

DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 27 Aibreán 2022

Wednesday, 27 April 2022

Tháinig an Comhchoiste le chéile ag 9.30 a.m.

The Joint Committee met at 9.30 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Colm Burke,	Frances Black,
David Cullinane,	Lorraine Clifford-Lee,
Bernard J. Durkan,	Martin Conway,
Neasa Hourigan,	Annie Hoey,
Bríd Smith.*	Seán Kyne.

* In éagmais / In the absence of Deputy Gino Kenny.

Teachta / Deputy Seán Crowe sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: Deputy Bríd Smith will be substituting for Deputy Gino Kenny. A draft copy of the minutes of the meeting of 6 April 2022 has been circulated to members. Are the minutes agreed? Agreed.

Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018: Discussion

Chairman: Today, the committee will meet with representatives of the National Women's Council, NWC, and the Irish Family Planning Association, IFPA, to discuss issues that may be relevant to the review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018. From the National Women's Council, I welcome Ms Orla O'Connor, director, and Ms Alana Ryan, women's health co-ordinator; and from the Irish Family Planning Association, Ms Maeve Taylor, director of advocacy and communications, Ms Alison Spillane, senior policy and research officer, and Dr. Caitriona Henchion, medical director. They are all very welcome to our meeting this morning.

All witnesses are reminded of the long-standing parliamentary practice to the effect that they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable or otherwise engage in speech that might be regarded as damaging to the good name of the person or entity. Therefore, if their statements are potentially defamatory in relation to an identifiable person or entity, they will be directed to discontinue their remarks. It is imperative that they comply with any such direction. I call on Ms O'Connor to make her opening remarks.

Ms Orla O'Connor: I thank the committee for inviting the National Women's Council to present to it today. We appreciate the opportunity. As the committee knows, the National Women's Council is the leading national women's membership organisation, with more than 190 members. We also convene and chair the Abortion Working Group, a collective of more than 20 civil society organisations and healthcare providers, which was established in 2019. We collectively submitted to the abortion review as we believe that significant legal changes and practice improvements are required if the health Act is to guarantee equitable, accessible and legal abortion for all women and pregnant people who need it.

We want to take this opportunity to recognise and acknowledge the significant positive change the introduction of abortion in Ireland has brought to women's reproductive rights and to women's lives. We are at a critical moment now where we can fully realise the overwhelming vote of the Irish public to enable access for all women who need abortions. As time is limited, I will focus on three key challenges that we believe must be addressed. The first is the restrictive legal framework. The second is the national coverage, and the third relates to data collection.

In terms of the restrictive legal framework, instead of creating an enabling legal framework, the law acts as a gatekeeper creating a series of obstacles that prevent access to abortion, disproportionately affecting the most marginalised. The World Health Organization's 2022 guidance recommends against laws that prohibit abortion based on gestational age limits and is clear that gestational age limits are not evidence-based. Legal limits are contrary to the ideal model

of patient-centred care whereby medical needs are met in line with clinical best practice and patient preferences. Our strict 12-week window, which is actually just ten weeks from conception, is particularly challenging if you have irregular periods or need to undergo an ultrasound scan, and then in addition there is the mandatory three-day wait. As with all rigid frameworks, it is women who are the most vulnerable who are impacted the most. For example, adolescents, disabled women and pregnant people and women in situations of domestic violence who may not have freedom to leave the house.

In addition, the 28-day mortality clause for fatal foetal anomalies is also very problematic. This clause means doctors are unable to provide abortion care in cases where the life expectancy for the foetus after birth is short, but may not be as short as 28 days. This has caused significant challenges for doctors in determining eligibility, as well as huge heartbreak for women and families. We are particularly concerned that the proportion of Irish residents travelling to the UK on these grounds has significantly increased, accounting for a third of all those who had to travel in 2020. Analysis of the data suggests that the 28-day clause has created a two-tier system whereby for every three women deemed eligible for care here, two are forced to travel to the UK. We must be clear that rigid gestational limits, mandatory waiting periods and narrow foetal mortality clauses, all serve to impede the ability of doctors to provide urgent care when required, while also placing additional stress on women and pregnant people during a challenging and stressful time.

Furthermore, under the terms of the Act, a doctor who provides abortion outside the specific circumstances laid out in the law may face a prison sentence of up to 14 years. This means health professionals, under the threat of prosecution and criminalisation, are essentially forced to police themselves, determining when and whether the statutory criteria for access to care have been met. That is why we are recommending that abortion be available on request up to viability to ensure that no woman or pregnant person is forced to travel abroad for essential reproductive healthcare. We recommend the removal of the three-day wait period and the full decriminalisation of abortion care in line with the WHO guidance.

I will now turn to the national coverage. At present, just one in ten general practitioners, GPs, are providing abortion services in Ireland and, concerningly, the pool of GPs registered with My Options who provide care to the general public is even fewer than this at just 7% of the overall GP population. Data shared with the National Women's Council by the HSE in March 2022 show that half of counties have fewer than ten GPs offering the service currently; in some counties it could be as low as one GP per county as the data were provided in a zero to ten range rather than the total number. Indeed, only four out of 26 counties have a well-developed community network of providers - Dublin, Cork, Galway and Wicklow. Although abortion providers are very committed, limited coverage is therefore a significant barrier to access. The reality of poor nationwide coverage coupled with the two-appointment requirement is a heightened burden on women and pregnant people, particularly the disabled community.

GPs have highlighted the threat of anti-abortion activities as one of the biggest impediments to new providers coming on board. As such, it is difficult to disentangle the urgent need for safe access zones legislation from the issue of poor geographical coverage. We are recommending that to address regional barriers to access, there must be focused efforts to improve community and hospital coverage. Adequate early abortion care should be understood as a core part of our primary care services. If it needs additional resources from the HSE, they should be provided as required. Maternity hospitals must also be mandated to provide the service in line with the law. Where necessary, new medical appointments should be fast-tracked to address any gaps

in service provision and the necessary resources should be made available to address the infrastructure challenges. Safe access zones legislation must be introduced to give healthcare staff assurance that in stepping up to provide this vital service they will be protected from harassment and intimidation.

