SUBMISSION FOR THE REVIEW OF THE OPERATION OF THE HEALTH (REGULATION OF TERMINATION OF PREGNANCY) ACT 2018

Abortion Rights Campaign

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List of Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality Framework
ARC	Abortion Rights Campaign
ASN	Abortion Support Network
BPAS	British Pregnancy Advisory Service
c-PTSD	Complex Post Traumatic Stress Disorder
CEDAW	Committee on the Elimination of All Forms of Discrimination Against Women
CRPD	Committee on the Rights of Persons with Disabilities
D&C	Dilation and Curettage
EMA	Early Medical Abortion
GP	General Practitioner
HSE	Health Service Executive
ICCL	Irish Council for Civil Liberties
IFPA	Irish Family Planning Association
IOG	Institute of Obstetricians and Gynaecologists
ISL	Irish Sign Language
LARC	Long-Acting Reversible Contraceptive
LMP	Last Menstrual Period
NWCI	National Women's Council of Ireland
PLDPA	Protection of Life During Pregnancy Act 2013
PPSN	Personal Public Services Number
SAZ	Safe Access Zone
TFMR	Terminations for Medical Reasons
UN	United Nations
WHO	World Health Organization

Executive Summary

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

This report comprises our submission for the review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018. It identifies barriers to abortion care in the legislation, in the clinical guidance, and in the implementation of services, and provides first-hand accounts that demonstrate the significant impact these barriers have on abortion-seekers and providers in Ireland. It also makes recommendations for reducing these barriers.

Our submission draws on a range of primary sources, including research conducted by ourselves and the World Health Organization (WHO) and data provided to us directly by the Abortion Support Network (ASN), a UK-based charity that provides information and support for those seeking abortion care abroad. Our recommendations are also informed by relevant international research, best medical practice, and relevant human rights standards.

Barriers in the Law

- Anyone who performs or assists an abortion outside the limited terms of the 2018 Act risks a criminal penalty of up to 14 years' imprisonment. Criminalisation stigmatises abortion care and those who provide it and also contributes to a chilling effect that results in delays and denials of care.

- The mandatory 72-hour waiting period is medically unnecessary and contrary to best international practice. It delays and, in some cases, even prevents people from accessing the care they need. It also undermines abortion-seekers as competent decision-makers in a way that is often perceived as demeaning and patronising.

- The 12-week gestational time limit for abortion means abortion care remains inaccessible in Ireland for those at a later gestational stage unless very specific and narrow grounds are met. Hundreds of Irish residents continue to travel abroad for abortion care every year, while those who cannot must continue their pregnancies.

- The grounds that allow access to abortion after 12 weeks are very narrow, meaning only a small proportion of people seeking a later abortion can do so in Ireland. Even among those who are eligible for care in Ireland, the continued criminalisation of abortion encourages a conservative approach among doctors that can delay or prevent care.

- The 2018 Act does not use gender-inclusive language. By referring solely to a "woman" who may need abortion services, it risks creating legal obstacles for transgender, non-binary and intersex people.

- The 2018 Act permits physicians to refuse to provide abortion care on conscience grounds, provided they transfer care to a willing provider "as soon as may be". Since there is a poor geographic distribution of services and no timeframe is specified, this can serve to delay or even prevent care. Moreover, our research identified cases where no referral was provided at all.

Barriers in the Clinical Guidance

- While clinical guidance on abortion states that abortions initiated prior to 12 weeks can be lawfully completed, this does not apply to cases of failed medical abortion that require a repeat course of treatment. Since medical abortions fail approximately 2% of the time and access to surgical abortion is limited in Ireland, this is a significant problem. Moreover, it has been reported that some doctors are refusing care for patients approaching the gestational time limit due to ongoing concerns about criminalisation, despite the clinical guidance.

- While positive steps have been taken, abortion has not yet been fully integrated into Ireland's existing healthcare structure. In order to normalise and strengthen abortion care, more training and support for healthcare providers is needed.

- Pregnant people who receive a diagnosis of foetal anomaly must navigate the narrow restrictions of the 2018 Act, which only permits abortion post-12 weeks if two doctors certify the condition is likely to lead to the death of the foetus within 28 days of birth. These narrow criteria, combined with the chilling effect of criminalisation, means that hundreds of Irish residents in these circumstances continue to have to travel for abortion care abroad at considerable emotional, physical, and financial cost to themselves.

- Doctors in Ireland are legally permitted to refer individuals to abortion providers outside the state if they cannot access abortion in Ireland, and are obliged to provide continuity of care in such cases. Unfortunately, this does not always happen. This lack of clear referral pathways puts the health and well-being of abortion-seekers at risk.

- The implementation of telemedicine abortion care during the COVID-19 pandemic has been shown to be highly successful in removing barriers to care and has high levels of acceptability among patients and providers. It has not yet been established whether this effective mode of delivery will remain in place beyond the pandemic.

Barriers in Implementation

- Information about abortion – including how to access the procedure and relevant supports – is not always well-known. More could be done to publicise the MyOptions helpline and make it more accessible and suited to people's needs. Regulation of rogue agencies that attempt to dissuade people from abortion through deception and misinformation is also urgently needed.

- We have also identified a knowledge gap around medical abortions. Some people

report that they did not feel they have been adequately informed about what to expect during this procedure (including the level of pain and the amount and duration of bleeding they might experience), or advised on how to manage these effects.

- In theory, people accessing abortion under 12 weeks in Ireland should be able to choose between a medical or a surgical procedure. In practice, a lack of hospitals willing and able to provide surgical abortion means that medical abortion is often the only (or at least the strongly encouraged) option. This lack of choice in method is contrary to international best practice.

- Only 10% of GPs and just 10 of the country's 19 hospital maternity units provide abortion services. The geographic spread of services is poor, with services tending to be concentrated in urban areas and sparse in rural regions. Lack of access to local abortion care translates into longer travel times, which at best come with additional logistical, financial, and physical challenges and at worst can delay and even prevent abortion access.

- The 2018 Act states that abortion care is free for anyone resident in Ireland regardless of citizenship status. Nonetheless, there have been reports of people without a Personal Public Services Number (PPSN) or medical card being asked to either apply for a PPSN or pay for abortion care themselves. Such requests can delay or even prevent people from accessing abortion in Ireland.

- Disabled people have also reported additional difficulties in accessing care. They may face barriers specific to their disability, such as logistical and transportation challenges and accessibility and privacy issues. They can also struggle to find doctors or clinical teams willing or able to provide abortion care to people with complex medical needs.

- Harassment and anti-abortion protests outside clinics providing abortion services are detrimental to the safety and wellbeing of clinical staff, patients, and passers-by. It deters doctors from providing abortion care and causes distress and anxiety among abortion-seekers. We continue to wait for legislation for the creation of Safe Access Zones (SAZs), which was promised in 2018.

- A lack of quality ultrasound scanning can be an additional delay to abortion care for abortion-seekers. A lack of clear and consistent referral pathways can delay or even prevent care, and in some cases has forced people to travel across the country or pay for private scanning to ensure they do not miss the 12-week cut-off. In some cases, poor-quality scanning has also resulted in pregnancies being incorrectly dated, leading people to travel abroad for abortion care unnecessarily.

- While we welcome the introduction of free contraception for women aged 17-25, universal access to free contraception is still urgently required. People availing of

abortion care should be offered the full range of contraceptive options, including long-active reversible contraceptives (LARCs), without cost being an issue.

- People seeking abortion care should be treated with dignity and respect by all healthcare and administrative staff they encounter. Sadly, this is not always the case. Reported incidences range from feeling stigmatised and judged to outright obstruction and refusal of care.

- In many parts of the country, it remains difficult to access hospital-based abortion due to a lack of providing hospitals, infrastructural and capacity limitations, and unclear referral pathways. This limits choice in abortion method, and can also delay or in some cases even prevent access for those requiring hospital-based care.

Our Recommendations

1. Decriminalise abortion in all circumstances (Sect. 23 of the 2018 Act).
2. Repeal the medically unnecessary mandatory 72-hour waiting period (Sect. 12 of the 2018 Act).
3. Repeal the arbitrary 12-week limit for abortion on request and extend on-request access throughout pregnancy (Sect. 12 of the 2018 Act).
4. Make explicit the right of transgender, non-binary and intersex, people to access abortion care.
5. Make explicit the right of pregnant people to bodily autonomy and independent decision making.
6. Repeal refusal of care ('conscientious objection') (Sect. 22 of the 2018 Act).
7. Amend the law to ensure that anyone who legally initiates abortion care in Ireland can complete their abortion in Ireland.
8. Improve the geographic distribution of primary care and hospital providers, and increase access to abortion by authorising nurses, midwives and other doctors to provide abortion care in line with international best practice.
9. Increase the availability of surgical/aspiration abortion in primary care and hospitals across all geographic areas.
10. Make permanent the provision of telemedicine.
11. Add an appointment-booking service to MyOptions.
12. Provide easy-to-read information on abortion access and adequately resourced and staffed language interpretation services, including Irish Sign Language (ISL).
13. Provide services to enable Travellers, people in Direct Provision, disabled people, and others who must travel outside their county to access an abortion.
14. Fully implement the guarantee of free abortion care for all who live in Ireland, including people residing in Northern Ireland, regardless of possession of a PPSN or medical card.
15. Legislate for and fully implement Safe Access Zones to ensure abortion care without harassment.
16. Legislate for and fully implement an end to deceptive rogue agencies that deliberately misinform patients about abortion.
17. Provide free access to all methods of contraception approved by Irish regulatory agencies to all who wish to avail of it.

Introduction

This submission was prepared by representatives of Abortion Rights Campaign (ARC).

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

We advocate for free, safe, legal, and local abortion care. Research shows that free, safe, legal and local access to abortion care is the only model that supports meaningful choice in pregnancy-related healthcare and supports the human rights of the pregnant person. Abortion legislation must centre the pregnant person's right to bodily autonomy and integrity, without avoidable barriers or impediments to care provision. When we advocate for free, safe, legal, and local care, we are advocating for accessible care without financial or geographic barriers, without the threat of criminalisation, and without medically unnecessary restrictions. We are also advocating for a standard of care that is in line with the Availability, Accessibility, Acceptability and Quality (AAAQ) framework, established by the World Health Organization (WHO) as the baseline for healthcare which is compatible with the human right to health.[1]

The stated purpose of the Health (Regulation of Termination of Pregnancy) Act 2018 (referred to as the '2018 Act' throughout this submission) is: "to provide for and regulate for the termination of pregnancy".[2] To assess whether the 2018 Act achieves this stated aim in a way that supports meaningful choice that adheres to AAAQ standards, this submission will address the barriers to free, safe, legal, and local care that arise from the operation and implementation of the legislation. Because many elements of the legislation serve to inhibit rather than facilitate the provision of abortion, this submission will also consider barriers inherent in the legislation itself. As such, this submission will first address barriers to care arising from specifics in the legislation, then barriers to care arising from the clinical guidance, and finally barriers to care arising from operational and implementation issues.

