Submission by Abortion Access Campaign West
on
Ireland's Review under the International Covenant on Civil and Political Rights 2022
regarding
Termination of Pregnancy
in
'Termination of pregnancy, maternal mortality and reproductive rights' (arts. 2, 3, 6, 7 and 24).

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Abortion Access Campaign West (AAC West) is a women's collective based in Galway. We aim to ensure that those who need abortion care receive it in a respectful and caring environment that meets their needs. AAC West is particularly concerned about securing abortion services for marginalised groups and is in regular contact with doctors in the West of Ireland on how abortion services are being implemented.

AAC West has made a submission report in preparation for the Irish government's 3 year Review of the Health (Regulation of Termination of Pregnancy) Act 2018 which is currently underway.

AAC West ask that our research and recommendations outlined in our submission attached are taken into consideration in respect of Ireland's review under the ICCPR 2022.

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(a) '…the inclusion in section 12.3 of the Health (Regulation of Termination of Pregnancy) Act of a mandatory three-day waiting period after a woman requests an abortion, including its application in cases where the gestational age of the fetus is close to the 12-week cut-off point, and the effects of such provisions on women's access to services, including reports of women being denied abortions and/or having to travel abroad for such care…'

Mandatory waiting period.

There are difficulties for certain women in complex situations being forced to attend two separate appointments in order to access an abortion in Ireland i.e., 1st appointment to register request for service, 2nd appointment to receive treatment after serving the 3-day mandatory waiting period.

Provisions must address the justice gap and ensure access to abortion care to those who, because of financial concerns/ economic disadvantage, are not able to access such care. Lack of transport and difficulties travelling to nearest abortion provider is a problem, especially in rural areas. Precarious employment, or inability to obtain time off work, dependency on availability of alternative carer/childminding arrangements, ill health or disability mobility restrictions, domestic violence or family control issues preventing free movement can all act as unsurmountable barriers because of the imposition of the 3-day waiting period.

Extra demands can also entail women being put in a position of having to inform others of their pregnancy to make the necessary arrangements to attend the extra appointment enforced by the mandatory waiting period- which compromises privacy and confidentiality.

Official statistics calculate that 98% of terminations in the state occur where the gestational age of the foetus is under the 12-week cut-off point for abortion. We do not know however the percentage of patients who attended an appointment to register their request for an abortion but did not follow this up after serving the mandatory waiting period, or why they failed to do so. Consideration must be given to the likely possibility of extenuating circumstances preventing them from doing so- rather than a change of mind during the mandatory waiting period.

Gestational age of the foetus is close to the 12-week cut-off point.

A feature of the deliberations of the Oireachtas [Houses of Parliament] Joint Committee on the Eighth Amendment of the Constitution was that timely access to abortion is key. This is particularly relevant in cases where the gestational age of the foetus is close to the 12-week cut-off point and a mandatory 3-day waiting period must be served after a woman has registered a request for an abortion.

Statistics published by the UK Department of Health and Social Care (2020) reveal that 375 women and pregnant people travelled from Ireland for abortions to England and Wales in 2019. Most of these cases are those who have gone beyond the 12-week gestational age limit,

as well as cases of failed early medical abortion (EMA).
Under Section 12 of the Health (Regulation of Termination of Pregnancy) Act 2018, abortion is accessible up to 12 weeks gestational age. The Chief Medical Officer confirmed that the 12-week limit is to be strictly interpreted; in other words, "12 weeks plus 1 day exceeds 12 weeks. Therefore, 12 weeks is 12 weeks plus 0 days" (Kennedy, 2021.)

The limit of 12 weeks + 0 days is still adhered to even if an EMA was attempted earlier in the pregnancy. This has led to some women having to continue with the pregnancy after an attempted EMA because they had reached the 12-week limit. Continuation of pregnancy after an attempted abortion has serious effects on the foetus.

How many women/pregnant persons go over the limit of 12 weeks + 0 days gestation because of having to serve the 3-day waiting period is unknown but is no doubt an issue.

*Numbers of cases should be recorded, and the statistics made available for scrutiny which include how many women are denied abortion on gestational age grounds in such circumstances and/or must travel abroad for abortion care.

*A change in the legislation to remove the mandatory waiting policy entirely would be in the best interest of patients, ensuring that those seeking an abortion have a greater chance of availing of one, and that it is free, safe, legal, and available in the state.

