Invited statement to the Joint Oireachtas Committee on the Eighth Amendment

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Summary

Dr Caitriona Henchion is Medical Director of the Irish Family Planning Association (IFPA), which is at the frontline of crisis pregnancy services in Ireland. The IFPA's accredited counsellors provide free pregnancy and post-abortion counselling at ten centres nationwide. At its two Dublin clinics, the IFPA offers comprehensive reproductive health services, including free post-abortion medical check-ups.

Unintended pregnancy is a frequent occurrence among women of reproductive age. IFPA doctors and counsellors are witness every day to the harms this causes, and to the harms caused by the Eighth Amendment. The majority of IFPA clients who are considering abortion do so because the social and economic burden of an unintended pregnancy is an intolerable crisis in their life. The Eighth Amendment places unacceptable burdens on women. It forces them to travel to another state for medical care. Travelling abroad for a legal abortion can prove impossible for some. This leaves them with little option but to risk prosecution by obtaining abortion pills online.

An unintended pregnancy can mean the difference between a woman determining her own future, or seeing her plans derailed and her aspirations frustrated. Women make rational and responsible decisions not to continue unintended pregnancies, often in the best interest of their families: denying them the option to do so in Ireland is harmful to their health and well-being.

The Eighth Amendment, the Abortion Information Act, and the Protection of Life During Pregnancy Act are unacceptable barriers to women's reproductive health and to good medical practice. They must be repealed.

Appendices

Presentation

Senator Noone, members of the Committee,

Thank you for the invitation to address you today.

I am a medical doctor and have specialised in reproductive health for over 20 years. I am registered with the Irish College of General Practitioners as a contraceptive tutor and a tutor in the provision of long-acting reversible contraception. I am a member of the European Society of Contraception and Reproductive Health and the Irish Association of Sexual and Reproductive Healthcare Providers. I have been Medical Director of the Irish Family Planning Association (IFPA) since 2008.

The IFPA is Ireland's leading sexual health charity, and promotes the right of all people to sexual and reproductive health information and dedicated, confidential and affordable healthcare. We operate two not-for-profit medical clinics where we deliver services including contraception, post-abortion medical check-ups, cervical screenings and screenings for sexually transmitted infections. We also have ten centres nationwide where we provide free pregnancy counselling and post-abortion counselling services.

My colleagues and I work in the context of an extremely restrictive legal framework – principally the Eighth amendment of the Constitution. We are also bound by two pieces of legislation that include criminal sanctions – the Protection of Life During Pregnancy Act and the Abortion Information Act[1]. Navigating these complex legal barriers while trying to maintain a caring clinical relationship is an immense challenge for us as healthcare providers.

This presentation will address the socio-economic dimensions of crisis pregnancy and the impacts of current Irish law on women who experience an unintended pregnancy or a pregnancy that has become a crisis for other reasons.

I have included case vignettes in Appendix 1 to further illustrate women's decision-making.

Unintended and crisis pregnancy

Unintended pregnancy is a frequent occurrence among women of reproductive age. While for some women this is a joyful and welcomed situation, for many it is a traumatic and devastating life event. Conversely, a wanted or planned pregnancy can become a crisis. An unintended pregnancy can mean the difference between a woman determining her own future or seeing her plans derailed and her aspirations frustrated.

In 2016, more than 3,000 women and girls gave Irish addresses at UK abortion clinics. These women were from all walks of life and from every county in Ireland. In addition—as Dr Abigail Aiken explained—women are increasingly accessing the abortion pill online.

IFPA doctors' and pregnancy counsellors' clients include women who have made a decision to have an abortion for a wide range of reasons related to their physical and mental health and well-being and their ability to cope with a pregnancy. The majority of our clients who consider abortion do so because to continue an unintended pregnancy would be intolerable burden at

[1] The full title of this Act is the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995.

this time in their life. Any meaningful change from the current legal situation must include these women.

Women's decision-making in the context of unintended and crisis pregnancy

Each woman weighs up her particular circumstances very carefully before deciding that she is unable to cope with a pregnancy. The factors a woman considers include her family situation; her income; her social support networks; her plans for education; her working conditions; her social and physical environments in terms of housing, relationships and so on. Many women in this situation already have children. They know what it means to be a mother; for them, the need to care for their children is the primary reason they decide not to continue with another pregnancy. A woman may be trapped in an abusive relationship, or fear that continuing the pregnancy will trap her and her children into a lifelong relationship with an abuser.