This submission draws on a number of primary sources to inform our recommendations, as well as international research, best medical practice, and relevant human rights standards. In particular, we draw extensively on the following sources:

- Original research conducted by ARC and Dr. Lorraine Grimes into the experiences of abortion-seekers in Ireland since January 2019.[3] The research consisted of an online survey collecting qualitative and quantitative data, which was analysed by Dr. Grimes. The full research report is also attached to our email submission.

[1] See: https://www.who.int/hhr/Right_to_health-factsheet.pdf and https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf.

[2] https://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html;

[3] ARC & Lorraine Grimes. 2021. Too Many Barriers: Experiences of Abortion in Ireland After Repeal. Available at: https://www.abortionrightscampaign.ie/wp-content/uploads/2021/09/Too-Many-Barriers-Report_ARC1.pdf.

- Findings from primary research on abortion policy implementation in Ireland conducted by the WHO.[4] The WHO study included interviews with healthcare providers, patients and key informants, as well as an examination of abortion statistics and policy documentaiton.

- Information provided by the Abortion Support Network (ASN) directly to ARC. Founded in 2009, ASN is a charity that provides information, practical assistance and financial support to those forced to travel for abortion access. It has continued to provide this service to residents of Ireland since the legalisation of abortion. Between 1 January 2019 and 31 December 2021, ASN provided information and support to 492 people based in the Republic of Ireland, as well as providing financial grants totalling £124,748.[5,6]

  The data is qualitative in nature and used in this submission to illustrate the barriers that people in Ireland encounter. All identifying information has been removed to protect privacy.

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

[5] Information supplied by ASN directly.

[6] ASN does not require its clients to share their gender, age, ethnicity or the reason for their abortion; the information provided by ASN is based upon what clients have chosen to share, noted by helpline volunteers, while accessing support.

Section 1: BARRIERS IN THE LAW

Criminalisation of abortion

At present, there is a criminal penalty of up to 14 years' imprisonment for anyone who performs or assists an abortion outside the terms of the 2018 Act, setting abortion services apart from all other forms of healthcare.[7] Criminalisation perpetuates stigma of providers and patients, undermines doctors' ability to provide care according to their clinical judgement and professional standards, and dissuades doctors from providing care.[8] In studies conducted by the WHO, NWCI, and University College Cork, abortion providers in Ireland have repeatedly expressed concern about the criminalisation of care, particularly in cases involving foetal anomaly or a serious health risk to the pregnant person.[9,10,11]

The chilling effect of criminalisation can result in delays and denials of care, with potentially devastating consequences for patients, as the following responses from our survey illustrate:

> "The legislation in Ireland had just passed and they honestly didn't know how to behave ... When [early medical abortion] didn't work I asked the next doctor I met why I couldn't have a [surgical abortion] and she admitted 'the legislation is new and we're being very cautious to protect ourselves'."
>
> "Their hands were tied, they couldn't help us any more than they did."
>
> "I had to terminate for medical reasons. Our consultant said our case 100% warranted a termination and we also got a second opinion from [hospital] but the consultant here said he couldn't be sure our baby would die within 28 days of birth and because I was 15 weeks he couldn't help us."

Participants also spoke of doctors being "wary" of providing information of abortion overseas, despite this being legal.[15]

Additionally, although abortion is decriminalised with respect to one's own pregnancy in Ireland, the presence of criminal sanctions can prevent people from seeking medical care. In our research, one participant who imported pills stated: "I was scared I was going to die but I felt I couldn't go to the hospital I case I got in trouble because I did not meet the criteria

[7] Health (Regulation of Termination of Pregnancy) Act 2018, Section 23. https://www.irishstatutebook.ie/eli/2018/act/31/section/23/enacted/en/html#sec23.

[8] Donnelly, M. and Murray, C., 2020. Abortion care in Ireland: developing legal and ethical frameworks for conscientious provision. International Journal of Gynecology & Obstetrics, 148(1), pp.127-132.

[9] Power, S., Meaney, S. and O'Donoghue, K., 2021. Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study. BJOG: An International Journal of Obstetrics & Gynaecology, 128(4), pp.676-684.

[10] National Women's Council, 2021, Accessing Abortion in Ireland: Meeting the Needs of Every Woman, 24 May. https://www.nwci.ie/learn/publication/accessing_abortion_in_ireland_meeting_the_needs_of_every_woman.

[11] Mishtal et al., 2021, Policy Implementation report.

[12] ARC & Grimes, 2021, Too Many Barriers, p. 51.

[13] ARC & Grimes, 2021, Too Many Barriers, p. 58.

[14] ARC & Grimes, 2021, Too Many Barriers, p.66.

[15] ARC & Grimes, 2021, Too Many Barriers, p. 68.

for a legal abortion.[16] An ASN client asking for information on abortion travel also asked: "Am I still legally safe to do it? My parents are aware of the pregnancy and threatened me to go to Gardai and report me if I do fly over to get the abortion. I have 2 children I love more than anything in this world and worry that if I get prosecuted they'll be left without me." Uncertainty over the status of abortions performed outside of the strict bounds of the legislation has left pregnant people distressed and fearful of seeking medical care. Full decriminalisation would remove that uncertainty.

Furthermore, the United Nations (UN) Committee on the Rights of Persons with Disabilities (CRPD) and the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) found that only full decriminalisation of abortion provision can provide a framework under which pregnant people's autonomy and the value of disabled people's lives can be guaranteed.[17]

ARC therefore recommends the decriminalisation of abortion. Decriminalisation would support doctors to make patient-centred decisions without fear of prosecution, in line with international best practice.[18] It would also ensure compliance with international human rights standards, which overwhelmingly supports the removal of punitive abortion measures to protect the health, equality, and dignity of people.[19] Ireland's continued failure to decriminalise abortion is in oppostion to the recommendations of the European Court of Human Rights, WHO and United Nations.[20, 21, 22, 23, 24, 25, 26]

72-hour waiting period

The 2018 Act requires patients to wait 72 hours between consulting a doctor about an abortion and receiving an abortion.[27] This directly contradicts guidance from the WHO, which states that: "mandatory waiting periods can have the effect of delaying care, which can jeopardise women's ability to access safe, legal abortion services and demeans women

[16] ARC & Grimes, 2021, Too Many Barriers, p. 55.

[17] UN Committee for on the Rights of Persons with Disabilities (CRPD) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), 2018, Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities joint statement, para 5.

[18] Berer, M., 2017. Abortion law and policy around the world: in search of decriminalization. Health & Human Rights, 19(1), pp.13-27.

[19] Erdman, J.N. and Cook, R.J., 2020. Decriminalization of abortion–a human rights imperative. Best Practice & Research: Clinical Obstetrics & Gynaecology, 62, pp.11-24.

[20] European Court of Human Rights, 2007. Tysiąc v. Poland. Application no. 5410/03, 45.

[21] World Health Organization, 2012. Safe abortion: technical and policy guidance for health systems, 2nd edn, https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

[22] UN Committee on the Elimination of Discrimination Against Women, 2017. Concluding observations, CEDAW/C/IRL/CO/6-7, para 43.

[23] UN Committee on the Rights of the Child, 2016. Concluding observations, CRC/C/IRL/CO/3-4, paras 57-58.

[24] UN Committee on Economic, Social and Cultural Rights, 2015. Concluding observations, E/C.12/IRL/CO/3, para 30

[25] UN Human Rights Committee, 2014. Concluding observations, CCPR/C/IRL/CO/4, para 9.

[26] UN Committee Against Torture, 2011. Concluding observations, CAT/C/IRL/CO/1, para 26.

[27] Section 12, Health (Regulation of Termination of Pregnancy) Act 2018.

as competent decision-makers".[28] Both the Council of Europe's Commissioner for Human Rights and the WHO have called for Ireland to remove this barrier.[29]

This medically unnecessary waiting period prevents some people from accessing healthcare in Ireland. ASN is aware of at least 40 people who were pushed over the legal 12-week limit by the mandatory 72-hour waiting period.[30] A similar phenomenon was noted in a study in Utah in the USA.[31] Studies in the USA have found that extended waiting periods "provide no medical benefits and the potential for harm and delay of care remains."[32] One study found that the 72-hour delay translated into, on average, eight days between the first and second appointments, because of delays in scheduling appointments, doctors not being available seven days a week, and so on.[33]

For disabled people, the need to travel for appointments in a restricted time frame can be a significant barrier to access, particularly if specialist transport is required or a person needs to schedule appointments around their Personal Assistance hours.

In our research study, participants reported an overwhelmingly negative experience of the 72-hour waiting period, stating that it added stress and anxiety and increased mental and physical discomfort.[34] As one participant shared:

> "I had to spend three days waiting for care, which in the grand scheme of things may not seem to be significant, especially because I was under 6 weeks pregnant. However, I was exhausted and suffering from morning sickness. At no point was I hesitant in my decision, and the waiting period prolonged my discomfort. It also felt so patronizing and condescending. It's my choice, and I should be able to execute it without delay."[35]

The mandatory waiting period often leads to longer delays when it interacts with additional barriers, such as refusal of care. One participant in our research ended up waiting over two weeks from her first appointment before starting her abortion:

[28] World Health Organization, 2012. Safe abortion: technical and policy guidance for health systems, 2nd edn, https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

[29] Ellen Coyne, "Three-Day Wait for Abortions Must Go, Rights Chief Demands," The Times, December 15, 2018, https://www.thetimes.co.uk/article/three-day-wait-for-abortions-must-go-rightschief-demands-thdrb826x; see also Mishtal et al., 2021, Policy Implementation report.

[30] S Cobbin & Co (2021) Report of the Trustees and Financial Statements for the Year Ended 31st December 2020 for Abortion Support Network. https://www.asn.org.uk/wp-content/uploads/2021/06/Abortion-Support-Network-final-signed-accounts-2020.pdf

[31] Roberts, S.C., Turok, D.K., Belusa, E., Combellick, S. and Upadhyay, U.D. (2016), Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women. Perspectives on Sexual and Reproductive Health, 48: 179-187. https://doi.org/10.1363/48e8216

[32] Morse JE, Charm S, Bryant A, Ramesh S, Krashin J, Stuart GS. The Impact of a 72-hour Waiting Period on Women's Access to Abortion Care at a Hospital-Based Clinic in North Carolina. North Carolina Medical Journal. 2018 Jul-Aug;79(4):205-209. doi: 10.18043/ncm.79.4.205. PMID: 29991607.