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(b) '…reports that the provisions in section 11 of the Act concerning exceptions to the 12-week limit on the basis of fetal abnormalities convey overly restrictive requirements, which could, in certain cases, limit access to abortion in cases of serious risk to the future health of the unborn child'

Overly restrictive requirements concerning abortion iro: foetal abnormality post 12-week.
The overly restrictive legislation contained in the Health (Regulation of Termination of Pregnancy) Act 2018 and implementation of policy does not take a patient-centred approach, in regards to access to abortion in cases of foetal anomaly. Decisions should be patient centred. The Act does not allow for termination in cases classified as non-fatal foetal abnormalities regardless of how serious a risk to the future health of an unborn child.

Statistics published by the UK Department of Health and Social Care (2020) reveal that 375 women and pregnant people travelled for abortions to England and Wales in 2019. Most of these cases are those who have gone beyond the 12-week gestational age limit set by the Act for abortion upon request, as well as cases of failed early medical abortion (EMA) and cases of foetal anomaly.

Under Section 12 of the 2018 Act, abortion is accessible up to 12 weeks gestational age. The Chief Medical Officer Dr Tony Holohan confirmed in November 2018 that the 12-week limit is to be strictly interpreted as 12 weeks + 0 days. and further in the 2018 guidelines of the Institute of Obstetrics and Gynaecology
(see https://www.rcpi.ie/news/publication/interim-clinical-guidance-on-termination-ofpregnancy-under-12-weeks/, accessed July 2021)

Foetal Abnormality.
The strict 12 week + 0 days limit is still adhered to even if an EMA was attempted earlier in the pregnancy. This has led to some women having to continue with the pregnancy after an attempted EMA because they had reached the 12-week limit. Continuation of pregnancy after an attempted abortion has serious effects on the foetus and more than likely will not make it to term or will be born having serious health conditions. (Fielding, 1978).
Serious foetal health conditions do not warrant abortion care under the Act unless confirmed and accepted as 'fatal enough' i.e., that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth.

*A change in the interpretation of the legislation and a change in policy could allow abortion post-12 weeks in cases of failed EMA. If it is the same pregnancy, then the abortion should be completed.

Section 11.1 of the 2018 Act states that two medical practitioners, one being an obstetrician, must be "of the reasonable opinion formed in good faith that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28

days of, birth".
The restrictive specifications of Section 11 have left hundreds of Irish women with foetal abnormality conditions having to continue with the pregnancy or travel abroad for care because medical practitioners cannot guarantee when the foetus will die, and if it will be within 28 days of life. While there are many life-limiting foetal diagnoses, putting a timeframe in legislation makes it extremely difficult to certify.

The Institute of Obstetricians and Gynaecologists guidelines provide a list of diagnoses which are considered fatal (IOG, 2019).
Service providers tend to interpret these lists restrictively. This list is not a complete list, and should not be considered so, yet research carried out with patients has found that women were told the foetal anomaly "…did not tick a box" and therefore they had to travel abroad or continue with the pregnancy. (Mishtal et al., 2021)

In cases of foetal anomalies, all decisions are under review by a multidisciplinary team (MDT). An MDT "is a formally constituted committee of the hospital – this is likely to be at hospital group level where the foetal medicine expertise is concentrated" (IOG, 2019).
This means that several doctors, sometimes up to 10 - 12 experts, are reviewing one case, even though the legislation states that only two medical practitioners are needed to sign off on an abortion under Section 11.
The patient's consultant presents the case to their colleagues who all debate the case. This practice completely removes the woman from the decision-making process and does not take her wishes into account. The woman is left relying on her consultant to present her case sufficiently to gain approval from the MDT for the abortion. Having 10 to 12 doctors agree on complex cases is always challenging, and not legally necessary.

The natural reaction of healthcare practitioners is to make conservative judgements to ensure that they cannot be prosecuted as abortion in Ireland remains a criminal offence if undertaken outside of the very narrow context legalised as part of the 2018 Act. Ongoing criminalisation provides a critical context for services and individual service providers.
Carnegie and Roth (2019) outline early examples of the challenges facing women and abortion services providers because of the combination of criminalisation and the use of ill-defined terms in the legislation; these include a couple having to travel to the UK because their pregnancy was not considered fatal, despite life threatening anomalies.
Many similar examples continue to date (see Fegan, 2019; Hogan, 2019; Calkin, 2020; Enright, 2021; Kennedy, 2021).