Pregnancy counselling services, such as the IFPA, can support women through their decision-making and give them information about abortion services. Increasingly, our clients are women who experience multiple forms of disadvantage, which in turn, restrict access to abortion. Indeed the term "socio-economic" masks the reality that an unintended pregnancy can have devastating impacts on a woman's life and that of her family.

Obstacles and difficulties

Once a woman in Ireland has made the decision to have an abortion, she is faced with a range of further obstacles and difficulties. Cost will be a significant factor in the decision of almost every woman. She will need to consider the practical supports available to her. Can she organise childcare? Can she get a sick cert from her doctor? Can her partner get time off to accompany her? As a migrant woman, is she legally able to leave the country? Will she be able to navigate the immigration procedures? If she has a disability, how will this impact on her ability to access care?

Not everyone lives in Dublin or Cork. Women who live at a distance from the major cities, particularly if they're dependent on public transport, may have a very lengthy journey to an airport if they decide to travel to the UK for safe and legal abortion. Clearly, this constitutes a further significant barrier.

For minors, of course, all of the above is immensely more complicated.

Non-judgemental, non-directive counselling by a trained professional can be a huge support to a woman at this time. But it is no substitute for access to services. And we cannot ignore the fact that socio-economic factors frequently determine whether a woman ultimately travels for a legal abortion or resigns herself to the reality that her only option is an illegal abortion. Of course, for some women, the obstacles are insurmountable, and they are forced to continue the pregnancy against their wishes.

Burden on women in Ireland of accessing abortion care

When abortion is criminalised, as it is in Ireland, the burden of accessing care falls on the woman rather than the healthcare system. This is because whether a woman travels abroad for legal services or has an illegal abortion in Ireland, she must leave the mainstream healthcare service. Her experience will not meet international healthcare standards, such as

those of the World Health Organization and the Royal College of Obstetricians and Gynaecologists.

If a woman decides to travel for abortion, the Information Act prohibits her doctor from making a referral to services in another state—even if she does not speak English, or has a poor educational level, or has an underlying medical condition. Unlike any other medical treatment situation, the continuum of care is broken. The onus shifts to the patient to make contact with a doctor outside Ireland and to provide her medical history. She must make her way to a private medical facility in another country without the supports that apply in other situations where people travel for healthcare.

A woman who is unable to travel—or for other reasons opts for illegal abortion—is faced with the challenge of trying to find a reliable online provider without medical assistance. And she also risks prosecution under the Protection of Life During Pregnancy Act if she self-induces abortion, as does anyone who assists her. In either scenario, an underlying medical condition that is easily managed in the context of legal abortion may become more risky.

Barriers to post-abortion contraceptive care

Yet another way in which care falls below acceptable standards is lack of contraceptive provision. As Professor Arulkumaran explained, best practice in contexts where abortion is legal is that contraception is offered as part of integrated abortion care, at the initial presentation and the post-abortion consultation. However, for women in Ireland, this is not the case. This may be because her first presentation is not with a doctor, and so she does not have immediate access to contraceptive information. Online abortion pill providers are not in a position to provide ongoing contraception.

In my practice in the IFPA, I frequently see women, who, having paid all the costs of going to a private clinic for an abortion—perhaps €600 for an abortion at 10 weeks, plus travel costs—cannot afford to pay for post-abortion contraception, particularly their preferred option of a long acting reversible method.

Barriers to post-abortion medical care after legal and illegal abortion

All of these failures of care are related to the disruption and fragmentation of care in the context of restrictive criminal abortion laws. We see this also in relation to post-abortion care. Women who can access abortion in their own country have a clear post-abortion care pathway with the same provider. In the event of complications, there are robust and timely pathways for referral, as recommended by the RCOG. This is not the case for women who travel from Ireland. While free post-abortion care is funded by the HSE and available to women from providers such as the IFPA, our experience is that only a small number of women avail of this.

And, of course, women who access illegal abortions receive a still lower standard of care. In addition to the fragmented care pathway, they risk inadvertently accessing medication from an unreliable online source, which could be inactive, inadequate or potentially harmful. In my clinical experience, women accessing medication online tend to report problems late – fear of prosecution is a real deterrent to accessing healthcare for some of these women.

