negligence, but because the problems inherent in determining whether death will occur before 28 days. It is also possible that some terminations occur where the baby could have been "an outlier" and lived for a short period beyond 28 days.

The TFMR (Terminations for Medical Reasons) group submission to the public consultation demonstrates how women and their partners have been adversely impacted by the uncertainty surrounding the implementation of *section 11.* The following two accounts are illustrative of their experiences,

> *"Our medical team in the hospital helped us process the news as much as they could but in the end the consensus was that our child would likely never survive birth and if he did, he would die soon after. However, to our utter and additional shock we were told by the head of foetal medicine 'we can't help you here because we can't be sure he will die within 28 days although we are sure he will die soon after if not before birth'. We were told by our consultant that we had two options: 1. Continue and let nature take its course or 2: travel to the U.K. for a termination for medical reasons." Author F*

> *"This news was delivered sensitively and with great empathy. Both my husband and I felt listened to and respected. All our options were discussed but it was made clear to us, that my pregnancy was past the twelve week point at which I would be eligible for a termination on any grounds, and that the hospital could not facilitate a termination for medical reasons (TFMR) despite the medical experts being very clear that my baby would be unlikely to survive." Author A*

The rigid, arbitrary restriction in practice to offer terminations to women whose pregnancies are affected by complex, severe life-limiting anomalies, that might outlive the 28-day time period, by a few days or weeks, arguably is extremely unfair, particularly when it is the difference between receiving care at home and having to travel abroad.

Section 8.4: Procedure to review refusal pursuant to *section 13*

In its current form, *section 11* is not easily operable. The right to a review of a determination before an independent review panel, pursuant to *section 13,* exists, but it follows that the members of the panel would encounter the same complex issues in making their determination. Utilisation of the Review procedure is low. Notifications to the Minister for Health show that no reviews were carried out in 2019, two were carried out in 2020, and 1 was conducted in 2021. The submission of the TFMR group to the public consultation may partly explain why uptake is low. They report that they are unaware of anyone utilising the procedure in the context of *section 11.* They attribute this to,

- the possible length of time that it has already taken to obtain the initial decision, throughout which women are extremely distressed, and wish to avoid further delay;

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[26] Power S, Meaney S, O'Donoghue K. Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study. BJOG: 2021

- the statutory timelines for the review being too long, and
- their desire to terminate the pregnancy before 24 weeks gestation to come within Ground C in England.

Section 8.5: Review process affected by lack of training

The providers' research refers to two consultant neonatologists speaking directly about the challenges surrounding the review process. One had participated in a review in 2019 and explained how they received no guidance on how the review should be conducted or advance training on their obligations as a reviewer. They stated,

> *"I felt we were all somewhat ill prepared for this. This was clearly a new process that hadn't really been thought out very well. There were some very good people involved, but down to basic stuff, there wasn't really a formalized structure for the meeting".*

Another consultant spoke about the lack of training of review members being problematic,

> *"There was talk about trying to get some training for the review, that review panel but that's not really happened as far as I know"* (R124).

Very few reviews have occurred since the commencement of the service. This Review did not explore whether training for participation in reviews has been provided or offered.

Section 8.6: Resources required to support the service

Resources to support medical practitioners charged with forming the requisite opinions under *section 11* are considered here under two headings, multi-disciplinary team input and pre-natal screening services.

Section 8.6.1: Multidisciplinary team (MDT) input

Multi-disciplinary team input is a normal feature in healthcare. It enables a broad range of disciplines to contribute knowledge and skill to a patient's care. The Institute of Obstetricians and Gynaecologists' Interim Clinical Guidance Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed During Pregnancy - Termination of Pregnancy[27], recommends multi-disciplinary team discussions to inform the assessment of foetal anomalies, their prognosis and outcomes. The discussions enable the two medical practitioners tasked with certifying their opinions to listen to and consider their colleagues' thoughts and then decide on what should be done. Discussion also facilitates education and learning.

The two medical practitioners who are tasked with making the determination as to whether a case fulfils *section 11* criteria, should feel supported by their MDT. Conversations with medical practitioners in course of the Review identified the following factors important to the good functioning of an MDT: confidence that colleagues' opinions are underpinned by up-to-date knowledge, the right mix of expertise with direct or indirect access to relevant specialties, members

[27] Version 1.0 published January 2019/Revision Date: January 2020, page 15

being able to dispassionately consider the issues without their judgement being clouded by their personal morals, values, understanding and respect for each other's role and areas of expertise, and psychological safety enabling members to challenge views put forward by other members.

Access to relevant disciplines and up-to-date knowledge requirement

For an MDT to function properly, it must include members with up-to-date knowledge across the range of specialties required for its caseload. Prior to the commencement of the Act termination of the grounds of fatal foetal anomaly was not available in this jurisdiction. Hence, the commencement of the Act placed an additional burden on MDT members to diagnose and assess prognosis in terms of whether the foetus would demise before birth or die within 28 days of being born. The Chair was informed by senior medical practitioners that she spoke to that no additional training, education or supports were provided prior to the commencement of services. Consequently, some hospitals (including large hospitals) were unprepared.

Whilst references were made to MDTs that function extremely well, two respondents from different hospitals, interviewed directly by the Chair, highlighted an issue regarding colleagues delivering opinions based on out-of-date knowledge (one referred to knowledge being out of date by 20 years) and sometimes with such force that other members were reluctant to challenge them. This is indicative of a psychologically unsafe environment. In both cases, the opinions were described as not supportive towards an option to terminate the pregnancies. One respondent expressly stated that it is of paramount importance that the two medical practitioners tasked with making the relevant decision have relevant up-to-date knowledge and experience in their specialist fields.

Medical practitioners spoken to by the Chair reported that there has not been any mandatory requirement on MDT members to update their knowledge, although the Interim Clinical Guidance acknowledges that appropriate training and support for healthcare professionals is required for successful implementation of the pathway of care and goes on to say that it is the responsibility of representative bodies to provide training to their members, in keeping with international best practice[28]. It is the Chair's understanding that no assessments of members' training and educational needs have been carried out. Unless members are able to recognize their limitations, they are unlikely to do anything to address them.

The HSE NWIHP has developed an online educational resource for service providers engaged in termination of pregnancy. This was uploaded onto HSELand, the HSE's online portal, in the latter part of 2022. It is not known whether this includes materials pertaining to *section 11.*

Right mix of expertise

The Interim Clinical Guidance lists the suggested members of the multi-disciplinary team[29]. Guidance contained in the HSE's Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed During Pregnancy (Perinatal Palliative Care), when addressing making antenatal diagnoses, refers to the need for all foetal medicine units to have timely access to

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[28] Interim Clinical Guidance – Pathway for management of fatal fetal anomalies and/or life-limiting conditions diagnosed during pregnancy – Termination of pregnancy. Institute of Obstetricians and Gynaecolgists – Royal College of Physicians of Ireland – Version 1.0 published January 2019 / Revision Date 2020. Page 15.
[29] Ibid page 15

specialists in perinatal cardiology, peadiatric radiologists and clinical genetics specialists, when appropriate.

Not all cases require full multidisciplinary team inputs. In straightforward cases obstetricians may form the opinion in good faith that grounds exist for termination of a pregnancy for fatal fetal anomaly in accordance with the Act. More complex cases require specialist inputs.

This Review was not resourced to examine the extent to which fetal medicine MDTs had timely access to specialist inputs. However, one strong theme which emerged was the lack of access to clinical genomics.

Dispassionate consideration, understanding and respect for each other's knowledge and roles, and psychological safety

The Chair learned of tensions at some MDTs that may be grounded in members' personal views on termination of pregnancy, a lack of understanding of the knowledge, role and scope of practice of other members, and psychological safety issues where members' dominant conduct could influence the outcome of the decision to provide termination of pregnancy.

MDTs involved in termination of pregnancy cases arguably differ from other medical MDTs due to the moral dimension for those involved. Individuals on the multi-disciplinary team may hold different values towards termination of pregnancy, some may hold a conscientious objection, some may be conscientious providers, others may experience cognitive dissonance. There may be differences between specialties as regards the emphasis of care, with some placing greater emphasis on the foetus and others on the pregnant woman. These issues can potentially underpin bias.

One respondent spoke of experiencing a lack of respect from colleagues as regards the scope of her expertise and distrust in her opinions germinating from being known as a provider of termination of pregnancy. This respondent had witnessed colleagues being cowed into submission during meetings by colleagues who held very strong views against termination of pregnancy.

While some MDTs are described as functioning very well, others appear to have need for interventions to improve their approach to working more effectively and safely. This could include further training and education; mandatory participation in values clarification workshops and collective leadership interventions to improve their ability to work together.

Section 8.6.2: Prenatal screening and diagnosis

Prenatal screening and diagnosis of foetal anomalies are essential to inform the management of care going forwards, including the options to continue or to terminate a pregnancy or to provide suitable interventions in utero or neonatally. Diagnosis is dependent on the availability of equipment, skills and experience of the team caring for the pregnant woman.

According to Interim Clinical Guidance approximately 2-3% of pregnancies are affected by congenital abnormalities, of which 15% are life-limiting or potentially life-limiting. In Ireland, the National Perinatal Epidemiology Centre reported that the three main factors associated with perinatal death are major congenital anomaly, placental disease and respiratory disease in pre-term births.

Screening of fetal abnormalities by ultrasound

The detection of significant structural anomalies can occur at a fetal anomaly scan at around 18-24 weeks gestation. The National Maternity Strategy 2016 recommended that pregnant women have equal access to standardized ultrasound services to accurately date the pregnancy and to assess the fetus for ultrasound diagnosable anomalies. The HSE has confirmed that dating and anomaly ultrasound scans performed at two points in time are now routinely available in 19 maternity units.

Until recently, there was not any recognised national screening programme for detection of foetal anomalies in Ireland. This led to inequitable services with "*different units offering ultrasound at varying stages of gestation and to varying degrees of accuracy and detail*"[30]. Earlier this year, the HSE published the National Clinical Practice Guidelines on fetal anomaly ultrasound[31]. The implementation of the Guidelines will require support of the HSE, the Department of Health and management support at hospitals. Successful implementation will result in a more equitable and better-quality service.

MRI screening may be required as an adjunct to ultrasound in some cases. Funding was provided to the National Maternity Hospital for a foetal MRI scan.

Screening for genetic chromosomal anomalies

Screening for genetic chromosomal anomalies can be performed by using non-invasive pre-natal tests (NIPTs) which involves only taking a blood sample from the mother to screen for certain chromosomal conditions, such as Down Syndrome (trisomy 21), Edwards Syndrome (trisomy 18) or Patau Syndrome (trisomy 13). The test can be performed from nine weeks of pregnancy and might be recommended later in the pregnancy as an adjunct to scanning if an abnormality is suspected. It does not carry the risk of miscarriage that is associated with invasive testing. Currently, NIPT is routinely available only through the private sector and accordingly has an associated cost to the parent(s). It is not available through the public health system, however, the HSE has confirmed that it may be provided in certain circumstances, when deemed clinically appropriate, and the associated costs may be absorbed by the individual hospitals.

Following a screening test result/scan indicating a high risk of a congenital abnormality, invasive diagnostic testing in the form of amniocentesis and chorion villus sampling together with other forms of genetic testing is required for diagnostic purposes. These tests are available in the public health system, when clinically indicated.

Role of clinical genetics and genomics in reproductive health

Clinical genetics and genomics have a wide application in reproductive health from pre-conception, to screening in early pregnancy to third trimester, to early neonatal care.

In supporting the provision of termination of pregnancy for fatal fetal anomaly, consultants in clinical genetics can provide expert guidance to MDTs as regards appropriate testing and interpretation of test results. The service can improve efficiency by guiding the MDT to bespoke testing and

[30] National Clinical Practice Guidelines The Fetal Anomaly Ultrasound. Dublin. Institute of Obstetrics and Gynaecologists (IOG) 2023

[31] produced by the Institute of Obstetricians and Gynaecologists and the HSE National Women's and Infants' Health Programme.

obviating the need for less relevant and more time-consuming tests with consequential costs and waiting time implications.

An example provided by a medical practitioner based at the National Maternity Hospital illustrates how a patient's access to a clinical geneticist and the application of bespoke testing may lead to faster (and possibly cheaper) diagnosis, prognosis and counselling of the parents:

Family A (no clinical geneticist guidance)	Family B (clinical geneticist guidance)
20-week gestation scan scan: short long bones, small chest, frontal bossing, skull shape abnormal	20-week gestation scan: short long bones, small chest, frontal bossing, skull shape abnormal
Amniocentesis	Seen by foetal medicine specialist on same day as scan
QF PCR - normal (Stg£300)	Joint clinic (fetal medicine and clinical genetics) 2 days later
Array – normal (Stg£791)	Non-invasive test – FGFR3 Targeted test ? thanatrophoric dysplasia (Stg£1,200)
Karyotype – normal (Stg£400)	Result 6 days later
Skeletal dysplasia panel (Stg£1,400)	
Total cost: Stg£2,891	Total cost: Stg£1,200
Time to diagnosis: 9 weeks (29 weeks gestation)	Time to diagnosis: 6 calendar days.

A clinical geneticist can apply their specialist knowledge to assist counselling of parents on the associated outcomes. This enables clear advice to be provided on what special needs the baby will have, what supports are available, what interventions might be provided in utero or after being born, and the risk of recurrence of the condition in future pregnancies. This is supportive of parents when deciding whether to continue or terminate the pregnancy.

Despite the vital role of clinical genomics in underpinning the operation of *section 11*, the State has not employed a consultant specializing in perinatal genomics. It was acknowledged that the national genetics service based at the Children's Hospital, Crumlin, was stretched to capacity dealing with children who have been born and that it did not have adequate resources to also handle perinatal genetics referrals.

The lack of a public service was specifically highlighted to the Chair as being a barrier to the operation of *section 11* by three medical practitioners. Each voiced dissatisfaction with the lack of support for service delivery from the Department of Health and the HSE. A fourth medical practitioner, from one of the larger maternity hospitals, felt that their service had sufficient expertise in this area as the maternal fetal medicine consultants had acquired requisite skills while training abroad.

Specialists working in maternity settings, such as foetal medicine specialists, may have varying degrees of knowledge of clinical genetics. It is likely that in larger hospitals, where there are relatively greater numbers of pregnancies affected by fetal anomalies, medical practitioners can acquire more knowledge through experiential learning than those based at smaller fetal medicine units. One consultant in foetal medicine in a smaller unit described how they had embarked on self-educating themselves. To the knowledge of the author, there has not been any research undertaken by the HSE to measure the requisite competence in clinical genetics/genomics required of healthcare professionals involved in *section 11* decision making, nor the requirement for additional education and training needs.

The National Maternity Hospital appointed Dr. Sam Doyle, a consultant in clinical and biochemical genetics with special interest in perinatal genomics, from its own funds. Her appointment has been described by medical practitioners as "a game changer" in providing expertise to guide MDTs as to which tests to perform (as not all tests are deemed possible or necessary) and interpretation of test results which enabled reaching a clearer diagnosis and prognosis, more efficiently in terms of time and other resources. Prior to her arrival, they and their fellow MDT members felt restricted by their own lack of knowledge.

The Chair interviewed a service user who had benefited from the appointment. She had two pregnancies affected by foetal anomalies that only became apparent after 20 weeks, at the second ultrasound scan. During the first pregnancy the foetal anomaly was not accurately diagnosed. She was advised that the baby would not live long after being born, but as the duration of life could not be determined with sufficient clarity to satisfy *section 11*, if she chose to terminate the pregnancy, she would have to travel to England. As a late termination of pregnancy, she would have to have the procedure carried out as a private patient at an NHS hospital, costing her in excess of €5,000. During the second pregnancy, a diagnosis was made by Dr. Doyle. On that occasion, the woman continued the pregnancy and her baby died one hour after being born. Being able to understand the condition of the baby and being able to come to terms with it and experiencing palliative care was influential on her decision to continue the pregnancy.

The Chair learned of another woman who had for unexplained reasons multiple pregnancies that had resulted in babies dying shortly after birth. It was not until she engaged with Dr. Doyle's service that she was able to get a diagnosis of her genetic condition that was the cause of her loss.

The National Maternity Hospital has been able to benefit its patients through Dr. Doyle's input into the development of the its clinical genomics service which extends beyond diagnosis and care of pregnancies affected by fetal anomalies and includes *inter alia* follow-up clinics for babies born with a diagnosed genetic condition, babies born without a diagnosed genetic conditions, babies who are unwell but where nothing was suspected during pregnancy; clinics for seeing women whose pregnancies are at risk of a genetic condition; clinics for parents with a genetic condition who are planning pregnancies and clinics for women who have suffered recurrent miscarriages. A reproductive genomics MDT has been established and includes specialist inputs from genetics, fetal medicine, gynaecology, fertility medicine, pathology, neonatology, maternal medicine and genetics, bereavement midwives and fertility fellows. The Hospital is now receiving trainees in clinical genomics from Northern Ireland.

In December 2022, the HSE launched the first National Strategy for Accelerating Genetic and Genomic Medicine in Ireland which is due to begin implementation in 2023. Pending implementation of the strategy, the service will not be fully integrated into reproductive healthcare.

Two medical practitioners highlighted an urgent need for nationally agreed guidelines for screening, investigation of recurrent miscarriages, deaths of babies in utero or shortly after being born, fetal anomalies and maternal medicine, as well as improved financial resources to build on existing infrastructure for service delivery, training and education.

The HSE has recently published national clinical guidelines on recurrent miscarriage and a clinical practice direction on Stillbirth – prevention, investigation and management of care. Both of these include recommendations on genetic testing.

A genetics/genomics service will also be required to implement Part 6 of the Assisted Reproduction legislation when passed.

Section 9: Travel to other jurisdictions

Medical practitioners have informed the Chair that cases where women are refused their requests for termination of pregnancy on the grounds that the diagnoses are made of non-fatal or not fatal enough to come within *section 11,* (or that they do not qualify other grounds) parents request terminations and, being ignorant of the law, are unaware that they have to travel overseas for care. This causes additional distress on top of the existing trauma caused by learning of their baby's likely prognosis and outcome.

There are a cohort of people who due to various reasons may not be able to travel abroad for care. These include disabled people and those who may not the financial means to travel, who may be in coercively controlled relationships and do not have access to their passports, who may not have clearance to travel, such as asylum seekers.

Section 9.1: Need for a standardized care pathways

The submission of TFMR group to the public consultation sought further support in the in the form of a pathway of continuous care between the Irish hospital and facility abroad, enabling their consultant to transfer their medical records and files, and their return to their hospital/maternity unit for follow up care.

The current position is that if the parent(s) decide to proceed to travel, the referral may be facilitated by their consultant and the pregnant woman may return to her local maternity hospital for bereavement counselling and medical review. However, due to a lack of a standardized approach, not all women are aware of follow-up care on return as being an option and may only find out if they have to attend at the hospital for management of complications.

Section 9.2: Challenges faced by women travelling abroad

Currently, those patients whose conditions do not make them eligible for termination of pregnancy care in Ireland, continue to face personal challenges associated with having to travel overseas to obtain services. These challenges were described by Professor Fergal Malone in his opening statement to the Joint Oireachtas Committee on the Eighth Amendment of the Constitution, on 11th October, 2017. He describes:

- practical challenges associated with travelling to another country for receipt of healthcare, without proximity to family and other support networks;

- the costs, particularly those associated with late gestation termination and travel/accommodation costs. Depending on the method of termination being provided, the procedure could involve a hospital stay of up to 72 hours. The financial burden can lead to inequitable access to overseas treatment based on a person's means;

- decisions regarding what to do with the baby's remains, whether to repatriate them, and if so the method of repatriation (by courier or personal collection at a later date) or have them cremated at the providing medical unit.

- Travelling home post the termination procedure may also pose risks to the pregnant woman's health, as outlined by Prof Malone, page 7, *"post-termination haemorrhage occurs in 0.5% to 1% of procedures, retained pregnancy tissue occurs after 1% to 8% of procedures, and infection occurs in 0.1% to 4% of procedures".* He referred to one known death occurring from a complication a surgical termination of pregnancy while travelling between the centre abroad and Ireland. He also referred to the toll on the person's emotional well-being was likely to be *"negatively impacted"* by being forced to travel to another jurisdiction to receive healthcare.

- limited access to autopsy and genetic testing which would be publicly available in Ireland for diagnosis and for assessing risk of recurrence in future pregnancies, but which have to be paid for abroad. Persons affected are those who have not been able to receive an overarching diagnosis which would require a detailed perinatal autopsy, perhaps supplemented by additional genetic testing, to confirm the diagnosis and assess risk of recurrence. This places them at a disadvantage to women in the same situation who have had terminations in Ireland, who can then be counselled on their future reproductive options.