[33] Roberts, S.C., Turok, D.K., Belusa, E., Combellick, S. and Upadhyay, U.D. (2016), Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women. Perspectives on Sexual and Reproductive Health, 48: 179-187. https://doi.org/10.1363/48e8216

[34] ARC & Grimes, 2021, Too Many Barriers, p. 41.

[35] ARC & Grimes, 2021, Too Many Barriers, p. 42.

> "I first went to a doctors surgery that didn't provide abortion service (Mon eve). Called My Options after recommendation by that doctor Mon eve. Called recommended GP Tues am - got appt for Fri. Follow up appt scheduled for Mon, ultrasound showed 11 weeks. Referred to [hospital]. Called Wednesday by [hospital] to come in Friday. Took first pull [sic] Friday at appt and attended for medical abortion Sunday 14 days after first doctors appointment but 2 days after first hospital appointment."[36]

Since earlier abortions have fewer complications, unnecessary delays serve to make abortions more unsafe.

For all these reasons, **ARC recommends the complete repeal of mandatory waiting periods.**

12-week gestational time limit

> "I'm 13 weeks pregnant and looking for help."
>
> "I'm nearly 12 weeks pregnant and unemployed."
>
> "I am just over 12 weeks into pregnancy."
>
> "My 17 year old daughter is 12 weeks and one day - she thought she was 10 weeks. She is confident in her decision to have an abortion."
>
> \- ASN clients

The 2018 Act permits abortion on request for pregnancies that are less than 12 weeks gestation, and allows services under certain limited circumstances after 12 weeks. In 2019, 6,542 abortions were performed up to 12 weeks of pregnancy, according to Irish government statistics.[37] At least 375 people also travelled to the UK to obtain an abortion.[38]

Research on abortion travel within Europe shows that "the primary reason reported for going abroad was having exceeded gestational age limits in their country of residence".[39] Patients in Ireland contend with a myriad of barriers that can cause a delay in accessing abortion services and result in the denial of services due to the 12 week gestational limit. Such barriers include:

- Poor geographic distribution of services.
- Insufficient access to surgical abortion.

[36] ARC & Grimes, 2021, Too Many Barriers, p.39.

[37] Department of Health, Health (Regulation of Termination of Pregnancy) Act 2018 - Annual Report on Notifications 2019, 30th June, 2020, https://www.gov.ie/en/publication/b410b-health-regulation-oftermination-of-pregnancy-act-2018-annual-report-on-notifications-2019/

[38] UK Department of Health and Social Care, 'Abortion statistics, England and Wales: 2019', 11th June, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/89 1405/abortion-statistics-commentary-2019.pdf

[39] De Zordo, S, Zanini, G, Mishtal, J, Garnsey, C, Ziegler, A-K, Gerdts, C. Gestational age limits for abortion and cross-border reproductive care in Europe: a mixed-methods study. BJOG 2021; 128: 838– 845.

- Poor distribution of ultrasound scanning services to date pregnancies and problems arising from inaccurate scanning results.
- Insufficient access to abortion care between 10-12 weeks because patients must obtain care in a hospital, contrary to medical evidence and best practice, and also because of doctors' fear of providing an abortion too close to the 12-week cut-off.
- Inadequate access to hospital-based care, as 9 of 19 maternity hospitals refuse to provide services on request, and three of the hospitals that do are in Dublin.

Data from ASN illustrates just some of the many situations in which people need abortion care after 12 weeks. Often those who need an abortion after 12 weeks are people who are already marginalised or struggling, such as single parents, those with limited incomes, migrants, children and young people. Cases of people ASN has helped include:

- A woman who waited two weeks to get a scan that dated her pregnancy at 11w4d. She thought she'd had a period since then. Rather than offering prompt access to abortion care, a second scan was scheduled instead.
- A single mother was scanned and told her pregnancy was 13w2d. She couldn't remember her last menstrual period (LMP). She only gets €258/week in benefits.
- A university lecturer who also receives welfare because of low income. She was 12 weeks and needed help funding her travel for an abortion.
- A 19-year-old student who was scanned at 17 weeks. She needed support organising travel and logistics of accessing abortion abroad. She has no income apart from what her parents occasionally give her. Despite ASN offering financial support, the client was adamant she would get the money herself - either through borrowing money or selling possessions - as it was her responsibility.
- A 17-year-old who was scanned a 12w1d, she and her mother thought she was 10w4d. As she had to travel for abortion, she wanted to be able to bring her mother with her, which involved the mother needing to arrange care for her other children. This was complicated by the additional cost of abortion abroad after 14 weeks; ASN helped this child get an abortion with her mother by her side when our legislation failed her.

The rigid cut-off also disadvantages people with certain conditions. For example, autistic people can struggle with interoception (one's internal sense of body), which can put them at higher risk of missing early symptoms of pregnancy, if they have any. ASN reports that it has seen three cases of people seeking abortion care past 12 weeks who had been in and out of hospital for various illnesses and so had not noticed signs of pregnancy during this time.

ASN has also received multiple calls from Irish residents considering abortion who were worried they may not come to a decision before the 12-week cut-off, as well as abortion-seekers from Ireland who were now over 12 weeks because they had needed more time to reach their decision. This indicates that the gestational time limit is detrimental for people who would like more time to make their choice, potentially compelling them to either rush their

decision or else travel for abortion care or continue an unwanted pregnancy.

While ARC acknowledges the fact that the majority of those who need an abortion can now receive this essential healthcare at home, the fact that hundreds are still travelling demonstrates that problems with the legal framework and implementation have left too many people behind. Many of those who are still forced to travel are in similar situations to those whose heartbreaking stories politicians were at pains to hold up during the referendum. Yet we continue, to some extent, to "export our problems".[40]

It is worth noting that, even in countries where abortion is accessible until later gestations, the vast majority of abortions are still carried out in the first trimester. In England and Wales, where abortion is widely available up to 24 weeks, 88% of abortions are performed under 10 weeks' gestation.[41] In the Netherlands, where it is available up to 22 weeks gestation, 85% take place in the first trimester.[42] If Ireland was to extend the availability on abortion on request, it could reasonably expect to see similar trends.

ARC recommends the removal of the arbitrary 12-week limit on abortion on request and extension of on-request access throughout pregnancy. This would be in keeping with the WHO's latest abortion care guidelines, which explicitly call for the removal of all laws and regulations that prohibit abortion based on gestational age limits.[43]

Grounds-based access after 12 weeks

The 2018 Act only legalises abortion access after 12 weeks LMP under certain grounds:

- Under section 9, abortion is available if there is "risk to the life, or of serious harm to the health" of the pregnant person and the foetus has not reached viability.[44]
- Under section 10, abortion is available if there is "immediate risk to [...] life, or of serious harm to [...] health" and it is "immediately necessary" to carry out an abortion to end that risk.[45]

[40] Statement by An Taoiseach Leo Varadkar, 29th January 2018 https://www.gov.ie/en/speech/69db33-post-cabinet-statement-taoiseach-leo-varadkar/

[41] UK Department of Health and Social Care, 'Abortion statistics, England and Wales: 2020', 10th June, 2021 https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020

[42] Facts and figures, Kenniscollectie https://fiom.nl/kenniscollectie/abortus/cijfers-feiten#Abortus Cijfers%20en%20 abortus ratio%20iets%20 gestegen

[43] World Health Organization (WHO). 'Chapter 2. Abortion regulation including relevant recommendations Law & policy Recommendation 3: Gestational age limits (2.2.3)', Abortion care guideline, https://srhr.org/abortioncare/chapter-2/recommendations-relating-to-regulation-of-abortion-2-2/law-policy-recommendation-3-gestational-age-limits-2-2-3/

[44] Health (Regulation of Termination of Pregnancy) Act 2018, Section 9.

[45] Health (Regulation of Termination of Pregnancy) Act 2018, Section 10.

- Under section 11, abortion is available if there is “a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth”.[46]

In sections 9 and 11, two doctors must certify that these legal grounds have been met. In section 10, one doctor is sufficient.

We believe that grounds-based access is an inherent barrier to safe and dignified abortion care. During the Citizens’ Assembly and Joint Oireachtas Committee processes, specialists in maternal foetal medicine advised against being prescriptive in their legal terminology so as not to constrain care.[47] The requirement for doctors to parse nebulous legal terms and legally certify their opinion of the same before providing healthcare is unique to abortion. That exceptionalism drives abortion stigma and, when coupled with criminalisation of doctors, reduces their willingness to provide care.

Available data clearly demonstrates that grounds-based access is insufficient to deal with the realities of people’s lives and pregnancies in Ireland. We will address the problems associated with section 11 (abortion for foetal anomaly) in detail in a later section. Here, we will discuss the problems associated with sections 9 and 10, where abortion is granted only if doctors certify there is risk to life/health.

Department of Health figures indicate that abortion on risk to life/health grounds is as difficult to access under the 2018 Act as under the final years of the 8th Amendment. Under the Protection of Life During Pregnancy Act 2013, which permitted abortion if there was a “a real and substantial risk of loss of the woman’s life,”[48] an average of 25 abortions were performed each year. [49] Yet under the ostensibly more liberal grounds set out in the 2018 Act, just 24 people had abortion under risk to life/health grounds in 2019 and 25 in 2020.[50, 51] If these grounds are as difficult to access now as they were under the 8th Amendment, it is a gross failure of the 2018 Act.

Our survey findings back up this concern, indicating that access to grounds-based abortion after 12 weeks is very hard to access. Only one participant in our survey had their mental health taken into account, and even then they had to travel to another hospital as the initial consultant refused to take the perinatal psychiatrist’s report into consideration.[52]

Since January 2019, ASN has supported 342 people who were over 12 weeks gestation to access abortion, including a number of individuals dealing with health issues who had not

[46] Health (Regulation of Termination of Pregnancy) Act 2018, Section 1.

[47] E.g. Dr Peter Thompson https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-11-29/3/

[48] Protection of Life During Pregnancy Act, Section 7ff.

[49] Annual Report of notifications in accordance with the Protection of Life During Pregnancy Act, 2013" [44] Health (Regulation of Termination of Pregnancy) Act 2018, Section 9

[50] Department of Health ‘Health (Regulation of Termination of Pregnancy) Act 2018 - Annual Report on Notifications 2019’, https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/

[51] Department of Health ‘Health (Regulation of Termination of Pregnancy) Act 2018 - Annual Report on Notifications 2020’, https://www.gov.ie/en/publication/ef674-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2020/.

[52] ARC & Grimes, 2021, Too Many Barriers, p.56.

been able to access abortion under risk to life/health grounds in Ireland. In one case, a client with serious mental health problems was trying to exit an abusive relationship. In another, a client was in early recovery for addiction. In several cases, those who contacted ASN had suicidal ideation at the prospect of continuing their pregnancy. One wrote:

> "I am recently out of a very toxic and abusive relationship which left me suicidal. I am speaking with a counsellor and on medication but I can't continue with this pregnancy. I don't want to be pregnant and thinking of ways that I can end it myself. It is consuming me. I have a child and a baby and I can't let my ex back into our life. We need to be able to move on."