A substantial number of women are accessing abortion in this manner. As Dr Aiken made clear, most women experience relief at the availability of this option. But that is not to say that it is acceptable healthcare. It is an unregulated and unsafe practice, the harms of which are

not being reviewed or measured by any public body. No one is being held accountable for this. And the government cannot continue to ignore it.

The impact of stigma on women who access abortion care

In considering the very real health concerns associated with the criminalisation of abortion, we must not forget the impact of stigma on women. Research by the American Psychological Association[2] has found that feelings of stigma, perceived need for secrecy, exposure to anti-abortion picketing, and low perceived or anticipated social support for the abortion decision negatively impact women's post-abortion psychological experiences. Every day IFPA counsellors hear from women about exactly these experiences.

Women's privacy and informed consent are invaded in ways that do not happen when services are locally available. Some women must make multiple disclosures of a private and personal health situation to, for example, community welfare officers, officials in the Department of Justice, staff in direct provision centres, social workers. Decisions made at this level can turn obstacles into barriers.

Women's dignity is violated at every step. Their right to confidentiality is taken from them so many times, right up to the moment when they find themselves in taxis from airports to abortion clinics with women they don't know.

Conclusion

In conclusion, our legal system imposes a significant burden on women at a time of crisis and stress in their lives. It criminalises women and healthcare providers. All women are disadvantaged and discriminated against when they are forced to travel to another state to access abortion services, and even more so if they access illegal abortion.

The requirement to travel for abortion forces a reduced quality of care on women. Again, this is even more the case with illegal abortion.

We have an urgent need for safe and legal abortion care in this country. This means equitable access—regardless of socio-economic status—to high-quality, affordable, local services in Ireland that respect women's autonomy and decision-making. As a society, we need to take responsibility for ensuring that this becomes a reality in law and in healthcare practice.

Thank you for your time and I am happy to answer any questions.

[2] American Psychological Association, Task Force on Mental Health and Abortion. (2008). Report of the Task Force on Mental Health and Abortion. Washington, DC: Available at http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf

Appendix 1

Case vignettes

These vignettes illustrate some of the wide range of reasons why IFPA clients seek abortion and the barriers they face in doing so. None of the vignettes is based on any individual experience; each draws on the accounts of a number of different women. The names used have been chosen randomly. We have changed potentially identifying details, such as place names, locations of airports and names of hospitals.

1. “Helen”: a mother making a decision in the best interest of the family

2. “Jana”: underlying health issues and lack of dignity in access to healthcare

3. “Jennifer”: unable to afford to travel for a legal abortion

4. “Breda”: the disproportionate burden on women living on low incomes

5. “Mary”: The Protection of Life During Pregnancy Act: a question of acceptability

1. “Helen”: a mother making a decision in the best interest of the family

A 39-year old mother of three living in rural Galway, Helen’s job in a local hotel is part-time and seasonal. Her children are all at school and she is starting to look for a full-time job. She and her husband Michael are in mortgage arrears. He has recently found work again after a long period of unemployment and the couple believe they are on the way to getting out of debt and getting their life back on track.

Helen plans to get an intrauterine contraceptive device—the Mirena coil—but as she does not have a medical card, she hasn’t been able to afford this yet, and in the meantime she and Michael use the withdrawal method. Helen is extremely distressed when she discovers she is pregnant. She is worried about confirming the pregnancy with her GP and admitting that she can’t continue with the pregnancy. She feels ashamed to have an unintended pregnancy, but is sure that ending the pregnancy is the best option. She and Michael borrow money from her sister and make an appointment for a pregnancy termination in a clinic in Liverpool.

Helen has a surgical abortion at a cost of €600. She takes a bus from Galway at 2.45am to get to Dublin airport in time for her 7.00am flight. They can’t afford for Michael to take the day off work, so she travels alone. After the procedure she is tired, bleeding and in pain as she begins the journey home. The flight to Dublin gets in at 8:30pm. The bus leaves her in Galway city at 11.30pm where Michael is waiting to collect her. It is well after midnight when they get home and Helen has been travelling for almost 24 hours. She is exhausted, but relieved.

2. “Jana”: underlying health issues and lack of dignity in access to healthcare

Jana is a married mother of one living in Roscommon. Her first pregnancy was very difficult and took a serious toll on her health. When she learns she is pregnant for a second time, she worries about how she’ll care for her two year-old daughter if she has the same problems as her first pregnancy.