  The challenges for women in these circumstances were illustrated by Natalie, a respondent, in the UnPAC study, who had to self-manage the logistics of bringing the foetal remains back to Ireland,

  " But part of the follow-through (for us) was honouring and respecting (our baby's) legacy and getting genetic testing done and making sure that there was nothing else that we could have foreseen ..... you have all of the issues of how do you access a post-mortem, how do you access tissue sampling to bring home for genetic testing. How do you bring your baby's remains home, how do you get there and back? ..... And we decided to bring (our baby's) remains home with us, we had a conversation at the 11th hour, ... So we were in frickin' Halfords buying a plug in fridge for the care to have the baby's remains cold on the way home, just stuff you should never have to do. But there's just no system, or if we'd been able to access a termination in a hospital there's a system organized for how the baby's remains are managed. But there isn't for this situation. And because .... We didn't want to leave (them) behind, we didn't want to go down the cremation route. But there's nothing more horrifically surreal than being in Halfords buying a plug-in fridge for your car while your baby is kicking in your belly. Because (they were) kicking away and it was just insanely horrific".

The care pathway should provide as much information to women as possible as regards the care they might expect to receive abroad and logistical issues, such as repatriation of the foetal remains. The UnPAC report shows how lack of preparation around repatriation may affect parents. As stated by Francesca,

"The nurse (when booking me in to the clinic in England) asked if we wanted to bring the baby home. And I had read up just a tiny bit before we left in their online booklet about it, but I guess with everything else that was going on we really didn't have time to think about it and that's something else then that you have to organize. You have to organize, like she said that we would, it would be put in a container and we would have to put it in our check-in bags which we didn't have. But I would have checked in a bag but then I was like, "what do we do then?". Like do we have to call a funeral director?" We had to leave our baby in England and that's closure that we will never get … and we will never be able to bury our baby because our baby is in England (upset) … Yeah, that is something that, as well that I wish we could have spoken about. Again, I don't know if (staff at the hospital) know these things. But the piece that BPAS had on their booklet, you know it didn't tell you exactly what you had to do, like it didn't say, like I know that if the remains are not kept on ice, they don't last very long. And so that was something else, like I panicked in the waiting room after she said it to me, I was like, "what do we do?", like …. Yeah, I still don't, it wasn't even set out, it was just like, "we can put it in a container, and you'll have to bring it back in check-in, you can't bring it in hand luggage". But then, after that it's like then what do we do? We had no idea do you have to call a funeral parlour, can you bury it yourself? Like is that even legal? Like and that's why we panicked and we just said no. Because we didn't know what to do".

The question has to be asked as to what persons do if they are refused a termination of pregnancy in Ireland and cannot afford to travel. Financial assistance may be forthcoming from voluntary support agencies. However, the logistics and costs associated with travelling to receive care abroad would be a major obstacle for some people, particularly those without means of travel due for financial reasons or because they cannot leave Ireland (for example asylum seekers and women in coercively controlled relationships).

Section 10: Palliative care, foeticide and bereavement support

Section 10.1: Palliative (perinatal hospice) care for babies born alive

In circumstances where there is a prospect of the baby being born alive, birth without prior foeticide[32] may be the parent's preferred option, even though it may have been recommended. The incidence of this occurring in Irish hospitals is not known to the Chair.

The RCOG recommend that "*in such cases termination of pregnancy should only be undertaken after careful discussion between obstetric, midwifery and neonatal staff and the woman and her family, with all parties agreeing a written care plan before termination takes place".*[33]

Palliative (perinatal hospice) care is regarded as being essential to provide comfort to babies born alive following a *section 9, 10 or 11* termination of pregnancy or born pre-term at a pre-viable stage

[32] a medical procedure to cease the foetal heartbeat so that the baby is not born alive

[3333] Royal College of Obstetrics and Gynaecologists, Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. Report of Working Party. May 2010. P.31.

of gestation where a pregnancy has continued its natural course. A pre-viable stage of gestation is generally accepted as being less than 22 weeks and six days.

The provision of comfort care for babies is only one element of perinatal palliative care. The British Association of Perinatal Medicine (BAPM) defines palliative care as, *"the planning and provision of supportive care during the life and end of life care of the foetus, newborn infant, or infant and their family in the management of an appropriate condition"*[34].

In Ireland, the palliative care pathway is regarded as being well-developed, as prior to 2019, termination of pregnancy was not an available option for parents who received an antenatal diagnosis of life-limiting fatal anomalies or where a very poor life-limiting prognosis became apparent after the birth. In such cases, decisions could be made not to perform extraordinary interventions aimed at prolonging life, but to provide comfort care aimed at promoting comfort and minimizing the baby's distress.

Neonatologists, palliative care specialists and maternal foetal medicine specialists have had an important role in the development of clinical services and have contributed to the evidence base in the area which has informed the Irish National Perinatal Bereavement Standards[35], the Pathway for Management of Fatal Fetal Anomalies and/or Life Limiting Conditions diagnosed during pregnancy[36], and Termination of Pregnancy for Fatal Fetal Abnormality[37] [38]. The care pathway encompasses a compassionate approach involving anticipatory bereavement care, planning of labour and delivery, postnatal care for the mother and care of the baby.

Paediatricians and neonatologists have a key role in the provision of perinatal palliative care, including the provision of comfort care to newborns. The findings of this Review indicate that the degree to which they are prepared to become involved differs across settings and circumstances of birth. Some participants in this Review described having very good support from their neonatal and paediatric colleagues in managing comfort care for babies born alive following a termination of pregnancy, describing their role as being essential. Others described a lack of willingness to provide comfort care in such cases as being an issue. This has led to midwives and obstetricians providing comfort care in their stead and this is viewed as being unsatisfactory.

One of the consultants who participated in the Review stated that the refusal of neonatologists to provide palliative care had led to colleagues feeling under pressure to advise administration of foeticide in cases where they may have deemed it unnecessary were the neonatologists prepared to provide the necessary comfort care to the surviving baby.

Another stated that from their perspective, neonatologists were differentiating in whether to provide comfort care to babies who were born as a result of termination and those born

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[34] Care P. A Framework for Clinical Practice in Perinatal Medicine. BAPM. August 2010. P.3.
[35] O'Donoghue, K. Pathway for management of fatal fetal anomalies and/or life limiting conditions diagnosed during pregnancy. 2019.
[36] Pathway for management of fatal fetal anomalies and/or life limiting conditions diagnosed during pregnancy: termination of pregnancy. Dublin: Institute of Obstetricians and Gynaecologists, (IOG), 2019.
[37] Health Service Executive. Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death. Dublin: HSE; 2016.
[38] Aine Ni Laoire, Daniel Nuzum, Maeve O'Reilly, Marie Twomey, Keelin O'Donoghue, Mary Devins. Perinatal Palliative Care. Oxford Textbook of Palliative Care for Children. Edited by Richard Hain, Ann Goldman, Adam Rapoport and Michelle Meiring. Oxford University Press. Print publication date: July 2021. Published online: Jul 2021. DOI: 10.1093/med/9780198821311.001.0001

prematurely but who were not being given life sustaining treatment. In the case of the former, they were refusing to engage in the provision of comfort care but were in the case of the latter.

There is a need to fully explore the attitudes of neonatologists and peadiatricians to palliative care in termination of pregnancy to better understand their decisions. The preliminary observations of the CORALE study indicate that some peadiatricians and neonatologists have expressed discomfort with involvement of termination of pregnancy as they do not see that as falling within their role. However, the Act does not make foeticide mandatory. Whilst it is possible under the legislation to withdraw from direct involvement in the termination of pregnancy procedure, due to a conscientious objection, there is still a duty of care for other aspects of care of the mother and the baby, including specialist neonatal/peadiatric input into comfort care.

The ethical considerations of comfort care to the newborn baby were considered in the chapter, "Perinatal Palliative Care", in the Oxford Textbook of Palliative Care for Children (3rd edition)[39]. One of the authors of the chapter, Dr. Daniel Nuzum, is a hospital chaplain and member of the European Foundation for Care of Newborn Infant's Ethical Decision-Making and Palliative Care Framework. The chapter addresses the challenging legal and ethical issues specific to perinatal palliative care and provides a framework to guide MDTs in providing high quality, holistic care to babies and families from diagnosis through to birth and bereavement. They state that, *"a baby born with a diagnosis of a life limiting condition deserves a high standard of care and attention to their palliative care needs. This includes the highly distressing situation when there is a live birth following a planned termination of pregnancy"*[40].

Section 10.2: Foeticide

In cases of termination of pregnancy, death may occur before delivery due to the administration of foeticide (a medical procedure to cease the foetal heartbeat so that the baby is not born alive). The Royal College of Obstetricians and Gynaecologists recommends foeticide for terminations over 21 weeks plus six days, with the only exception to this rule being when the fetal abnormality itself is so severe as to make neonatal death inevitable irrespective of the gestation at delivery[41]. It recommends that foeticide should be discussed with parents.

Research into the attitudes to foeticide by professionals and by parents, referred to in the Royal College of Obstetricians and Gynaecologists working group report, showed that many find the procedure stressful, but that most agree that foeticide will prevent parents and labour ward staff from facing the agony of neonatal distress and pain[42]. Views obtained during the course of this review confirmed that staff who witness the procedure do find it psychologically difficult.

Some participants also stated that foeticide can be perceived as the only option if appropriate palliative care is not going to be provided by neonatologists or paediatricians. A lack of supportive management and peers can add to the psychological burden.

Foeticide should only be provided by a medical practitioner who has the requisite competence. A fetal medicine specialist with whom the Chair met during the course of this Review informed at the

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[39] Ibid p.2

[40] Ibid p.9

[41]Royal College of Obstetricians and Gynaecologists, Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. Report of Working Party. May 2010. P.29.

[42] Royal College of Obstetrics and Gynaecologists, Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. Report of Working Party. May 2010. P.30.

commencement of the Act, in January 2019, medical practitioners did not feel comfortable conducting this procedure as for many their last experiences of having done so would have been during training in another jurisdiction. Upskilling was required involving performing the procedure under supervision. Foeticide became an option in Ireland in June 2019. One medical practitioner described having to bring their patient to London for the procedure prior to it becoming available here.

Foeticide is currently provided at three maternity hospitals. Patients may be referred from other hospitals to undergo the procedure. This may involve travelling a considerable distance particularly in circumstances where the termination of pregnancy is taking place at the referring unit. This can add to her and the family's distress. However, as foeticide is a subspecialty requiring the medical practitioner involved to have a sufficient caseload to maintain the skill, it would be important that increasing access would not inadvertently cause practitioners to deskill.

The issue of whether pain relief is desirable for the foetus undergoing foeticide has been raised in the Dáil and in the Seaned. As the Chair is not a medical practitioner, this issue is not within her field of competence. However, the opinions of two fetal medicine specialists and one obstetrician were ascertained as part of the Review and their views were that the administration of pain relief was not required.

Section 10.3: Bereavement support

The HSE has produced Standards for Bereavement Care following Pregnancy Loss and Perinatal Death[43] to guide health care workers to provide compassionate care across all settings.

Bereavement support services appear to be well developed across maternity units. Staff with whom the Chair met spoke with pride about how well their bereavement support midwives, chaplains and other staff provided sympathetic care to parents going through bereavement irrespective of whether the death of the foetus or baby had been brought about by termination of pregnancy.

It would appear from the providers' research that staff providing the service may not have adequate support for their heavy workloads.

In the main, the three women with whom the Chair met directly described their bereavement care teams as being kind and sympathetic towards them. The UnPAC study reveals that service users value the pregnancy loss protocols. One respondent Karla, who qualified for care in Ireland at 25 weeks gestation depicted her care pathway as a collaborative process, and described how well the hospital had facilitated her and her partner spending time with their baby and having a memorial service, which both herself and her partner were very grateful for. She said,

> *"When we had [James], it was in the evening and my husband's family ….. were able to travel to see the baby as well and so they, yeah (the hospital) allowed them to come and visit us even though it wasn't the right time for visiting hours. That was really nice because it was quite late into the night by*

[43] Standards for Bereavement Care following Pregnancy Loss and Perinatal Death. Dublin. HSE 2016.

> *the time they arrived. But it was really nice that [baby] stayed in our room and they could see, and you know pick him up … so he stayed in the hospital, I think it was Tuesday when we had him, wasn't it? And then Friday was the cremation so we went there and we, [the hospital] had the chapel set up for us and we could park the car on the side, so it was, you know away from everyone else in the hospital as well. And we were able to spend a bit more time with him before putting him in the car to bring to the cremation. And we had a service there".*

The UnPAC report also shows that there may occasions where staff have wrongly assumed parents' wills and preferences as regards the interventions provided by the bereavement team. The report points to experiences of parents where the approach of the team has been at odds with their perspectives of the outcome of the pregnancy. In these cases, the interventions unintentionally caused distress to parents who perceived the loss as a failed pregnancy rather than the loss of a baby. For example, some parents found the actions of the team in making memorial boxes to be distressing to them, some felt distressed by discussions around whether they would hold or see the baby after it had been born.

Bereavement care following termination of pregnancy abroad

It emerged during the course of the Review that in some cases women who had to travel abroad for termination of pregnancy services, only discovered the bereavement service at follow-up visits to the maternity hospital for management of a complication. These women stated that they felt that they would have benefited from earlier interaction with the service. The risk of people losing out on this care could be addressed by having a standardized care pathway expanding the continuum of care on return from treatment abroad that includes access to follow-up support by the bereavement service.

Section 11: Operation of *section 12* (early pregnancy)

Section 12

12(1) 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.

12(2) A termination of pregnancy under this section shall not be carried out under this section unless the medical practitioner referred to in subsection (1) has certified his or her opinion as to the matter referred to in that section.

12(3) the termination of pregnancy shall not be carried out by a medical practitioner unless a period of not less than 3 days has elapsed from:

(a) *The date of certification under subsection (2) by that medical practitioner; or*
(b) *Where a certification was previously made in respect of the pregnancy by another medical practitioner for the purposes of subsection (2), the date of that previous certification.*

12(4) *A termination of pregnancy to which the certification referred to in subsection (2) relates shall be carried out as soon as may be after the period referred to in subsection 3(a) or (b), as the case may be, has elapsed but before the pregnancy has exceeded 12 weeks of pregnancy.*

12(5) *For the purpose of this section, "12 weeks of pregnancy" shall be construed in accordance with the medical principle that pregnancy is generally dated from the first day of a woman's last menstrual period.*

Notifications to the Minister for Health reveal that the highest proportion of terminations of pregnancies in Ireland are under *section 12*. For the years 2019 – 2012, the data shows,

Year	Number of terminations under *section 12*
2019	6542
2020	6455
2021	4513 (unreliable)

Section 11.1: Strengths of operation of *section 12*

The commencement of the early termination of pregnancy services has enabled women to access termination of pregnancy services in Ireland. Prior to the 1st January, 2019, they would have had to travel abroad to receive care.

Positive service user experience

The UnPAC study shows that generally, women have had very positive experiences of the service and that it is enhancing their well-being, dignity and reproductive autonomy. They positively evaluated the care provided by GPs and women's health clinics.

As regards GPs, women appreciated their non-judgmental, sympathetic and empathetic approach. They expressed high satisfaction levels with the information that they were given and their support. Some commented on GPs providing them with their personal mobile numbers and urging them to call if they had any concerns self-managing their care post treatment for termination of pregnancy. Some reported GPs "*going over and above*" to accommodate their needs, with flexible appointments and follow-up care.

Women's health clinics were perceived as having expertise in reproductive healthcare and they expressed high levels of satisfaction with information and support throughout their treatment.

As regards women's experiences of self-managing their early medical abortions, the UnPAC report revealed that most women were able to recall the information and guidance that they have been provided with, which was regarded as being indicative of good compliance. Women valued being able to care for themselves in the comfort and privacy of their own homes. However, women who lacked privacy in their living arrangements found this challenging and some resorted to booking

hotel rooms or staying with friends. It was noted that self-management of an early medical abortion would be particularly challenging for women in abusive relationships trying to conceal their pregnancies and for homeless people.

The My Options service was generally very positively evaluated and this is discussed further below.

Participants in the UnPAC study also evaluated hospital abortion care, as mainly positive. Many of the service users commented on the staff, "helpful", "caring", "fantastic", "excellent" and "lovely". One person felt less favourably about aspects of her care. The location of the hospital service emerged a major issue and the research concluded that the location of services within maternity settings could be disconcerting for some who encountered pregnant women and their babies.

Positive service provider experience

The literature review conducted as a component of the providers' research shows that GPs and providers at women's health centres regarded the community model of care as being successful[44]. This is also reflected in in the qualitative study and illustrated by the following respondent,

> *"I suppose it's good we have a system, it's not perfect, it's better than it was for sure. At least the majority of women are able to access termination now in their own community as opposed to having to travel. So that's good. There is definitely room for improvement" (*R108)

Section 11.2: Challenges to accessing services

Section 11.2.1: Uneven distribution and low numbers of service providers

The operation of *section 12* is dependent upon GPs and women's health centres being willing to provide the service. Data from the Department of Health shows that as of February 2023, shows that 422 primary care providers have signed contracts with the HSE to provide the service. 412 of these are contracts with individual GPs and 10 are with entities, such as student unions and women's health centres.

Data shows that in some areas of the country, particularly in the south-east, north-west, midlands and border counties, women are depending on very low numbers of providing GPs, which makes for extremely tenuous service provision, at risk of ceasing altogether were the provider to withdraw the service. The UnPAC study reveals that the uneven geographic spread of GPs has resulted in some women having to make long journeys to access services and some having to do so by public transport, including one whose only option was to take a taxi, costing her €91. Arguably, expensive travel costs may act as a barrier to service for people who are of limited financial means. The incurrence of expensive travel costs to access services is at odds with the spirit of the policy to provide care, free of charge.

[44] Mistall J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

Section 11.2.2: Challenges navigating services

The UnPAC study shows that women may experience challenges when trying to navigate the service. Respondents (n=45) in the study varied in how they accessed a provider. Thirteen different pathways of care, as set out in the table below, were identified[45].

Pathways to abortion care provider experienced by participants

Pathway Number	Pathway Details	n
1	Self-Referral to My Options → Referral to Abortion Care Provider	15
2	Self-Referral to Abortion Care Provider	11
3	Self-Referral to Non-Providing Health Care Professional → Referral to Abortion Care Provider	4
4	Self-Referral to Non-Providing Health Care Professional → Referral to My Options → Referral to Abortion Care Provider	4
5	Self-Referral to Non-Providing Health Care Professional → Self-Referral to Abortion Care Provider	2
6	Self-Referral to Non-Providing Health Care Professional → Self-Referral to My Options → Referral to Abortion Care Provider	2
7	Self-Referral to Non-Providing Health Care Professional → Referral to Abortion Care Provider and Referral to My Options → Referral to Abortion Care Provider	1
8	Self-Referral to Non-Providing Health Care Professional → Referral to My Options → Self-Referral to Abortion Care Provider	1
9	Self-Referral to Non-Providing Health Care Professional → Referral to Non-Providing Health Care Professional → Referral to Abortion Care Provider	1
10	Self-Referral to My Options → Self-Referral to Abortion Care Provider	1
11	Self-Referral to Providing Health Care Professional → Referral to My Options → Referral to Abortion Care Provider	1
12	Self-Referral to Providing Health Care Professional → Referral to Non-Providing Health Care Professional → Referral to My Options	1
13	Self-Referral to Online Telemedicine Provider → Referral to My Options → Referral to Abortion Care Provider	1

Some women were under the misunderstanding that all GPs were providers and hence, many women commenced their journey by attending at their local (non-providing) GP. The study found that it was not the norm for non-providing GPs to provide details of My Options or arrange for their care with another provider. This may be attributed to a GP holding a conscientious objection or to a lack of knowledge of the legislation and/or the Medical Council Code of Ethics, or lack of understanding of the process.

[45] UnPAC report

Section 11.2.3: Risk of encountering delay and obstruction when trying to access services

The UnPAC study and data collected as part of this Review from GPs and women's health clinics shows that women have and are at risk of encountering delay and obstruction when accessing services.

In some cases, obstruction takes the form of protracted rounds of appointments, misleading information about the gestation period, and anti-abortion directive counselling, designed to delay or prevent access to care within 12 weeks. This conduct interferes with a person's reproductive autonomy.

Examples of obstructive care are provided in the UnPAC report. The following two examples of experiences of respondents in the UnPAC report illustrate how women may be affected.

> One respondent described becoming pregnant by sexual assault and attending non-providing GPs who delayed their access to a providing GP by repeatedly arranging two further consultations, for which he charged a fee of €180 in total, before reluctantly providing her with information about My Options to enable her to contact a provider.
>
> Another respondent reported being advised that she was earlier in her pregnancy than she thought she was, only to discover being perilously close to 12 weeks gestation when she presented at a women's health clinic.

Section 11.3: The HSE's My Options helpline

The HSE established My Options helpline to provide support to the public in identifying providers of abortion services, availing of non-directive counselling by counsellors who have at least three years PQE and specialist training in pregnancy counselling, and providing access to a 24 hour clinical advice helpline, staffed by nurses and a doctor, to support women who are managing their termination of pregnancy.