*The anomalies and conditions affecting a foetus that warrant a patient to be able to avail of abortion care must be expanded.
*The practise of using multiples of practitioners to review and determine likely fatality of foetal anomalies in relation to abortion legislation must be addressed.
*Abortion must be decriminalised to allow medics to do their job correctly in the best interests of their patients rather than having the chilling effect of 14 years imprisonment over-riding their opinions.

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(c) 'barriers to the provision of abortion services as now mandated by the law, including resistance to provision of services among general practitioners, the continued criminalization of medical professionals for undertaking abortions outside the scope of the new law and the reported chilling effect on their interpretation of such provisions, and efforts by those opposed to abortion to undermine the legal rights of Irish women to safe, legal and free abortion services'

Resistance to Provision of Services among General Practitioners
Just 10% of all general practitioners (GPs) nationally have opted into providing abortion services. Half of the counties in Ireland have fewer than 10 GPs offering the services as of May 2022. (Independent.ie Coyne 25/5/22)

Conscientious objection is dealt with in Section 22 of the Health (Regulation of Termination of Pregnancy) Act 2018.
It is concerning that the number of medical practitioners exercising their right to conscientiously object to carrying out the termination of pregnancies may be so high as to limit the number of primary care givers and hospitals around the country providing abortion services.
*This needs to be officially and comprehensively investigated and addressed.

Section 22 of the 2018 Act frees medical practitioners, nurses, and midwives from the obligation to provide lawful abortion care on grounds of conscientious objection. It does not refer specifically to hospitals, and it does not refer to the wider health and social care professions with whom a pregnant person may come into contact, and to whom considerations of conscientious objection may also apply.
*The legislation should ensure appropriate referral mechanisms for transfer of care by the wider cohort of health and social care professionals in the event of conscientious objection.

Section 22 fails if its purpose is to provide a lawful "out" to a conscientious objector while at the same time ensuring that a woman's legal rights to a medical procedure are protected. Lack of access to abortion services in a local primary care setting/ hospital is not an equivalent substitute to the provision of care at another primary care provider/ hospital when one considers the added obstacles and burdens to accessing that care in a distant or difficult to reach location. It is not a choice between two equally legitimate possibilities.

Those who conscientiously object "must refer the woman to a willing and trained provider in the same area, or another easily accessible healthcare facility, in accordance with national law" (WHO 2012 p. 69).
Healthcare centres which are not staffed and equipped to provide induced abortion "must be able to refer women promptly to the nearest services with minimal delay" (WHO 2012 p. 33).

There is an acknowledged deficit of general practitioners (GPs) throughout Ireland, and also of GPs willing to register new patients or take on referral patients from other practices, and

also to take on abortion care as an extra service provision. Given the distances involved in travelling to access a practitioner on the Health Service Executive (HSE) list or hospital providing abortion services, it is often extremely difficult for women to be referred promptly, urgently and with minimum delay to a willing and trained provider in the same area at another easily accessible healthcare facility. Women and pregnant people are still being forced to travel for abortion care, costing them unnecessary time, money, and trauma.

*We need clarity in Ireland as to what extent conscientious objection is being utilised and what parameters operate. The legislation should be clear as to the extent of the right of conscientious objection and the position as regards any essential aftercare.

Stigma can affect abortion service providers thus preventing them from providing abortion services.
A study of 156 hospital doctors and GPs by researchers in the National Maternity Hospital and the Coombe found that Irish doctors were more likely to be alienated by family, friends, or acquaintances due to their abortion work than their international counterparts. Some Irish doctors also reported disapproval and disrespect from colleagues over their work. (Dempsey et al., 2021)
The authors who include Mary Favier of Doctors for Choice, noted that Irish physicians who provided abortion services report higher levels of "stigma-related social isolation" from family and friends than counterparts in the USA (ibid).

Criminalisation and the Chilling Effects

Criminalisation of abortion was retained in the 2018 Act, based on confidential and unpublished legal advice from the Attorney General to the Minister for Health at the time. This means that anyone who helps a woman to procure an abortion in Ireland outside the narrow criteria of the 2018 Act could be imprisoned for up to 14 years.

The continued criminalisation of abortion has been strongly contested by many in the legal community (Carnegie & Roth, 2019).
A resolution of the European Parliament (2021) called for EU member states to decriminalise abortion to ensure international human rights standards have been met.

Ongoing criminalisation provides a critical context for services and individual service providers. This includes anyone who helps a woman get abortion pills. The major impact of continued criminalisation is on healthcare practitioners, who need to be very sure that the provision of termination services falls within the guidelines.