Her GP advises her that she may experience similar medical problems in a second pregnancy. Jana asks her GP about a termination. He tells her that because of the law, he cannot make a referral for her to an abortion clinic in the UK.

Jana considers her options and decides that, because of her health issues, ending the pregnancy is the right decision for her and her family. She has an early medical abortion at a clinic in the UK and returns home the same day. The abortion medication begins to take effect at the airport, and there is a lot of bleeding. She has to change her clothes. The bleeding continues for the duration of the flight and the bus journey home from the airport. She finds the experience extremely distressing and humiliating.

3. "Jennifer": unable to afford to travel for a legal abortion

Jennifer is 20 and in her third year at a Further Education College where she is studying to be an accounting technician. She has been in a relationship for six months. She is taking the contraceptive pill, but becomes pregnant unintentionally.

Jennifer is the first in her family to finish school and go on to further education. She lives with her parents, who both work full-time. Her sister, who is her only sibling, has three small children and lives in another county.

She does not feel at all ready to become a parent, and does not know how she would cope if she continued the pregnancy. She hates the idea of dropping out of college and feels that she would be letting her family down terribly if she did. She does not feel that she can confide in anyone. Her situation causes her almost unbearable anxiety and an overwhelming sense of pressure and desperation.

Jennifer cannot afford to travel to the UK for an abortion. She gets the name of a website and has an online consultation with a doctor. She pays €70 for the pills which are sent by post. Jennifer takes the pills one evening in her flat and later passes the pregnancy in her bathroom. She is alone, and the experience is distressing. Afterwards, Jennifer searches for information about post-abortion care, and sees she can attend a free post-abortion medical check-up with the IFPA. The doctor is able to confirm the pregnancy has ended and also gives her information about contraceptive options and post-abortion counselling.

4. "Breda": the disproportionate burden on women living on low incomes

Breda is unemployed and living in poverty. She becomes pregnant unintentionally. She has two children, both in foster care as a result of problems she experienced with drug dependency. She has remained sober for a year and is working with social workers to try to regain custody of her children. She had a history of mental illness during her pregnancies, and is battling depression.

She knows that having another child at this moment of her life would jeopardise her health and her chances of regaining custody of her children. She decides to travel to England to have an abortion.

Breda approaches a religious charity and seeks financial assistance. She discloses her situation to a case-worker, who takes detailed notes. A week later, she is told that because of the charity's ethos, she won't be helped to access an abortion. She borrows money from a money lender at a high interest rate. She travels to England alone and in secrecy and has an abortion at 9½ weeks pregnant. She is careful not to alert the social workers or miss a contact visit with her children. She returns to Ireland the day after the abortion for her contact visit with her youngest child.

She feels humiliated and degraded by her experience with the religious charity. She is still struggling with depression, and firmly believes the abortion was the right decision for her.

“Mary”: The Protection of Life During Pregnancy Act: a question of acceptability

Mary is in the early stages of an unintended pregnancy. This is causing her extreme distress. She has a history of mental illness, with previous episodes of suicidal ideation and intent. Because of this, she does not feel able to continue with the pregnancy. Her GP makes judgemental comments about abortion. He does not give her information about pregnancy counselling. Mary feels completely unsupported by her GP, and this upsets her greatly.

Mary attends the IFPA for pregnancy counselling. As she may be eligible for a termination under the Protection of Life During Pregnancy Act 2013, the counsellor explains the assessment procedures under Section 9 of the Act, which deals with risk of loss of life from suicide.

On hearing about the complicated procedures under the Act, Mary worries that going through it may exacerbate her mental health issues. At this point, due to her medical history, she has already attended two psychiatrists at her local regional hospital, as well as her GP. She is shocked by the certification process under the Act: She’ll have to be assessed by two psychiatrists and an obstetrician in order to be certified as eligible for an abortion under the Act, and by two more psychiatrists and a further obstetrician if she has to seek a review of the initial decision.

The thought of the assessment process exacerbates her already heightened sense of anxiety about the pregnancy. She doesn’t want to wait, but wishes to end the pregnancy as soon as possible. She is further concerned that, if her request for a termination is refused, a lot of time will have elapsed, and she will then have to face the stress and expense of arranging an abortion outside the State.

Although she is eligible to apply for a termination under the Protection of Life During Pregnancy Act, Mary worries about the potential delays involved in the process. This, and the uncertainty as to the outcome, makes her reluctant to subject herself to the process. She decides that her only realistic option is to travel to the UK for a termination as soon as possible.