Women can call the My Options freephone number which is answered by an experienced counsellor and can receive the names and contact details of three providers close to their area and ascertain whether their own GP is a provider of services. If they wish to do so, they can avail of counselling during the same call, and may arrange future counselling sessions. The service is provided by One Family.

The My Options service also has a webchat feature on their website to reach younger or hearing impaired people for general information and counselling, but callers may only access providers' contact details by phone.

In terms of supporting women's access to services, the My Options helpline is regarded by service users and providers as being central to patient access and for the privacy of providers and service users. The UnPAC report shows that the model of care enables women to find out if their own GP is a provider minimizing the risk of attending at their local clinic to discover otherwise, which may lead to feelings of embarrassment and a sense of being judged for their decision.

Section 11.3.1: Number of GPs on My Options Open List

My Options maintains lists of contact details of GPs who are willing to provide the service to anyone (the open list) and the contact details of GPs who are willing to provide only to their own patients (the closed list). However, in research carried out by Duffy D *et al* to inform this review, it emerged that of the 413[46] GPs and women's health centres contracted to provide the service, 164 (39.8%) GPs had chosen not to have their details registered with My Options. Of those who did elect to have their details registered with My Options, only a small number of this cohort have chosen to appear on the open list[47], compounding difficulties for women accessing services in some areas. The reasons for choosing not to go on to the open list are likely due to existing workload pressures that would make additional service provision untenable.

Section 11.3.2: Protecting privacy of GPs

In the development of the My Options helpline service, the Department of Health and the HSE were cognizant of the need to provide a means through which women could access care and at the same time support providers by safeguarding their identities.

My Options is the sole source of information on GP providers. The Chair learned from people involved in running My Options that for various reasons, GPs do not want to make this information more publicly available. Some fear that they would encounter adverse reactions from their local community, others fear that they might become overwhelmed by requests from service users, if they were perceived as being the only provider in the area.

It would perhaps be more convenient to non-providing GPs in fulfilling their legal and ethical obligations to transfer care of the pregnant woman to a provider if contact details of providers were available to them through a secure online platform. Some may be aware of providers in their local area, but this may not always be so.

It is clear from the UnPAC report that some respondents regard the lack of an availably open list of providing GPs as a barrier to care. They regard having to contact My Options as an additional step that should not be necessary for them to access services, and for that reason, some women have actively avoided contacting the service, trying instead to directly access a providing GP. For some, this has not been possible and ultimately they have had to contact the My Options service. Other respondents understood that a balance had to be made between publication of an open list and protection of providers.

Section 11.3.3: Assistance in making appointments

My Options does not directly engage in making appointments for women with GP providers. This was criticised by some respondents in the UnPAC report. Some felt uncomfortable at the prospect of calling GP clinics, due to a sense of stigma attached to their decision and fear of encountering cold

[46] As of May 2022

[47] Review of the operation of the Health (Operation of Termination of Pregnancy) Act 2018, based on information provided by the HSE to the National Women's Council of Ireland. National Women's Council of Ireland Abortion Working Group (2022)

responses from receptionists. My Options counsellors try to assist by providing advice on how to approach the appointment, for instance, by advising people to refer to My Options when making their appointments, which would alert the receptionist to the reason for the appointment.

It was felt that migrants who have poor fluency in English language may be particularly disadvantaged when trying to arrange appointments with GPs or women's health clinics. The Chair understands from staff involved in running My Options that the provision of an appointment making service would be logistically challenging, particularly where appointments needed to be changed.

My Options does have access to translators for providing its service. However, this service does not extend to attending appointments at GP clinics. Mishtal J *et al* found that GPs encountered challenges in engaging interpreters through the HSE's service. Accordingly, it might be helpful if the My Options translation service were expanded to assist women who lack proficiency in speaking English, in making and attending at GP appointments and translating The provision of reliable interpretation services for non-English speaking people attending at GP clinics is recommended in the WHO study by Mishtal J *et al*[48].

Section 11.3.4: Need for the HSE to sustain efforts to raise awareness of My Options

The findings in this Review indicate that lack of awareness of My Options is problematic. Mishtal *et al*[49] also found that some service users were unaware of or could not remember that My Options was the national referral service in Ireland. The UnPAC report found that women who had grown up or lived in Ireland for some time, generally had a good sense of awareness of the service.

The submission from the START group to the public consultation revealed that some providing GPs were encountering colleagues who were unaware of the My Options service. The submission also reveals that they encounter women who are not aware of the service. This lack of awareness of My Options clearly creates barriers to access as non-providing GPs may lack knowledge to transfer their patient's care or inform them of the service.

Section 11.3.5: Steps taken by My Options to improve awareness

The HSE has engaged in activities to raise public awareness of My Options. Activities have been targeted at individual groups through social media, and generally through radio and GP clinics. It has taken steps to raise its online profile on search engines. Survey data collected in 2022[50] to measure My Options communication performance reveal that the initiatives have been somewhat effective. When compared to 2020 data, My Options is shown to be the best known service for those experiencing an unplanned pregnancy; 20% of respondents had general awareness of the service, and knowledge was highest between 18 – 24 year olds; awareness of its role as a provider of counselling services increased from 16% - 38%.

Despite targeted campaigns, there would still seem to be a problem regarding awareness of My Options among GPs and service users. Duffy *et al* highlighted the particular problems faced

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[48] Mishtal J, Reeves K, Chakravarty D, Grimes, L, Stifani B, Chabkin W, et al. (2022) Abortion policy implementation in Ireland. Lessons from the community model of care. PLoS OEN 17(5) e 0264494
[49] Mishtal J, Reeves K, Chakravarty D, Grimes, L, Stifani B, Chabkin W, et al. (2022) Abortion policy implementation in Ireland. Lessons from the community model of care. PLoS OEN 17(5) e 0264494
[50] Made available to the Chair by the HSE

experienced by women in rural areas and migrants, where it would appear that promotional campaigns were less visible[51] . IHREC has highlighted the importance of universally accessible public health information in the interests of serving the needs of rural dwellers, migrants and disabled people across all impairment groups[52].

A GP with whom the Chair spoke recommended that My Options should include the word "abortion" in its title to raise the profile of this aspect of its service in the general public. However, doing so might negatively impact on people's perceptions of its role in providing of non-directive counselling.

Without the existence of and knowledge of My Options, it can be difficult for women to navigate their way to consultations with community providers, particularly as approximately 90% of GPs in Ireland do not provide the service and some counties are particularly poorly served. Many women experience a sense of stigma in approaching GPs for care and this is compounded by being informed by doctor's receptionists that the service is not provided. Without the My Options service, service users would be in a very vulnerable position.

Section 11.3.6: Accessing non-directive counselling services

It is important that women are able to receive non-directive counselling during their decision-making process. Counselling services are provided by My Options and are also directly available to women in women's health centres. Counselling should be non-directive. Issues were raised in the media during the course of the Review regarding directive, pro-abortion and anti-abortion counselling taking place at different agencies. Directive counselling, whether pro-life or pro-choice is not respectful of people's reproductive autonomy. The introduction of quality assurance measures across the pregnancy counselling sector should be considered by the Department of Health, to safeguard women from the effects of unintended bias and from rogue counselling agencies that purport to be pro-choice but who aim to deter or obstruct access to termination of pregnancy services.

Section 11.3.7: Access to the 24-hour helpline

Women who undergo termination of pregnancy at home are provided with information on the role of the 24-hour helpline and its contact details. The helpline, run by clinical staff, is regarded by providers as essential to providing advice to women who are concerned by symptoms following termination of pregnancy. It enables women to feel reassured and signposts them to their medical practitioner or the emergency department, if appropriate. It provides support to the medical practitioner to whom the woman might otherwise turn in the absence of the service.

The providers' research refers to a study conducted by Cameron *et al* that emphasized the need for expert clinical advice to be available around the clock for women who have had an early medical termination at home. Findings show that 13% (n= 224/1726) of women made contact with a helpline after taking home misoprostol prior to 9 weeks. The majority of those that telephoned were reassured (84%, n=188) whereas a minority (16% n=36) were advised to attend for emergency

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[51] Duffy D *et al* Information flows as reproductive governance. Patient journey analysis of information barriers and facilitators to abortion care in the Republic of Ireland (2022) SSM Population Health 19, p 4-5

[52] Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018. Irish Human Rights and Equality Commission. November 2022.

medical review. Overall, only 2% (36/1726) of women attended for emergency review after home misoprostol prior to 9 weeks (Cameron *et al.* 2015).

Section 11.3.8: Overall positive experiences of My Options

Overall, My Options is regarded very positively by providers and service users. The UnPAC report shows a general consensus of women having good experiences of the service. The service was regarded in the main as being responsive to service users' needs. Some women commented on how they felt the contact person was able to accurately pick up on cues as to how they were feeling and respond appropriately. The women valued support provided in navigating the care pathway, in accessing contact details for providing GPs.

The service was described as useful and compassionate by respondents in an ARC survey. In an article based on the survey findings, it was concluded that the service primarily benefits people who are seeking early medical abortion (not exceeding 12 weeks pregnancy). However, it was found that some respondents lacked clarity as regards the scope of the service and a lack of information on accessing abortion after 12 weeks. This may be due to a lack of clarity around pathways of care for *sections 9, 10* and *11.*

The WHO study conducted by Mishtal *et al*[53] described My Options as being, *"one of the more successful strategies facilitating access to care"* and stated that it, *"stands out as the key structural facilitator making abortion accessible through a single, centralized portal of entry for accessing care anywhere in Ireland"*

Section 11.4: Three day wait (mandatory waiting period)

The statutory mandatory requirement that informed consent may only be given after at least three days has elapsed from the date of the first consultation is a contentious issue. Submissions to the public consultation vary as to whether it should be abolished, retained in its current form or extended beyond three days.

Ireland is not alone in requiring women to wait a specified amount of time between requesting and receiving an abortion. In some jurisdictions, women must also receive counselling or ultrasound during these waiting periods[54] The position of the World Health Organisation is that a mandatory waiting period should not be required as a condition precedent to accessing a termination of pregnancy under the Act. It states in the Abortion Care Guideline that, *"the evidence did not establish any benefits of mandatory waiting periods for women",* and states that it impacts on healthcare facilities by increasing staffing costs, logistical difficulties, mandating additional visits or interventions outside standard clinical practice.

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[53] Mistall J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

[54] Abortion Care Guideline. WHO (2022)

Section 11.4.1: Service users' perceptions on the three-day waiting period

The UnPAC report shows that respondents wished to access care as expeditiously as possible and did not perceive any benefit of having a three-day period for reflection on their decision. They stated that they felt certain of their decision, that they had not taken the decision lightly and had reflected upon it prior to calling My Options or arranging an appointment with a GP/community provider. Researchers found that the respondents were almost universally consistent in their portrayal of the three-day wait as having had next to no impact on their personal decision-making process, regardless of the length of time it took to make the decision.

It was perceived by some as an infringement on their personal reproductive autonomy and that it signified that women could not be trusted to make their own decisions and were not capable of giving informed consent to treatment to terminate their pregnancies unless they had a reflection period. This differentiates termination of pregnancy from other forms of medical treatment. Research with medical practitioners carried out by Mullally *et al* (2000) supports this perception and described the necessity for a waiting period as being, "presumptive" and "patronizing".

Women in the UnPAC study suggested that rather than being mandatory, the three-day wait could instead be operationalized with an option to waive it. Others felt that a shorter time period might be more appropriate. One woman felt that it should be waived in cases of sexual abuse or for women who were at risk of timing out of care under *section 12*.

Section 11.4.2: Service providers' perspectives

The submission to the public consultation from START group, which represents 300 providers of abortion care (most of whom are GPs), favours removal of the mandatory three day wait period and regard it as a material barrier to women accessing care. From their experience, it can result in a four to five day wait for treatment, when weekends and bank holidays occur during the process, if the first visit takes place towards the end of the week.

The providers' research refers to problems associated with the mandatory three-day wait being compounded by the need to complete terminations before 12 weeks gestation. This has been found to be particularly so where the women are required to have dating scans and/or are in need of referral to maternity units for treatment (such as administration of anti-D) or where termination of pregnancy cannot occur in the community setting. In these cases, care has to be coordinated by her GP/community provider, private scanning facility and maternity unit. This may depend on the availability of staff in private scanning facilities and in maternity units, which may not be available in a timely manner, leading to the woman timing out of care. The providers' research quotes a women's health centre provider stating that such availability cannot be guaranteed,

> *"Every Christmas we've had people who are ringing around desperately trying to get appointments because there's going to be no clinics next week because there's going to be so many bank holidays. So if they're in that ten to twelve weeks, we literally can't get them an appointment. It has definitely happened that I've spoken to someone on Christmas Eve saying, "I'm sorry, by the time the next clinic is available, you're going to be over twelve, there's nothing I can do" and that was having rung all the hospitals on Christmas Eve which is just a horrible thing to have to*

tell somebody that, "Yes, you're actually legally eligible, but you're not going to get there". That's purely down to the three days. I mean if that lady, because I had seen her maybe a day before that, she had had her scan, she was further on than she thought so she wasn't eligible for me to look after the next week. That was a bank holidays on successive Mondays and there was no other clinic that week so that was it. She just wasn't going to make it" (R101).

The findings in the providers' report show the commitment of healthcare providers who participated in the study to trying to minimize the potential for timing out. They reported adopting agile and flexible working patterns (including working out of clinic hours and responding to short notice requirements for scans) as well as undertaking and leading in training in their settings.

The WHO study by Mishtal et al[55] found that all but one GP in the study wanted the legal requirement for a three day wait to be lifted or to be made optional.

Section 11.4.3: Physical and psychological impact of mandatory waiting period on women

Submissions by health care providers to the public consultation highlight the punitive effect of the delay as the level of pain and bleeding and the risk of complications increases with increasing gestational age. It points to international evidence that shows that women experience the time before the treatment as the most difficult and refer to their own observations of the three-day wait adding to the psychological and physical burden carried by women in the waiting period. This is consistent with the findings of the UnPAC study that reported that the wait increased anxiety around the procedure itself,

"I found those three days quite tough as well because it's sort of build up the anticipation for how much is this going to hurt, how much am I going to bleed, is this going to go ok?" Quinn.

A 2021 ARC study also outlined the negative impact of the three-day wait on service users psychologically and, in some cases for travel overseas due to "timing out" (Grimes and ARC 2021). Again, this is supported by respondents' experiences recorded in the UnPAC report.

Section 11.4.4: Three-day wait may be particularly onerous for people in marginalized groups and living in rural areas

GPs working in the HSE's inclusion medicine services, who participated in the providers' research reported that the mandatory three day wait between the first and second consultation was particularly problematic for marginalized and vulnerable service users. They described how organizing and attending multiple appointments could be challenging for members of the homeless community who, *"would not have GPs and would not have access to GPs"* (R102). The necessity to attend two appointments to satisfy the three-day wait criterion, could present substantial barriers as it required travel,

[55] Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

“it’s to do with logistics. And even though (city) is very small, it is a big deal if you have an addiction to get on a bus and go out to area A, or go down to area B, to see your GP, or something like that, you know” (R102).

Another perspective obtained in the study from a GP in a different city highlighted the same challenges with patients failing to attend the second consultation,

“The other thing is people often come to these inclusion health settings because they don’t trust or have had bad experiences in normal GP practices, in hospitals, in other settings [.....] you will see the minute I start saying, “okay, you need to go across the city, round the corner at 3 o’clock tomorrow afternoon, the amount of people you lose to follow up even if it’s me, even if it’s literally me”.

The Chair learned directly, by talking to an inner city-based GP, about challenges in contacting homeless patients and those with addictions regarding their care as they may have lost their phone or be out of credit or be otherwise uncontactable.

For people in rural areas, the three-day wait can also present a logistical burden such as the cost of travel. A GP in the north-west who participated in the participants’ perspectives study, commented,

“I think the cost of fuel is a big one to be honest. It’s not a free service if you have to spend €100 on petrol to get you there and back” (R215)

Section 11.4.5: Risk of timing out of self-managing care at home due to the three-day wait

GPs expressed concern about women approaching nine weeks plus six days gestation (the cut off point for self-management of abortion at home) in circumstances where systems delays may occur, for example, there may be only one GP provider at a clinic or the clinics have limited opening hours, in which case the three-day wait may run into the weekend, including bank holiday weekends, when the clinic is not open.

Consultations with non-providing health care professionals prior to accessing a providing GP are not considered to constitute the first appointment, even if the pregnancy was dated by that doctor. This can exacerbate delays. The UnPAC report shows that women have encountered this situation.

The consequence of exceeding nine weeks and six days is that the termination of pregnancy must occur in a hospital setting which is more resource intensive and may place additional stress on the woman.

Section 11.4.6: Free and informed consent

Decision-making around continuing or terminating a pregnancy needs to be supported by healthcare professionals. There are risks that women may regret their decision, and this may potentially have a lasting impact on them.

The law does not provide a definitive consent duration for any other medical procedure. The person should be provided with all the information they require and the person taking the consent should be satisfied that they are able to understand the information and weigh up the consequences of

their decision. The information should be accurate and evidence-based and provided on a confidential basis[56]

A holistic approach is taken to abortion care. The model is not just focused on completing the termination, but also on consulting with patients to ascertain whether they are in a position to provide consent, whether they have given their decision due consideration understanding that it is not generally regarded as being a reversable procedure. The consent process involves observing whether a woman seems ambivalent, uncertain or coerced around their decision, or definite about their choice.

Meetings between the Chair and medical providers conducted during this Review reveal that they feel confident that they are able to pick up on cues that suggest a person may be uncertain, hesitant or are being coerced into decision-making, which would lead them to advise the person to take additional time to consider their decision. In such circumstances, it would be extremely important that the woman (and her partner) be offered free of charge non-directional counselling to help them to consider their decision of whether to continue the pregnancy or progress to a termination.

In practice, from the UnPAC report it would appear that women are certain of their decisions before they present for their first appointment. When women present to their GPs in the earlier stages of gestation and feel they require more time to consider their options, they may comfortably take time to do so. In theory, women who first present at the first consultation towards the end of the first trimester, may feel panicked by the prospect of their choices disappearing and pressurized into making a hasty decision.

Section 11.4.7: Women not proceeding to the second appointment

Data shows that a small percentage of women do not proceed beyond the first consultation with the GP. In 2019 study over six months, looking at 475 women who presented at the first consultation, 11 (2%) did not return for the second visit. The reasons are not ascertained. Potentially, they may have changed their minds, they may have spontaneously miscarried, they may have presented at another provider and commenced the process again, they may have travelled abroad to procure an abortion, or they may even have illegally procured abortifacient medication to self-manage their own abortion. Further research, preferably in the form of a national data collection framework, is required to obtain a better understanding of the reasons why some women are not attending at second appointments.

Section 11.5: Timing out of access to early medical abortion due delays in seeking care

This may occur in circumstances where a person does not realise that they are pregnant or where they delay seeking care for other reasons.

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[56] General Comment No.36 Article 6 of the International Covenant on Civil and Political Rights, on the right to life. Geneva. United Nations. Human Rights Committee (124th session); 2018 (CCPR/C/GC/36)

Section 11.5.1: Dating the pregnancy may be confusing

Section 12(5) specifies that 12 weeks of pregnancy shall be construed in accordance with the medical principle that pregnancy is generally dated from the first day of a woman's last menstrual period. Accordingly, the clock starts ticking prior to conception. It is quite likely and understandable that some women (particularly those experiencing pregnancy for the first time) would be utterly ignorant of this method of calculation and would incorrectly date the pregnancy from around the time of conception. They are at risk of presenting later in gestation.

A 2019 study conducted over six months from 1st January 2019[57] involving 475 women across 27 GP practices showed that the mean gestational age at the time of first consultation with the GP was 49 days (seven weeks). 1% (5) presented at a gestational age beyond 12 weeks.

Section 11.5.2: Delay in seeking care for other reasons

Some women may not be aware that they are pregnant until they have advanced into the second trimester and accordingly fail to meet *section 12* criteria. Reasons for delay are multi-factorial and have been identified[58] as, not expecting a pregnancy (perhaps due to use of contraception or relatively recent childbirth) and not recognizing potential signs that in hindsight could have been attributable to pregnancy; typical signs of pregnancy (nausea, weight gain, cessation of menstrual bleeding) being absent, and women with irregular menstrual cycles not attributing the absence of menstrual periods to pregnancy.

The submission of the START group refers to their experiences of meeting with women in their clinics who do not present until later within the first trimester, and state that this is based on a variety of factors, including medical factors, work, family, occupation, finances, education, language, culture and domestic abuse situations. They observe from experience that women who present later are more likely to be in disadvantaged groups and are, therefore, disproportionately affected by the 12-week limit.

The problems associated with delays in seeking care are also compounded by the need to complete the termination before 12 weeks gestation.

Section 11.5.3: Timing out of care due to failure of treatment

The early medical termination of pregnancy service depends predominantly on medical means of abortion. Treatment may fail. The recently published Clinical Practice Guideline on investigation and management of complications of early termination of pregnancy[59] states that there is a less than 3% chance of ongoing pregnancy when both mifepristone and misoprostol have been taken.