In another case, an assault victim with mental and physical health issues and clear suicidal ideation was directed to ASN by MyOptions staff as she was over 12 weeks. When our legal structures are such that those with complex mental and physical health issues cannot be cared for within their own community, it is clear that the 2018 Act has not met its stated purpose. Clinicians ought to be facilitating appropriate care on an individual basis rather than interpreting the legal ramifications of "serious harm to health".

It is also worth noting that, although the 2018 Act does not permit abortion after 12 weeks for pregnancy resulting from rape or incest, there appears to be some misperception that it does. ASN has been contacted by four people pregnant under such circumstances who reported that they had believed the 12 week limit would not apply to them (a belief that, shockingly, was also shared by one of their legal advisors). This is obviously highly concerning.

To remove unnecessary and cruel barriers to care, **ARC recommends the removal of grounds-based access and extension of on-request access throughout pregnancy.**

Abortion access for transgender, non-binary, and intersex people

The 2018 Act consistently refers to the "woman" who may need abortion services, and defines "woman" as "female person of any age".[53]

Since 2015, it has been possible for Irish residents to change their gender marker in law. As such, there are trans men, legally male, who may need to access abortion services. In addition, non-binary and interesex individuals may also need abortion care. There was widespread support from civil society organisations and across the Oireachtas for ensuring the Act included the language "pregnant people".[54] Despite this, the Health Minister refused all proposals to amend the legislation, citing unseen advice from the Attorney General and

[53] Health (Regulation of Termination of Pregnancy) Act 2018, Section 2 http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/print#sec2

[54] Health (Regulation of Termination of Pregnancy) Bill 2018: Second Stage, 6th December 2018, https://www.oireachtas.ie/en/debates/debate/seanad/2018-12-06/13 and Health (Regulation of Termination of Pregnancy) Bill 2018: Second Stage, 16th October 2018, https://www.oireachtas.ie/en/debates/debate/dail/2018-10-16/26/

the Interpretation Act.[55] Notwithstanding the Minister's claim, the legislation does not account for non-binary and intersex people.

Although our research indicates that some transgender and non-binary people have accessed abortion in Ireland since 2019, very little is known about their experiences.[56] In 2021 it became clear that an incorrect gender marker could be a barrier to accessing healthcare, when a cisgender woman who was incorrectly noted as "male" was prevented from accessing maternity services until her gender marker had been changed.[57]

International research confirms that transgender and non-binary people do have abortions.[58] Moreover, they often face specific barriers and deterrents to abortion care, such as gendered legislation and policy, lack of gender-affirming healthcare, and discrimination.[59] Concerningly, research from the USA also indicates that a high proportion of transgender individuals attempt abortion without clinical supervision, often in ways that are unsafe and ineffective.[60] The provision of gender-affirming abortion care is an issue of safety as well as respect. This must start with a legislative framework that reflects the reality that people of all genders and none need abortions.

Ireland's current legislation fails to protect transgender, non-binary and intersex people from discrimination. Amending the legislation to include "pregnant person" indicates the intent to support all those who need abortion, regardless of gender. Similar wording has been used in other state-produced information about reproductive healthcare, such as cervical screening. There is no reason for abortion legislation to remain discriminatory.

ARC recommends that the wording of the legislation is altered to include "pregnant person/ people" throughout.

Refusal of care on conscience grounds

The 2018 Act permits physicians to refuse to provide abortion care (often referred to as "conscientious objection"), provided they transfer the care of the patient to a willing provider "as soon as may be". [61]However, given the poor geographic distribution of services and lack of a specificed timeframe for the transfer of the patient's care, allowing doctors to refuse care creates a barrier to people obtaining an abortion within the 12-week limit. An international review of the literature highlights that conscientious objection constitutes a barrier to care.[62] In Ireland, only 10% of GPs provide community abortion care and just 10 of the country's 19

[55]Interpretation Act 2005, https://www.irishstatutebook.ie/eli/2005/act/23/enacted/en/print#sec18

[56]ARC & Grimes, 2021, Too Many Barriers, p.18.

[57] Gráinne Ní Aodha, "Pregnant woman couldn't avail of maternity care because she was registered as a man by the State" https://www.thejournal.ie/pregnant-woman-hse-system-maternity-services-5490012-Jul2021/

[58]Jones, Witwer & Jerman (2020).

[59] Fix et al (2019).

[60] Moeson et al (2021).

[61] Section 22(3), Health (Regulation of Termination of Pregnancy) Act 2018.

[62] Morrell KM, Chavkin W. (2015) Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents. Current opinion in obstetrics & gynecology. Oct;27(5):333-8. doi: 10.1097/GCO.0000000000000196. PMID: 26241174.

[63] National Women's Council, 2021, Accessing Abortion in Ireland, pp. 21-23.

one maternity hospital has asserted that it will not provide any abortion care, violating the Act's prohibition on institutions (as opposed to individuals) refusing to provide care.[64]

In our research, almost one in five people who responded to a question on this said they had been refused a referral to another doctor. Being denied a referral had a negative impact on these patients. As one participant shared:

> "I visited my GP first, assuming she could prescribe the necessary medication, she refused treatment. I had to call MyOptions to find GPs in my area that perform abortions, I rang three different practices and two of the receptionists were very rude on the phone to me. One hung up on me before I even had a chance to say thank you or goodbye. It was very distressing. At this point I had to call MyOptions for a second time, I was extremely upset because I wanted to have the abortion ASAP. She gave me numbers for doctors outside of my county."[65]

Other participants described feeling "fear", "confusion" and "unnecessary stress".[66]

At present, there are no legal consequences for those who obstruct the abortion process and/or refuse to refer onwards. We strongly recommend that the legislation be updated to repeal refusal of care ("conscientious objection"), in line with international evidence that this creates a barrier to accessing abortion. Until this is achieved, clear procedures for filing complaints if doctors do not comply with the law should be established, and the Medical Council and HSE should be required to monitor refusal of care and discipline physicians who fail in their ethical duties. This would ensure compliance with the ethical standards in Ireland, as well as those of the International Federation of Gynaecology and Obstetrics, who consider regulation of conscientious objection essential to the realisation of sexual and reproductive rights, and believe states have a positive obligation to act in this regard under international human rights law.[67]

[64] Catherine Shanahan, "Kilkenny Hospital Unsuited to Abortions, Say Medics," Irish Examiner, June 22, 2019, https://www.irishexaminer.com/breakingnews/ireland/kilkenny-hospital-unsuited-toabortions-say-medics-932314.html

[65] Too Many Barriers, p. 55.

[66] Too Many Barriers, p. 55.

[67] Zampas, C. (2013). Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. International Journal of Gynecology & Obstetrics, 123, S63-S65. https://globaldoctorsforchoice.org/wp-content/uploads/1-s2.0-S0020729213600053-main.pdf

Section 2: BARRIERS IN THE CLINICAL GUIDANCE

Clinical interpretation of 12-week limit

Available evidence reveals a number of ongoing problems associated with how the 12-week gestational limit is interpreted in clinical settings.

Firstly, there is the issue of failed medical abortions (abortions using pills). While medical abortions are safe and effective, they fail around 2% of the time. Despite this, HSE clinical guidance states that even if a medical abortion does not work, people cannot access abortion care in Ireland after 12 weeks unless other grounds apply. We contend that this interpretation of the Act represents a denial of appropriate continuity of care, abridging the right to health enshrined in numerous UN treaties.

The practical consequences of the current clinical guidance can be serious and devastating. Since January 2019, ASN have supported more than 50 people who were forced to travel for abortion care after being denied continuity of care following failed medical abortions in Ireland. One of our survey participants summarised their own experience of this:

> "I was left with the thoughts after my failed abortion in Ireland that my baby could be born with abnormalities or I could miscarry. Nowhere in Ireland could help me and I don't think anyone should be left in that state after a failed abortion."[68]

At least one person has had to continue their pregnancy following three failed medical abortions administered in Ireland; she lived in an area with no surgical abortion provision, was not referred prior to the 12-week limit, and was unable to travel outside the country due to COVID-19 travel restrictions and being the primary carer for her three children, including one disabled child.[69]

Secondly, WHO research has highlighted that some GPs fear legal repercussions in providing abortion services to patients who are nearing the time limit.[70] ASN has supported several clients who were scanned at 11w4d, 11w5d and 11w6d and told they would not be able to access care in Ireland, despite being under the legal gestational limit. This is the chilling effect in action; providers are concerned about the risk of criminalisation, and pregnant people are denied care and forced to travel at their own expense for care they should be getting at home.

The removal of the 12-week limit would allow for appropriate continuity of care at every stage of the abortion process. However, to deal with these issues should the 12-week limit remain in the 2018 Act post the legislative review **we recommend that the clinical guidance be updated to clarify that gestational age refers to age at the beginning of the abortions, and that abortions, once initiated, should be able to be completed, even if completion occurs after 12 weeks and requires repeated or additional treatments.**

[68] ARC & Grimes, 2021, Too Many Barriers, p. 77.

[69] Abortion Rights Campaign, "Press Release: Organisations Condemn the Government for Failure in Continuity of Abortion Care," 10th December, 2020, https://www.abortionrightscampaign.ie/2020/12/10/press-release-organisations-condemn-thegovernment-for-failure-in-continuity-of-abortion-care/

[70] Mishtal et al., 2021, Policy Implementation report.

Lack of training and support for healthcare providers

While the integration of abortion care into Ireland's existing healthcare infrastructure can be regarded as generally successful, research has identified gaps in provision linked to a lack of training and support among healthcare providers.[71, 72, 73] In order to normalise and strengthen abortion care across the healthcare system, additional training and professional development opportunities are required.

Abortion care should be fully integrated into Ireland's medical, nursing and midwifery undergraduate curricula, and advanced training in abortion care should be offered across all GP training sites. In order to expand abortion care and relieve the burden on existing providers, nurses and midwives should be permitted and trained to provide abortion care in community and ambulatory gynaecological settings, in line with WHO recommendations.

Moreover, research with abortion care providers in Ireland has highlighted the valuable role played by peer support and training, such as that currently being provided on an unpaid and voluntary basis by the Southern Task Group on Abortion and Reproductive Topics (START).[75,76,77] **We therefore recommend that such initiatives be protected and expanded through the provision of funding and resources.**

Issues accessing abortion for foetal anomaly

A pregnant person who receives a foetal anomaly diagnosis can only access abortion care in Ireland if the foetus's condition meets the stringent criteria of section 11 of the 2018 Act. Under section 11, an abortion will only be allowed if two medical practitioners certify they are of the reasonable opinion that the condition will likely lead to the death of the foetus within 28 days of birth.[78] While it is possible to diagnose some foetal anomalies prior to 12 weeks, most diagnoses happen later in a pregnancy. This requires the pregnant person, or couple, to not only process the shock of a life-altering diagnosis and the possible loss of a much-wanted pregnancy, but to navigate the burdensome restrictions of the 2018 Act.