Turning to the issue of data collection, we are concerned that the very low number of providers in community and hospital settings is reflective of silent refusal to provide abortion care, which is not being monitored or recorded appropriately and which is impacting on the effective operation of the Act. Ensuring that conscience-based refusal of care does not hinder access to essential reproductive health services requires a clear, legal and policy framework and this must be urgently developed. Medical providers should be obliged to record refusals of care on the grounds of conscience and detail the service to which they referred the woman or pregnant person. We believe enhanced data collection is key for mitigating risks and barriers to service users. As the Institute of Obstetricians and Gynaecologists in Ireland stated, abortion is “a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being.” We recommend expanding the current publicly available abortion data set to include wait times, recording of refusal of care and referral onwards. Conscience-based refusals to provide care should be monitored by the Irish Medical Council to ensure compliance, and failures to adhere to guidelines regarding swift referrals should lead to sanctions.

The repeal campaign that led to the landslide “Yes” victory for removal of the eighth amendment from the Constitution was one of the most important social movements in our history for Irish women. The message was clear - all women should be able to access healthcare at home with their doctors and make decisions regarding their care needs. That is why we believe the review of the legislation is such a critical moment to deliver on the referendum and to deliver to women the reproductive rights they need.

Ms Maeve Taylor: I thank the committee for the invitation to share our perspectives. The Irish Family Planning Association, IFPA, is a specialist provider of early abortion care, contraception, specialist pregnancy counselling and other healthcare services. We have advocated for sexual and reproductive health and rights since our foundation in 1969. The last time we addressed an Oireachtas committee on abortion, it was to call for the introduction of abortion services. To be here today to discuss the review of those services feels genuinely historic.

The review clause in the 2018 Act is a wise and prescient measure. We have insights now from the provision of abortion care that were simply not available in 2018. There are two key insights. First, the Act has been transformative for reproductive rights in Ireland and abortion provision is now an established social good. Second, significant challenges arise for the operation of services from the interaction of the legal framework, health system challenges and pervasive abortion stigma.

To start with the positives, the availability of services to terminate pregnancies and the public funding of those services unambiguously signal that abortion is essential healthcare. The law provides for access to abortion on request. Nobody who seeks early abortion care is required to explain or justify the decision about the pregnancy. We know from our clinics and our pregnancy counselling service how important this is to service users. The protection in law of these principles is a real strength of the Act. Moreover, the model of care is working well for those who can access it. The availability of abortion care within mainstream, local healthcare and without cost helps reduce the stress of unintended pregnancy and the stigma associated

with abortion. In principle, women can choose their provider. They can opt for a specialist reproductive healthcare centre, such as the IFPA, attend their regular GP or find a GP through My Options. The introduction of telemedicine has broadened women's access to essential, time-sensitive healthcare in very important ways. Critical additional supports, including specialist pregnancy counselling and a 24-7 medical helpline, are also available without cost and are funded by the HSE.

However, there are problems. The Act is modelled on the Protection of Life During Pregnancy Act. This was a restrictive, criminal statute. That framing gets in the way of access and choice. Outside sections 9 to 12, inclusive, abortion is subject to prosecution and to harsh punishment on conviction. Criminalisation of abortion relegates it to the margins of healthcare. The European Court of Human Rights recognised this in the *A, B and C v. Ireland* case. Criminal laws, even when they are not aggressively enforced, create a chilling effect on healthcare providers. Section 23, the criminal provision, fosters stigma towards the conscientiously committed providers of abortion care and can discourage others from providing abortion. Furthermore, while the right of healthcare practitioners to deny care on grounds of individual beliefs is recognised as conscientious objection, this implies, very erroneously, that only those who refuse care, but not those who provide it or access it, act with conscience.

The Act is far too restrictive. The IFPA knows from our services that the vast majority of people who present for abortion care have thought through their personal circumstances, assessed the supports available to them and made a clear decision. However, section 12 requires that they must first see a doctor and then wait three days. Therefore, in fact, the gestation limit is eleven and a half weeks. The waiting period implies distrust of women's capacity to make rational decisions in pregnancy. It forces doctors to impose delay for no reason related to women's health, even when that delay pushes a woman past her gestation limit. Most women and girls availing of abortion in Ireland do so well before 12 weeks of pregnancy. However, crisis in pregnancy cannot be neatly confined to the first trimester. The IFPA's experience is that the burdens of the 12-week limit disproportionately affect the young, the vulnerable, the marginalised and the disadvantaged. After 12 weeks, access is narrowly restricted to grounds of health and fatal foetal anomaly. This is exclusionary. We know from our counselling services how traumatising this is for those who are excluded.

We also recommend that Ireland follow the recommendations of the WHO in its abortion care guideline, which calls for decriminalisation of abortion in all circumstances. It recommends that instead of the imposition of mandatory waiting periods, grounds and gestational age limits in laws, access to abortion should be on request. This would mean aligning service availability with the best interests of women and girls, rather than organising this part of the healthcare system around restrictive provisions.

We also have some other concerns, and I will not repeat some that have been mentioned by our colleague from the National Women's Council. One issue we are concerned about is choice of method. Abortion can be provided through either medical or non-invasive surgical methods. However in Ireland most women are only offered one method which is home self-management of medical abortion. This suits most women but not everyone has a suitable home environment and those who do not have a home that is suitable for self-management of care are not eligible for referral to hospital on those specific socioeconomic grounds. The IFPA provides care to undocumented service users. Currently, there is a lack of clear arrangements for reimbursement. This is problematic. The IFPA is absorbing those costs but this is not sustainable. We are in discussions with the HSE about this and we hope this will be resolved.

These inequities in the operation of abortion services must be addressed. Following the review of the Health (Regulation of Termination of Pregnancy) Act 2018 we believe the Oireachtas must address the flaws in the legislation and align the law with international best practice and human rights standards. Moving into the future, the Oireachtas must identify health systems measures to institutionalise the current strength of the service and ensure excellence, leadership, innovation and sustainability into the future. We should have a model of an excellent abortion care service in Ireland. We believe the Oireachtas should continue to monitor the operation of abortion care in Ireland to ensure it is equitable, is of high quality and is available, accessible and acceptable to all who need it.

Deputy Colm Burke: I thank both witnesses for their presentations this morning, for their work and for the changes they have brought about over the past number of years. I wish to deal with the issue in regard to section 11 of the Act dealing with fatal foetal anomalies. The witnesses referred to the 28-day rule. I have spoken to medical practitioners who have also raised concerns about this. The witnesses' view is that this section of the Act should be removed or the Act should be amended to take out this 28-day time limit. It is obviously putting many restrictions on medical practitioners. The witnesses referred to the issue in regard to the Act where a medical practitioner can be prosecuted for making a decision which does not comply with the legislation. Do they believe the 28-day rule is a huge restriction in regard to decisions being made? Is it only a small number? No matter what number it is, even if it is only one a year, it is one too many. Do they believe this restriction resulted in people being forced to travel? Is there any evidence of people being forced to travel in regard to that?