The recent Guidelines and the Interim Clinical Guidance Termination of Pregnancy Under 12 Weeks advise that patients be counselled on the potential risk of continuation of pregnancy and of risks of fetal anomalies occurring due to the teratogenic effects of abortifacient medication. The 2019

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[57] Horgan P, Thompson M, Harte K and Gee R. Termination of Pregnancy Services in Irish General Practice from January 2019 to June 2019. Contraception 104 (2021) 502 – 505.

[58] Purcell, C. Cameron, S. Caird, L. Flett, G. Laird, G. Melville, C. and McDaid, LM. 2014, "Access to and experience of later abortion accounts from women in Scotland", *Perspectives of Sexual and Reproductive Health*. Vol 4, no.2, pp 101-8.

[59] National Clinical Practice Guideline Investigation and Management of Complications of Early Termination of Pregnancy. Dublin: Institute of Obstetricians and Gynaecologists, (IOG) 2023 Version 1.0.

Guidelines refer to research findings describing over 35 fetal anomalies being associated with teratogenic medication use[60].

The issue of reversing the effects of abortifacient medication by use of progesterone has been raised. The recent Guidelines on investigation and management of complications of early termination of pregnancy states that there are not any high quality national or international clinical guidelines that recommend the use of progesterone to reverse the effect of mifepristone, and no evidence that it increases the likelihood of continuing pregnancy compared to expectant management care alone. It points to several international professional bodies not supporting the provision of progesterone to stop medical termination of pregnancy.

There is not any discretion in the Act to extend the 12-week limit to progress the process to completion. The only option available to the medical practitioner is to direct the woman to non-directive counselling or discussion about options of continuing pregnancy with threat of harm to baby or travel abroad.

It is questionable as to whether it is ethical to insist that a woman continue with a pregnancy following a failed medical abortion, if she has timed out the 12-week period.

Section 11.6: Remote model of care

On 6th April, 2020, the Department of Health issued Covid 19 public health emergency termination of pregnancy – temporary provisions for early pregnancy model of care in response to Covid 19. This allows for the first and second visit to be fully remote (by telephone or video conferencing calls), and face-to-face, if necessary. This was introduced without any need for legislative changes. The START organization proposed telemedicine consultation protocols, which were adopted by the HSE when developing the modifications[61]. Additional supports were introduced into the care pathway, designed in collaboration with the IFPA's clinical, counselling and communications staff. These supports included the development of a step-by-step guide to using the home care pack and a series of videos explaining how the pathway works. The translation function on the IFPA website enabled greater access by service users. Women were provided with information leaflets to read through in addition to verbal explanations. The home care pack, containing the abortifacient medication and other medicines necessary to manage the termination of pregnancy at home, were available for collection at clinics.

The Chair learned at the START annual conference that in practice, most GPs have taken a blended approach to the model of care, even during Covid restrictions, having at least one of the

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[60] Guidelines state that data in this area is limited to case reports, case control and cohort studies, some of which report self-prescribed non-validated non-clinician supervision, with dosage ranging from 200 micrograms to 16,000 micrograms (Philip, Shannon & Winikoff 2002). It reports to over thirty five different fetal anomalies being described, "*with lower limb defects being most common (82%), followed by central nervous system anomalies (55%), upper limb defects (40%) and skeletal defects (27%). Specific anomalies included equinovarus, terminal transverse limb defects, arthrogryposis, cranial nerve abnormalities and Moebius syndrome (Gonzalez et al. 1998, Da Silva Dal Pizzol, Knop & Mengue 2006, Vauzelle et al. 2013)*".

[61] Mishtal J Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

consultations in person. In person visits are regarded as being beneficial to gaining more information about the woman's circumstances, particularly if they are not their usual GP, to identify and mitigate against potential problems, detecting coercion or intimate partner abuse, assessing gestational age where this might be uncertain and to provide and offer screening for venous thrombolism, genital infections, sexually transmitted diseases and risks of Rhesus D sensitization.

The ability to carry out at least one consultation through telemedicine is perceived by providers as having enhanced access by women who are time constrained by educational activities and work, and/or have commitments to family duties, and as having alleviated difficulties associated with travel for women, particularly those living in rural areas, who may have to travel long distances to a providing GP and who may not have independent means of transport.

The UnPAC study found that the remote model of care is perceived by women as increasing their accessibility to termination of pregnancy services which is of particular benefit to women in rural areas where GP coverage might be limited. The study analysed data from Women on Web and found that people contacting the service demonstrated a preference for the perceived privacy and comfort afforded by telemedicine services.

Section 11.6.1: Safety of remote model of care

An English study comparing outcomes before and after implementation of medical abortion without ultrasound via telemedicine concludes that a telemedicine hybrid model for a medical abortion pathway of care for women less than 10 weeks pregnant, that includes no test telemedicine and treatment without ultrasound is effective, safe, acceptable, improves access to care[62].

The study compared outcomes for women who experienced the pre-Covid model of care, having to attend in person at clinics to receive an ultrasound scan and the administration of mifepristone, with those who received treatment under a model of care introduced in response to Covid-19 utilising telephone or video consultations, ultrasound scans only if indicated and administration of mifepristone at home.

The study was based on a population sample of 52,142 Of these, 22,158 received are under the traditional model involving in person visitsand ultrasound between January and March 2020, and 29,984 received services under the new hybrid model of care (in person or via telemedicine) of whom 18,435 had no test telemedicine service between April and June 2020.The results of the study show that mean waiting times from referral to treatment was 4.2 days shorter in the hybrid telemedicine model, more abortions were performed at or earlier than six weeks gestation than in the traditional model (40% versus 25%), and treatment was delivered successfully in both (98.8% v 98.2%), fewer serious adverse events were recorded for the hybrid model (0.02% versus 0.04%) and incidence of ectopic pregnancy remained the same at 0.2%. . Within the telemedicine hybrid model, effectiveness was shown to be higher with telemedicine than with inpatient care (99.2% versus 98.1%), acceptability levels were high (96% satisfied) and 80% reported a future preference for telemedicine.

[62] Aiken A, Lohr PA, Lord J, Ghosh N. Starling J. Effectiveness, safety and acceptability of no test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. Bjog. 2021, 128(9): 1464 – 74.

Section 11.6.2: Telemedicine and reproductive coercive control

Reproductive coercive control is behaviour that interferes with a person's autonomy to make decisions about their reproductive health. It can take a variety of forms (physical and non-physical violence) and always involves an abuse of power. The perpetrator could be a spouse, a civil partner, a person who was or is in an intimate relationship with the victim, a family member, or other person able to exercise power over the individual concerned, such as a health care professional.

Advocates of sustaining the remote model of care introduced during Covid 19 restrictions believe that it provides women in coercively controlled relationships with easier access to GPs, as it does not require face-to-face consultations, and accordingly does not necessitate the woman leaving the house which could be impeded by her partner.

Critics of the model believe that it empowers the controlling partner to more easily coerce the woman into having an abortion. They believe that a woman could be forced against her will to phone the GP and that this means of communication would not be conducive to the GP identifying coercive control which might be picked up in a face-to-face private consultation with the GP.

It would appear that both models of care have potential benefits and disadvantages to women in coercively controlled relationships.

Section 11.7: Ultrasound dating scans

The Interim Clinical Guidance provides that at the first consultation, the medical practitioner must assess the gestation of the pregnancy. This may be done by reference to the first day of the woman's last menstrual period. Ultrasound dating scans are not routinely required but may be recommended from a clinical perspective. This aligns with the evidence-based recommendation contained in the recent WHO Abortion Care Guideline.

Section 11.7.1: The need for universal reliable access to ultrasound dating scan services

The literature review conducted as part of the research undertaken in the providers' research refers to the WHO study[63] which highlighted unreliable referral pathways for ultrasound scans as being challenging in some cases, stating that *"not all GPs have a reliable and timely pathway to access ultrasound scans"*. A separate study by Duffy *et al*[64]outlined that the timeliness and cohesiveness of referral to ultrasound scans were reported by providers as impacted by the availability of staff. Arranging scans could be, according to providers who participated in the study, a protracted process.

[63] Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

[64] Duffy, D., Mishtal, J., Grimes, L., Reeves, K., Chakravarty, D., Stifani, B., Chavkin, W., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. (2022**)** What are the informational barriers and facilitators to abortion care? Patient Journey Analysis of abortion access under new services in the Republic of Ireland. *Social Science and Medicine – Population Health,* 19. p. 101132

Prior to service commencement, the HSE contracted the services of private companies to provide ultrasound scans for dating pregnancies across the whole of Ireland. However, the service is only provided in six facilities and some facilities have chosen not to provide the service[65]

Section 11.7.2: Service providers' experiences

Medical practitioners have experienced different standards of service from private providers. At a recent meeting attended by the Chair, some rated the private sector service in some regions as being excellent, but in other regions, the service was described as being very slow. The WHO study by Mishtal *et al*[66] reports some of the private facilities lacking adequate staffing with referring doctors complaining that, "*when that radiographer is off, there is no access to scans*" or *"they fail to provide a timely service".* The study refers to GPs lacking confidence in the service. One rural GP is quoted as describing not having any idea as to how long it will take for the referred woman to get an appointment, stating that they could hear nothing for a few days, follow up and then be told that there is not a sonographer available, requiring further attempts to secure a scan appointment elsewhere*".*[67]

Within maternity units/hospitals providing ultrasound services for *section 12* patients, there can be capacity issues if the regular sonographers' lists are very busy, and there may be cases on the list with higher priorities. One hospital's solution to this was to train midwives in sonography to help streamline the service.

Section 11.7.3: Service users' experiences

UnPAC study shows that women can experience anxiety whilst waiting for a scanning appointment and this anxiety continues until the GP or community provider is able to confirm the result. Some women felt that the sonographer should be able to inform them directly of the date of gestation, as this would relieve their worry, particularly if they were uncertain about timing out of eligibility under *section 12.*

The START group and the UnPAC report refer to access to ultrasound varying significantly depending on geographical location, and some women in rural areas and areas of poor hospital coverage having to travel long distances for scans. In general, their *section 12* community-based providers reported a high level of satisfaction with services provided in local maternity units/hospitals.

Recommendation 8 of the Interim Clinical Guidance states that women should be asked about their wishes to see the ultrasound screen or not. According to the UnPAC study, the will and preferences of the women regarding seeing the scan is being accommodated in most cases. It reports that in the main, sonographers are very sensitive to the women's needs. However, the study reveals that some sonographers do not appear to be conscious of the effect on women of seeing the scan, and in some

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[65] Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

[66] Mishtal J Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

[67] Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

cases the screen was in full view, which women found distressing. An obstetrician who spoke directly to the Chair, described how one of their patients had complained about the sonographer making inappropriate comments to the woman about how the foetus was "*a fighter*" and "*had a strong heartbeat*".

Section 11.8: Hospital care for early medical termination of pregnancy

The model of care provides that women at nine weeks and six days gestation should be referred to hospital for *section 12* termination of pregnancy. Patients who do not exceed this gestational limit may need to be referred to the maternity hospital for other reasons, for example the Interim Clinical Guidance on Termination of Pregnancy Under 12 Weeks recommends that if patient is seeking a termination of pregnancy is 7 weeks' gestation or greater (≥49 days post LMP), a blood group and Rhesus D testing is advised, in order to identify those who are Rhesus D negative, and take steps to prevent Rhesus D sensitisation during future pregnancies.

Community providers require reliable pathways of care identifying access points to the closest maternity hospital that is providing early medical abortion services. As eight maternity units do not provide full early termination of pregnancy services, GPs and women's health clinics may be required to make referrals to hospitals that are outside their catchment area. Consequently, they may be less familiar or strangers to individuals within the hospital who are involved in coordinating and providing the services. In the absence of a clear pathway integrating care between the community providers and key personnel at the maternity unit, community providers may be left almost feeling like they are fumbling in the dark for information. Peer support from members of the START group or other networks might assist in information sharing, but obtaining this information whilst the patient is present, is not practical or desirable.

Section 11.8.1: Lack of medical providers in hospitals - unpredictable access

Access to hospital care for early medical termination of pregnancy is in part reliant on a small number of champion providers within the hospital who have worked to commence service provision. When those hospital providers are on leave, it can result in unpredictable access to secondary care as cross-cover from colleagues is not always facilitated. To overcome this barrier, GPs and community providers require the HSE to ensure that pathways for secondary care referral and scans are secure and that cross-over is available to facilitate access during hospital coordinator and provider leave.

Section 11.8.2: Service coordinators perform a critical role

Critical to the efficient running of the care pathway is the appointment of a dedicated termination of pregnancy nurse or midwife coordinator at the providing hospital. This person acts as a point of contact for GPs and community providers to make arrangements for the woman's care with sonographers for gestational dating scans, consultants, bed managers and other necessary servicers within the hospital prior to the woman's admission. The known presence of the coordinator is regarded as a key enabler to service delivery.

Issues can arise if the coordinator is not readily available, due to being on leave or for other reasons, as described by a respondent in the providers' research report,

> *"When you contact the lead person there, the clinical nurse specialist, everything works really smoothly. Fantastic. If they're on holiday or they're not there that afternoon and then I'm off the next day, and it gets lost – not lost but just – that streamlining isn't there, you know. So, for me, that's probably the biggest issue with the hospitals".*
> (R213).

The providers' research found that depending on resources available, some providing hospitals might only have one person dedicated to coordinating termination of pregnancy services and that person may only be available on a part-time basis. This can have implications for delay with potential risk of timing out of the service for women close to 12 weeks gestation. The Chair found that some hospitals have introduced systems to compensate for lack of full-time cover by utilizing a mobile phone number as the point of contact and transferring the phone to other members of staff, including senior management team, to ensure continuity of service.

The providers' research revealed that it is not unusual for committed staff in maternity hospitals/unit to work outside of their normal working hours to provide care to women seeking early medical abortions. This includes working additional time to accommodate women who have to travel long distances to the unit due to being unable to access the services at their local unit, as described by one respondent,

> *"If someone's coming from (area) on a bus, there's no point me saying, "can you come in at 9 o'clock in the morning?" If they've kids, or maybe no partner, I'll stay late, or I'll come in on a Saturday morning in a time sensitive situation. It means I have to be flexible because the access in the surrounding areas is limited"* (R212).

Section 11.9: Ongoing need for education

Non-providing medical practitioners may encounter women seeking termination of pregnancy services, in which case they need to be aware of their legal and ethical obligations under the Act and the Irish Medical Council Guide to Professional Conduct and Ethics to make arrangements to transfer the care of the woman, as may be necessary to enable her to avail of the termination of pregnancy concerned.

Non-providing GPs may be presented with women who have complications following an early medical termination. If the woman has had to travel a significant distance to attend a providing GP service, she could be present to a different GP, or to a different GP in the same practice, for management of failure of termination (pregnancy continued despite medication), incomplete elimination / retention of products of pregnancy; infection, or severe bleeding requiring transfusion.

The Institute of Obstetrics and Gynaecologists in collaboration with the HSE's National Women's and Infants Health Programme have recently published National Clinical Practice Guidelines for investigation and management of complications of early termination of pregnancy. These Guidelines are targeted at providers and non-providers of the service in both the primary and acute care settings. The guidelines are comprehensive and recommend that all health care providers should be aware of the complications that may present following an early termination of pregnancy.

The Guidelines are a welcome development and support should be provided to enable implementation.

Section 11.10: Remuneration for services

The contractual agreement between the HSE and GPs for provision of early medical termination of pregnancy services provides a schedule of payments for each of the three visits (two prior to the termination and one follow up visit). However, the Chair has learned that the real experience of GPs is that they have unsuccessfully claimed for remuneration for the first visit only leading them to believe that they are eligible for payment only if the compete the termination of pregnancy.

The Department of Health has confirmed to Chair that they are eligible to be paid for each visit and this information needs to be relayed to GPs and confirmed with the PCRS.

Section 11.11: PPS number required to access services under the scheme

Free of charge access to termination of pregnancy services is restricted to people who have a PPS number (PPSN). The reimbursement system is based upon doctors providing patients' PPSN numbers to the HSE PCRS.

The necessity to have a PPSN to access free of charge services potentially adversely affects access to the service by people who do not have a PPSN number, such as asylum seekers, migrants, undocumented individuals, people in Ireland on a temporary basis, such as international students and women from Northern Ireland[68].

The WHO study by Mishtal et al[69] found GPs and My Options try to accommodate these patients by finding doctors who will not charge them. An employee of the IFPA informed the Chair that their organization had borne the costs the region of €11,500, in supporting patients that were not eligible for free care due to not having a PPSN.

[68] Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018. Irish Human Rights and Equality Commission. November 2022

[69] Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin, W, Duffy D, Favier M, Horgan P, Murphy, M and Lavelanet, A.F. (2022) "Abortion policy implementation in Ireland: Lessons from the community model of care". Scott J (ed). PLOS ONE, 17(5) p.e0264494

Section 12: Operation of *section 22 (c*onscientious objection) and refusal by health workers to provide termination of pregnancy care

Section 22

(1) *Subject to subsections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to participate in carrying out, a termination of pregnancy, in accordance with section 9, 11 or 12 to which he or she has a conscientious objection.*

(2) *Subsection (1) shall not be construed to affect any duty to participate in a termination of pregnancy in accordance with section 10.*

(3) *A person who has a conscientious objection referred to in subsection (1) shall, as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned, as may be necessary to enable the woman to avail of the termination of pregnancy concerned.*

(4) ....[i]

Section 22 allows medical practitioners, nurses and midwives to refuse to provide abortion services if they have a conscientious objection. This places termination of pregnancy services at odds with other forms of healthcare.

Many other countries also feature conscientious objection in their laws governing access to abortion. They aim to strike the balance between freedom of thought, conscience and religion of healthcare professionals and the rights of women to access lawful healthcare. Other countries, such as Sweden, Finland, Iceland, Czech Republic, do not permit conscientious objection to be exercised by medical practitioners in provision of abortion care services.

The WHO recommends that States that allow conscientious objection must organize their health system and abortion provision in such a way that ensures that conscientious objection does not result in the refusal of legally available abortion care and must regulate the exercise of conscientious objection in a way that reflects best international clinical practice, protects abortion seekers, and ensures refusal does not undermine or hinder access. Ireland purports to do this through the 2018 Act by clearly outlining who may object, prohibiting institutional claims of conscience, requiring objectors to make arrangements for transfer of the woman's care, and purporting to regulate conscientious objection in an emergency situation. However, challenges have occurred in operating this section of the Act. These are discussed below.

Section 12.1: Ambiguity in statutory interpretation

Section 22 seeks to achieve a balance between a right to conscientiously object and a woman's right to access termination of pregnancy services. In mandating the medical practitioner to "*make such arrangements for the transfer of care of the pregnant woman concerned, as may be necessary to*

enable the woman to avail of the termination of pregnancy concerned", it purports to achieve a compromise between ensuring both the rights of the medical practitioner and the woman are accommodated.

The section does not define what is meant by making arrangements for the transfer of care. It does not specifically state that the person must facilitate a direct referral to another provider, which could be conflicting for the individual. This is supported by the preliminary observations of the CORALE study where some participants, particularly those in community practice, felt that the requirement to refer was not consistent with the right to exercise a conscientious objection and for some, even sharing the number of My Options felt like a violation of their right. Arguably, in the community setting, at a minimum the section requires a medical practitioner to inform the pregnant woman of how to access the contact details of the closest provider. This minimal requirement was unsuccessfully legally challenged in *NZ Health Professionals Alliance Inc v Attorney General of New Zealand [2021] NZHC 250.* The High Court in New Zealand held that the duty was a necessary safeguard for people who do not have the means to navigate their way through the health system without assistance.

The section lacks clarity as to what is meant by the term, "or to participate in carrying out". The preliminary observations in the CORALE study also indicate that there is ambiguity around what is meant by "participating in", as used in *section 22.*

Section 12.2: No mandatory statutory duty to provide termination of pregnancy in emergency circumstances

Due to the wording of *subsection 22(2)* and *section 10* (risk to life or health in an emergency), medical practitioners, nurses and midwives holding conscientious objections are not under any mandatory duty to provide termination of pregnancy services to a woman in an emergency situation where the continuation of pregnancy is an immediate risk of harm to health or her life.

The wording of *subsection 22(2)* states,

> *"Subsection (1) shall not be construed to affect any duty to participate in a termination of pregnancy in accordance with section 10"*

However, the wording of *section 10* (which is intended to qualify *section 9* by enabling the abortion to be performed on the basis of the opinion of one rather than two medical practitioners) provides a discretionary power to the medical practitioner to do so, as it uses the word, *"may",*

Subsection 10(1),

> *"Notwithstanding the generality of section 9, or any determination made or pending pursuant to section 16, or an application under section 13(2), a termination of pregnancy may be carried out ….."*

The failure of the legislation to provide a mandatory obligation to provide a termination of pregnancy in an emergency situation potentially has disastrous and tragic consequences were a woman to present *in extremis* at a hospital/maternity unit where all obstetricians were exercising a conscientious objection. This may have never occurred, but in theory it could and the legislature needs to address this by amending the Act.