[71] Mullally, A., Horgan, T., Thompson, M., Conlon, C., Dempsey, B. and Higgins, M.F., 2020. Working in the shadows, under the spotlight–Reflections on lessons learnt in the Republic of Ireland after the first 18 months of more liberal Abortion Care. Contraception, 102(5), pp.305-307.

[72] Horgan, P., Thompson, M., Harte, K. and Gee, R., 2021. Termination of Pregnancy Services in Irish General Practice from January 2019 to June 2019. Contraception.

[73] Mishtal et al., 2021, Policy Implementation report.

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

[75] Dempsey, B., Favier, M., Mullally, A. and Higgins, M.F., 2021. Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland. *Contraception.*

[76] Mullally, A., Horgan, T., Thompson, M., Conlon, C., Dempsey, B. and Higgins, M.F., 2020. Working in the shadows, under the spotlight–Reflections on lessons learnt in the Republic of Ireland after the first 18 months of more liberal Abortion Care. Contraception, 102(5), pp.305-307.

[77] A Mishtal et al., 2021, Policy Implementation report, p. 13.

[78] https://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html

Section 11, coupled with the chilling effect of criminalisation, results in medical practitioners interpreting legislation, and doing so conservatively in order to avoid prosecution. This means that many people find themselves ineligible for abortion care in Ireland because their situations have been deemed “not fatal enough”. In the first two years of the 2018 Act’s operation, 197 people accessed abortions under section 11.[79] Over that same time period, 127 people giving Irish addresses accessed abortions in England and Wales under ground E of the UK’s 1967 Abortion Act,[80] which permits 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.”[81] Due to COVID-19 travel restrictions and the withdrawal of the UK from the EU, the figures for 2020 are likely not a true reflection of the number of people who were forced to travel to other jurisdictions. Nonetheless, they point to a continued willingness to “export our problems” that is not in keeping with what the Irish electorate voted for.

Statistics alone do not provide a true reflection of the emotional, physical, and financial trauma experienced by people who seek abortions folllowing a prenatal diagnosis. The submission from Terminations For Medical Reasons Ireland (TFMR) provides an in-depth analysis of the clinical consequences of the 2018 Act, as well as testimony from a small number of people and couples who have lived through the experience of having to travel to another jurisdiction to access abortion care. We would like to add to this by sharing just some of the stories from people in similar circumstances that were shared with us by ASN:

> “We are seeking some help/info on how things work. Firstly, as this is a medical abortion will I or can I be with be with my wife at all times? Secondly, would you know what paperwork is required for us to leave the hospital with our boys remains & declare at the boat for our departure back to Ireland?”
>
> “Planning to take the ferry so she can take the remains home.”
>
> “Just returned to ROI after [a foetal anomaly] abortion in X, they want advice on how to get the foetal remains back to X. The hospital in Ireland said they would organise getting the remains back to Ireland, but they have not been communicating with the couple and it’s been 10 days.”
>
> “Waiting on further test results. Hospital have informed them that they won’t get test results back until the pregnancy is almost 24 weeks. The couple were unhappy with the lack of support from the hospital - haven’t been able to get a doctor to contact Client X regarding their poor mental health exacerbated by uncertainty around the pregnancy and feeling rushed into a decision.”
>
> “[...] she is expecting a baby with a very serious cardiac condition and wishes to have a termination, however she does not meet the criteria for termination under the fatal foetal abnormality rule under our current termination legislation. I have been advised by the foetal medicine dept that the most appropriate place for her to have her termination will be X due to her diagnosis and gestation, the cost will be approximately €3000 - €4000.

[79] Notifications in accordance with section 20 of the Health (Regulation of Termination od Pregnancy) Act 2018 - Annual Report 2019 https://assets.gov.ie/78445/ed81dafb-963c-4e1c-ba29-98cce5118d7c.pdf and Annual Report 2020 https://assets.gov.ie/138755/6ae02c5a-c60b-4954-b438-8e8397eb0aaf.pdf

[80] UK Department of Health Abortion Statistics for England and Wales 2019 https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019 and 2020 https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020

[81] UK Abortion Act 1967 https://www.legislation.gov.uk/ukpga/1967/87/section/1

Since 1 January 2019, ASN have supported over 100 people who had to travel to the UK for abortion care following a prenatal diagnosis.

ARC recommends repealing ambiguous wording regarding abortions for health risks and "fatal" foetal diagnoses, and providing legal avenues for abortion in all cases where foetal anomalies are diagnosed. We also recommend the decriminalisation of abortion in all circumstances, making explicit the right of pregnant people to bodily autonomy and independent decision making.

Lack of continuity of care and care referral pathways

Under the 2018 Act, healthcare professionals may provide information on abortion services that are legally provided outside the state. This means that providers are legally permitted to refer individuals to abortion providers in the UK or elsewhere in Europe if they are not able to access abortion under Ireland's legislative framework. Additionally, doctors are legally obliged to provide continuity and referral of care, even if they are unable or unwilling to provide that care themselves.

Providing continuity of care for those who need to travel, and care referral pathways, ensures that those who access care outside the state do so in a safe manner and are treated with respect and dignity. Research indicates that travelling outside one's home jurisdiction for abortion care results in a lack of pre- and post-abortion care, as well as later abortions, restricted choice of method, and significant stigma.[82, 83, 84] According to WHO guidelines and research literature, safe and high-quality abortion care includes continuity and follow up care, provision of contraception care, provision of care according to individual medical history, and referrals to other health services as appropriate.[85, 86] Without continuity of care and clear referral pathways, it is not possible to provide safe, high-quality abortion services.

From ARC's research, there is little to no continuity of care for those who access abortion outside the state, including those who have experienced a failed medical abortion or prenatal diagnosis. 73% were not given a referral or any information to organisations that could help them access care, such as ASN, BPAS or Marie Stopes.[87] In some cases, patients

[82] Aiken ARA, et al. BMJ Sex Reprod Health 2018;44:181–186. doi:10.1136/bmjsrh-2018-200113.

[83] https://doi.org/10.1371/journal.pone.0209991 p.26.

[84] Aiken ARA, et al. BMJ Sex Reprod Health 2018;44:181–186. doi:10.1136/bmjsrh-2018-200113.

[85] WHO guidelines on safe abortion p. 31ff https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

[86] Dennis et al (2017).

[87] ARC & Grimes, 2021, Too Many Barriers, p. 64.

were refused access to their medical records,[88] in direct contravention of HSE guidelines.[89] In some cases, this obstruction appeared to be intentional:

> "Some staff deliberately tried to delay scans and put us off asking for harmony tests saying we didn't need it and then tried to delay amniocentesis."[90]

In others, it appeared tied to ongoing concerns around criminalisation or arising from a lack of knowledge or up-to-date information. One participant noted that hospital staff were "wary [of] giving any info on abortion in UK" despite being permitted to do so.[91] Another participant informed us that staff "admitted to protecting their interests above my health even when I got an infection" after presenting at an Irish hospital following an abortion in the UK.[92] It is unacceptable that hospital staff are unable or unwilling to prioritise their patient's health for fear of repercussions.

According to data provided by ASN, some of their clients were referred directly to them while others were told to contact UK hospitals themselves; in some cases, clients were told to contact Liverpool Women's Hospital despite the fact that the hospital stopped providing care to non-UK patients at the end of 2019 and only restarted on a case by case basis in February 2022. The lack of proper referral is often compounded by misinformation, leading to additional delays, cost and stress at an already difficult time. ASN also reports a lack of clarity about the process for approval for abortion after 12 weeks in Ireland, particularly about how long the process will take. This is important as the legal limit for abortion on request is 22 weeks in Holland and 24 weeks in England, meaning abortion beyond this is more complicated and expensive to manage, and often not available at all, since it can only be legally performed under restricted grounds.

ARC recommends that clear care referral pathways for those who cannot access care within the state are developed and implemented without delay. All patients should be given full access to their medical records when requested, timely referrals to external services when needed, and provided follow-up care upon their return.

Telemedicine

Four weeks after the WHO declared COVID-19 to be a pandemic, Ireland's Department of Health issued a revised model of care permitting telemedicine or "remote" provision of medications for early abortion.[93]

[88] ARC & Grimes, 2021, Too Many Barriers, p.70.

[89] Health Records Manangement, Safe Patient Care, HSE https://www.hse.ie/eng/about/who/qualityandpatientsafety/safepatientcare/healthrecordsmgt/healthcare-records-management.html

[90] ARC & Grimes, 2021, Too Many Barriers, p. 58.

[91] ARC & Grimes, 2021, Too Many Barriers, p. 68.

[92] ARC & Grimes, 2021, Too Many Barriers, p. 69.

[93] Ryan, V. (2020) 'Telemedicine abortion consultations permitted — Health Minister'. Irish Medical Times. 26 March https://www.imt.ie/uncategorised/telemedicine-abortion-consultations-permitted-health-minister-27-03-2020/

This innovation serves the needs of patients and the general public by reducing travel and in-person visits to GPs. It significantly improves the availability and accessibility of abortion care and reflects international best practice. There is a substantial body of international peer-reviewed research confirming that telemedicine is safe and effective in the delivery of early medical abortion.[94] A study of more than 50,000 abortions in the UK during 2020 showed that telemedicine abortions were 98.8% successful without further intervention or complication.[95] Telemedicine also reduced waiting times, led to earlier abortions, and had high acceptability (96%).

In our research on the experiences of abortion-seekers in Ireland, many participants noted that telemedicine made access easier as it reduced the need to travel, provided more privacy, and reduced the need to take additional time off work or arrange additional childcare.[96] Telemedicine was found to mitigate some of the barriers presented by the legislation, as this participant noted: "I was worried about having to travel to an appointment but the doctor did the first consult over the phone, which was really helpful and prevented me going to the clinic twice."[97]

Telemedicine is a highly effective way to address access barriers in the current legislation, which disproportionately impact marginalised communities and those without accessible transport. However, telemedicine is currently only permitted until the COVID-19 emergency ends. To better serve the needs of patients seeking abortion in early pregnancy, **we recommend that telemedicine be maintained as a permanent feature of abortion care provision after the pandemic.**

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

[95] Aiken, ARA, 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: 1464– 1474. https://doi.org/10.1111/1471-0528.16668

[96] ARC & Grimes, 2021, Too Many Barriers, p. 49.