Ms Orla O'Connor: We certainly know from our members in Termination For Medical Reasons that this is a real cause for concern. This was certainly one of the issues that people believed would be solved by the referendum, and that people in that dreadful situation of fatal foetal anomaly would not be in a situation of having to travel and all the trauma that goes with that. This really is a critical one, irrespective of the numbers. I might ask Ms Ryan to go through the numbers given that this is affecting an important number of people. I cannot stress enough how important this is for those families and couples in that situation and just how difficult that 28-day rule has made things for them.

Deputy Colm Burke: On section 11, there is supposed to be a review panel. Where the person has been refused a termination, there is a review panel. I was contacted by one medical practitioner who advised me that they are not aware of the existence of the review panel even though it is provided for under section 11. What is the witnesses' understanding about the review panel? Is it in existence? Who is it made up of?

Ms Alana Ryan: Termination For Medical Reasons, which is the group of families affected by this, has said that it is quite challenging to appeal a decision, especially in very time-limited circumstances. While the right to appeal is there, and that avenue exists, it is not accessible and it means that when you are up against a very tight time limit, particularly if you know that you most likely have to seek care in England where there are also limits, you are most likely going to travel because you would be worried that if you delayed and continued down the route of trying to appeal a decision in Ireland, you might end up being ineligible here. Then you would be in a terrible situation where you might have lost your ability to travel to access the care elsewhere and you would have been denied it at home.

Deputy Colm Burke: Will Ms Ryan go back to section 11? Section 11 of the Act provides for a review panel. Is Ms Ryan aware whether that panel exists? Is it physically in place at the moment? My understanding is that it is not in place.

Ms Alana Ryan: My understanding - and the IFPA may correct me on this - is that when you have been given a decision about your eligibility under section 11, you are entitled to appeal if the decision is not one you think is correct. As to whether the review panel is functional and meeting the needs of families, I cannot speak to that. I have heard that the operation of section 11 is very restrictive because ultimately it is hard in these cases to say with certainty whether the foetus will survive for less than 28 days.

Deputy Colm Burke: Is Ms Ryan's experience-----

Chairman: Let us allow Ms Spillane in.

Ms Alison Spillane: To add to Ms Ryan's point, sections 13 to 17, inclusive, of the Act outline this review process. It appears that this review process is really not working in practice. There is a requirement under section 18 for the HSE to report annually on the number of reviews sought and carried out under this mechanism. In year one of the provision, 2019, no reviews were sought. In year two, only two reviews were sought, one of which was successful and one of which was not. It appears that this review process is not functioning. I think that speaks to what the Deputy is hearing on the ground that practitioners are actually not aware of these structures and mechanisms.

If I could add one more point in terms of the operation of section 11, there is important research coming out of University College Cork by Professor Keelin O'Donoghue and Dr. Stacey Power Walsh. It would be useful for the committee to hear from foetal medicine specialists who are providing care under this section. What they have done is they conducted qualitative research with foetal medicine specialists throughout the country about the operation of the Act. These practitioners describe the Act as difficult and restrictive and the combination of the language and that definition in section 11 with the criminal provision means that practitioners fear getting a diagnosis wrong due to criminal liability and media scrutiny. There is a great deal of fear around the operation of this section.

Deputy Colm Burke: These are the sections the witnesses believe need to be amended, including section 11, and the issue in regard to criminal prosecution of medical practitioners. The Act provides for an annual report under section 18. My understanding is that the report is being made available to the Minister by 30 June but I understand that report is not published. Is that correct?

Ms Alison Spillane: It is but it is very difficult to find. It appears under documents laid in the Houses of the Oireachtas but it does not appear to be published anywhere on the HSE or the Department of Health websites. If you spend a good deal of time looking for it, you can find it. It is a very short report. It reports that there were zero reviews in year one of the provision and two reviews in year two.

Deputy Colm Burke: Are these the type of fundamental changes the witnesses want to see in the legislation, including to section 11 and the criminal prosecution? Are there other areas they believe should also be amended? There are many things we would like to see amended but it is a question of making the essential changes that are required now. These are the key changes of which the witnesses speak.

Ms Maeve Taylor: I would signal one particular change, which is the mandatory waiting period. My colleague, Dr. Henchion, can talk about its impact on service users. The waiting period is not related to women's health, yet doctors are forced to require women to wait for

three days regardless of their circumstances. Most women have made their decision, present to their doctors clearly about the decision they have made and have assessed their circumstances. The WHO's guideline is clear that mandatory waiting periods demean women and are unrelated to health.

A wider point that we would make about the law is that, since it is based on a criminal statute, it has a tendency towards disapproval of abortion care. There is an exception under sections 9 to 12, inclusive. This weighs heavily on providers and is not something that is present in consultations with patients in other cases. We believe that a significant improvement to the Act could be a set of overarching guiding principles that establish that access is based on human rights principles of reproductive health, centring the Act around access rather than it being built out from a criminal provision.

Deputy Colm Burke: I wish to touch on another issue.

Chairman: Before the Deputy does, we will let Dr. Henchion reply.

Dr. Caitriona Henchion: As Ms Taylor said, the three-day period does not provide any medical help. There is a proper informed consent process in any procedure, and medical abortion would be considered such a procedure. A doctor has to go through clearly with the person all of the adverse effects, risks, benefits and everything else involved. The doctor also has to establish that the person is certain about going through with it. In a proper consent process, anyone who is not certain or ready to proceed is immediately identified. Obviously, the person will not go ahead at that time and may say that he or she needs a little more time. This often happens with many procedures, yet we are not relying on the law to make them take that time. Rather, we are relying on good clinical skills to identify these situations and communicate well enough to ensure that people understand that they have extra time. In no consultation do we speak as much about the law as we do in abortion consultations. We never bring it into any other consent process. The only other time that the law might come into a consultation would be when dealing with minors, where a doctor might have to apprise them of his or her responsibilities in terms of reporting.

The thing about speaking about the law in abortion consultations is that one becomes used to doing it and almost forgets that it is not a medical part of the consultation. A doctor has to advise people because they have to understand that there is a 12-week limit, which means that, if the procedure has not worked, they have to figure out what they are going to do quickly because, if they do not, they may find themselves beyond 12 weeks, still pregnant and having taken medication that could cause harmful effects to that pregnancy. The law is an ever-present part of these consultations in a way that is not related to the medical practice side.