The 2018 Act lays out that there needs to be a risk of "serious harm" to health to permit abortion beyond a gestational age of 12 weeks. No definitions of "serious harm" or "health" are provided. This lack of clarity hampers clinical decision-making, with consequences for both women and service providers. A similar challenge surrounds pregnancy dating, since ultrasound dating requires time and resources that can take the woman beyond the 12-week limit. The natural reaction of healthcare practitioners is to make conservative judgements to ensure that they cannot be prosecuted.

It is vital to consider that restrictive interpretations, as have previously been commonplace in Irish abortion practice, likely place Ireland in breach of its international law obligations.

Carnegie and Roth (2019) outline early examples of the challenges facing women and abortion services providers because of the combination of criminalisation and the use of ill-defined terms in the legislation; these include a maternity hospital placing the time limit at 11 weeks rather than 12 to protect staff, and a couple having to travel to the UK because their pregnancy was not considered fatal, despite life threatening anomalies. Many similar examples continue to date (see Fegan, 2019; Hogan, 2019; Calkin, 2020; Enright, 2021; Kennedy, 2021).

Retaining criminalisation has meant the continuation of abortion stigma (Cullen & Korolczuk,2019) and its dangerous sequelae.
Kumar (2020) argues that criminalisation "stigmatises [healthcare practitioners], caregivers assisting in the process and women seeking abortion, all of which ultimately hinders access to safe abortion" (p. 1).
Furthermore, as Kennedy (2021) points out, "to apply criminal law to abortion exclusively sets it apart from other forms of healthcare and suggests that the doctors providing abortion care are in some way inherently less conscientious than other professionals" (p. 53).
The stigma thereby attached to abortion provision leads to fewer providers and impacts equality and timeliness of access for women.

As de Londras (2020) points out, the 2018 Act was designed to be palatable to the middle ground and was never about women's agency, freedom or rights, and thus it has failed to deliver reproductive justice to the women of Ireland.
The arguments for decriminalisation do not just consider reproductive justice, nor the "chilling effect" of criminalisation, which impacts both service providers and women seeking care (WHO, 2012; BPAS, nd).

Continued criminalisation of abortion has multiple impacts on service providers. It has facilitated those intent on exposing and harrassing abortion providers, meaning that there are many potential providers who simply are not willing to take the risk
(Carnegie & Roth, 2019).
Potential for prosecution also means that healthcare practitioners in training are less willing to specialise in this area of women's healthcare (We Trust Women, nd).

Existing rationales for retaining criminalisation are based in supposition and ideology, rather than on the existing evidence base from other countries where decriminalisation has occurred. Researchers argue that the main impact of decriminalisation is to "eliminate fears and stigma associated with potential criminal sanctions while enhancing individuals' autonomy, equality, dignity and privacy" (Johnson et al., 2019, p.125).

*Ireland needs decriminalisation of abortion to support safe abortion care, timely provision of services, protection of healthcare practitioners, and women's rights by removing Section 23 (1-7) from the legislation.

<u>Undermining Legal Rights to Abortion</u>
Rogue agencies such as the unregulated Gianna Care pregnancy agency which has branches in Galway, Dublin, and Tralee have been operational in a number of locations around Ireland since the passing of the Health (Regulation of Termination of Pregnancy) Act 2018 and implementation of the legislation in 2019. They also appear on internet searches when

women are trying to access care. They use misleading advertising and operate a free 24/7 helpline. Fraudulent helplines and websites by antiabortion groups have left women confused, distressed, and upset.

*Legislation should be introduced to ensure that these agencies do not block access to healthcare.

Many women still do not know how to access abortion services in Ireland.
In one study, half of respondents said that they did not know where to get an abortion and a third said they did not know where to find information on abortion (ARC & Grimes, 2020). Women in Ireland should not have to rely on volunteer groups to provides this information, especially as this paves the way for rogue agencies. The lack of general awareness of how to access abortion information and services has meant that a woman/pregnant person can unknowingly stumble into the hands of those opposed to abortion.

*Public awareness of how to access abortion information and knowledge of services available needs to be improved.

A study conducted by the WHO on abortion in Ireland (Mishtal et al., 2021) found that already marginalised communities and those living in rural areas are more vulnerable to informational obstruction at “point of entry”.

AAC West, based in Galway on the western seaboard of Ireland, has first-hand experience of the difficulties faced by women in isolated rural areas, many of whom have patchy or no internet access. They are susceptible to referrals to anti-abortion crisis pregnancy services or church influenced counsellors by locals who have their own agendas of obstructing abortion access.