[97] ARC & Grimes, 2021, Too Many Barriers, p. 79.

Section 3: BARRIERS IN IMPLEMENTATION

Lack of information about accessing abortion services

Our survey found that there is a significant gap in terms of information on how to access an abortion: 54% of respondents reported that they did not know where to go to get an abortion, only 65% were aware that abortion was free when they initially sought care, and 32% said they did not know where to find information on abortion.[98] These findings mirror information provided by ASN, who report they have been contacted by multiple abortion-seekers resident in Ireland who either had not heard of MyOptions or thought that ASN was the MyOptions helpline.

Our survey also revealed a worrying lack of information about what the abortion procedure and process would involve. While 79% of respondents reported that they felt that they were given all the information they needed about the procedure during their first appointment, 16% felt they were not. One participant said:

> "Information provided by the doctor was vague, leaving me scared and nervous something would go wrong. [I was] not offered a follow up or any sort of scan/blood work."[99]

Survey respondents also highlighted a need for more information about counselling services, and referrals to such supports through MyOptions, particularly to those with a diagnosis of fatal foetal anomaly, who have passed the 12-week limit and/or had pre-existing health conditions. MyOptions itself only provides information and counselling between 9am and 8pm on weekdays and 10am to 2pm on Saturdays, which is insufficient when people are facing crisis pregnancies in the context of a 12-week limit on abortion. GPs and hospitals should also ensure patients are referred to counselling support.

Another issue is accessibility. MyOptions is not fully accessible. While the provision of Irish Sign Language (ISL) is welcomed, not all in the Deaf community speak ISL. This provision also does not support people with speech impairments, language processing impairments or neurodivergent people. Moreover, interpretation is not always made available to those accessing abortion services who require it. In our survey, six respondents stated that they needed an interpreter at their appointments but only four were provided with one.[100]

The effect of the identified information gap is compounded by the ongoing impact of rogue crisis pregnancy agencies. The goal of such agencies is to prevent abortion access through misinformation, intimidation and harassment. Many have been operating in Ireland for over a decade and have continued to do so after the introduction of legal abortion services.[101]

[98] ARC & Grimes, 2021, Too Many Barriers, p. 28.

[99] ARC & Grimes, 2021, Too Many Barriers, p. 35.

[100] ARC & Grimes, 2021, Too Many Barriers, p. 35.

[101] see e.g. Christine Bohan, 'How rogue crisis pregnancy agencies have been operating outside the law here for more than a decade', The Journal.ie, 5 September 2016, https://www.thejournal.ie/rogue-pregnancy-advice-agencies-2964770-Sep2016

Especially concerning is the fact that some have even mimicked the HSE services.[102] In 2022, the HSE is still issuing warnings to avoid such "disingenuous agencies," while simultaneously failing to introduce appropriate legislation to regulate them.[103] In our research, 12 participants reported encounters with rogue agencies, with one participant recalling: "I went to get a pregnancy test and look at options but they only tried to talk me out of abortion and toward adoption".[104] Similar stories are reported by ASN, where clients report having been lied to regarding gestational age, directed towards adoption, and "traumatised" by their experiences. One ASN client, who had been raped in an abusive relationship, was delayed from accessing care by two rogue agencies, denied care or a referral from an Irish hospital, and eventually needed to travel for abortion. Marginalised people, such as disabled people or migrants, can be particularly vulnerable to the false information being stated by these rogue agencies.

A number of survey respondents indicated frustration and surprise that they had to contact GPs to book an appointment themselves. Some respondents reported having to call numerous GPs before finding one who could provide an appointment. Others reported rude treatment from reception staff that upset and intimidated them. Adding a booking service to MyOptions would streamline timely access to care, and prevent abortion seekers from falling prey to misleading rogue agencies.[105]

We recommend that steps are taken to promote respectful, patient-centred care through the provision of clear, understandable information about how to access abortion services. We also recommend that the practice of deceptive agencies is ended without delay through appropriate regulation.

Lack of information about the medical abortion process

Despite the high percentage of respondents in our survey who said they received the information they needed, one particular gap stood out in the analysis: some patients undergoing a medical abortion did not feel they had been properly informed about the level of pain or the amount and duration of bleeding they might experience during the procedure, or advised on how to manage these effects. Respondents spoke of feeling "shocked" by the level of pain and bleeding experienced, finding the experience "scary" and "traumatising", and described being home alone, without adequate pain relief or sanitary products, and uncertain of whether there was a problem and who they should contact for advice.[106]

Providing adequate information and support at every stage of the process is crucial to providing quality abortion care, and is included in the WHO's recommendations for

[102] Evelyn Ring, 'HSE slams fake crisis pregnancy agencies', *Irish Examiner*, 3 January 2019, https://www.irishexaminer.com/news/arid-30895545.html

[103] Órla Ryan,'Frightening' language and no abortion information: Warning issued over rogue pregnancy services, TheJournal.ie, 17th January 2022, https://www.thejournal.ie/unregulated-crisis-pregnancy-services-in-ireland-5650166-Jan2022/

[104] ARC & Grimes, 2021, Too Many Barriers, p. 28.

[105] Grimes, L., et al. Forthcoming. "Analysisng MyOptions: Experiences of Ireland's Abortion Information and Support Service," BMJ Sexual and Reproductive Health.

[106] ARC & Grimes, 2021, Too Many Barriers, p. 36.

self-managed medical abortion.[107,108] If patients are informed about the levels of pain and bleeding they might experience during a medical abortion, they will be better able to prepare. ARC therefore recommends that the government take steps to make this information more widely available and ensure it is communicated to patients in an effective and timely manner.

Resources that our survey respondents suggested they would have found helpful include:[109]

> "more information on what a normal abortion looks like, and how long it can last"

> "a go-to website with some kind of forum to ask questions when going through the abortion to clarify questions and just talk about what's happening to someone who has been through"

> "some FAQ or common experiences covered on the [MyOptions] website"

Lack of choice in abortion method

Choice is a fundamental element of patient-centred care. This includes choice of method for a particular health intervention. In Ireland, pregnancies under 12 weeks' gestation can be ended through either a medical abortion (with pills) or a surgical abortion. Patients seeking abortion should be given the option to avail of whatever method they deem most suitable, and should not be asked to justify their choice of method.

Unfortunately, our research found that many were unaware of their options in this regard. Some participants reported feeling like medical abortion was being "pushed" above others. One stated:

> "medical is pushed as the best option -why? Surgical is immediate and more economic, less visceral."[110]

Another respondent said:

> "The pills were sold to me as the easier option but I was not prepared for the length of bleeding afterwards. If I was to get another abortion I would opt for a surgical one with D&C just to speed up the process."[111]

The lack of choice in abortion method can be a compounding barrier for members of marginalised groups - such as disabled people living with carers or in residential settings,

[107] Dennis, A., Blanchard, K. and Bessenaar, T., 2017. Identifying indicators for quality abortion care: a systematic literature review. Journal of Family Planning & Reproductive Health Care, 43(1), pp. 7-15.

[108] World Health Organization, 2020. WHO recommendations on self-care interventions: self-management of medical abortion, https://apps.who.int/iris/handle/10665/332334.

[109] ARC & Grimes, 2021, Too Many Barriers, p. 76.

[110] ARC & Grimes, 2021, Too Many Barriers, p. 37.

[111] ARC & Grimes, 2021, Too Many Barriers, p. 37.

asylum-seekers living in Direct Provision or people affected by domestic violence - who may lack the privacy they want or need in order to undergo a medical abortion at home.[112]

Findings such as these echo research conducted by the WHO, which found that hospitals that provide the full range of options for abortion are relatively rare in Ireland while the promotion of medical abortion is commonplace.[113] The report cited lack of expertise (e.g. doctors being unwilling or unable to perform other forms of abortion) and infrastructural limitations (e.g. shortage of operating theatres, time slots for surgical procedures, and long gynaecological waiting lists) as potential drivers of the resistance to surgical abortion. However, it should be noted that other methods, such as vacuum aspiration abortion, could be delivered safely and effectively in primary care settings and would not require an operating theatre.

The WHO report recommended that Irish practice be amended in line with international best practice, suggesting that second trimester procedures be moved into ambulatory care, and that methods such as vacuum aspiration and suction curettage be established as clinical norms.[114] **We support these recommendations.**

Lack of access to local care

ARC believes that abortion should be free, safe, legal, and – crucially – local. It is not reasonable or acceptable to expect pregnant people to travel large distances to access essential health services, yet geographic coverage in Ireland remains patchy. At present, only 10% of GPs provide community abortion care and just 10 of the country's 19 hospital maternity units provide abortion services.[115] Since these services are orientated around urban centres, the problem is particularly acute in rural areas, especially in the Northwest.

For many of the individuals who responded to our survey on abortion experiences, this lack of local access to services represented a significant barrier and burden. 57% of respondents stated that they had to spend longer travelling than they usually would to access medical care, with 30% travelling between 4 to 6 hours to access abortion services.[116] Respondents living in rural Ireland reported the greatest difficulties.[117]

Many of our survey respondents reported a lack of providers locally.[118] Some noted long wait times for appointments, sometimes of 2-3 weeks. Others described having to contact several GP surgeries before finding a provider with availability. Those who had to travel long distances for appointments generally described it as having a negative effect on their mental and physical wellbeing.[119] Many spoke of the financial costs and difficulties of arranging

[112] ARC, ASN and TFMR. 2021. "Joint Submission from Abortion Rights Campaign (ARC), Abortion Support Network (ASN) and Termination for Medical Reasons (TFMR) for the 39th Session of the UPR Working Group, 25th March 2021."

[113] Mishtal et al., 2021, Policy Implementation report.

[114] Mishtal et al., 2021, Policy Implementation report.

[115] National Women's Council, 2021, Accessing Abortion in Ireland, pp. 21-23.

[116] ARC & Grimes, 2021, Too Many Barriers, p. 8.

[117] ARC & Grimes, 2021, Too Many Barriers, p. 22.

[118] ARC & Grimes, 2021, Too Many Barriers, pp. 33-34.

[119] ARC & Grimes, 2021, Too Many Barriers, pp. 44-45.

travel, especially when relying on public transport or lifts. Others spoke of having to arrange childcare and take extra time off work. Many noted that having to travel far to an unfamiliar place made them feel more upset and vulnerable than they otherwise would have. Many also reported experiencing physical illness – such as vomiting, cramping and bleeding – while in transit on these long journeys.

This barrier is particularly difficult for disabled people; for example, a wheelchair user would find it near impossible to be able to book public transport for a 4-6 hour journey once, never mind twice in three days. Travellers, people experiencing socio-economic disadvantage (particularly those who may need childcare), and people in Direct Provision also face additional challenges in accessing services at a distance.