Deputy Colm Burke: I wish to ask about people who feel that they have to travel abroad because the system in Ireland does not adequately care for them and about the lack of support for them when they return, in that there is no structure in place. Has the IFPA come across evidence of this? What needs to be changed? The whole idea was that people would have the necessary level of care in Ireland as opposed to needing to travel abroad, but people are travelling abroad and there is no follow-up care or structure available here.

Dr. Caitriona Henchion: The IFPA has a specialist pregnancy counselling service. When we identify someone attending us who is going to fall outside the legislative conditions and will have to travel, we ensure that there is a catch-all so that we follow up with her from a mental health perspective as well as to offer a physical check-up afterwards. In the HSE model of

care, that follow-up medical care is reimbursable. Many people might not be aware of this, so it needs to be more widely known. We are careful to try to bring those people back and ensure that they get whatever follow-up care is required, but it might not happen widely.

As Ms Taylor mentioned, if people are in the small minority who find themselves having to travel, particularly if it is just because they narrowly missed a gestational limit or their foetal anomalies were not considered severe enough, they are more stigmatised than people who had to travel ever were, as they are in this group that is considered not worthy of care here. They may be less likely to seek aftercare because they feel like they are in that very marginalised position.

Chairman: I will move on to the next member, as Deputy Burke's questions will arise in some of the other questions.

Deputy Colm Burke: I thank the witnesses.

Deputy David Cullinane: I welcome the witnesses from both organisations and thank them for their comprehensive opening statements as well as their extensive submissions to the review. I thank them for their work in this area.

It is clear from the import of both presentations that women are still travelling for abortion services. Perhaps I will start with the IFPA, whose representatives said that this was a minority of women, but there are still women travelling. Are there data on the number of women travelling abroad?

Ms Alison Spillane: Yes. Every year, the Department of Health and Social Care in England and Wales publish an annual statistical report. In 2019, it recorded 375 women who gave Irish addresses. In 2020, 194 women and girls gave Irish addresses. Almost 200 women travelled during a pandemic to access essential healthcare, enduring all of the financial, physical and emotional burdens of travelling for a health procedure. We do not have the 2021 statistics yet, as they are published in June of each year.

In addition to what Dr. Henchion said about what these women endure in terms of stigma and ostracisation in the health system, a key issue is that this safety valve that Ireland has used for abortion care for decades is insecure because abortion services in England and Wales are under pressure. Some of our clients, particularly those in specialist pregnancy counselling services who are travelling, are waiting weeks before they can get appointments at clinics in England and Wales. We cannot rely on other countries to provide this healthcare. It must be provided within the Irish health system. We need to stop ostracising and stigmatising these women and families.

Deputy David Cullinane: I thank Ms Spillane. I will probably not get to ask all of my questions, given that there are many that I wish to ask, so I will focus on the opening statement of the National Women's Council and some of the data presented on poor national coverage, which were shocking in and of themselves. Am I correct in saying that the data that Ms O'Connor presented were data that the National Women's Council received directly from the HSE?

Ms Orla O'Connor: Yes.

Deputy David Cullinane: According to these data, one in ten GPs is providing abortion services. That is shocking. I thought it would have been much more than that. Only 7% of

GPs who provide care to the general public are registered with the My Options service. That is even less than 10%. Half of counties have fewer than ten GPs offering the service, but that is not the worst of it, given that there is a range. As Ms O'Connor pointed out, the figure could be as low as one GP in some counties. Before I ask about the reason for this, perhaps she could speak about its impact, particularly in rural areas but also in some urban areas. If women have difficulty in accessing abortion services through GPs, what impact does that have on the women and their ability to go on to access full services?

Ms Orla O'Connor: This is a big issue for our members and for women. For example, there are difficulties in rural areas in just being able to get to services physically because of public transport, the small number of providers, finding out who is providing abortion care and having to make those journeys at a stressful and challenging time. There are also compounded issues for particular groups of women. That is why the abortion working group has highlighted that all the things we and the IFPA are talking about today concerning barriers are made much more difficult, for example, for a disabled woman trying to access a service. It is made much harder for different groups of women, such as women experiencing domestic violence. These barriers to access make it much harder for those groups of people and we wish to highlight this aspect to the committee today. As was pointed out, even the data we have, because they are in ranges of zero to ten - we do not have actual figures - means we are talking about people who must travel long distances to be able to access services and, as I said, find out where those services are. That is not acceptable for what is not only a key and essential healthcare service, but also one that must be provided in a timely fashion because of its nature.

Deputy David Cullinane: I have a follow-up question. I support the recommendation that medical providers should be obliged to record refusals of care on the grounds of conscience and to detail the services they refer women and pregnant people to. That is important. As much data as it is possible to record should be recorded, because that will inform us about this aspect. It should not only inform this review itself, but ongoing reviews of service provision.

The NWCI's opening statement goes on to outline the importance of supports from local maternity hospitals for GPs. This is an important point. We also know that not all maternity hospitals are providing abortion services. My understanding is that the Act itself allows for individual clinicians to conscientiously object but not for institutions to do so. Would it be the NWCI's view that there is the possibility that some maternity hospitals are institutionally not providing the service, or is this coming down to individuals? I ask that because I wonder how some maternity hospitals could not be providing any services. I would like a comment on that aspect first.

Ms Alana Ryan: It is a combination of factors. In certain hospitals, the lead gynaecologist may be a conscience-based refuser. There are also issues, however, regarding theatre space and practical measures which the hospitals are not equipped for now. That has been uncovered by the WHO research report. Therefore, a combination of factors is involved. There are probably members of staff who are within their rights to object to providing the service, but then there are also practical and structural issues involving the scheduling of abortions, and particularly surgical abortions. Hospital-based care is received after ten weeks, usually in the context of medical abortions, but further along, however, it will become a surgical abortion. Equally, our stance is that service users should always have the preference regarding whether they would like a surgical abortion or a medical abortion. In practice, however, the theatre space does not always exist. That would----

Deputy David Cullinane: I wish to come back in here because I do not want to be unfair

to any of the maternity hospitals involved. It may well be that capacity issues are at work here. Where those exist, they must be addressed, and it is for the Minister for Health and the Department to do that. What I am hearing from the NWCI's opening statement, though, is that only one in ten GPs is providing services, and not all maternity services. We also do not have sufficient linkages between GPs and maternity services, if some maternity hospitals are not providing the service. Therefore, that means there will be delayed access for some women. This is the problem. We must deal with the capacity issues, but if other factors are at work, whether institutional or otherwise, preventing any maternity hospital from providing these services, then that is not on. The provision of these services is provided for under law.