*Official information on how to access abortion information and services must be made available to those who are not computer literate or do not have internet access.

WHO study findings recommended that migrants who are unfamiliar with health systems in Ireland require more support in accessing care (Mishtal et al., 2021). .
For reasons of culture and religion, verbally seeking information from persons within their own communities may lead to referrals to those intent on restricting abortion.
Immigrants and asylum seekers may not have English as their first language. The national booklet produced by the Health Service Executive (HSE) on accessing abortion in Ireland is available in English and Irish language only
See: https://www2.hse.ie/file-library/unplanned-pregnancy/guide-to-medical-abortion.pdf.

The HSE booklet is not available in any other European languages and there has been a major lack in the dissemination of information on how to access the service.

*The availability of information in an easily accessible format is crucial, and its promotion would help women in communities where abortion remains taboo.
*The HSE booklet needs to be translated into the 10 most common spoken languages in Ireland and distributed widely.

MyOptions is a national helpline run by the HSE that aims to provide “free and confidential information and counselling to people experiencing an unplanned pregnancy. The MyOptions

information line is only available 9am - 8pm Monday to Friday, 10am – 2pm Saturday. This has left women who are seeking information on an unwanted pregnancy outside of these times opting for using 24/7 freephone help lines, the likes operated by Gianna Care.

*More advertising of MyOptions and the services it provides is essential. The information and counselling line must be available 24/7.

Women are at risk of encountering anti-choice General Practitioners (GPs) and receiving judgement or bias from receptionist staff when trying to make an appointment. This creates an additional barrier.
MyOptions does not arrange appointments, the onus is on the woman to do this herself. Some women who rang the MyOptions line and were provided with numbers of providing GPs were still unable to make an appointment because staff were unaccommodating (Grimes, O'Shaughnessey et al. 2022)

*MyOptions could provide an efficient and timely booking service for women to help avoid such situations.

Anti-abortion campaigners have established protests outside some of the healthcare services providing abortion from the very introduction of the new services in Ireland in 2019. Patients accessing abortion services, GPs and medics delivering the service deserve privacy, dignity and safety.

During the passage of the 2018 Act, the issue of legislation covering safe access zones around the premises of abortion service providers was raised. A majority agreed that patients have a right to access healthcare services without intimidation or harassment. It was decided, however, to consider the issue separately later.
Legislation on this issue was promised by the Government at the time but has still not been delivered.

AAC West became aware of protesters picketing Galvia West Medical Centre in Galway from just three days after termination services became available in primary care settings. Demonstrators outrageously claimed that they were targeting this medical practice because it was "on the HSE list as being an outlet for the abortion pill", drawing national media attention (Cullen, 2019).
AAC West has had feedback from abortion providers stating that concern over protesters outside surgeries may now be a barrier to GPs registering with the public list through MyOptions as a provider.

Fear of being targeted by anti-abortion demonstrators sometimes acts as a deterrent, putting GPS off from participating in abortion services. This can be especially the case in rural areas where they are embedded in the local community. Other staff working in a targeted service such as receptionists in small practices, can find such demonstrations unpleasant and upsetting which puts pressure on GPs to avoid the distress by not providing the service. This can leave women without any primary service abortion provider in their area. Ireland requires

more general practitioners/medics providing abortion treatment; they need encouragement, not dissuasion.

On 2nd January 2020, after anti-abortion protesters demonstrated outside the National Maternity Hospital, the then Minister for Health once again committed to implementing safe access zones around hospitals carrying out termination procedures.

The Programme for Government also contains a commitment to "Establish exclusion zones around medical facilities" (Department of the Taoiseach, 2020, p. 47).

On 17th November 2020 the Minister for Health Stephen Donnelly said:
"Women and healthcare staff should be assured that there is existing legislation in place to protect them [service providers] and to protect patients."
This is not the case.

It came to the attention of AAC West that there were instances of anti-abortion protesters assembling outside a Galway hospital providing abortion services.

People using targeted healthcare premises contacted AAC West, relating to us how distressing their experiences were. Upsetting graphic imagery and cruel, judgemental sloganeering is commonly used.
AAC West has been told that patients from all age groups have complained of feeling uncomfortable or frightened having to pass anti-abortion protesters.
The effects of demonstrations, and of being identified by protesters, can have negative consequences for individuals in their employment and private lives. This fear of even facing a potential anti-abortion demonstration sometimes acts as a deterrent, putting patients off from attending a clinic or hospital for their treatment.