Appendix 2

The Irish Family Planning Association (IFPA)

Values

The Irish Family Planning Association (IFPA) is Ireland's leading sexual health charity. The organisation promotes the right of all people to sexual and reproductive health (SRH) information and dedicated, confidential and affordable healthcare. Motivated by the suffering caused by the State's blanket ban on contraception, the IFPA was established by seven volunteers in 1969. Since then the IFPA has been to the fore in setting the agenda for sexual and reproductive health and rights (SRHR) both nationally and internationally.

The core values which guide the way we undertake our work are outlined in our Strategic Framework 2017 to 2022 as follows: the IFPA believes:

- In full access to high quality information, education and health services regarding sex, sexuality, conception, contraception, safe abortion and sexually transmitted infections
- In the right to decide freely on the number and spacing of children, so that every pregnancy is a wanted pregnancy
- That abortion services should be accessible as early as possible and as late as necessary
- In equal rights for all people and their empowerment in obtaining full participation in, and benefit from, social, political and economic development
- In the right to enjoy a fulfilling, positive and healthy sexual life
- In working in alliance with all those who share our aims and in cooperation with interested governmental and non-governmental bodies
- In high performance, ethical standards and transparency throughout our organisation

Sexual and Reproductive Health Services

The Irish Family Planning Association (IFPA) operates two not-for-profit medical clinics in Dublin and ten centres nationwide where we provide free pregnancy counselling services. We deliver sexual and reproductive health consultations, including cervical screenings, screenings for sexually transmitted infections (STIs) and contraceptive services. The IFPA's medical team comprises nine doctors and six nurses. The pregnancy counselling team consists of 11 counsellors, all of whom are accredited counsellors or psychotherapists. These teams are supported by the clinic administrators, clinic receptionists and a helpline operator for our National Pregnancy Helpline.

Health promotion is a key aspect of the IFPA's work. For example, we work in partnership with the HSE's Cervical Check programme to promote cervical screening through our annual Pearl of Wisdom Campaign. We operate a free clinic for the treatment of women who have undergone female genital mutilation (FGM). The IFPA is a member of the HPV Alliance of more than 30 organisations working to improve uptake of the HPV vaccine by teenage girls.

The IFPA has provided family planning medical training since 1977. Our two-day certificate course in Contraception for Nurses and Midwives is accredited by the Nursing and Midwifery Board of Ireland. With our Speakeasy and Speakeasy Plus training programmes, we provide parents with the information, skills and confidence needed to talk to their children about

relationships, sexuality and keeping safe. Additionally, we provide life-skills training and workshops for parents, carers, professionals, service providers and young people.

Nationwide Pregnancy Counselling

The IFPA is the leading provider of pregnancy counselling in Ireland: our counselling services are fully funded by the HSE and free to women and girls. In 2015, we delivered over 3,700 counselling services, including crisis pregnancy counselling and post-abortion support. The IFPA is the only nationwide service in Ireland that provides non-directive information on all options—abortion, adoption and parenting—to women. IFPA pregnancy counselling services support women in relation to an unintended pregnancy, or a pregnancy that has become a crisis, whether their decision is to continue or end the pregnancy. Every pregnancy counselling client's experience is different and a pregnancy can become a crisis for many reasons. But all women and girls in Ireland who come to a decision that continuing a pregnancy is not the right option need additional support in relation to the denial and criminalisation of abortion services.

Best international healthcare practice

IFPA services are operated in line with best international practice. We develop and review our policies and protocols drawing on the expertise of health policy and standard setting organisations, such as the HSE, HIQA the Irish College of General Practitioners, the accrediting bodies of professional counselling practice, and also the Royal College of Obstetrics and Gynaecology (RCOG), the International Federation of Obstetricians and Gynaecologists (FIGO) and the World Health Organization. The IFPA is one of the 164 member associations and collaborative organisations of the International Planned Parenthood Federation, a global federation of sexual and reproductive health and rights organisations. The IFPA is committed to sharing our knowledge and expertise by delivering continuing professional development (CPD) training to other professionals, including our Contraception Foundation Course for Nurses and Midwives.