Returning to the opening statement from the IFPA, much of what was dealt with in that, and I do not disagree with it, concerned the restrictive nature of the Act itself, its limitations and the consequent limitations it puts on women accessing services. A review is under way and we had a lengthy discussion with the Minister for Health regarding its nature and extent. There is a concern regarding how extensive the review will be and whether it will lead to recommendations for legislative changes. We must wait and see. Given the IFPA's opening statement, and what we heard in the opening statement of the NWCI, will it be a failure of the review process itself if it does not recommend legislative changes?

Ms Maeve Taylor: Returning to the opening statement, we are clear that knowledge and experience exists now about the operation of the law and its practice which must be reflected upon regarding the legislative framework. For example, and as was mentioned, the legislative framework is creating barriers regarding conscientious objection. It privileges refusal as the only exercise of conscience and this can play into the wider "abortion ecosystem", to use that phrase. I refer to a situation where there is a separation between providers and non-providers and where the exercise of refusal is privileged. Those-----

Deputy David Cullinane: To ask the question more distinctly, and drawing on what I read in the opening statement, what is involved here are not simply problems with the operation of the Act but problems with the Act itself.

Ms Maeve Taylor: Yes, and in our view, the two are inseparable. We cannot simply separate out operational issues as if the legislative framework did not impact them. The review was included in the Act to draw on the knowledge gained over three years and to look carefully at whether the Act is delivering for the women who need care. One thing we have learned from the operation of the Act over three years is that those now excluded from care are excluded and stigmatised in particular ways. Prior to legal abortion, all women who needed abortion care and who had to organise their own care were stigmatised and excluded. Many were not aware of the supports available under law, such as specialised pregnancy counselling.

Now we have a situation where a small number of people are excluded from what is mainstream healthcare. I refer to the harm being done to those people from being denied something available from GPs. This is happening in the context where the law is specifying certain people cannot avail of the service because of the existence of a waiting period, even though the pregnancy concerned is less than 12 weeks. It means people will just miss the cut-off limit because of the waiting period included in the legislation for no reason related to women's health. Therefore, it would make absolutely no sense to consider the operational issues without looking at the impact of the law on them. Dr. Henchion has been clear regarding a situation where, unlike any other healthcare procedure, the law is in the room and in the consultation. We never talk about the law as much in other contexts. Therefore, returning to the question of the review not addressing this aspect, it can certainly address things on the fringes but we must also look at the

overall picture and the impact of the law in this regard.

Deputy David Cullinane: I thank Ms Taylor.

Chairman: I call Senator Clifford-Lee.

Senator Lorraine Clifford-Lee: I thank all our guests who gave us a comprehensive overview of where we stand in this regard. I also thank them all for their work over the years. It is a historic moment for them to be here with the committee not discussing whether women should be able to access healthcare, but how we can improve that healthcare for women in Ireland. The review was much discussed during the campaign. Those of us involved in the campaign always stressed the need to have our services based on Irish data and best practice for the Irish experience. Therefore, it is right and proper that we are here discussing this aspect today and that we are having the review. I have several questions, and the representatives of the IFPA would be best placed to answer the first. What kinds of challenges do they see in practice with the 12-week limit?

Dr. Caitriona Henchion: There are a few different challenges. Without harping on this point too much, but to return to this issue again, the first concerns the three-day waiting period. We have had women in this situation. It tends to occur in the context of bank holidays and similar periods, when women present within the 12-week limit, but in situations where they are close to the end of those 12 weeks. The need to refer them to hospital means that we cannot get them an appointment before their 12-weeks are up. Even though they have presented to us within the terms of the legal framework, it is still difficult even within that time, plus the three days. The three days themselves might just put these women over the limit. This gives rise to situations where it is necessary to have a discussion with somebody to say that if I had been able to do what was required yesterday, it would have been fine, but it is not today. That is a really difficult conversation to have with somebody for whom the consequences are going to be financial, social and very difficult.

The other thing where the 12 weeks really come into play, and I referred to this earlier, is with regard to the people who might have a failed termination. The risk of failure with medical abortion is between 1% and 2%, depending on gestation. That is a significant number of women, and we see it. In the community, we would see people up to nine weeks plus six days, and from then onwards they need to go to hospital. If we have seen somebody at nine weeks plus, and it is two or two and a half weeks before she can do a pregnancy test to check that it has been successful, she is pretty much at 12 weeks at that stage and if it has failed, she has to travel. We have given her medication that is potentially teratogenic, which means it could cause harmful foetal anomalies. We are now telling women they have to travel to continue this treatment. We are not giving any flexibility to continue that treatment for that person where it has failed.

Those would be two biggest areas, the people who have narrowly missed it and the people who have had a failed termination. Again, with regard to the people who narrowly miss it, we would have dealt with people who have had contraceptive failure, the failure of a contraceptive that would stop them having periods. It is not that surprising that they did not realise they were pregnant on time, because the contraception they were using was causing them to have no periods. It will take longer for those women to recognise they are pregnant. There are also women who, due to physiological reasons or medical conditions such as polycystic ovaries, only have two, three or four periods per year. It will take them longer to discover that they are pregnant than somebody who has a very regular cycle. The 12 weeks can be very difficult for some people to recognise on time. It is very difficult if people are just beyond it and it really

comes into play, big time, when it comes to the risk of failed termination.

Senator Lorraine Clifford-Lee: What is the international experience with time limits?

Ms Alison Spillane: It varies. Across Europe, access-on-request provisions tend to be around the 12-week to 14-week mark. The important thing there is that many of these laws are quite old. Ireland was significantly behind the times in reforming its Constitution to allow for abortion access. Many countries across Europe introduced abortion laws in the 1960s, 1970s and 1980s when less was known about abortion care. Certainly, at that point early medical abortion did not exist. Laws generally tend to allow for a period of on-request or on broad socioeconomic grounds and then more restrictive grounds thereafter. However, it is important to look at what is emerging from the World Health Organization. Just last month, the WHO published its abortion care guideline. It has assessed global evidence and clinical best practice with respect to abortion and it has come up with important recommendations about the way the law relating to abortion should function. One is that abortion should always be decriminalised in all circumstances. Another is that mandatory waiting periods and gestation limits function as barriers to access and they should not be included in law.

From our perspective, this review is an opportunity to think about the role of law in this area of healthcare. As Dr. Henchion outlined, the fact the 2018 Act is a criminal statute means it sits in the consultation room between a patient and a doctor in a very negative way. It hangs over consultations as a ticking clock. Further along, when one looks at cases of foetal anomaly or risk to health, the potential criminalisation hangs over medical practitioners. The law should function as an enabling tool, a tool that provides the framework that articulates the rights of people who are entitled to access care and the duties on the State to provide and organise services in a manner whereby they are accessible to all.