Section 12.3: Impact on women

The right to consciously object clearly impacts on women's access to lawful healthcare. In this jurisdiction, the lack of provision imposes burdens on women in terms of delayed access to care or having to travel greater distances to access a provider, potentially causing distress.

The UnPAC report indicates that some GPs may be directly contravening the law by not making arrangements to transfer the care of the pregnant woman to another provider – this was shown to be the norm; healthcare professionals may be attempting to delay women's access in an attempt to deter them from procuring services, and they may be attempting to make the women feel guilty about their decision. Other individuals, such as GP receptionists, were also cited in the report as expressly or impliedly demonstrating disapproval towards the women contacting clinics for the purpose of procuring abortion services. Consequently, these women were made to feel stigmatized and judged.

Section 12.4: Impact on health service provision

The numbers of medical practitioners holding conscientious objections has negatively impacted on service provision.

Whilst conscientious objection is a factor in non-providing GPs decisions not to provide the service, the findings of a survey conducted as part of this Review indicate that the dominant reason for non-provision by GPs is not related to conscientious objection but rather to lack of capacity to manage the additional workload.

The HSE has attributed conscientious objection held by consultants as being a significant factor in the roll-out and development of the service. Hospitals that do provide the services (including *section 12* under the Act) are dependent on a small number of practitioners (this is so even in some of the larger maternity units). The service provision is described by the NWIHP Director as being "tenuous". This Review reveals that the prevalence of non-providers in hospital settings had significant workload implications on the small number of providers. They are required to logistically manage services (including maneuvering schedules) to ensure that they have willing staff available on the wards and in theatres, as and when required.

Interesting insights into the operation of *section 22* in the clinical context that did not emerge in the Review, have arisen from the preliminary observations of the CORALE study[70] that investigates for the first time, the operation of the right to conscientious objection in the provision of termination of pregnancy services in Ireland in clinical settings[71]. These indicate that:

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[70] Data gathered in the qualitative research phase of the Conscientious Objection after Repeal: Abortion, Law and Ethics (CORALE) study (Trinity College Dublin), being conducted by Dr. Andrea Mulligan, Prof. Joan Lalor, Prof Linda Hogan and Dr. Desmond Ryan. The study is ongoing

[71] These are also referred to in other parts of the report.

- in the hospital and in the community settings, not having a formal system in place for staff with a conscientious objection to declare their position may put unfair pressure on individuals who might not feel comfortable coming forward in their workplace setting, and

- in situations where there is limited staffing to attend a patient, a person with a conscientious object may feel undue pressure to participate in care.

Management of these issues require principals (GP practices) and senior management at hospital level to provide the necessary supports needed to promote an inclusive culture and protect the rights of conscientious objectors by managing rosters to ensure that they are not put in compromising positions.

Section 12.5: Declaring conscientious objection

Currently, formal lists or registers of willing and non-willing service providers are not maintained and knowledge is gained informally by line managers and medical practitioners. Maintaining a formal register would be beneficial in terms of providing staff with a means to communicate their views and providing clarity as to who is willing to support the service. However, there is no guarantee that it would be utilised as intended especially in cultures where NCHDs are not willing to express a contrary view to their consultants in fear of future employment prospects being affected.

Views have been expressed that disclosing conscientious objection in a hospital setting may not be conducive to good patient care. Professor Fergal Malone in a submission to the Joint Committee on the Eight Amendment of the Constitution[72], stated his view that knowing a doctor's political agenda, in terms of whether they are pro-life or pro-choice, could be deleterious to the relationship of trust between a patient and her doctor as, *"some patients may no longer trust the professional advice we provide when they are in a vulnerable position having just received information regarding a serious fetal anomaly".*

Section 12.6: Overcoming the barriers to service provision

The HSE NWIHP Director has informed the Chair that various initiatives have been taken to overcome the barrier to service provision, caused by the prevalence of conscientious objectors to abortion within the hospital setting. Values clarification workshops and training programmes have been held. Training on values clarification is a key enabler to enabling participants to reflect on their values and thoughts about termination of pregnancy services by looking at their own beliefs and attitudes from the needs of women seeking the service. According to the Director, seven[73] structured values clarification workshops have taken place between 2018 and June 2022. They were run in conjunction with the World Health Organisation who facilitated the sessions. 126 staff were scheduled to attend the sessions. Further series of values clarification workshops will be across hospital networks as additional hospitals commence full services provision under the Act.

[72] Wednesday, October 7th, 2017 – Session B

[73] . structured workshops took place at the Rotunda, the Coombe Women and Infants' Hospital, the National Maternity Hospital, Cork University Hospital and Limerick University Hospital.

The HSE NWIHP Director has also confirmed that efforts to overcome conscientious objection as a barrier to service provision are ongoing and include the development of peer support mechanisms, increased senior clinical leadership both within and between maternity hospital networks, ongoing engagement between the HSE NWIHP office, the Clinical Lead for termination of pregnancy services and individual hospitals and maternity hospital networks.

The ICGP has indicated that it will facilitate its members attending values clarification workshops. However, given that UnPAC research reveals that patients' experiences may be negatively impacted by receptionists or other administrative staff whom they may encounter, it would be advisable that the training be expanded to include support staff working in surgeries.

There is an ongoing need for education and training on conscientious objection and termination of pregnancy for staff working in maternity settings Persons (whether intending to provide or not) require knowledge of their obligations pursuant to *section 22* and under the Medical Council Guide to Professional Conduct and Ethics as well as training on conscientious objection and the opportunity to participate in values clarification workshops.

Section 12.7: Measures to address abuse of right to conscientiously object

There is not any statutory prohibition on healthcare professionals who actively obstruct a woman's access to care by conduct such as misleading her to believe that they are providers and delaying her care, or by misleading her as to her gestation intending to time her out of care, for example. Currently, persons who abuse the right to conscientiously object seem to be able to do so with impunity under the Act. There may be a low level of awareness among service users of the legal and ethical obligations upon medical practitioners which might enable them to report the conduct to the Medical Council. IHREC have recommended that procedures should be put in place to allow service users to report practitioners who obstruct and/or refuse to refer.

Further discussion in this report on *section 23* (criminal offences) discusses how the Oireachtas might introduce an offence of reproductive coercive control.

Section 12.8: Inhibitory effect of local community reaction on health care providers

The Chair learned through an interview with a consultant in a smaller hospital of the inhibitory effect adverse local community reaction may have on medical practitioners' willingness to provide services. In that hospital, letters objecting to service provision on moral grounds were received by obstetricians. Only one of the obstetricians had been willing to provide services but was not prepared to lead the service. The appointment of a second obstetrician at the hospital who was willing to provide the service had a positive impact, enabling termination of pregnancy services to commence. However, this doctor confirmed that he and his colleague still continue to receive letters from objectors in tones that they find unsettling. This demonstrates the effectiveness of the HSE's recruitment strategy and supports the need for legislation to provide safe access zones and protect service providers from harassment.

Section 12.9: Conscientious objectors in the workforce not covered by *section 22*

Only medical practitioners, nurses and midwives, have a right under the Act to raise a conscientious objection. However, other members of the workforce may also be reluctant to support service delivery, and some have made their disapproval known by engaging in inappropriate conduct.

Managerial support is required to establish the parameters of conscientious objection and non-provision. Staff must be enabled to clearly understand their responsibilities. One midwife in the providers' perspectives study described how having pro-active management engagement with theatre staff and educating them on the boundaries of conscientious objection and value clarification had a very positive effect.

Section 13: Operation of *section 23 (*criminalization)

(and sections 17(7), 23 and 24)

There are three separate criminal offences contained in the Act (sections 17(7), 23 and 24). Of these, issues pertaining to the operation of Section 23 emerged as a main theme in the Review.

Section 23

(1) It shall be an offence for a person, by any means whatsoever, to intentionally end the life of a foetus otherwise than in accordance with the provisions of this Act.

(2) It shall be an offence for a person to prescribe, administer, supply or procure any drug, substance, instrument, apparatus or other thing knowing that it is intended to be used or employed with the intent to end the life of the foetus, or being reckless as to whether it is intended to be so used or employed, otherwise than in accordance with the provisions of this Act.

(3) Subsections (1) and (2) shall not apply to a pregnant woman in respect of her own pregnancy.

(4) It shall be an offence for a person to aid, abet, counsel or procure a pregnant woman to intentionally end, or attempt to end, the life the foetus of that pregnant woman otherwise than in accordance with the provisions of this Act.

(5) A person who is guilty of an offence under this section shall be liable on conviction on indictment to a fine or imprisonment for a term not exceeding 14 years, or both.

(6) A prosecution for an offence under this section may be brought only by or with the consent of the Director of Public Prosecutions.

Termination of pregnancy is a criminal offence unless carried out in accordance with the terms of the Act. According to the WHO, abortion is commonly regulated through criminal law. Even New

Zealand, which can be regarded as operating a relatively liberal regime having amended its abortion law in 2020 to provide abortion up to 20 weeks gestation and thereafter if the clinical practitioner believes that it is clinically appropriate[74], has retained criminal sanctions[75] against healthcare providers of abortion services in circumstances where it is carried out outside of the specific grounds of the Contraception, Sterilisation and Abortion Act 1977.

Section 13.1: Recommendations of WHO and human rights bodies

The WHO Abortion Care Guidance[76] recommends the full decriminalization of abortion so that there would not be any criminal penalties for having assisted with, provided information about or provided the service. Its position is supported by numerous human rights bodies and mandate holders, including CEDAW, CESR and UNHRC.

This recommendation does not align with stated public policy in Ireland.

Section 13.2: Public policy

The rationale for the inclusion of a statutory criminal offence was set out by the then Minister for Health, Simon Harris TD, during a motion before the Dáil to fully decriminalize abortion in the Regulation of Termination of Pregnancy Bill in November 2018[ii]. Minister Harris stated that he felt a responsibility to stick to what was in the general scheme of legislation presented to people before the referendum and that the criminal penalty was included in that scheme. He stated that criminalization was necessary from a public policy perspective and that to remove it would present a risk to the lives and health of women and that it would protect women who were forced into seeking an abortion, or where there was a dominant personality or sexual abuse. He agreed that the matter needed to be carefully monitored and might form part of the three-year review.

Section 13.3: The woman's perspective

The criminalization of abortion *per se* can be stigmatizing. In the paper, "Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand[77]", Jeanne M. Snelling's review of the literature reveals that from the patient's perspective,

> *"… regulating abortion as a crime reinforces its social and cultural framing as an immoral and aberrant act. This may cause significant distress for women, delay decision making, and potentially creates a disincentive for health providers to participate in abortion service provision[78]"*

Women are also impacted by the travel costs and delay in access that are consequential of the effect that criminalization has on healthcare workers to provide the service.

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[74] Sections 10 and 11 Contraception, Sterilization and Abortion Act 1977, as amended (New Zealand)
[75]Section 182 Crimes Act 1961, as amended (New Zealand)
[76] Abortion Care Guidance. WHO (2022)
[77] Snelling Jeanne M. Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand. Medical Law Review Vol. 30, No.2 pp 216 - 242
[78] NZLC, *Alternate Approaches (n46)[4.8] [citation provided in* Snelling Jeanne M. Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand. Medical Law Review Vol. 30, No.2 pp 216 – 242]

Section 13.4: Disincentivising effect on healthcare professionals

Section 23 is not solely targeted at medical practitioners, but applies to "any person", whether that be another healthcare professional, a friend of the pregnant woman who might procure abortifacient medication for her, or a person who is exerting coercive control over the woman's reproductive choices, among others. It does not apply to the pregnant woman herself.

The defence to Section 23 for medical practitioners is to prove that they held "*a reasonable opinion formed in good faith*" that the criteria contained in the relevant sections are satisfied.

Within the current framework of the legislation, it is not possible to provide assurances to medical practitioners that they would not be faced with a criminal investigation and/or charge pursuant to *section 23*, even where they and their peers felt confident that they formed a reasonable opinion in good faith. Lord Scarman's judgement in the case of *R v Smith [1974] All ER 376* illustrates the complex issues involved in applying the defence:

> *"The question of good faith is essentially one for a jury to determine in the totality of the evidence. A medical view put forward in evidence by one or more doctors is not a substitute for the verdict of a jury. An opinion may be absurd professionally but formed in good faith; conversely, an opinion may be one which a doctor could have entertained and yet in the particular circumstances of the case may be found either to have been formed in bad faith or not to have been formed at all"*

The Act does not require medical practitioners to be certain in their opinion. However, in practice, this does not appear to ameliorate fear. Consultants spoken to by the Chair during this Review, believe that the prospect of being involved in a criminal investigation and adverse media scrutiny, weighs heavily on those involved in making the determinations and in some cases has led to overly cautious, risk adverse decision-making, tending towards refusing to provide the service. One respondent informed the Chair that they could "*sense the tension in the room during MDT discussions*", another referred to colleagues deciding that the decision to approve termination would not be worth the risk of falling foul of the law and adverse media attention and that the person could travel abroad. There exists a fear of unwittingly falling foul of the law.

A consultant foetal medicine specialist who participated in the providers' study, also referred to their experience of how continued criminalization impacted on the conduct and tone of multi-disciplinary teams. This participant remarked,

> *"But again, there is a reluctance to be … and I think it's … if that's true, I don't think it's anything to do with conscientious objection or anything, it's the fear of getting something wrong and subsequently being challenged on that or there being a case. So again, criminalization, I think, feeds into that. Okay, so there's a lot more discussion, a lot more worry about it than there would be in other types of MDTs"* (R204).

The providers' research revealed that consultants in neonatology, maternal and foetal medicine, and perinatal psychiatry who participated in the research, all identified criminalization of healthcare as a problem. Some felt that the location of termination of pregnancy in the criminal law deterred health workers from engaging in provision, not because they did not want to provide but because they felt that the law did not protect them. This was articulated by a participating consultant neonatologist working in a larger maternity hospital,

> *"I would like the criminality aspect of the Act removed or dealt with really significantly to allow people to practice in a professional way and would make people feel more protected but also more inclined to get involved. It's a real barrier to many clinicians now wanting to get involved in these cases because they're afraid of what it will mean for them professionally and personally if even one case goes wrong, which means that you'll be left with very few, there's only 20 or 30 neonatologists in the country. You could find yourself with very few people that are willing to engage in the process purely because it doesn't protect them, not because they don't want to".*

The tension described is understandable given that medicine is not an exact science, but is predictive, so, for example, it is not possible to be completely certain that a termination of pregnancy will avert the risk presented by a person's psychiatric condition, if applying section 9, or that the fetal anomalies that are present will lead to the death of the foetus in utero or within 28 days of being born. The uncertainties that can surround decision-making in *sections 9 -11* can "*cause concerns about personal safety or exposure or criminal liability*", as stated by a consultant neonatologist participating in the providers' perspective research.

Furthermore, terminations occurring under *sections 9* and *11*, the legality of the procedure depends upon two medical practitioners both holding the requisite beliefs in good faith. It therefore follows that if only one of the two were to hold the requisite belief, the procedure would be unlawful, thereby potentially exposing the other practitioner to prosecution.

Even though Section 23(6) provides that a prosecution may only be brought on the consent of the Director of Public Prosecutions who would have the expertise to consider the evidence in deciding whether a person should be charged, there would still remain the fear of being sent forward for trial and the prospect of the imposition of a custodial sentence up to 14 years.

Section 13.5: Potential effect of excluding medical practitioners from section 23

Adverse events happen in the practice of medicine and sometimes with very tragic results. However, in this jurisdiction no other statutes regulating healthcare impose criminal liability on practitioners in circumstances where things go wrong in the delivery of care even where there is a causal link to the action (or inaction) of an individual. A plaintiff's normal recourse is to civil litigation if negligence is a contributing factor. The criminal law, as it applies to fatal and non-fatal offences against the person, would likewise be applicable.

The CHR, in its Concluding Observations on the fifth periodic report of Ireland recommended that the State consider taking action to remove criminal sanctions to medical service providers[79].

If the criminal sanction were removed, there could be an increased risk of persons willfully providing termination of pregnancy services outside of the scope of the regulations. Arguably, it would be challenging on an individual to do in the current model of care. All women with pregnancies over nine weeks and six days are referred to a maternity hospital for care where medical practitioners and other staff are peer reviewed. Two medical practitioners are required to certify their opinions, one of whom must sign a register to access the abortifacient medication. The case may have been considered by a multi-disciplinary team (sections 9 to 11). The woman has to be admitted and cared for on a ward staffed by professionals with requisite knowledge and expertise to recognize intentional or reckless non-compliance with the regulations.

Whilst the issues that *section 23* purports to address, as set out by Minister Harris during the Dáil debate, may seem reasonable, and consistent with some international comparators, the section has had unintended consequences on the operation of the Act. Unlike New Zealand, where the law is very clear and is based on dating the pregnancy, Ireland's legal framework poses far more challenges, including uncertainty, to medical practitioners when trying to determine whether *section 9, 10* and *11*, criteria are satisfied, and far more risk of being accused of falling foul of the law.

The presence of the criminal sanction in its current form has the potential to act as a significant disincentive to healthcare professionals to provide the service with a consequential effect of on pregnant women's ability to access services in this jurisdiction.

Section 13.6: No legal recognition of controlling conduct intended to force a woman to continue a pregnancy

As referred to above, Simon Harris, TD, explained that criminalisation was necessary from a public policy perspective and that to remove it would present a risk to the lives and health of women and that it would protect women who were forced into seeking an abortion, or where there was a dominant personality or sexual abuse.

No legal framework exists to protect women from dominant or controlling behaviour purporting to force a woman to continue a pregnancy unless it comes within the scope of *section 39* of the Domestic Violence Act 2018, which makes it an offence for a spouse, a civil partner or a person with whom the pregnant woman was in an intimate relationship to knowingly and persistently engage in behaviour that is controlling or coercive that has a serious effect on the relevant person and the behaviour is such that a reasonable person would consider likely to have a serious effect on the person.

Accordingly, other people, such as medical practitioners and directive counsellors, may purport to control a woman's reproductive autonomy with impunity. This conduct may take the form of

[79] Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018. Irish Human Rights and Equality Commission. November 2018, p19. Submission refers to (Human Rights Committee (27th July 2022). Concluding observations on the fifth periodic report of Ireland. Advance unedited version. Para 25, p6.

attempting to exert pressure on a woman to continue a pregnancy, or active interference with her access to services by the provision of misleading legal or medical information, for example, misleading her as to her eligibility under the Act or as to her as to her gestation period, with the aim of timing the woman out of care under *section 12.*

Section 13.7: Section 17(7) Review Committee

Pursuant to *section 17(7)* it is an offence for a medical practitioner to fail or refuse without reasonable excuse to comply with a direction of the review committee under *subsection (1)* to produce documentation or attend before the committee. Consideration should be given to decriminalizing this section and replacing it with a statutory obligation, remediable in tort by actions for breach of statutory duty, for which the Plaintiff could claim damages. The current fine under *section 17* is up to €2,500.

Section 13.8: Section 24 offence by a body corporate

Under this section a body corporate is criminally liable where an offence is committed under the Act. In addition, a director, manager, secretary or other officer, may also be criminally liable if it were proved that the offence was done with his or her consent or connivance, or was attributable to any wilful neglect, of a person who was a director, manager, secretary or other officer of the body corporate. On indictment, they may receive a custodial sentence up to 14 years (*section 23*) or fined up to €2,500 *(section 17(7)*.

Section 14: Training and Education

Training and education are a vital component for the provision of high-quality termination of pregnancy services under each of the grounds of the Act.

The WHO, in its recent Abortion Care Guidelines, refers to the importance of training for health workers involved in sexual and reproduction health services. It recommends that,

- unique competencies required for abortion care;
- provision of people-centred care;
- human rights, law and policy and its interpretation in a human rights way;
- communication to enable decision-making;
- values clarification;
- interprofessional team-working,
- empathetic and compassionate approaches to care

should be included in training programmes and promoted by professional societies. It states that it is *"especially critical that the attitudes and behaviours of health workers be inclusive, non-*

judgmental and non-stigmatising, and that they promote quality and safety", and that it is the responsibility of managers of healthcare to delivery services appropriately, meeting standards based on professional ethics and internationally agreed human rights principles.

Health workers need to be supported to provide competent care. The time period between the referendum to repeal the eight amendment in May 2018 and the commencement date for service delivery, 1st January, 2019, provided a very short time frame to plan for the introduction of services in the community and hospital setting.

Section 14.1: Education and training prior to roll-out of services

Following a coordinated multi-agency approach, involving the Department of Health, the HSE and professional bodies, supported by the Southern Taskforce for Abortion and Reproductive Topics group (START), training initiatives for healthcare providers commenced in late 2018.

From the 2019 annual report of the National Women and Infant's Health Programme it appears that primary care training was designed and led by the ICGP in conjunction with the Southern Taskforce for Abortion and Reproductive Topics (START).