AAC West has members with personal experiences of the need for safety zones. These include:
● Genuine concerns of being approached, which is even more frightening if one must attend the premises alone.
● Having to pass an anti-abortion demonstration outside a multi-purpose health centre being an intimidating ordeal, causing worry of being labelled a "murderer" (The Journal, 2020).
● Accompanying a woman accessing an abortion service with anti-abortion protesters outside the building. The prospect of having to pass such a demonstration when accessing treatment forces some patients to have to resort to telling a friend, or even a stranger, their personal health details to secure a companion to cross the path of the protesters and get into the building safely. Some activists around the country offer a service providing escorts because there are patients who feel they need them.

Although anti-abortion demonstrations had subsided during the Covid-19 pandemic, some continued to take place in both urban and more rural settings, including outside Limerick Hospital and a rural GP surgery in County Roscommon. There is no reason to doubt that the number and frequency of such demonstrations will increase again now that pandemic restrictions have ceased.

An undercover reporter revealed a campaign led by US organisation Sidewalk Advocates for Life (Coyne & O'Neill, 2019) whose aims include targeting patients and medics across Ireland.

This campaign has links to the unregulated Gianna Care pregnancy agency which has branches in Galway, Dublin, and Tralee.

Currently, individuals seeking to access abortion services without the traumatic experience of encountering a protest that is taking place outside a healthcare facility, and staff requiring demonstrators to be moved away from the premises to avoid unpleasantness, must rely on discretionary use of powers by An Garda Siochana [police]. This is proving inadequate.

AAC West has encountered instances regarding unsatisfactory responses by Gardaí to complaints:-
We were informed that a Galway medical centre experiencing anti-abortion protests outside their premises had reason to call An Garda Siochana to prevent intimidation of patients. Staff at the GP clinic contacted the gardaí whilst the protesters were outside. Regrettably, no garda personnel arrived on the scene at the time, nor responded later.
In April 2019, AAC West contacted the local Joint Policing Committee Administrator to look into this issue. Given the important role of the Joint Policing Committee, we proposed that recommendations be made so that any future complaints from the public relating to such incidents are followed up and responded to immediately by Gardaí. We heard nothing back.

There is currently no adequate legislation in place protecting those accessing abortion services premises from intimidation. There is nothing to stop protestors interfering, communicating, and causing distress to women and pregnant people outside these health care facilities.
*Necessary measures must be taken to guarantee protection rather than relying on Gardai to react with public order directives after rights have been infringed. This must be attended to urgently.

As the public in general finds harassment of patients and staff unacceptable, attempts have been made to introduce safe access zones through local by-laws:
● February 2019: A motion was passed by Louth County Council to introduce a bylaw allowing SAZs to be established around abortion service facilities.
● March 2019: An emergency motion calling for bylaws to impose “exclusion zones” outside hospitals and GP clinics that conduct abortions was moved at Dublin City Council. This was ruled “out of order” by the Lord Mayor.
● March 2019: Sligo County Council passed a motion calling on the Minister for Health to speed-up legislation on SAZs.
● May 2019: AAC West initiated a similar motion, which was proposed to Galway City Council. Although a majority of Galway City Councillors supported the introduction of a bylaw, the interpretation was that the Council did not have the authority to implement SAZs. Instead, a motion was passed demanding urgent nationwide legislation.
● July 2021: Limerick City and County Councillors voted unanimously to call on the Health Minister to legislate for SAZs amid ongoing anti-abortion protests outside University Maternity Hospital, Limerick (UMHL) and other healthcare settings. They wrote to the Health Minister Donnelly urging him to prioritise legislation for SAZs (O’Rourke, 2021).

There is a huge amount of support and demand for legislation to protect women accessing abortion care without dissuasion and harassment.
2022: The Safe Access to Termination of Pregnancy Services Bill 2021 is currently going through the Oireachtas. Meanwhile many remain concerned and frustrated by the Government’s refusal to act speedily and decisively on this matter (Moore, 2022).

*The Government is failing to meet its obligations to protect rights under the Irish Constitution, and the European Convention on Human Rights among others. The Irish government needs to act speedily to vindicate the rights of those seeking abortion services by passing the The Safe Access to Termination of Pregnancy Services Bill 2021 and enacting safe access zone legislation immediately.

Are hospitals unwilling to provide abortion services on grounds of ethos?
Only 11 of the 19 maternity hospitals/units available are currently providing public abortion services in Ireland. It is unclear why the service is still so limited 3 years after the legislation was enacted.