Senator Lorraine Clifford-Lee: Could the witnesses elaborate on the impact of criminalisation on healthcare providers?

Dr. Caitriona Henchion: It is very difficult to say. First, it depends on the environment in which one is working. The IFPA has a number of doctors and nurses, we have our specialist counselling team and we are providing this care, so we have a network of supportive people set up. We have colleagues to whom we can turn to discuss cases, we have colleagues with whom we can discuss anything that is difficult and we have our counselling team for women who are in a lot of distress or have additional needs. That could be women suffering in domestic violence situations, women with disabilities or women with difficulties with travel. For all those things we have a support network in place.

As I said earlier, it is almost unconscious that it is sitting there all the time and it is putting a great deal of pressure, particularly in cases where one feels that ticking clock. There will be women who will say they cannot go into hospital, but one knows they will be past the time when we should see them by the time the three days go by, whereas if one could have seen them straight away that would not have been the issue. It is there all the time. In the community we are dealing with the 12-week situation. That is very black and white. We are not afraid so much of our judgment being questioned in the longer term because we have to operate within that 12 weeks. It is much more something one needs to think about in terms of whether that is the reason there are only one in ten GPs opting in. Is that why so many people do not want to provide services? Why get oneself involved with something where one has to know the ins and outs of a very complex Act when one can just opt out?

Then one must look at the enabling environment that will allow GPs to do that, which is the proper geographical spread. If one knows that the local hospital is not providing services, then every time one sees somebody who is over nine and a half weeks one will have to refer her to a distant location and one will have to go through that complex pathway with that person. That is a deterrent to a GP. The GP also knows that if the patient has a complication, she will be going into a hospital where this is not a provided service for her after-care if she has bleeding. One does not know what type of treatment she is going to get, what type of bias she will come up against and what the level of knowledge to look after her is. It is much more than just asking, “Am I afraid of being prosecuted?”. I am not, particularly. It is the entire deterrent and the way it forces one to deal with people, for example, the amount of additional blood testing we will do for women who might be coming to 12 weeks after a possible failed termination.

Chairman: Ms Ryan wishes to contribute.

Ms Alana Ryan: I wish to speak briefly on the last point about gestational limits. In England and Wales, the limit is 24 weeks but when we look at the data on the time at which women access the service, the vast majority still access it at under 12 weeks. It is 88% under ten weeks, 6% between ten and 12 weeks and only 2% in the later stage of over 20 weeks. The idea that a longer gestational limit or removal of gestational limits will mean that service users will wait until the last minute to access care is not borne out by the evidence.

Senator Lorraine Clifford-Lee: I was not suggesting that at all, absolutely not.

Ms Alana Ryan: It is just an additional point about what we can see from the international data.

Senator Lorraine Clifford-Lee: Okay.

Ms Maeve Taylor: Briefly, I believe it would be very useful for the committee to hear also from foetal medicine specialists, GPs and perhaps the GPs in the Southern Task-Force on Abortion and Reproductive Topics, Start, doctors group. There are particular issues that are faced by GPs in smaller communities, GPs who live closer to their practices and small practices. There is a range of issues where the criminal law might be more burdensome and where the reasons for non-provision would be different for them rather than for an organisation such as the IFPA.

There is a final point regarding the gestational limit. Internationally, as Ms Spillane mentioned, in many countries there are specific socioeconomic grounds. We do not think it is right that women should have to present socioeconomic grounds. It is a very good thing that in current Irish law women do not have to justify their decisions. However, there are issues that arise during the first trimester. Women’s lives and circumstances can change. People lose jobs, relationships fail, family circumstances change, there are different caring responsibilities or opportunities arise. There are many reasons a pregnancy can become a crisis during 12 weeks. A woman is then over 12 weeks with a crisis pregnancy, and that crisis has been growing. We know, for example, from evidence during Covid of situations of people living in violent relationships. There are pressures on families, including the current pressures involving inflation and other economic issues. There are lots of pressures that can come to bear during a pregnancy and then for women to find themselves excluded by a rigid gestation period is simply unfair.

Senator Lorraine Clifford-Lee: I have one other question and then, if I have time at the end, I might come in with some more.

Chairman: You are out of time already so this will have to be your last question.

Senator Lorraine Clifford-Lee: How do we safeguard abortion services into the future?

Dr. Caitriona Henchion: First of all, a lot of it is about the geographical spread and making sure that services are spread across all of the units. We must try to incentivise GPs and take away barriers that might be stopping them from opting in. There are other things we can do, including for example, creating a faculty of sexual health that would provide a peer support network for doctors who are providing services who may be geographically more isolated and who could be linked into a bigger group for support. Another thing we could consider would require legislative change. In the legislation at the moment, a medical practitioner is defined very distinctly as a doctor but there are lots of other parts of the health service in which specialist nurses or midwives are included in that category. That would be an enabling part of the legislation, if that was to be done, which would help to broaden the base and protect services into the future.

Ms Orla O'Connor: This review is a really important moment and one of the key points is that it should be centrally informed by the experiences of women. The research that is being done by Dr. Catherine Conlon in TCD, commissioned by the HSE, which is about gathering those experiences, should form a key part of this review in terms of the changes that are necessary. We know from talking to our members and to women that the changes we are bringing forward are rooted in their experience and going forward, that is exactly what needs to happen, as it does in other areas of women's health care. Women's experiences need to lead the reform.

Chairman: Deputy Shortall is next.

Deputy Róisín Shortall: I warmly welcome both groups here this morning. I thank them for their submissions and for their ongoing work over so many years. In their submissions and comments here this morning, both groups make a really compelling case for the review to include recommendations on the legislation itself, as opposed to the operation of the Act. We had this debate with the Minister some months ago but his tendency was to restrict it to just the issue of the operation of the Act. As Ms O'Connor said, this is a really important moment. We have the experience of the last couple of years and we have to go forward on the basis of identifying the issues that have been highlighted and the shortcomings in the legislation. The review will not count for anything unless it includes very clear recommendations in relation to the Act itself and the legislative provisions therein. The committee would be very much at one with the witnesses on that issue. We have a job to do in making the case for legislative change and amendment.