Advocacy for fulfilment of Sexual and Reproductive Health Rights

At various times throughout our history, the law in Ireland has restricted the IFPA's ability to provide the highest standard of care to our clients. This has led to our involvement in high-profile legal cases, including landmark cases such as *McGee v. Attorney General* in 1973, which established the constitutional right to avail of contraception. More recently, the IFPA gave counselling and practical support to three women who took a case (*A, B and C v. Ireland,* 2010) to the European Court of Human Rights challenging Ireland's abortion laws. The Court found Ireland in breach of the European Convention on Human Rights for its failure to give effect to the constitutional right to abortion where a woman's life is at risk.

The IFPA has presented evidence to a range of United Nations treaty monitoring bodies, in relation to Ireland's implementation of its obligations under international human rights law. This includes the expert committees that oversee implementation of the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the UN Convention on the Elimination of all forms of Discrimination Against Women, the UN Convention on the Rights of the Child and the UN Convention Against Torture. Each of these expert bodies has issued strong condemnations of Ireland's abortion laws. The IFPA has participated in the reviews of Ireland under the Universal Periodic Review process of the Human Rights Council in 2011 and 2016, as part of the Your Rights Right Now alliance of nongovernmental organisations. These reviews have also resulted in strong condemnation of Ireland's abortion laws.

All Party Oireachtas Interest Group on Sexual and Reproductive Health and Rights

The IFPA is the Secretariat to the All Party Oireachtas Interest Group on Sexual and Reproductive Health and Rights (APG). Established in 2000 and consisting of members of all parties in the Dáil and Seanad, the All Party Group works to advance sexual and reproductive health and rights (SRHR) in Ireland and globally. Its role is to raise awareness through regular briefing documents and meetings for parliamentarians, of international human rights law and best healthcare practice in the context of sexual and reproductive rights issues. Issues range from contraception, cervical cancer and the HPV vaccine, to overseas aid funding and global policy in relation to family planning, and the human rights considerations for the provision of safe abortion.

International development and global advocacy

In 2016, Irish Aid granted the IFPA funding to for a three-year project with our partners, the Bolivian IPPF member association, CIES—Centro de Investigación, Educación y Servicios (the Centre for Research, Education and Services), the leading sexual and reproductive health organisation in Bolivia—and the IPPF Western Hemisphere Regional Office. Entitled "Migrants and Citizens: Promoting the Sexual and Reproductive Health and Rights of Bolivian Youth", the project is aimed at vulnerable migrant youth in the cities of El Alto, Cochabamba and Santa Cruz. In 2016, we launched a video entitled *Joining the Dots: How Investment in Family Planning Safeguards Women's Human Rights*.

Funding

IFPA services are funded by a combination of own income and grants from the Department of Health: Health Services Executive (HSE) Social Inclusion programme; HSE Sexual Health and Crisis Pregnancy Programme and the National Cancer Screening Service. Government funding for service provision is regulated by annual service level agreements with the HSE. IFPA own income comes largely from provision of services, with some income from personal donations, event fees and rental income from shared offices. We have received some financial support from the Centre for Reproductive Rights (CRR) towards partnerships with CRR to raise awareness of international human rights standards and best healthcare practice. In 2015 we received a grant from the Women's Rights Programme of the Open Society Foundations to support our work. The IFPA receives financial support from the IPPF and UNFPA for our global advocacy work which highlights the need for recognition of sexual and reproductive health and rights within overseas development assistance and intergovernmental policy. The annual accounts can be found on the website. Established in 1969, the IFPA is a limited company (028395) and has charitable status (CHY 5694).

Governance

The IFPA organisational structure is laid out in the Memorandum and Articles. The membership elects the Board, according to the rules and term limits established in the Memorandum and Articles. The Board sets IFPA policy and ensures accountability to its values, vision and mission. The strategic direction of the organisation is set by the membership and is outlined in the Strategic Framework 2017 to 2022. Board members are listed on the IFPA website, where IFPA annual reports and the Strategic Framework can also be accessed.

Appendix 3

Links to international best practice guidelines

Best practice in Comprehensive Abortion Care. Best practice Paper No. 2 (2015). Royal College of Obstetricians and Gynaecologists.

The Care of Women Requesting Induced Abortion (2011). Royal College of Obstetricians and Gynaecologists.

Ethical Issues in Obstetrics and Gynecology (2012). International Federation of Gynecology and Obstetrics (FIGO).

Safe abortion: technical and policy guidance for health systems (2012). World Health Organization.

Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009). Irish Medical Council.

Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales (2010). Royal College of Obstetricians and Gynaecologists.