Voluntary public hospitals are sometimes owned by private bodies such as religious orders. Other voluntary public hospitals are incorporated by charter or statute and are run by boards which are only sometimes appointed by the Minister for Health. Most of the income for Voluntary hospitals comes from the State.

A Report by the Independent Review Group- which was established to examine the role of voluntary organisations in publicly funded health and personal social services (Department of Health, 2019) includes the following recommendations:
7.3 i) The State should provide full information about the availability of, and timely access to, all lawful services as close as possible to the location of the service user.
ii) All organisations, including any that decide not to provide certain lawful services on grounds of ethos, should ensure that they provide service users with adequate information on the full range of services available in the State and how and where to access such services.
iii) All organisations should make available all relevant patient records to ensure the safe and timely transfer of care.
7.4 i) In emergency situations, the life and well-being of patients must always take precedence over the ethos of the organisation and therefore organisations must ensure that all legally permitted treatment is made available safely to the greatest extent possible within the capabilities available to the organisation.
ii) The principles of patient choice and right of access to all lawful services and procedures appropriate to that person would also require that any organisations that refuse to provide certain services have the obligation to provide service users with information on the full range of choices available to them in the State, and where they can be provided with these services. In addition, information on where all lawful services are available should be provided by the HSE in each healthcare region.

*These recommendations were accepted by the then Minister for Health. They should be operating in relation to abortion care. The government must also clarify if hospitals are allowed as institutions to refuse to provide abortion services as a matter of ethos either in theory or in practise.

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(d) '…the disproportionate impact of continued barriers to abortion services on migrant women, survivors of domestic violence, asylum seekers and women living in rural areas.'

Migrant women

WHO study findings recommended that migrants who are unfamiliar with health systems in Ireland require more support in accessing care (Mishtal et al., 2021).
Immigrants may not have English as their first language. The national booklet produced by the Health Service Executive (HSE) on accessing abortion in Ireland is available in English and Irish language only
See: https://www2.hse.ie/file-library/unplanned-pregnancy/guide-to-medical-abortion.pdf.

The HSE booklet is not available in any other languages and there has been a major lack in the dissemination of information on how to access the service.

*The HSE booklet needs to be translated into the 10 most common spoken languages in Ireland and distributed widely.

Whilst obtaining information and navigating health care services for abortion is difficult for documented migrants it is daunting for undocumented migrants. All information formats state that accessing free legal abortion services requires the woman/pregnant person to have an Irish address and a registered national insurance number (PPS no.). There is serious risk for undocumented persons in registering for a PPS No. and this requirement alone would deter most from pursuing the legal route any further. Research shows that fear of detection leads to underuse of services.

Undocumented persons can get healthcare and medical treatment for a payment, but they would have to establish this fact first, then find a general practitioner who will accept them. The service can be unaffordable for many of the undocumented who are liable to exploitation with low wages and high privately rented housing costs. NGOs have indicated that access to specialised health care is difficult for this group.
Even if they do go through the channels to request an abortion, they may find that they do not fit the restrictive time limits or grounds to entitle them to care in Ireland, yet they are not able to travel abroad for care because of their status.

*Much more needs to be done to make this essential health care service accessible for this vulnerable group.

Survivors of domestic violence

Information on accessing abortion services needs to be improved and options to obtain abortion information expanded in order to reach marginalised women such as survivors of domestic abuse.

If a woman seeking a termination is in an abusive relationship, it could be extremely difficult for her to find a provider, arrange travel to a doctor and cover the cost of travel because of control issues.

*Information campaigns advertising the HSE MyOptions website and the service it provides needs a high profile.
*Information on how to access an abortion needs to be easily accessible to those who are not computer literate.
Written information booklets should be readily available in public information areas such as libraries, childcare facilities, social services, citizens information centres, hospitals, universities, community centres, adult education centres, and trade unions. It is also needed in refuges, shelters and distributed through charities and NGOs dealing with survivors of domestic violence.

Survivors of domestic abuse may have to avail of services where there are no risks of encountering their abuser, which may require them having information on providers and location so that they can access abortion care in safety.
*Publicly accessible information/helpline on nearest abortion providers and available care is necessary.

The HSE MyOptions phone helpline which directs patients to abortion care is not available 24/7 which means survivors of domestic abuse may not have ability to call at a safe time.
*The hours need to be expanded.