We strongly recommend that steps be taken to register more GPs as abortion care providers, especially in rural areas, and to ensure full participation in abortion provision by all 19 maternity hospitals. This is the only way to ensure that the full suite of abortion services - including both community and hospital-based care - are available and accessible to all pregnant people in Ireland. The introduction of Safe Access Zones will be critical in achieving more providers.

Issues accessing services due to citizenship status

Despite the fact that the 2018 Act states that abortion care is free for anyone resident in Ireland, in practice, those without a Personal Public Services Number (PPSN) or medical card are often obligated to pay for abortion care themselves.[120] This gap between the law and practice can prevent people without PPSNs from accessing abortion care free of cost, especially asylum seekers who have recently arrived in Ireland, undocumented migrants and international students. Free abortion care is also unavailable to residents of Northern Ireland.

In our research, people who were not able to produce their PPSN at the appointment were asked to pay for their care directly; in some cases this led to a delay in care, while in others the patient had to cover the cost.[121] ASN has also been contacted by residents of Ireland who were told to apply for PPSNs in order to access abortion or else find the money themselves. One wrote:

> "I'm in Ireland for almost 2 years and just found out that I'm pregnant. I'm considering abortion, but I have no money cause I'm a language student and only work part time. I'm probably 8 weeks by now, and I need help."

Issues relating to citizenship are compounded when a pregnancy is beyond 12 weeks. One ASN client, an 18-year-old asylum seeker who was pregnant as a result of rape, was concerned that she would not be able to return to Ireland if she left the country to access an abortion. The client's solicitor had incorrectly believed that access to abortion in cases of rape was legal post-12 weeks LMP, and was trying to organise an abortion on risk to health

[120] ARC & Grimes, 2021, Too Many Barriers, p. 43.

[121] ARC & Grimes, 2021, Too Many Barriers, p. 43.

grounds. Social workers often contact ASN asking for information on how to support refugees and asylum seekers to access abortion care.

We should not be relying on a UK charity to support the most vulnerable in our society. **We recommend the government take steps to close the gap between policy and practice so that abortion is freely available to any individual resident in Ireland, regardless of citizenship status.**

Issues accessing services due to disability

As we have already discussed in other sections of this submission, disabled people (including those with long-term physical illnesses and mental health conditions) often face additional barriers to accessing appropriate care due to their specific health needs. In our survey, 45% of respondents who fit these criteria stated that it had affected their experience of getting an abortion.[122] Some described how barriers, such as logistical and transportation challenges and accessibility and privacy issues, led to increased stress and waiting times that were detrimental to their mental and physical health:

> "I have depression and anxiety so the lead up to it worsened it".[123]
>
> "the ordeal was extremely stressful and I had to go to hospital at one stage because my mental health was so poor."[124]
>
> "Borrowing money and working as much as I could but I'm disabled so it was very hard. I hate that I owe my friends now."[125]

Finding a doctor or clinical team that is willing and able to provide abortion care to an individual with medically complex needs can also prove challenging. One survey respondent said that being disabled made abortion:

> "So much harder to access - even though I was told that I would quite likely break my spine if my pregnancy continues - they didn't want to touch me because of my disability."[126]

To increase access to services for people with disabilities, **we recommend that steps be taken to expand the geographic availability of abortion services and close the gap between policy and practice so that abortion is available to all individuals, regardless of disability.**

[122] ARC & Grimes, 2021, Too Many Barriers, p. 24.

[123] ARC & Grimes, 2021, Too Many Barriers, p. 24.

[124] ARC & Grimes, 2021, Too Many Barriers, p. 25.

[125] ARC & Grimes, 2021, Too Many Barriers, p. 43.

[126] ARC & Grimes, 2021, Too Many Barriers, p. 25.

Clinic harassment and anti-abortion protests outside providers

Anti-abortion protests outside provider clinics, including GPs, has been a persistent problem since the introduction of abortion services in January 2019.[127, 128, 129] This is concerning, since international evidence shows that such protests have a chilling effect on provision, deterring doctors from becoming providers.[130, 131]

Anti-abortion activity outside clinics also has a negative impact on patients. In ARC's survey, 14% of respondents said they had encountered anti-abortion activity while attempting to access abortion care.[132] These included:[133]

> "protests, verbal abuse, posters"
>
> "people doing rosaries and saying hurtful things about going to hell and punishment"
>
> "people with coffins outside praying"
>
> "an anti-choice sign (maybe a picture of a foetus) outside the private ultrasound clinic where I had to go to ensure I was within the 12 weeks"

Unsurprisingly, respondents found these encounters upsetting:[134]

> "It was shocking. [They were] waving [a] photo of dead babies"
>
> "It made my experience a lot harder as I was alone"
>
> "It was awful. I felt sick when I saw them. I just wanted to be left alone"
>
> "This should be illegal, they have no idea what I've been through"
>
> "It was horrendous, they don't care about women"

This is in line with international evidence showing that protests outside abortion providers create high levels of stress for abortion seekers and can be intimidating and anxiety-inducing.[135, 136, 137] Clinic protests can be an equality of access issue, especially for autistic people and those with complex post-traumatic stress disorder (c-PTSD), anxiety

[127] Eilish O'Regan, "Anti-abortion group plans six-week protest outside Holles Street," Irish Independent, September 20, 2019, https://www.independent.ie/irish-news/health/anti-abortion-group-plans-six-week-protest-outside-holles-street-38516087.html

[128] Dr. Brian Kennedy, "GP: My patients do not need to see your placards with your value judgements," The Journal.ie, August 12, 2021, https://www.thejournal.ie/readme/protest-abortions-safety-zones-5520859-Aug2021/

[129] Bernie English, "Hospital accused of ignoring calls over anti-abortion group's protests," Limerick Post, December 16, 2021, https://www.limerickpost.ie/2021/12/16/hospital-accused-of-ignoring-calls-over-anti-abortion-groups-protests/

[130] Cozzarelli, Major, Karrasch, & Fuegen, 2000.

[131] Caudill & Mixon, 2003.

[132] ARC & Grimes, 2021, Too Many Barriers, p. 60.

[133] ARC & Grimes, 2021, Too Many Barriers, p 60.

[134] ARC & Grimes, 2021, Too Many Barriers, p 60.

[135] Greene Foster, Kimport, Gould, Roberts, & Weitz, 2013.

[136] Lowe & Hayes, 2019.

[137] Reddy & Nolan, 2019.

disorders or a variety of mental health conditions. It has also been reported that protests, especially outside maternity services, can cause distress for those attending for pregnancy loss, pregnancy complications, fertility treatment and a range of other obstetric related concerns.

ARC supports the right to protest and has no objection to those against abortion publicly demonstrating. However, when these demonstrations are outside abortion providers, this right collides with a person's right to access abortion services safely. **We therefore support efforts to legislate for the creation of Safe Access Zones (SAZs) - that is, designated areas where protests and demonstrations are prohibited - around clinics providing abortion services.** Calls for SAZs in Ireland are supported by a wide range of civil society and human rights organisations, including Together for Safety, Amnesty Ireland, and the Irish Council for Civil Liberties (ICCL).[138] There is also strong public support for the introduction of SAZs.[139] Similar legislation has already been passed in parts of the UK, USA, Canada, and Australia, demonstrating feasibility.[140, 141]

Quality and reliability of ultrasounds and scanning

An individual requesting a first trimester abortion may be required to undergo ultrasound scanning in order to determine gestational age and/or to address any clinical concerns.[142] However, a lack of availability of quality ultrasound scanning can act as an additional delay to abortion care. As ultrasounds are used to determine eligibility towards the end of the first trimester, even brief delays can lead to a pregnant person exceeding the 12 week limit and being unable to access abortion.

The WHO study found that GPs in Ireland lack clear and consistent pathways to refer patients for ultrasounds, and that this lack of clarity acts as a delay. One provider stated: "I sent in scan requests [...] on a Monday or Tuesday, and I get a phone call on the Thursday or Friday, we've got no Sonographer. [T]hen I have to go back and try and source this somewhere else".[143]

Similarly, ARC research found that scans delay care, with 53% of patients waiting more than three days after the scan to access abortion. Many participants noted having to travel

[138] ICCL. (2020). A Rights Based Analysis of Safe Access Zones. Irish Council for Civil Liberties. Retrieved September 5, 2021, from https://www.iccl.ie/wp-content/uploads/2020/01/ICCL-Investigation-Abortion-Safe-Zones.pdf

[139] Ryan, 2020.

[140] Oireachtas Library & Research Service, 2019, L&RS Note: Safe access zones – What do other countries do? https://data.oireachtas.ie/ie/oireachtas/libraryResearch/2019/2019-05-08_l-rs-note-safe-access-zones-what-do-other-countries-do_en.pdf

[141] Government of Western Australia. (2021, August 18). Public Health Amendment (Safe Access Zones) Act 2021. Retrieved from https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/Public-health-act/Public-Health-Amendment-Safe-Access-Zones-Act-2021.pdf

[142] The guidelines note that ultrasound can also be used to counsel on whether surgical or medical abortion is most appropriate; in practice, medical abortion is offered regardless.

[143] Mishtal et al., 2021, Policy Implementation report, p. 14.

[144] ARC & Grimes, 2021, Too Many Barriers, p. 38.

across the country to access scans, with one paying for a private ultrasound to ensure that she did not exceed the 12-week limit.[145]

ARC research also demonstrated that quality of ultrasound scanning and care can be an issue. One participant shared that her pregnancy was dated incorrectly and so she was forced to travel for care:

> "[I] was told I was over 12 weeks and had to travel and pay around 600 euro, turns out I was 8 weeks and was told 12 weeks incorrectly by the doctor and didn't have to travel or spend all my savings and end up losing my room."[146]

Another noted inappropriate language from the sonographer referring to "my 'baby', and asking if it was my first".[147] This highlights the need for values clarification for all those involved in the provision of abortion care.

Information from ASN also shows issues with scanning. Its clients reported delays of between three days and 2.5 weeks while waiting for scan results. One client, a single parent with two children, had their scan delayed by five days and was then scanned at 11w5d and told they were ineligible for abortion in Ireland, despite being within the 12-week limit. Another client, a mother of three who had recently left an abusive relationship, initially got in touch with ASN while waiting for a scan in Ireland which she believed would show she was over 12 weeks gestation, meaning she would most likely need to travel. Her scan in Ireland dated her at 17-19 weeks. When she travelled for her abortion two weeks later, she scanned at 23w3d - meaning that she was at least two weeks further along that she had been told in Ireland and close to the cut-off for legal abortion abroad. This client struggled with mental health issues as well as domestic abuse; poor scanning in Ireland nearly meant that she could not access abortion even outside the state.