I wish to take up the points Ms O'Connor made in her opening statement about geographical coverage nationally. It seems that the figures have remained the same since the legislation became operational. Is it the case that there is a view that just a number of GPs and maternity hospitals will provide the service and nothing can be done to change that situation? Have the witnesses had any engagement with any of the GP organisations and the HSE on improving the situation? Is work being done on identifying why so few doctors are participating and, from the HSE's point of view, why only just over half of the maternity hospitals are providing services? It is completely unacceptable that there is such institutional resistance. Has work been done or have the witnesses had engagement with any of those organisations?

Ms Alana Ryan: It is important to acknowledge the work done by the Start doctors on the ground on peer support and enabling more GPs to upskill and become part of the network. That has been an absolutely vital component of bringing more GPs on board. The WHO research also highlights that the HSE has been very good at being a direct contact for GPs for queries they may have and in providing assistance in a timely way.

The issue of coverage really comes down to some key points around the continued lack of safe access zones which we know is vital for giving GPs and hospital-based practitioners the assurance that if they stand up and deliver this care, they will be protected from harassment and abuse. GPs have also flagged to us that the issue around the maternity hospitals not providing the service in line with the law has a knock-on impact on primary care provision. We need to be thinking about fast-tracking appointments if there is a case of conscientious objection at the top, by the clinical lead, in a hospital so that a team can be in place to provide care and in doing so, give the signal to GPs in the local area that there is a referral pathway into a local maternity hospital. Without having that joined up network between primary and hospital-based care, the picture will not improve dramatically.

Deputy Róisín Shortall: Is there a correlation, or has one been identified, between the lack of services in the local maternity hospital and GPs not providing services?

Ms Alana Ryan: We know, for example, that Dublin has the best GP coverage and also has the best number of providing hospitals. That could be illustrative of that good working relationship between primary and hospital-based care but it is the capital-----

Deputy Róisín Shortall: Sure, but Dublin obviously has a very large population, a lot of GPs and a lot of hospitals. I am just wondering if, in the regions, there is a clear correlation between the maternity hospital not providing services and the GPs in the catchment area also not providing services?

Ms Alana Ryan: We would need to double check that, based on the data.

Deputy Róisín Shortall: Okay. Dr. Henchion spoke in very compelling detail about the impact of the time limits, both the 12-week gestational period and the three-day waiting time. Does she have data showing the number of people who have had to travel as a result of both of those time limits?

Dr. Caitriona Henchion: The simple answer is that I do not have data that I can give the Deputy now but I would say that those numbers are very small. The majority of women are presenting well before ten weeks so it would only be a small number of women for whom that would arise. Out of proportion to that number, however, is the concern about it. We go to a considerable amount of effort in following up women afterwards to make sure, if their test is positive. In most cases if they did the test again in a week, it would be negative by then but we are afraid of losing that week. We are bringing those women in and doing two blood tests on them to check that their pregnancy hormone levels are dropping. We are actually putting them through anxiety and difficulty, as well as ourselves. We are doing all of that without any extra fees. We are doing all of those extra consultations and that is part of the effect of it. There is extra anxiety for women and for providers. In our experience, only a very small number of women have come to us thinking they would be eligible but have turned out to be just over the limit or for whom the three days has put them over the limit although it definitely has happened. I have had those conversations with women but in a very, very small number of cases.

Deputy Róisín Shortall: An issue I wish to put to both witnesses which is central to what we are talking about today is the new maternity hospital and the likely services that will be provided there. I think most of us would argue that the type of services to be provided should be explicitly set out in any agreement. We know however that in recent weeks the HSE has come up with a form of words to describe the services that will be provided in the new national maternity hospital and that is they will be services that are clinically appropriate and legally

permissible. I would like to ask the witnesses what their understanding of what “clinically appropriate” would be. It strikes me that if we are talking about providing services that are clinically appropriate in the new national maternity hospital, then it is a clinician who decides what is appropriate as opposed to the woman herself. My reading of that is that it is contrary to the legislation. I do not mean to put them on the spot, but I would like to ask their views on that, because there is a real concern that this thing is going to be wrapped up finally in the coming weeks. I ask that they might pursue this issue with the Minister for Health because I think it is potentially very dangerous. Have the witnesses any comment on providing services on the basis of what is decided is clinically appropriate as opposed to what should be available on request with the woman being the active agent?

Ms Orla O’Connor: The National Women’s Council of Ireland, NWCI, shares the concerns that the Deputy mentioned. The NWCI is on record as saying, and all our members are very clear on this, we believe the new national maternity hospital should be a public hospital and that is the only way we can absolutely guarantee that there will be full reproductive healthcare within hospitals. We have also had the experience of Covid-19 where the Minister and the CMO say certain things should be happening in hospitals and yet that was not the case in regard to maternity restrictions. We have many concerns about the new national maternity hospital but in particular in regard to the provision of reproductive healthcare. Similar to the Deputy, we see what could be within the legal definitions about the clinical appropriateness. That absolutely raises concern. We already have the experience where we do not have full coverage of abortion services throughout our maternity hospitals. Now it seems as though we are going to have this new hospital which will be there for the future and which it is likely will face similar issues that we now face in other maternity hospitals. It is absolutely an issue that the Minister needs to address. In our view, it needs to go further in that it needs to be a public hospital.

Ms Maeve Taylor: To follow on from that, I think it comes back to the issue of sustainability and thinking into the future. Currently, the National Maternity Hospital is one of the key institutions in regard to the development of excellence in abortion care. It is a key support to primary healthcare providers and the doctors in the National Maternity Hospital have shown a great deal of leadership in establishing and institutionalising abortion care as part of healthcare in Ireland. That has to carry forward, regardless of the location and the ownership of the National Maternity Hospital. That ethos, professionalism and expertise has to transfer with it.

I return to one of Dr. Henchion’s points about the need for a faculty of sexual and reproductive healthcare and a professorship with specific responsibility for the development of excellence in abortion care. Going back to Ms Spillane’s point about how we cannot always rely on the UK, there are many strains and pressures on services in the UK, in particular in regard to advanced training for later abortion care, which is something that we need to develop here. We cannot think only about the new national maternity hospital in terms of the legal documents that will establish it and that are part of the move, although those are extremely important. We have to think about the institutional transfer of all of those skills. Locating a professorship and faculty of sexual and reproductive healthcare within the National Maternity Hospital now would be a really strong way of ensuring the transfer of those skills and excellence, so that clinical appropriateness would be considered within an institution that considered abortion healthcare to be critical to women’s care generally.

Deputy Róisín Shortall: That is obviously where the issue of governance comes up and why that is so important. I drew the witnesses’ attention to that form of wording, so that they may pursue that separately with the Minister for Health.