Midwives and nursing staff training was delivered through the pre-existing masterclasses of supporting unplanned pregnancy held at Maynooth University, developed under the HSE Sexual Health and Crisis Pregnancy Programme prior to 2018, and that the Institute of Obstetricians and Gynaecologists, collaborating with the WHO, also held "values clarification" training and information sessions for health care workers in late 2018[80].

National clinical guidance was commissioned by the HSE from the Irish College of General Practitioners and the Institute of Obstetricians and Gynaecologists to support healthcare professionals in the provision of services. The Irish College of General Practitioners[81] finalized its guidance two weeks before service provision commenced. The Institute of Obstetrics and Gynaecologists published the Final Interim Clinical Guidance Pregnancy Under 12 Weeks in December 2018. In January 2019 the Institute of Obstetricians and Gynaecologists published "Interim Clinical Guidance on Pathway for Management of Fatal Fetal Anomalies and/or Life Limiting Conditions Diagnosed During Pregnancy", and it was not until five months after the commencement of service that the "Interim Clinical Guidance on Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy" was published.

The timing of the publication of the guidance, close to or after the roll-out of service, may not have provided healthcare professionals with a lot of opportunity to familiarize themselves with the contents.

The HSE also adopted a strategy to support GPs in the early stages of the roll-out. It allocated staff to field queries from GPs, as they arose, and utilised the expertise of the senior people in the Department of Health to respond to queries, and when clinical issues emerged, the HSE mobilized experienced GPs to ring the GP with the answers[82] .

[80] Annual report National Women and Infants Health Programme 2019. HSE.
[81] Quick Reference Guide (version 2) (ICGP ORG)Clinical Support for Termination of Pregnancy in General Practice, Dublin. Irish College of General Practitioners
[82] Mishtal J, Reeves K, Chakravarty D., Grimes L, Stifani B, Chavkin W. et al (2022) Abortion policy implementation in Ireland. Lessons from the community model of care. PLoS ONE 17(5) e0264494

Peer to peer support and education was also available through the START group which runs a WhatsApp network and also has a "train the trainer" group that helps to train new providers.

Section 14.2: Hospital staff not feeling adequately prepared

The literature review and the qualitative interviews conducted as part of the realist review reveals that training of hospital staff appears to have been inadequate to prepare them for delivery of the services. Comments made to the Chair by some medical practitioners (some of whom are in tertiary referral units), which is supported by the literature, indicate that hospital staff felt unprepared, that no national training programme was carried out despite recommendations contained in the Interim Guidance documents produced by the Institute of Obstetricians and Gynaecologists that all clinical staff, including midwifery, nursing, and support workers should receive evidence-based training.

Research conducted in 2019 by O'Shaughnessy E *et al*[83] investigating levels of staff knowledge and training, and their perceived challenges and barriers to the successful integration of early medical termination of pregnancy services in a large maternity hospital refers to GPs and hospital staff raising concerns about the lack of training and education from the offset. The study found that knowledge of termination of pregnancy legislation, guidelines, methods and potential complications were lacking amongst hospital staff.

Responses were received from 133 staff members representing medical staff, nursing and midwifery, allied health professionals and lecturers. The study found that just under a quarter, 24.8%, of staff were able to correctly identify all of the following: maximum gestational age for termination of pregnancy, mandatory waiting time, main method for termination (medical regimen), and necessary requirements for a termination to proceed (certification by a medical practitioner, informed consent and medical prescription).

93.8% of the respondents expressed a wish for further training and there was strong support for healthcare students receiving more education on the general knowledge of termination of pregnancy, and more education about the legal aspects.

They identified clear protocols, staffing, training on regulations, resources and training on methods to be the most important factors in service provision. They highlighted the three biggest challenges to service implementation as being training (41.6%), staffing (37.9%), knowledge and education (35.2%) and resources (30.5%). In the study, just over 10% of staff stated that they had received training for the introduction of the service, some of whom had paid for it themselves.

O'Shaughnessy et al found that important factors for service provision included having protocols, adequate mix and number of key staff, training on the legal regulations, adequate resources, training on TOP methods.

Other sections of this report refer to a lack of adequate training and education to support the provision of services under *sections 9 – 11* and *section 12* in the context of non-providing GPs not having received sufficient education on their legal and ethical obligations and on how to manage complications arising post termination of pregnancy.

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[83] O'Shaughnessy E, O'Donoghue K, Leitao S. "Termination of pregnancy: Staff knowledge and training" (2021) Sexual and Reproductive Healthcare 28 (2021) 100613

Section 14.3: Training driven by committed individuals without management support

Training and education of health workers in abortion care requires the support of managers. It appears that there have been different levels of involvement by hospital based senior managers to the provision of staff training and education around termination of pregnancy.

The Chair learned from directly meeting with members of senior management of a large maternity hospital and a non-providing hospital, that in both cases, senior management had played a supportive role in facilitating education and training of staff. In the case of the non-providing hospital, protocols had been in the process of being drafted and a midwife designated to be the service coordinator had attended a larger maternity hospital to shadow and learn from the midwife in that role. The service, however, did not commence as there were insufficient numbers of consultant obstetricians willing to engage.

The providers' research shows that there has not been universal proactive support by senior management for training and education and that it has often initiated by individual staff without management support. As stated by one respondent, a consultant at a major maternity hospital,

> *"But again (training sessions) were run by a very small number of …. I would say, committed doctors on sites who, you know, drove this rather than necessarily by management or anything within the sites, yeah, so"*
> [R204]

Another respondent stated,

> *"I think a lot of the wider team aren't aware …. It was kind of rolled out in 2019, with no huge education, so I think now, I think it's only now that we're educating more staff. But, I've given education sessions on some of the wards, just like that providing education to them about what happens ….. if the midwifery team in the emergency room, they kind of know what to do if someone comes in and has heavy bleeding, you know? ….. So, I think everyone knows their little bit in their area that they need to know, but they don't know the other bits, you know, they don't know the wider bits that I suppose, that's what I'm trying to do, is educate staff now on that … and the education session I'm completely stretched doing that. It's basically trying to fit them in myself, on a lunch break, or something"*
> (R117)

This Review was not resourced sufficiently to explore the reasons for lack of engagement by senior management at individual sites. Potentially, conscientious objection to the provision of services is a factor, as may be an unwillingness for other reasons to provide the service, and regarding it as something that can be provided elsewhere. This may impact upon the perceived need for training. As one consultant perinatal psychiatrist explained when referring to a hospital's attitude to later-term terminations,

> *[The hospital] don't like doing terminations. They don't feel trained and set up for it. There's a lot of moral objection to it, certainly at quite senior level is the feeling I get. So that's a definite barrier to people getting late-stage terminations. They want to just be able to refer it up because they refer their high-risk stuff to Dublin anyway. They want to refer it up. They see Dublin, it's more acceptable to staff so they just don't bother to get themselves trained up*

because they don't want to anyway because they don't want to deliver these terminations" (R203)

Section 14.4: Continuing initiatives by the HSE to support training and education

Since the commencement of service provision, the HSE NWIHP office has engaged in several initiatives to make evidence-based training and education available to service providers. It has collaborated with and funded training initiatives delivered by professional bodies. This includes the ICGP who (as of October 2022) report that it has run 14 introductory courses on early medical termination of pregnancy, between December 2018 and January 2022, attended by 672 participants and run two online training course, one in December 2018 and another in January, 2022, attended by 474 participants. Some of the participants may have attended more than once, to refresh their knowledge.

However, despite HSE NWIHP's investment, the providers' research indicates that there is insufficient staff to enable engagement with continuous professional education, and that staff are developing and delivering training sessions independently of HSE NWIHP and informally, during lunch breaks and peer support sessions.

In early 2020, Dr. Aoife Mullally was appointed as the Clinical Lead for Termination of Pregnancy. She chairs a clinical advisory forum (CAF), comprising multiple stakeholders representative of providers and special interest groups, which works to enable the implementation of safe, high-quality termination of pregnancy care. Education and training is one aspect of CAF's remit. Other aspects are access, quality assurance, capacity, engagement and professional development.

HSE NWIHP has continued to engage with the Institute of Obstetricians and Gynaecologists in the production and update of evidence-based guidelines. Earlier this year, national clinical guidelines on foetal anomaly ultrasound and on investigation and management of complications of early termination of pregnancy were published.

In 2022, an online foundation training programme on termination of pregnancy for healthcare professionals across different disciplines, was made available through HSELand. HSE NWIHP commissioned this training programme from the Office of the Nursing and Midwifery Director in 2021.

To enhance peer support and mentoring, HSE NWIHP has engaged with the British Society of Abortion Care Providers) with a view to establishing a peer support platform for practitioners who are or may be considering participating in termination of pregnancy services. A key component of the platform will be secure peer to peer messaging. The platform will be primary source of termination of pregnancy related information and materials, for example, the national clinical guidelines, the model of care, upcoming events and training events.

In 2021, HSE NWIHP appointed a Clinical Lead for Guideline Development (Maternity and Gynaecology), Professor Keelin O'Donoghue. Professor O'Donoghue leads a programme of work agreed between the HSE NWIHP and the Institute of Obstetricians and Gynaecologists. Earlier this year, two of the Clinical Practice Guidelines that were published refer specifically to termination of pregnancy services, National Clinical Practice Guideline - The Fetal Anomaly Ultrasound, and the National Clinical Practice Guideline - Investigation and Management of Complications of Early Termination of Pregnancy.

HSE NWIHP is also engaging with the Institute of Obstetricians and Gynaecologists as training partners with a view to development and delivery of consultant-led training courses in the area of termination of pregnancy, covering all components of the service.

Section 14.5: Sharing knowledge by improving information flow between hospitals and primary care

Effective communication between primary and secondary care is an integral aspect of successful integrated care. It facilitates a smooth continuum of care and is instrumental to educating GPs.

It would appear that communication between primary and secondary care providers can be somewhat deficient. During the Review the Chair heard GPs refer to the need for improved communications. It is important to them that they are aware of the patient's care plan in hospital particularly if they have been referred to specialist maternal or fetal health specialists, so that if they present at the surgery, they are able to discuss issues with them, without having to rely solely on their patient's account. In these situations, it may be more difficult to provide support to the patient.

Knowledge of the care plan of patients attending at hospitals for management of complications is also valuable, as it enables the GP to get a better understanding of how the patient was managed, thereby improving knowledge and informing future decision-making regarding appropriate referrals.

Section 15: Safe access zones and protection from harassment

Anti-abortion protests outside hospital and GP surgery settings have been reported in the media since the commencement of service provision in January 2019. Their activities range from[84] silent street gatherings, displaying posters and placards some of which have graphic images of foetuses, handing out anti-abortion fliers and praying, entering GP surgeries to complain about the provision of abortion services and leaving little white crosses outside for several weekends. A consultant at the National Maternity Hospital spoke to the Chair about the impact of some forms of protesting could have on women experiencing pregnancy loss.

Those who do engage in protest have a lawful right to do so. Their ostensible aim is to dissuade women from having abortions and health workers from providing the service. They have a legitimate right to freedom of association and freedom of expression. However, women seeking lawful healthcare have competing rights. This is further discussed below.

The WHO Abortion Care Guideline recommends that states should ensure that individuals seeking a safe legal abortion are not subjected to humiliating and judgemental attitudes leading to the denial or delay of such services in a context of extreme vulnerability for these individuals and where timely health care is essential.

[84] Fitzsimons, C. (2022) *Irish healthcare workers experiences of anti-abortion protesters and the case for safe access zones.* https://mural.maynoothuniversity.ie/16215

The Irish Council for Civil Liberties, in its paper, "A rights based analysis of safe access zones"[85], specifically refers to the effects that demonstrations are reportedly having on women seeking abortion services,

> *"The ICCL has been told by doctors that it is not only women seeking abortions who are negatively affected by such demonstrations but also women accessing other services at their GP's office or Maternity Hospitals, including medical services following miscarriages. Maternity patients have expressed concern about having to pass protesters when entering and exiting the National Maternity Hospital. Medical practitioners themselves have been impacted and have reported feeling anxious going to work"*
>
> *"ICCL has been told by doctors' representatives and NGOs providing services to women that more protests are happening in Ireland than are being reported either to the Gardai or in the media. ICCL was told that many medical practitioners and people seeking their services prefer to protect their privacy rather than publicise these protests"*

With only approximately 10% of GPs participating in provision of termination of pregnancy services and small numbers of consultant obstetrician and gynaecologists running services in the hospital setting along with small numbers of healthcare professionals supporting them, it is important that those who do are not intimidated, threatened or subjected to harassment by conduct of others that is intended to influence their decision to continue to provide the service. Similarly important is the deterring effect that such conduct may have on a GP's or hospital provider's willingness to become engaged in service provision.

Research undertaken in 2021 by Dr Camilla Fitzsimons, Associate Professor, Maynooth University School of Education, involving 75 providers of abortion services across different settings and areas of the country shows that protests impact 44% of respondents and vary from silent gatherings to patients and staff being approached. Those that did not have gatherings outside their clinics had fears that they could occur in the future. 77% support the introduction of safe access zones, 16% were not in favour of such a law and 7% were undecided[86].

In the context of this Review, the Chair also learned directly of the unsettling influence that anti-abortion campaigners can have on medical practitioners. In one case, a consultant obstetrician in a maternity unit located in the west of Ireland described how in 2019 one consultant obstetrician at the unit would have been prepared to provide termination of pregnancy services under the Act but was deterred from doing so not only by lack of support from colleagues, but also by the effect of receiving letters from anti-abortion campaigners. Letters have continued to arrive since the appointment of a second consultant to support service provision. The consultant described the tone and content of these letters as being quite upsetting to them. A GP also described how the effect of protestors outside the surgery had a chilling effect on her which she found difficult when trying to get to grips with providing new services. She worried that surgery staff, some of whom may have voted against repeal, may have felt they were being judged unfairly. As the practice is in a small town, she wondered if the patients felt that somehow the protestors might know the reasons for their attendance adding to their sense of feeling stigmatised and judged. Another GP

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[85] A rights based analysis of safe access zones. Irish Council for Civil Liberties. January 2020

[86] Fitzsimons, C. (2022) *Irish healthcare workers experiences of anti-abortion protesters and the case for safe access zones.* https://mural.maynoothuniversity.ie/16215

commented on how she worried about protestors knowing where she lived and whether she was safe.

Section 15.1: Government policy

It is government policy to protect women, service providers and their staff by legislating for the provision of designated safe access zones around sites that can provide termination of pregnancy services, not just those that do, and to prohibit conduct which intentionally or would reasonably be regarded as having the effect of influencing a person's decision to have a termination of pregnancy, or provide the service. On 5th August, 2022, it published the General Scheme of the Health (Termination of Pregnancy Services (Safe Access Zones)) Bill 2022.

The Bill purports to protect the rights of access of anyone needing termination of pregnancy services by providing safe access for women and providers and supporting staff around the country. It proposes to put in place measures to ensure that specific behaviours and activities, demonstrations and protests, are prohibited within 100 metres of a healthcare setting (including the curtilage) that can provide termination of pregnancy services, not just those that do. This would apply to shared buildings where a healthcare provider's clinic might be included, such as a shopping centre. The Bill also purports to criminalise harassment and intimidation of a service provider in relation to their decision to provide services. This includes repeatedly communicating with letters, social media, telephone, text, email or other electronic means, persistently following, watching, monitoring, pestering or besetting a service provider.

Research conducted by Lianne M. Reddy[87], in 2019 shows that safe access zones are a feature of abortion services in several jurisdictions. Countries have taken various approaches to prohibition on protests arounds the vicinity of healthcare facilities. Reddy M found that there are safe access zones provisions in Canada, Australia, parts of the United States and in the Isle of Man. In Croatia and Macedonia, peaceful assembly and public protest is prohibited near hospitals in a way that interferes with access to ambulances and disturbs the peace of patients and in France, it is an offence to attempt to prevent a termination of pregnancy by any means including disrupting access to a clinic or by exerting moral and psychological pressure, threats or any act of intimidation against persons seeking information about abortion or personnel working in relevant establishments. Other countries, such as England and Wales, provide local authorities with power to make buffer zones around clinics, as necessary, or to place limitations on public meetings/demonstrations and protests[1]

New Zealand has provisions for safe access zones in *section 13* Contraception, Sterlisation and Abortion Act 1977.

Section 15.2: Balancing conflicting rights stemming from the Irish Constitution and Ireland's obligations under international law

The rights to access healthcare safely, with privacy and dignity and the rights of persons to engage in protests or demonstrations in public are protected in the Irish Constitution and by Ireland's obligations under international law.

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[87] Reddy, ML. Safe access zones – What do other countries do? L&RS Note. Oireachtas Library and Research Service. Houses of the Oireachtas 2019

Article 40 of the Constitution sets out personal rights of all citizens, including the right to life, personal liberty, freedom of expression, freedom of assembly, freedom of association, bodily integrity, privacy, right to earn a livelihood and the rights of family, all of which are relevant to laws that purport to impose safe access zones.

The right to engage in legitimate protest is set out in Article 40.6.1 aligns with rights under Articles 10 (freedom of expression) and 11 (freedom of assembly and association) of the European Convention of Human Rights.

The right to personal liberty, the right to bodily integrity and the right to privacy align with Article 8 (right to respect for private and family life) and Article 9 of CEDAW that asserts women's entitlement to gender-related healthcare, requiring the State to "ensure women-appropriate services in connection with pregnancy".

Clearly there is conflict between the rights of women accessing abortion services and the rights of people to engage in demonstrations and protests conflict. They are not absolute rights. They can be limited and restricted by the Oireachtas. The Heads of Bill purports to strike a balance between them. It limits restrictions to that which is necessary to protect women seeking abortion services and those that provide the service by prohibiting certain conduct within 100 metres of the healthcare facility; it provides that members of the Gardai must first issue persons with warnings that their conduct is prohibited within the designated area, providing a person with knowledge, and the offence is committed under the Act if they repeat their conduct. A defence of honestly not realising that their conduct was in breach of the criminal law is available, as are exceptions that do not prohibit protesting or demonstrating at the Houses of the Oireachtas or activities that occur within places of worship that may be within 100 metres of a healthcare facility.

The establishment of safe access zones is supported by the Irish Council for Civil Liberties and the Irish Human Rights and Equality Commission and many other organisations that contributed to the public consultation process.

Section 16: Service Evaluation and Data Collection

Section 16.1: Current data collection requirements

The only requirement for data collection under the Act is contained in *section 20*. This requires limited information, as set out in *subsection (2),* to be submitted to the Minister for Health not later than 28 days after the termination has been carried out. It is required to be completed by the medical practitioners who certified their opinions that the termination of pregnancy came within the statutory regulations.

Pursuant to *subsection (2)*, the medical practitioners must provide,

(a) their Medical Council registration number of the medical practitioner who carried out the termination of pregnancy;
(b) the Medical Council registration number of each of the medical practitioners who made the certification pursuant to *sections 9, 10, 11* or *12;*
(c) the county of residence of the woman, or if she lives outside the state, her place of residence, and
(d) the date on which the termination of pregnancy was carried out.

This data captures statistics on the rates of termination of pregnancy in Ireland by the county of residence of the woman (or place of residence if she lives outside the State), the ground upon which the procedure was performed, and the Medical Council number of the medical practitioners. It does not contribute to improving the quality and safety of the service.

To date, there is no established monitoring and evaluation system for abortion services in Ireland. Effective monitoring and evaluating the service is, according to the WHO[88], essential for measuring quality and trends, as a basis to inform policy and evidence-based decision making to further improve service delivery and quality. The WHO is currently developing a set of abortion indicators and a comprehensive quality abortion care monitoring and evaluation framework.