ARC recommends that the ultrasound service is assessed for suitability, that values clarification is provided to sonographers, and that timely and accessible high-quality scanning services are provided to all patients who need it. We further recommend that the HSE consider contracting with private scanning companies to serve patients' needs.

Contraception choices and costs

The government had promised to introduce a universal scheme of free contraception for all people living in Ireland.[148] To date this has not been achieved. While we welcome the introduction of free contraception for women aged 17-25 from August 2022, more needs to be done.[149] Ireland is one of the few countries in the world which charges people for contraception. The most effective forms of contraception, including Long-Acting Reversible

[145] ARC & Grimes, 2021, Too Many Barriers, p. 43.

[146] ARC & Grimes, 2021, Too Many Barriers, p. 38.

[147] ARC & Grimes, 2021, Too Many Barriers, p. 40.

[148] Health Services Provision, Parliamentary Questions (32nd Dáil), Houses of the Oireachtas, 10th October 2019, https://www.oireachtas.ie/en/debates/question/2019-10-10/11/

[149] Department of Public Expenditure and Reform, Your guide to Budget 2022, https://www.gov.ie/en/publication/2c63a-your-guide-to-budget-2022/

Contraceptives (LARCs), are the most expensive.[150] While these are free for people on medical cards, costs in other cases can be prohibitive.

According to the WHO, access to contraceptive information and services enables individuals and couples to live healthy sexual lives, reduce their risk of unintended pregnancies and plan the number and spacing of their children, if any.[151] The Irish Family Planning Association (IFPA) recommends that any phased-in approach, such as an initial roll-out to all under-25s, should be part of a clear plan with a timeframe for its extension to all those requiring it.[152]

For these reasons, **we recommend that the government provide, at no cost, all methods of contraception approved by Irish regulatory agencies to all who wish to avail of them, regardless of age or gender.**

Healthcare and administration staff attitudes and behaviour to patients

The WHO reports that Ireland's hospital abortion services have been "set up by a handful of 'champion' doctors, nurses and midwives".[153] The dependence on the willingness and initiative of a handful of healthcare staff shows the fragility of abortion provision, and the general negative attitude that is still prevalent among healthcare providers.

Our survey found that a majority of the respondents were positive about their experience of treatment by healthcare providers and staff. However, it also identified problems with stigma, prejudice and discrimination in clinical settings, with 22% of respondents saying they did not feel they were not treated with dignity and respect by healthcare providers and staff. [154]

One recalled:

> "Felt shamed, judged, less than. Like a bad smell who had walked into the room, from the receptionist to the actual doctor, nothing but judgement."[155]

Refusal of care, judgement, dissuasion and obstruction were all reported.[156] These issues can cause significant delays in access to abortion services. In some cases, even potentially well-intentioned providers expressed attitudes that had a negative impact on patients. For example:

> "The doctor was a young man. He seemed like a nice person and he did treat me with respect, but at the first appointment, he suggested I might regret going through with it. I had to sort of assert myself and when going in for the second appointment, I was worried he might try to put me off. I don't think it was at all intentional on his

[150] LARC methods: entering a new age of contraception and reproductive health

[151] WHO, Ensuring human rights in the provision of contrapceptive information and services, 2014, https://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

[152] Irish Family Planning Association, Universal, free access to contraception in Ireland, September 2021, https://www.ifpa.ie/app/uploads/2021/09/Universal-free-access-to-contraception-in-Ireland-%E2%80%93-Framework-Report.pdf

[153] Mishtal et al., 2021, Policy Implementation report, p.18.

[154] ARC & Grimes, 2021, Too Many Barriers, pp. 57.

[155] ARC & Grimes, 2021, Too Many Barriers, pp. 59.

[156] ARC & Grimes, 2021, Too Many Barriers, pp. 55-61.

> part and I don't think he was being judgmental exactly though I got the impression he found it regrettable. [...]. This all made the whole experience even more difficult."[157]

The care provided to people dealing with a foetal anomaly also appears, in some cases, to be sadly lacking. ASN shared multiple reports from people they have helped who found their treatment in Ireland to be cruel or degrading - from being pressured to delay their abortion travel to engage in additional testing (even after a serious foetal anomaly had been definitively established) because they "wouldn't be able to live with themselves if they had an abortion before knowing exactly what was wrong," to being told burial in the hospital's "garden of angels" cemetery would be denied them if they had an abortion abroad.

Values clarification workshops have already proven valuable in some hospitals providing abortion services in Ireland, where they have been described as "key facilitators" of services.[158]

We therefore recommend the expansion of values clarification training provision, as well as anti-racism training, to all medical practitioners, reception staff, and hospital staff whose work intersects with abortion care.

Problems with hospital facilities

In the sections above, we have already identified a number of problems relating to hospital-based abortion provision, including:

- Poor distribution of ultrasound scanning services to date.
- Problems arising from inaccurate scanning results.
- Inadequate access to surgical abortion and hospital-based care.
- Nine of 19 maternity hospitals refuse to provide services, and three of the hospitals that do provide services are in Dublin, exacerbating the geographical barriers faced by many.
- At least one maternity hospital has asserted that it will not provide any abortion care, violating the Act's prohibition on institutions (as opposed to individuals) refusing to provide care.[159]

Clearly, there is not only an uneven geographical distribution of care available in hospital services and facilities, but there are also significant problems within the hospitals that do provide abortion care. The WHO underscores that there are significant challenges in accessing surgical abortion care due, in part, to infrastructural limitations including difficulties in accessing hospital operating theatres, shortage of providers, and objections

[157] ARC & Grimes, 2021, Too Many Barriers, p. 57.

[158] Mishtal et al., 2021, Policy Implementation report, p. 22.

[159] Catherine Shanahan, "Kilkenny Hospital Unsuited to Abortions, Say Medics," Irish Examiner, June 22, 2019, https://www.irishexaminer.com/breakingnews/ireland/kilkenny-hospital-unsuited-toabortions-say-medics-932314.html

raised by theatre staff.[160] These issues arise on top of the unclear referral pathway into hospital provision, as outlined by the National Women's Council.[161]

The limits on hospital facilities and the difficulties with referrals into hospital care means that many pregnant people exceed the 12 week limit and can be unable to access an abortion. Information supplied by ASN indicates that several clients were scanned at 11w4d-11w6d and told they were ineligible for care, or that there were no appointments available before their time ran out. One client was scanned on Thursday, told her pregnancy was at 11w4d on Friday, and advised to return the next week for a second opinion scan rather than being given a surgical abortion while she was within the legal time limit.

As discussed above, these issues also make surgical abortion under 10 weeks very difficult to access and mean that people have a limited choice in abortion method.

ARC recommends that more state resources be dedicated to gynaecological units across the country, to improve the standard of obstetrical care, and to list abortion provision as part of the job responsibilities in hospital positions.

[160] Mishtal et al., 2021, Policy Implementation report, p.18.

[161] National Women's Council, 2021, Accessing Abortion in Ireland, p.38.

RECOMMENDATIONS

We recommend that the government improve the availability, accessibility, acceptability, and quality of abortion care, to safeguard human rights, in line with WHO best practice, by taking the following steps:

I. Remove barriers to abortion in the legislation

- Decriminalise abortion in all circumstances, to support patient-centred care and bring Ireland in line with recommendations of the European Court of Human Rights, the WHO, and the United Nations.
- Repeal the mandatory 72-hour waiting period, in line with recommendations from the WHO and Council of Europe's Commissioner for Human Rights.
- Repeal the arbitrary 12-week limit for abortion on request, in light of evidence regarding the high numbers of people who are still travelling abroad for abortion care, to reduce the significant financial, physical and emotional hardship involved.
- Make explicit the right of transgender, non-binary, and intersex people to access abortion care. ARC strongly recommends that the wording of the legislation is altered to include "pregnant person/people" throughout.
- Repeal refusal of care ("conscientious objection"), in line with international evidence that this creates a barrier to accessing abortion.

II. Remove barriers in the clinical guidance

- Revise HSE clinical guidance to ensure that any abortion procedure initiated by patient and doctor before the current 12-week barrier can be legally brought to a conclusion within the state, even if a procedure fails and does not terminate the pregnancy.
- Integrate abortion and values clarification training into all medical curricula, and continuing professional development for these and all areas of healthcare support.
- Increase access to abortion by authorising nurses, midwives, and other medics to provide abortion care, in line with international best practice, and formalising peer support programmes.
- Repeal ambiguous wording regarding abortions for health risks and "fatal" foetal diagnoses.
- Provide legal avenues for abortion in all cases where foetal anomalies are diagnosed.
- Provide continuity of care for those who access abortion outside the state, developing and implementing clear referral pathways for those who cannot access care within the state.
- Maintain telemedicine as a permanent feature of abortion care, to maximise availability of abortions, in line with best international practice and research demonstrating the safety of telemedicine for abortion care.

III. Remove barriers in implementation:

- Improve access to knowledge and information about abortion:
    - Expand and further raise awareness of the HSE's MyOptions abortion information service, to make it widely known and accessible to all, including disabled people and people who do not speak or read English.
    - Legislate for and fully implement an end to deceptive rogue agencies that deliberately misinform patients about abortion.
    - Increase the operating times of MyOptions.
    - Ensure that all patients considering an abortion are given referrals to a counselling service.

- Increase patient choices when it comes to abortion method; increase access to aspiration abortion to give patients access to the method they prefer, especially to ensure the privacy rights of people who live in shared accommodation; and make abortion between 10-12 weeks available in non-hospital settings.

- Provide clear information about what to expect from a medical abortion, and ensure it is communicated to patients in an effective and timely manner.

- Improve the geographic distribution of primary care and hospital providers, to ensure that people can access abortion locally. At present, only 10% of GPs provide community abortion care and just 10 of the country's 19 hospital maternity units provide abortion services.

- Fully implement the guarantee of free abortion care for all who live in Ireland, regardless of citizenship status, without requiring a PPSN or medical card. This should include access to free abortion for residents of Northern Ireland.

- Legislate for and fully implement Safe Access Zones so that health care practitioners can provide and patients can access abortion care without harassment. This should also have the effect of increasing the number of GPs providing abortion services.

- Increase the number of ultrasound providers and the accuracy of scans, and values clarification training for sonographers.

- Provide all methods of contraception approved by Irish regulatory agencies at no cost to all who wish to avail of them, regardless of age or gender.

- Improve the resourcing of gynaecological units to improve standards of care, and include abortion provision in all job descriptions in hospital positions.

- Collect data that will facilitate evaluation of, and improvements in, abortion care provision, without policing doctors, and safeguard all such data with robust privacy protections. The data should be suitable for disaggregation by gender, race/ethnicity, migration status, and disability to increase understanding of how membership of particular groups affects access to abortion; collecting and analysing this data is the only way we can ensure access to abortion care is equal to all.

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