There are difficulties for women in domestic violence situations being forced to attend two separate appointments because of safety or control issues preventing their free movement. The 3-day mandatory waiting period may have a greater negative impact for survivors of domestic abuse because it demands attending at least two appointments with the medics. This delays the commencement of the procedure for a woman who may have to hide her choice of action from her abuser and may be experiencing restricted freedom and the privacy needed for multiple appointments.
*Removing the mandatory waiting period in its entirety would provide a greater chance of women in such complex personal circumstances of being able to attend a provider and avail of the service.

*Women should be given the choice to attend the appointments in person or via phone call. This choice could be extremely important for survivors of domestic abuse in order for them to avail of abortion services. The decision of when and where to commence EMA under 9 weeks should be with the patient, which could be of great benefit for women in such situations. Telemedicine and at home abortion provision must be retained.

In 2019, just 21 people accessed an abortion under Section 9 of the 2018 Act, where “there is risk to the health or life of the pregnant woman”.

WHO guidelines describe health as “a state of physical, mental and social well-being” (WHO, 2012)

The conservative interpretation of health of a women means that survivors of domestic abuse may have had to continue with unwanted pregnancies which seriously affect their mental

health when they are already in a vulnerable situation affecting their mental health.
*The health criteria must include mental health in such situations.

Asylum Seekers.

Asylum seekers (for whom English may not be their first language) are more negatively affected by the existing barriers to accessing information. Because of culture, religion or stigma, women seeking asylum may be too afraid to enquire about abortion here.

*Information on abortion in Ireland, what services are available and how to access should be provided to every asylum seeker entering the reception centre upon arrival and be freely available in every state Direct Provision centre.
*This information should also cover procedures for a person seeking asylum who is not entitled to an abortion under the current legislation but wants to avail of abortion services outside of the jurisdiction.
*Information on how to access an abortion must be made available to those who are not computer literate.
*The HSE booklet on abortion needs to be translated into more languages than just the English and Irish versions currently available.
*Improvements need to be made to the timely availability of translators for medics treating asylum seekers who need them, as they are not always available.

A woman or pregnant person arriving in Ireland seeking asylum could be very near the 12-week gestation cut of limit because of the circumstances of her migration. The 3-day mandatory waiting period could push their gestation to over the 12-week limit. This could be devastating for someone in such a traumatic precarious situation.
*The mandatory waiting period needs to be abolished.

The person may not satisfy criteria for an abortion post 12 weeks with the strict criteria used to allow terminations in such circumstances. It is far from easy for an asylum seeker to obtain a visa and the right to travel to another jurisdiction to avail of abortion services elsewhere.
*Women and pregnant persons in dire mental and physical situations seeking asylum should be able to have their requests for an abortion allowed because of their extenuating circumstances, and legislation should be improved accordingly.

Women living in rural areas.

Women living in rural areas can face many barriers to accessing abortion information and services because of their remote location, uneven coverage of abortion service providers outside cities, cost and lack of transport. They are also more susceptible to restrictions through culture, religion, and stigma in rural areas.

Obtaining necessary information can be difficult because of lack of broadband in the area or personal access to the internet.
*There needs to be increased public awareness of abortion services and information material must be widely available in public facilities such as community centres, all GPs and healthcare clinics, Citizen's Information Centres and such like welfare rights services, charities, and NGOs.

*HSE on-line information through the MyOptions website needs improving as women in rural areas can be restricted as in who they can talk to and ask the varied questions they may want answered on an ongoing basis.

For rural women, having the option of either in-person or telemedicine consultations and the availability of deciding where to commence the EMA procedure is especially beneficial.
*These provisions must be retained.

Public transport is extremely lacking in rural Ireland which makes attending multiple appointments to register for and then commence abortion treatment more difficult. There is also a difficulty in obtaining scan services in many localities which causes further inconvenience, costs and delays.
The 3-day mandatory waiting period can have an even more detrimental effect in acquiring abortion services for those living in rural arrears facing this additional barrier.

The limited number of GPs/hospitals providing abortion services around the country has a heavy impact on those in more remote locations as there may be no option but to have to travel to another county or across the country, which is not easily managed on public transport and costs can be prohibitive.
*There needs to be an increase in GPS available and providing abortions services plus extension of full abortion services to all suitable hospitals as a matter of urgency.

Women in close knit, less populated rural areas are also more vulnerable to the demonstrations and protests outside abortion service providers as they can be more easily recognised. Fear of being identified, publicly judged, and labelled can prevent someone from accessing health care from a providing GP or clinic in such an area.
* Immediate introduction of safe access zone legislation is necessary.