There have been calls for the development of a data collection framework in the submissions to the public consultation by the National Women's Council of Ireland (Abortion Working Group[89], the UnPAC report[90] and IHREC[91]. IHREC recommends that the characteristics of a national data framework would include:

- *Health system input monitoring, including governance, financing, workforce learning and development of data;*

- *Service delivery monitoring, including availability of services, wait times, abortions, conscientious objection, and any related referral information;*[92]

- *Individual care monitoring, including age of service user, gestation data, previous history, method of abortion, ultrasound referral, complications and contraceptive service uptake post-abortion;*[93]

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[88] Abortion Care Guideline. World Health Organisation Human Reproductive Programme (2022)

[89] National Women's Council, Abortion Working Group Joint Submission to the Public Consultation: Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018
[90] Conlon C, Antosik-Parsons K, Butler E (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study. Health Service Executive, p.225
[91] Submission to the Revie of the Health (Regulation of Termination of Pregnancy) Act 2018. Irish Human Rights and Equality Commission, November 2022, p.9
[92] National Women's Council, Abortion Working Group Joint Submission to the Public Consultation: Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018

[93] Conlon C, Antosik-Parsons K, Butler E (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study. Health Service Executive, p.225

- *Population outcome monitoring, including population data on access to services, and population knowledge of access to quality, affordable abortion care;*[94]

- *Impact measurement, including abortion related mortality and morbidity, and the incorporation of abortion service-delivery monitoring data into other administrative data collection mechanisms, including population-based surveys;*[95]

- *Appropriate disaggregation indicators, including geographic information, age, socio-economic status and ethnicity.*

The framework proposed by IHREC aligns with recommendations of healthcare practitioners who informed the Review, who desired data to be collected in the following domains to inform future public health promotion policy and improve the quality of services. These included,

Early medical abortion:

- How they identified a provider and whether they had experienced delay in identifying a provider
- Whether delay had been contributed to by services purporting to be pro-choice

- their social economic background,
- whether they were using contraception prior to becoming pregnant,
- whether they decided to commence contraception use after the abortion,

- the gestation period at which they presented for the first consultation,
- whether there was a need for ultrasound and how efficiently the service was accessed,

- Whether they timed out of care, and if so, the reason for timing out of care,
- If they timed out of care, whether they continued the pregnancy or had a termination of pregnancy under another ground in the 2018 Act or whether they travelled abroad to procure an abortion,

- Whether they attended the second consultation and if not, the reason for non-attendance
- whether they were treated in the community or hospital for termination

- the method of termination
- whether complications occurred and if so, the nature of the complications and where they were managed (community or hospital)
- whether they attended for the third consultation

Termination of pregnancy under *sections 9, 10 and 11*

- Basis of request for termination (the condition of woman and/or foetus)

[94] WHO (2022) Abortion Care Guidelines. P.19
[95] WHO (2022) Abortion Care Guidelines. P.19

- Whether woman underwent termination at the tertiary referral centre, and if so, the reason for doing so (for example, clinically advised for her care and/or that of live born baby, or otherwise, for example, refusal of referring hospital to provide),

- If it was refused, whether the woman chose to continue the pregnancy or travel abroad,
- The outcome of the termination
- Whether there were any major complications

Termination of pregnancy under *section 11*

As referred to in the section discussing the operation of *section 11*,

- Audit congenital anomalies leading to perinatal / neonatal death in Irish hospitals over an agreed period of time. Co-design the audit including NPEC, fetal medicine specialists and other relevant stakeholders.

Data collection of the experiences of service users is also critical to improving abortion services, especially so in circumstances where the service has not been fully established. The experiences of women, as revealed in the UnPAC report, set out clearly the strengths of the service and the barriers experienced by women in accessing care here and abroad, and follow-up care, and how this impacts upon their mental health. In a person-centred approach to care, a clear understanding of how the service is performing requires ongoing research into how it is responding to the service user needs.

Similarly, experiences of providers and policy makers is critical to understanding the service providers' needs. The realist review evaluation conducted to inform this Review, was designed to guide the development of the services and it has enabled the research team to produce an improvement guide, grounded in service providers' experiences, which is indispensable to those tasked at macro, meso and micro-levels to provide, sustain and improve services. As the termination of pregnancy service continues to develop in Ireland, further research in the form of realist evaluation and other forms of research, are critical to inform service development.

Section 16.2: HSE NWIHP initiatives

The Chair has been informed that HSE NWIHP's Clinical Advisory Forum is in the process of defining quality measures and data collection mechanisms for termination of pregnancy across the community and hospital settings. It has established a service evaluation steering group who have commenced some basic data collection with a number of hospital providers for the purpose improving understanding of how the service is being operated and informing further development of the roll out. The Chair has also been informed that HSE NWIHP is working to establish a data collection framework which will be the main point of contact for data collection from all sites.

The termination of pregnancy related National Clinical Practice Guidelines[96] issued early this year contain auditable standards. Individual facilities should be supported to achieve the standards.

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[96] National Clinical Guideline The Fetal Anomaly Ultrasound. Institute of Obstetricians and Gynaecologists. Dublin. 2023

Regular auditing of performance against the standards will enable insight into how well the service is operating and whether all women have equitable access to the same standards of care.

It is important that the processes for data collection and evaluation do not place onerous administrative demands on healthcare facilities which might affect compliance. Collaborative input from stakeholders in development of the processes would be desirable.

Several monitoring and evaluation frameworks exist. The WHO framework for monitoring and evaluation of safe abortion care[97] comprehensively covers the domains of health system input, service delivery, population outcome and impact. It is evidence-based.

Section 17: Free Contraception Scheme

The Interim Clinical Guidance on Termination of Pregnancy Under 12 weeks recommends that after surgical or medical termination of pregnancy, all women should be offered contraceptive information and, if desired, the contraceptive method of their choice or referral for this service.

Service providers reveal their experiences of meeting women who would like to choose long-acting reversable contraception following an early medical abortion, but that in many cases, the up-front cost of purchasing and fitting the device was financially prohibitive. They refer to their experiences of women cancelling appointments for fitting of long-acting reversible contraception (LARC) following a termination of pregnancy, due to cost, and of women attending for a second termination of pregnancy whilst saving up for a LARC.

The launch of the Government's free contraception scheme for women aged 17 to 26 years as part of the Programme for Government and Women's Health Action Plan commitments, is welcome to address the risk of unintended pregnancies.

The scheme will be expanded in September 2023 to include 27–30-year-olds. The expansion of the scheme to 16-year-olds is subject to detailed consultation, legal advice and the required legislative amendments.

The Department of Health reports that providers have engaged well with the Scheme. Almost 2,000 GPs and over 1,800 pharmacists have entered into contracts with the HSE for provision of this service. The service is also available through a number of specialist providers, including the Irish Family Planning Association and Dublin Well Woman Centre.

Funding of approximately €9 million was allocated for the scheme in Budget 2022. The HSE advises that expenditure for October (the first full month of operation) was approximately €780,000, indicating that people are availing of the service.

Further funding of approximately €32 million is provided, through Budget 2023, to support the contraception scheme and to expand it to include 16–30-year-olds in 2023.

National Clinical Practice Guideline Investigation and Management of Complications of Early Termination of Pregnancy. Institute of Obstetricians and Gynaecologists.

[97] Abortion Care Guideline. World Health Organisation Human Reproductive Programme (2022)

The scheme is currently open to 17–26-year-old women ordinarily resident in Ireland and provides for:

- The cost of prescription contraception;
- The cost of necessary consultations with medical professionals to discuss suitable contraception for individual patients and to enable prescription of same;
- The cost of fitting and/or removal of various types of long-acting reversible contraception (LARCs) plus any necessary checks, by medical professionals certified to fit/remove same;
- The cost of training and certifying additional medical professionals to fit and remove LARCs;
- The cost of providing the wide range of contraceptive options currently available to GMS (medical) card holders, which are also available through this scheme, including contraceptive injections, implants, IUS and IUDs (coils), the contraceptive patch and ring, and various forms of oral contraceptive pill, including emergency contraception.

Like access to termination of pregnancy services, this scheme is only available free of charge to people with PPS numbers. Accordingly, people who do not have a PPS number are required to bear the cost themselves. This is potentially too onerous on women with low income.

Digital information regarding the scheme, how to access it and wider information on contraceptive options is available through www.sexualwellbeing.ie. The scheme is also being publicised through various media channels by the HSE.

Discussion and Conclusion

The Act has enabled greater access to termination of pregnancy services by women in Ireland, but some are still travelling

The Act expanded the grounds upon which a woman is enabled to seek a termination of pregnancy. Prior to 1st January, 2019, there had to exist a risk to the loss of life of the pregnant woman that could only be averted by an abortion. Since then, women whose pregnancies do not exceed 12 weeks are eligible to receive abortion care, as are those who present with a risk to their life or health

that can only be averted by an abortion, and those whose pregnancies are affected by a foetal anomaly that is likely to lead to the death of foetus in utero or within 28 days of being born.

Based on notifications received by the Minister for Health, the reform of abortion law in Ireland has met the needs of approximately 17,820[98] women who underwent terminations of pregnancy between 1st January 2019 to 31st December, 2021.

Most of these terminations that occurred over this period were performed under the ground of early pregnancy, where the gestation period did not exceed 12 weeks and is indicative of the successful implementation of early medical abortion services in the country.

The objectives of the Act are being somewhat achieved by provision of termination of pregnancy services pursuant to the grounds in *sections 9, 10* and *11*. Numbers of terminations in these categories are reported as being quite low. However, data from England and Wales and the Netherlands indicates that women in later stages of pregnancy have been continuing to travel to these countries to access abortion services.

The decision to travel is potentially due to a number of different factors including seeking abortion on a ground not provided in domestic law. However, the findings of this Review indicate that women are also travelling because,

- they may have timed out of eligibility to receive an early abortion (having exceeded 12 weeks pregnancy);
- their requests for termination of pregnancy under *sections 9 – 11* were refused;
- they were uncertain of the outcome of their request for an abortion under *sections 9 – 11,* and in circumstances where the decision-making process was protracted, they feared that they would time out of care abroad if they were approaching 24 weeks gestation, and
- furthermore, some may have travelled because they were not aware of their legitimate right to have an abortion in Ireland and could not be supported by their medical practitioners who lacked appropriate clinical guidance to advise them.

Clinical grounds set out in sections 9 – 11 lack clarity as to when and how the law applies

The Review findings indicate that women who may well have been eligible to have their pregnancies terminated in Ireland under the grounds set out in *sections 9-11* have been denied care here due to the challenges operationalizing these sections.

The Review uncovered that medical practitioners face challenges implementing *sections 9 – 11* in the realities of clinical practice. Under *sections 9* and *10,* there is ambiguity as to the threshold of "risk" to the life, or serious harm to the health of the pregnant woman; there is a lack of guidance as to the threshold of "serious harm" and as to the extent to which the risk has to be averted. In the field of perinatal psychiatry, determining whether a termination of pregnancy would avert the risk is

[98] Figures are based on 6,666 abortions being performed in 2019, 6577 in 2020 and 4,577 in 2021. The figure for 2021 may not be accurate as there was a discrepancy between the numbers of claims made for payment to the HSE PCRS and the numbers of notifications received by the Minister.

particularly challenging. Under *section 11*, medical practitioners report that with the exception of a very small number of very straightforward conditions, such as anencephaly, the section is difficult to implement in practice as there is not any definitive list of conditions where death occurs in utero or within 28 days of being born.

In applying these sections, medical practitioners have a degree of discretion. Medical practitioners participating in this Review refer to the practice of defensive (or restrictive) medicine, erring on the side of safety from prosecution or adverse media scrutiny, in making determinations as to whether women are eligible for care in Ireland.

Under Ireland's international law obligations[99], the grounds under which women can access abortion in Ireland have to be sufficiently clear in practice. As matters stand, it is possible that these sections of the Act might be challenged by women affected on the grounds that they lack the required clarity. Ministerial guidelines interpreting *sections 9(1)* and *10(1)* may improve clarity.

Furthermore, the grounds under *section 11* of the Act do not align with recent recommendations of the UNHRC[100] and the WHO[101] who recommend that the State take the necessary steps to remove existing barriers and ensure that women with foetal abnormality conditions have adequate access to abortion services. IRHEC has recommended the reform of *section 11* so that there are legal avenues for abortion in all cases where fatal foetal anomalies are diagnosed.

The application of the law causes delay to women accessing services

Sections 9 – 11 – protracted decision-making

The operation of the Act under *sections 9 - 11* potentially delays a woman's access to abortion services. Deliberations as to eligibility can be protracted, adding to the sense of uncertainty and distress experienced by women. Some women have chosen to go abroad rather than experience further stress waiting for a decision, particularly if they are in the later stages of gestation and risk exceeding the thresholds in England (Ground C) and the Netherlands. The uncertainty of the outcome of a review and the time involved from application to decision disincentivizes women utilizing the process.

Sections 9-11 – Necessity for examination by two medical practitioners

Further delay may occur due to the necessity for two medical practitioners to certify their opinion as to eligibility for abortion under *sections 9* and *11.* This may particularly be so in smaller units where a second medical practitioner of a relevant specialty may not be available at the time of the woman's appointment, necessitating her travelling back to the unit on a second occasion, still

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[99] Concluding observations on the fourth periodic report of Ireland, 19th August, 2014 CCPR/C/IRL/CO/4, and Concluding observations on the third periodic report of Ireland, 8th July 2015, E/C.12/IRL/CO/3

[100] Concluding observations on the fifth periodic report of Ireland. Advanced unedited version, p.25 UN Human Rights Committee (27th July, 2022) (sourced from IRHEC submission to the public consultation on the Review of the Health (Regulation of Termination of Pregnancy) Act 2018

[101] Abortion Care Guidelines. WHO (2022)

uncertain about the outcome. However, in the context of termination of pregnancy being situated in a penal statute, formal back-up of opinion by a second medical practitioner may provide reassurance.

Section 12 – mandatory three-day waiting period

Delay is also associated with the mandatory three-day waiting period to access services under *section 12*. Mandatory waiting periods have been criticised widely and described as barriers to access. Not only does the three day wait incur delay in accessing services and may prevent a woman from accessing abortion in Ireland if it is extended due to lack of timely access to ultrasound and / or hospital services, it also imposes logistical and financial burdens on women, particularly those living in rural areas. The WHO[102] and the UNCHR[103] recommend against mandatory waiting periods.

Sections 9 – 12 – restrictions on the range of health workers who may carry out the procedure

Each of the sections requires the termination of pregnancy to be carried out by a medical practitioner. Expanding the range of health workers who could safely provide medical and surgical abortion services, for example suitably trained midwives and nurses, would facilitate greater access by increasing the numbers of providers. It could potentially address the inequitable uneven geographic access. The WHO recommends against regulation on who can provide abortion services. It provides evidence-based guidance on how to involve a wider range of health workers[104].

Section 22 – delay consequential to right to conscientious objection

Delay, longer travel times, logistical difficulties and failing to access care have been attributed to the consequence of the right by medical practitioners, nurses and midwives to exercise their conscientious objection. The prevalence of conscientious objection in hospital settings has created barriers to accessing abortion services. The service is dependent on a small number of providers and just over half of the hospitals provide full services under the Act. The lack of proximity to a providing hospital is also a significant factor on GPs' decisions to become engaged in provision of services which impacts upon national coverage in community setting, which also acts as barriers to women accessing care in certain parts of the country. As a matter of international human rights[105],

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[102] Abortion Care Guidelines. WHO (2022)

[103] Concluding observations on the fifth periodic report of Ireland. Advanced unedited version, p.25 UN Human Rights Committee (27th July, 2022) (sourced from IRHEC submission to the public consultation on the Review of the Health (Regulation of Termination of Pregnancy) Act 2018

[104] Abortion Care Guidelines. WHO (2022)

[105] IRHEC submission to the public consultation on the Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018 state regulating conscientious objection is in keeping with the views of the ECHR (RR v Poland (App 27617/04) 28 November 2011, para 43), the Council of Europe (McCafferty, Christine (Rapporteur), Council of Europe Parliamentary Assembly Social, Health and Family Affairs Committee, Women's access to lawful medical care: the problem of unregulated use of conscientious objection. Doc 12347, 20th July 2010, para 19), the European Social Committee (International Planned Parenthood Federation – European Network (IPPR EN) v Italy (Complaint No. 87/2012), and the International Federation of Gynaecology and Obstetrics, who consider the regulation of CO of fundamental importance to the provision of safe, timely and effective access to abortion care (Christina Zampas (2013) Legal and ethical standards for protecting women's human rights and the practice of CO in reproductive healthcare settings. International Journal of Gynaecology and Obstetrics 123. UNCHR in its concluding observations recommended that the State review provisions of the Act that could create barriers to women seeking safe abortions including those

regulation of conscientious objection should not result in barriers to accessing abortion care. The section does not regulate abuse of the right to conscientiously object by prohibiting conduct that is intended to delay or obstruct access to abortion, which has been found to feature in the primary care setting. The Act should address this. Abuse of the right should be effectively monitored and regulated by the HSE and the Irish Medical Council.

Section 23 – detrimental effects on willingness to provide services and practice of defensive medicine

This Review has found that the prospect of criminalization is a disincentive to medical practitioners in the hospital setting becoming engaged in service provision and has also led to the practice of defensive (restrictive) medicine when applying *sections 9 -11* in all but very straightforward cases. This not only adversely affects the numbers of providers in the health system but also may lead to delay or denial of termination of pregnancy services to women. Criminalisation of medical practitioners in Ireland's abortion law, where grounds are not sufficiently clear, is a barrier to accessing abortion care.

The WHO Abortion Care Guidelines[106] and international human rights bodies[107] recommend full decriminalization of abortion law. The UNCHR expressed regret that Ireland provided criminal liability in the Act and recommended full decriminalization and consider taking action to remove medical practitioners from criminal sanctions[108].

The restrictive grounds-based approach under the Act excludes women from access to termination of pregnancy in Ireland

The Act restricts abortion by clinical grounds (*sections 9 – 11)* and by gestational grounds *(section 12).* It does not provide for abortion where the circumstances of conception in cases of rape and incest. The UNCHR has recommended that should provide abortion in these cases, and also where carrying the pregnancy to term would cause the pregnant woman substantial pain or suffering or where the pregnancy is not viable. The grounds-based approach in the Act adversely affects women in these categories, as well as women who time out of early abortion care *(section 12).*

The scheme of the draft legislation was put before the people of Ireland prior to the referendum in May 2018. It is not known whether the outcome of that referendum would have been different were the grounds to reflect the UNCHR recommendations or those of the WHO which recommends

caused as a result of the exercise of CO by individual medical providers (Human Rights Committee (27 July 2022. Concluding observations on the fifth periodic report of Ireland. Advance unedited edition. Para 25, p.6

[106] Abortion Care Guidelines. WHO (2022)

[107] IRHEC's submission to the public consultation on the Review of the Health (Regulation of Termination of Pregnancy) Act 2018 cite UN human rights treaty monitoring bodes have a consistent consensus position that abortion must be completely decriminalized (Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against women, in particular women with disabilities. (29 August 2018; UN Committee on the Elimination of Discrimination Against Women (2017)

[108] Concluding observations of the fifth periodic report of Ireland. UNCHR. Advance unedited version. Paragraph 25, page 6. 27th July 2022. (source – IHREC submission to the public consultation on the review of the Health (Regulation of Termination of Pregnancy) Act 2018

against laws and other regulations that restrict abortion by ground. This Review highlights circumstances where the needs of classes of women are not being met.

Arrangements put in place to implement the Act

As a matter of human rights, women in all geographic locations should have equitable access to safe abortion services, including access to accurate, evidence-based, unbiased information and counselling, as well as close to home community and hospital-based providers.

Accurate, evidence-based information

As GPs do not publicly advertise the provision of abortion care, the HSE's My Options helpline has provided a vital service to provide evidence-based information and counselling to women to enable them to work through their options and to navigate them to service providers. Without this service, it would be challenging for women to know which GPs are willing to provide care and also to avoid navigating their way through non-providing GPs with the risk being provided with misleading information. Despite the helpline having a high ranking on Google searches and targeted media campaigns by the HSE, it appears that not all GPs are aware of the service and consequently, the legal and ethical obligation to make arrangements for the transfer of the woman's care, may be challenging. Not all service users are aware of My Options either and this may disproportionately affect those living in rural areas and those with lower levels of English language literacy. Accordingly further and sustained promotion of the service is required to improve access.

Access to free of charge services

The provision of termination of pregnancy services free of charge on the basis of having a PPS number facilitates access to care, particularly by women with financial difficulties. However, women resident in Ireland who do not have a PPS number, are subject to charges. Sometimes these costs are being absorbed by the provider. Indirect costs, associated with travel and accommodation if a person lacks an appropriate home environment to manage an early medical abortion, are particularly punitive to women with financial difficulties, which may arise from being in a coercively controlled relationship. Direct and indirect costs of care are potential barriers to access to abortion services.

Telemedicine / remote model of care introduced in response to Covid-19 pandemic

The introduction of telemedicine early medical abortion services enabled women to continue to access services during Covid-19 restrictions. It has ameliorated barriers to access including the logistical challenges associated with the three-day wait. It has also reduced the inequities in access to care experienced by women who do not have a GP or community provider close to home and who would otherwise have to travel long distances.

Investment in key staff and infrastructure

The Clinical Lead for Termination of Pregnancy Services commenced service in 2020. A Clinical Advisory Forum has been established to inform quality service development.

Funding has been made available by the Department of Health to establish services. However, currently, there is uneven geographic access to community and hospital-based service providers. The numbers of providers across both settings have only marginally increased since 2019. Approximately 90% of GPs and eight of nineteen hospitals do not provide services under the Act. Service provision across both settings has to be expanded.

It is not apparent that anyone within the HSE or the Department of Health has been specifically tasked with reiterating the initial efforts to encourage GPs to provide services, particularly in areas where the numbers of providers are low.

Increasing the number of provider hospitals and sustaining what has been described as untenable hospital service, is reliant on a recruitment policy. This has been shown to be effective. However, the recruitment process for consultants is slow, and from data provided on the status of recruitment, inferences may be drawn that it has not been a priority for senior hospital managers. The recruitment of willing providers may also be affected by reluctance to include provision of termination of pregnancy services as a condition of the employment contract. This should, however, be resolved by amending *section 22*, as discussed earlier in this Review.

Amending the legislation to remove the restriction that the service may only be provided by medical practitioners, and expanding it to other suitably trained health workers, would potentially be an efficient way to expedite an increase in the numbers providers across settings.

Limited choice of methods

Women have limited choice of options as regards the methods of terminating pregnancy. In the main, medical methods are utilised under each ground in the Act. This may not align with the woman's needs, choice or priorities. However, choice is contingent upon available resources and supportive management. The providers' research identified inadequate investment and management of infrastructural and service arrangements as being connected to lack of surgical options. The HSE has informed the Review that it is working towards making surgical options more available.

Surgical termination of early pregnancy may be performed in ambulatory care settings. However, there appears to be resistance to establishing the service in the new gynaecological ambulatory care units. Setting up this service in these units or in appropriately resourced primary care settings would enable more women to exercise choice may alleviate pressure on hospital resources.

Training and education

The HSE NWIHP has and continues to collaborate with multiple stakeholders, including the Office of Nursing and Midwifery Services Director, professional training bodies, such as the ICGP and the Institute of Obstetricians and Gynaecologists, and organisations such as START and the Family Planning Association of Ireland, to produce evidence-based training and education, values clarification, clinical guidance and guidelines. It has invested in workforce training annually and the Clinical Advisory Forum has produced an online training platform for providers, which is available on HSELand. However, the providers' research indicates that there is insufficient staff to enable

engagement with continuous professional education, and that staff are developing and delivering training sessions independently of HSE NWIHP and informally, during lunch breaks and peer support sessions.

The focus of education and training should not be solely on health care workers, but also on undergraduates. Universities and professional bodies should be cognizant of their responsibilities in that regard.

Monitoring, evaluation and quality assurance and improvement

Ensuring equitable access to safe, quality abortion care depends upon effective processes for monitoring, evaluation and quality assurance and improvement. The HSE NWIHP office is currently developing an evaluation framework of abortion services. The Clinical Advisory Forum has developed and is currently testing quality measures and data collection mechanisms for abortion across the community and hospital settings.

Care pathways

The providers' research identified a lack of reliable and standardized clinical pathways of care for all sections of the Act. Formal and reliable care pathways should enable providers to seamlessly refer cases to services and to hospitals, and should identify access points for referral of complex cases, particularly under *sections 9* to *11* of the Act. Care pathways should include access to post abortion services by women who have travelled abroad for abortions.

Sustainability of services

Sustaining services requires increasing the number of and supporting existing health workers willing to provide services. This Review raises concerns about service provision being reliant upon small numbers of providers in both the hospital and community settings who do not have sufficient peer or professional support. The data collected in the providers' research indicates that these staff are at a real risk of burnout. In some hospitals there is not any contingency for staff absence. Participants in the providers' research stated that they could not address unprofessional conduct or burnout without potentially risking the existence of termination of pregnancy services.

Sustaining services requires addressing issues identified by providers. These include barriers that emanate from the law itself that operates to dissuade or disincentivize people to engage in service provision. It also includes addressing issues raised in the providers' research – delays, excessive workloads, insufficient resources and staff burnout.

Realist evaluation – improvement guide

The realist evaluation undertaken in the providers' research is a tool for improving healthcare. It aims to feedforward and guide the development of services. Based on the data, the research team have produced an improvement guide, which is evidence-based and outlined in detail in the full report. It is recommended that the realist evaluation be read in conjunction with this report.

At the request of the Chair, the researchers summarised the enablers to excellent services across all settings, and made recommendations grounded in what has worked in hospitals and in primary care. These are set out below:

Enablers to excellent services

1. *Appointment of dedicated service coordinators and clinical leads. These can be new or existing staff. Consider the involvement of non-consultant hospital doctors in overseeing ToP services where consultant hours are restricted. Staff in these roles must receive sufficient workload hours, managerial support, and investment to consistently deliver and improve services.*

2. *All-staff meetings. Health care workers – and health care – benefitted from all-staff meetings to discuss the implications of the service, share staff concerns, outline the responsibilities of staff, and clarify roles. These meetings provided staff interested in providing ToP services to identify themselves to managers. They also offered a space for health care workers to ask questions, air concerns, and receive clear responses from managers. All-staff meetings should take place in primary and secondary care.*

3. *Targeted briefings and training for general practitioners, clinicians, midwifery and nursing staff.*

4. *One-to-one, confidential conversations with line managers and non-providers. Non-providers should feel fully supported and respected but must understand the limitations of conscientious objection. Line managers must ensure that non-providers understand their responsibility to providing all other general care for termination of pregnancy patients.*

5. *Establishing peer-support and mentoring structures for all ToP providers.*

6. *Patient journey 'walk-throughs' where providers map the patient journey and evaluate the standards of care from a patient-centred perspective*

7. *Embedding values clarification and legal training relating to ToP within health workers training and professional development days.*

8. *Assigning, with adequate workload and pay, midwifery and nursing staff participating in ToP services to advanced sonography roles. Training needs assessments of hospital workforce to ensure midwife and nurse sonographers are available. Investment in advanced training opportunities, with workload support, for midwives and nurses who want to provide ToP care.*

9. *Establishing networks between primary, secondary and specialist care services. Establishing clear pathways within each section of the Act is imperative to accessing timely care.*

10. *Appointing and adequate workloading of bereavement support teams and medical social workers. All settings should have access to these on site services to ensure patients are adequately supported.*

11. *Sustainability planning, specifically training and involving newly qualified, non-consultant health workers to carry out and oversee ToP services. This will ensure that provision of ToP is not dependent on small teams.*

Ongoing actions to deliver and develop Termination of Pregnancy services

- *Health professionals also reported on-going actions currently helping deliver termination of pregnancy care effectively and made recommendations of additional actions that would help the continued development and delivery of termination of pregnancy services.*

- *Health workers in secondary care emphasised the importance of ensuring coordinators to support the transition of patients between primary and secondary care. These coordinators need to have adequate workload and support, including arrangements for staff cover.*

- *Maintaining - through workload allocations and actively promoting - peer-support systems and professional training on termination of pregnancy care (including legal issues and complex cases) were emphasised as crucial to service development.*

- *Health workers pointed to the importance of on-going dialogue with non-providing staff and making sure opportunities to become a provider remain open. Providers in settings where there are also non-providing staff should not feel isolated in the workplace. Termination of pregnancy is a part of the health service and should not exist in a silo.*

- *Primary care health workers, particularly GPs, stated that providers need to be fully supported financially and in terms of staff capacity. This will make sure they can continue to provide termination of pregnancy care alongside their additional responsibilities.*

- *Feedback and information sharing about good practice and patient outcomes was underlined as essential by health providers. Continued development and improvement of ToP care depended on regularly sharing evidence of good practice as well as data on places where the service could do better.*

- *Capacity, workloading, and the distribution of staff responsibilities should be consistently monitored by line managers and hospital/practice managers. Burnout is a very real concern for health*

providers with detrimental effects for both health professionals ability to deliver care and for the continued availability of termination of pregnancy services.

Conclusion

There is need for further consideration of policy around operation of the Act and arrangement of services. Services for termination of pregnancy under the Act are available to all women in Ireland. However, challenges remain to remove the barriers identified in the Review (or take steps to ameliorate their effect). This will require a multi-agency collaborative effort (including further research), involving the Department of Health, the HSE, the professional bodies, universities, service providers, service users, lawyers and ethicists, and possibly other stakeholders. It will require ongoing support and leadership from the highest level, the Minister for Health.

Based on the research findings, it would appear that the legal framework governing termination of pregnancy is not aligned with Ireland's human rights obligations, due to the barriers associated with implementation. This could lead to future challenge by women seeking terminations of pregnancy.

The review of the Act should be an interative process. The services have not yet been fully integrated across all counties. There is a need to increase and sustain the numbers of providers across both hospital and primary care settings.

Appendix A (research methods)

Research Methodology of Unplanned Pregnancy and Abortion Care (UnPAC) Study

The HSE Sexual Health and Crisis Pregnancy Programme (HSE SHCPP) commissioned this study pursuant to the Programme's remit to build on the existing evidence base to understand emerging

trends relating to crisis pregnancy and sexual health, and to undertake new research initiatives to address knowledge gaps. The aim set out by the HSE SHCPP for the research study was to develop an in-depth understanding of the experiences of people who have accessed unplanned pregnancy support services and abortion services since the enactment of the legislation on 1 January 2019. The study objectives were:

- to gather in-depth information from people who have availed of unplanned pregnancy support services and clinical abortion services in Ireland;

- to provide a comprehensive description of the experiences of people who have availed of these services in Ireland, taking account of differing backgrounds, ages and locations, and

- to provide a comprehensive description of the trajectories of people who have accessed abortion care in Ireland, including linking with unplanned pregnancy support services and health care services.

The project began in December 2019 and was published in July 2022. The UnPAC research study comprised four work packages:

i) Work package one: A policy case study of the implementation of the Act;

ii) Work package two: A literature review which collated evidence on abortion provision in the Irish context since the implementation of abortion services in Ireland in January 2019;

iii) Work package three: An in-depth qualitative study of service users' experiences of unplanned pregnancy support services and abortion care, and

iv) Work package four: A quantitative and qualitative analysis of Women on Web (WoW) data, an online telemedicine abortion care provider to regions with limited access.

Qualitative methods were employed in this study of experiences of accessing and using unplanned pregnancy and abortion care services. The research approach taken was premised on the constructivist grounded theory (Charmaz, 2014) method and data generated following principles of purposive and theoretical sampling (Conlon et al., 2020). The qualitative research approach followed in the study was premised on the grounded theory (GT) method (Flick, 2018; Timonen et al., 2018), specifically the constructivist iteration of grounded theory (Charmaz, 2014; Conlon, 2020). The method is designed to generate understandings and meanings grounded in data generated through empirical observation and in-depth engagement with the phenomenon of interest.

As this study was concerned with a novel process and context from the perspective of key actors – women using abortion services – the grounded theory approach facilitated insights emerging from this novel context. Grounded theory was a good fit for a study inquiring into an area of health provision – unplanned pregnancy and abortion care services – that has been in place and the focus of research in the context at hand and other contexts for some time. It also allowed for specific insights into how

this area of health provision is being engaged with and experienced by service users given the particular socio-political/cultural context, regulatory framework and implementation model in the setting of interest.

The research design for this Grounded theory study allowed the examination of people's experiences of unplanned pregnancy supports and abortion care services in the context of a radical change in abortion care at legislative, policy and service delivery levels. While the method privileges empirical data over existing theories or frameworks, within this study the constructivist method was chosen and adapted. The constructivist iteration of grounded theory acknowledges pre-existing knowledge and frameworks and facilitates their application. This is best aligned with research carried out for applied policy purposes, where some specified parameters (e.g. pre-existing model of care and care pathways), as well as frameworks, are of interest to those charged with policy implementation. The principles of grounded theory employed primarily within the project research design then emphasised two key principles of:

- a maximally open approach to generating empirical data, and
- privileging the empirical data in constructing an analytical framework over existing theories or frameworks.

While a synthesis of literature and key existing frameworks was referred to, an emphasis on openness in the design of data generation and analysis facilitated new, context-specific insights emerging.

The requirement of the method to be maximally open meant collecting data early on using lightly structured data generation methods, e.g. interview guides. Critically, it meant starting analysis as soon as data was available, to identify concepts and processes emerging early from the data as empirically observed. Emergent insights informed generation of further data following theoretical sampling principles (Conlon et al., 2020) designed to deepen and test these insights, and regarding the processes, conditions and contexts relating to the phenomenon of interest on the ground. Theoretical sampling allows diverse or multiple conditions and contexts to be attended to, as the researcher notes not just patterns suggestive of emergent explanations but also gaps and anomalies, and seeks out data to fill gaps and illuminate anomalies. A key focus involves seeking out anomalous and contrasting contexts and perspectives to check continuously if the accounts and explanations emerging from analysis are rigorous and a good fit.

Semi-structured, in-depth interviews with people accessing unplanned pregnancy and abortion care services were considered the optimal format of data collection for this project. This interviewing format allows for maximally open and flexible data generation aligned with the grounded and emergent premises driving the study (Timonen et al., 2018). One-to-one interviews were also a format that best acknowledged the sensitivity of the topic and the centrality of women's accounts driving the project.

The target sample population was people using unplanned pregnancy support services and abortion care. The data was collected in a range of settings, and fieldwork sites were selected having regard to the different care pathways available to people accessing unplanned pregnancy and abortion care supports, including the following:

- people attending unplanned pregnancy counselling services who may decide to continue the pregnancy or not;

- people under 12 weeks' gestation seeking abortion care whose care pathway was confined completely to community/primary care settings;

- people under 12 weeks' gestation seeking abortion care who were referred to hospital settings for abortion care because of clinical indicators or reaching 10-12 weeks' gestation for abortion care;

- people under 12 weeks' gestation who had abortion care provided in community/primary or hospital settings who were referred to hospital for care relating to post-abortion symptoms;

- people over 12 weeks' gestation who seek and/or qualify for abortion care under the 2018 Act, and

- people accessing abortion care outside the jurisdiction since the implementation of the 2018 Act.

Purposive sampling was employed to recruit participants from across each of these categories as set out below. Within each category, theoretical sampling principles were followed to achieve an overall data set compiled with rigorous attention to diversity and depth.

Recruitment of participants took place in a range of community, primary care and hospital or tertiary care settings, reflecting the service delivery settings relevant to the focus of interest of the study. A total of 58 participants were interviewed for the study across various sites, as outlined in Table N below.

Table N. Gestational dates and initial recruitment sites of study participants (n=58)

Gestational date	Initial recruitment site	n (%)
≤ 12 weeks	GP	21 (36.2)
	Women's health clinic	11 (19.0)
	Hospital	7 (12.1)
	Pregnancy counselling	7 (12.1)
	Self	2 (3.4)
> 12 weeks	Hospital	6 (10.4)
	British Pregnancy Advisory Service	2 (3.4)
	Termination for Medical Reasons	1 (1.7)
	Self	1 (1.7)

Research Methodology of the Review of Health Providers' Perspectives of Termination of Pregnancy (ToP) Service Implementation

The research, as commissioned by the Department of Health, had six key objectives:

1. examine the arrangements put in place to implement the Act including, but not confined to, the following:

    a. service provision in the community setting, and

    b. service provision in the acute hospital setting;

2. gather and analyse data from service provider stakeholders to describe their experiences and observations on the operation of services under the Health Regulation of Termination of Pregnancy) Act 2018, in order to provide a comprehensive description of providing services/service provision under the Act;

3. assess the impact of the Act's operation on access to termination of pregnancy services in this country, taking into account the level of service provision before commencement of the Act, figures on Irish women accessing termination in this country and in other jurisdictions, service provision in Ireland in comparison with service provision in other countries in Europe or beyond, and any other factors which may be relevant;

4. identify any difficulties in providing services expressed by stakeholders which are associated with provisions in the Act, and highlight possible solutions to address any such difficulties, for example approaches taken in other countries, as appropriate;

5. assess from the service provision perspective the extent to which the Act's objectives have not been achieved and make recommendations to address barriers, if any, uncovered in that regard; and

6. explore and weigh the evidence for and against any proposed changes to the Health (Regulation of Termination of Pregnancy) Act 2018 from the service provider perspective, and provide conclusions based on the research findings, and draft suggestions on appropriate follow-up measures, if necessary.

The research was divided into two work programmes. Work programme one had two aims:

i. assess the impact of the Act's operation on abortion access in the Republic of Ireland and on abortion travel, and

ii. identify evidence gaps to guide primary data collection;

Work programme 2 involved a Realist Evaluation of the operation and achievements of the Act from the perspective of health professionals in primary and acute care. Realistic evaluation asks "what works, for whom, under what circumstances and when?" (Pawson and Tilley, 2001). For the purposes of the Review, 'working' was defined as:

1. developing a confident, knowledgeable termination of pregnancy workforce;
2. implementing clear legal pathways to care consistent with the aims of the Health [Regulation of Termination of Pregnancy] Act 2018;
3. ensuring equal access to a choice of termination of pregnancy services;
4. establishing cohesive, timely patient journeys to care inside the State, and
5. establishing a sustainable termination of pregnancy service.

Qualitative data was collected from health professionals in interviews between June and July 2022. Primary qualitative data was collected through semi-structured interviews. In total, we conducted 41 interviews will 43 participants. All interviews were conducted by phone or secure video communication platform. Following a mid-project meeting with the Chair and discussions with the Department of Health regarding the need for additional data collection from GPs (who provide the majority of termination of pregnancy services), a quantitative survey component was added. Survey data was collected between the end of July and September 2022.

Table N: Interviewees by setting (total=43)

Setting	Count
Primary (GP)	9
Primary (WHC)	4
Secondary	27
Other (including HSE programme leads)	3

GP survey

The survey component was designed to provide a robust picture of termination of pregnancy service provision in general practice. It aimed to explore further the reasons for provision and non-provision, the scale of non-provision, and the impact of provision in secondary care on provision in primary care.

The survey was developed through the Qualtrics platform and distributed using an anonymous link. The link was embedded in a public-facing summary of the research. The survey included a combination of closed- and open-response questions. Closed questions included yes/no and multi-choice questions and a series of Likert scale questions. Open-response questions provided a space for additional comments.

The survey included basic geographic data including the county location of the respondents' practice, the community health organisation they practised within, and the maternity hospital they referred patients to.

Except for consent questions and the beginning and end of the survey, there were no forced response questions. Participants could also review and change responses before submitting although the survey had to be completed in one sitting.

A consent question asking participants to confirm their responses could be analysed as part of the review was included. This allowed potential respondents to review all questions without agreeing to participate.

To reach the greatest number of GPs, we adopted an active recruitment strategy. This included the following components:

1. drafting and finalising the survey with GP providers to ensure the relevance of the questions;
2. following up direct email distribution with phone calls to confirm receipt of the survey;
3. following up phone calls to confirm receipt with reminder phone calls to encourage completion;
4. getting agreement from the HSE PCRS service to distribute and promote the survey through official platforms (the GP Suite);
5. distributing through established networks with GPs and GP networks,
6. raising awareness of the survey through the media, by placing an article in the Irish Medical Times, and
7. extending the completion period.

Initially, we distributed the link to a sample of GPs. We adopted purposive sampling, targeting counties with both a limited and high number of contracts for provision of termination of pregnancy services. In total, we distributed the survey to 1000 registered email addresses and followed up with confirmation phone calls.

Following a one-month review, we recognised that the number of completions was very low and changed to a 'whole cohort' distribution. This increased the number of completions. In total, once we excluded returned surveys with a completion rate of under 50% and surveys where respondents had not given consent to use their data in the report, we were able to analyse 188 surveys. Based on figures provided by the HSE on the total number of registered GPs, this amounts to a completion rate of 6%.

Methodology to review the submissions to the public consultation

The approach utilised by M-Co involved data anonymization, following which a "mixed methods sequential explanatory" methodology was applied. The rationale for their methodology is set out in their report, and is quoted below:

"This combines an initial quantitative analysis of responses to the closed ended questions, followed by a thematic analysis of the open-ended questions. This outlines what people said in relation to the consultation questions, as well as understanding why they said it. This is critical, as there will be various interpretations underpinning the answers people give to the closed ended questions.

"Thematic analysis identifies, analyses and reports patterns (themes) within qualitative and unstructured data. A theme or pattern is something important within the data that relates to the overarching consultation questions. In the context of this consultation this method presented several key benefits. The primary benefit of thematic analysis is that it allows the final interpretation to be understood by a diverse group of stakeholders (eg. Policy makers, advocacy groups, service users and service providers).

"These stages often involve iteratively relating back to the original consultation questions, the data and wider information in order to produce a concise report of the analysis.

"Some other principles of our approach include:

- *data is analysed without any moderation;*
- *all data is given equal attention without prejudice and bias is controlled;*
- *the coding is thorough, accurate and comprehensive, and*
- *data is synthesized rather than merely paraphrased (but not ranked)"*

Submissions to the consultation were accepted in several formats, those submitted online through survey form, by email as an attachment (PDF of Microsoft Word document) to the Department of Health or by post to the Department of Health. Submissions were received in the following formats:

- *Forms: submissions received in the requested survey format;*
- *Non-forms: submissions that address a select number of questions in the survey, however they did not provide their submission in the format of the consultation questionnaire;*
- *Bulk submissions: a number of submissions were received were identical and likely drafted on behalf of an organization and submitted multiple times by separate individuals. Each of these were accounted for.*

When bulk submissions were include, there were 6,976 submissions received by 1st April, 2022, and reviewed as part of the consultation process"

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[i] *Subsection 22(4)* provides definition of nurse and midwife, as defined in the Nurses and Midwives Act 2011
[ii] Dáil votes down motion to fully decriminalize abortion. Jennifer Bray, Political Reporter, The Irish Times (1921) November, 29th 2018.