Deputy Neasa Hourigan: I wish to talk about the issue of data and access to information. Before I do, however, on the issue of safe access zones, I noticed that this week or last week the UN Committee on Economic, Cultural and Social Rights published its list of issues ahead of Ireland's review and specifically asked about progress to safe access zones. That is indicative of how important it thinks safe access zones are in terms of addressing our challenge of national coverage and access to GP care in particular.

I am very interested in this idea of having to declare and having a declaration of a refusal of care or conscientious objection. I cannot remember who said it - it may have been Ms Taylor - but it is worth reiterating that "conscientious" is probably the wrong word because everybody who voted in the referendum to repeal the eighth amendment did so because they conscientiously engaged with the needs of women. Maybe if we are talking about changes to the legislation, we have to rephrase that. Just to be clear, would that include GPs? Would we require GPs to record their objections? At the moment how easy is it to access data about who is providing care and what the level of that care is? Hospitals and GPs are obviously giving different levels of care. If I am trying to access an abortion today, before I walk into the surgery or the hospital, how do I know who will deliver that service to me?

Ms Orla O'Connor: That is discovered by contacting the HSE's My Options. You would contact My Options and you would be told who you could go to. You can also go directly into a service yourself, such as your local GP but you may not know whether your GP provides it or not. My Options is the HSE service for people to go to that then refers them on.

Deputy Neasa Hourigan: Would Ms O'Connor describe that as a database?

Ms Orla O'Connor: No. Getting the information that you are looking for is very difficult. It has taken a long time to get this-----

Deputy Neasa Hourigan: This is what I am trying to get at. How difficult is it?

Ms Alana Ryan: It is difficult. Going back to what it means for the service user, with any healthcare concern, your automatic assumption is to go to your local GP and assume that he or she will be able to help you but because of the My Options route, it means that you have this additional step to go through. The knowledge of My Options is quite slim and much of the research shows that there needs to be much greater awareness and a publicity drive around My Options being the first step. Many service users face additional delays because they do not realise that they have to go through this. When it is a time-sensitive procedure, not automatically knowing the quick first step that you have to take is actually quite significant.

Deputy Neasa Hourigan: I will make a suggestion. Ms Ryan touched on a really important point. Most people who would access any type of care would assume that the first step is to go to their GP and say they have an issue they need help with. Is the creation of a database that outlines who offers care the wrong way around? If we are going to look at people who object to providing basic care - I include hospitals in this and I would suggest before putting forward my next proposal that every hospital in receipt of public funds should be offering basic services - should the database not be on who is not providing the service?

Ms Alana Ryan: One of our recommendations in the abortion working group submission is that it should be an opt-in to conscience-based refusal. You should be making a conscious decision that you are not going to provide essential reproductive healthcare and that should be clearly stated and monitored, rather than the current position where you seem to have a tacit

failure to provide it, perhaps for a variety of reasons, but the *status quo* is not-----

Deputy Neasa Hourigan: By picking out who is providing the service, the current legislation implies the *status quo* is not to provide the service, giving a list of people who will. Surely we should flip that so the *status quo* is the provision of a basic service of abortion care and if someone chooses to refuse, as an individual not as an institution, he or she would go on a database.

Ms Alison Spillane: That operates in some countries. It has been a barrier to access to abortion in Italy, where there is a register of objectors. What has happened there is it has become the default. When someone qualifies as a doctor, he or she goes on the register because abortion is stigmatised. It involves additional work and perhaps some additional training, and if a doctor wants to progress his or her career within medicine, he or she will go on the register because people do not want to be associated with that type of healthcare.

Deputy Neasa Hourigan: That is an unintended consequence. Can institutions be registered in Italy?

Ms Alison Spillane: I would have to check that.

Deputy Neasa Hourigan: Our guests may not be aware of this, but would the recording of refusal require new legislation?

Ms Alana Ryan: I think that would come under the section on conscience-based refusal. That is my understanding, although Ms Spillane might know more about it.

Deputy Neasa Hourigan: In some of our health discussions, the provision of data or disaggregated data for public health reasons can be problematic and sometimes needs additional legislation.

Ms Alison Spillane: I have a lot to say about data protection generally, but specifically on the issue of conscience, from the IFPA's perspective, I am not sure we are coming at the issue from the correct direction. We do not know that all those who are not engaged in the provision of care are objectors. Thankfully, a strand of research is just getting off the ground with providers that will, we hope, identify some of those reasons.

Work and efforts would be better focused on engaging with non-providers through education and values work. When the services were being established, at the end of 2018 and in early 2019, some significant work was done with the World Health Organization regarding what is called values clarification, that is, understanding the ethics of abortion care and the values that inform that kind of service delivery. That work generally focused on people who were going to be involved directly in the provision of care.

From our perspective, that work should be resourced and should engage all staff in maternity hospitals, even those who are not involved in provision. We certainly have experience of clients who have presented to emergency services or hospitals outside of the abortion service in the hospital and encountered inappropriate treatment in the form of stigma and judgment. Dr. Henchion might wish to come in on that.

Dr. Caitriona Henchion: If I could first focus on the initial question as to who should be on the register, whether objectors or non-objectors, in principle I really like what the Deputy said but the purpose of My Options is to help women, not to make them have to go through the

90% of people in the country who do not provide what they are looking for in order to see who is left over. That is important.

It is also important for someone to be able to expect to go to his or her GP for any basic healthcare. Not all GPs fit intrauterine devices, for example, but they should be able immediately to direct the patient where to go and offer any assistance the patient may need, whether it is a prescription or whatever. That is where the difference is. Patients should not have to call reception and be told they cannot see the doctor because a given service is not provided there, without being given anything else. In fact, that would not even be recorded as a refusal of care because the person would never even get to see a doctor. If a patient rings a GP practice, which takes a lot of courage, and is just told “No”, that will never be recorded anywhere.

The way to resolve this, as Ms Spillane said, relates to proper education, making it core curriculum throughout all medical healthcare curriculums and engaging with non-providers continually to at least say that while they may choose not to provide the service, whether because they are too busy or whatever, these women will nonetheless come in with problems after accessing the service. They need to know what happened, what their needs are and how to care for them. The evidence shows the more that people are exposed in some way to this care, the more acceptance will develop and the more likely people will be to have a much broader base in the future. It always comes down to education in these matters and that is important not to forget.

Ms Maeve Taylor: The law sets out the provision on conscientious objection, but medical ethics and the ethical guidelines of the Medical Council of Ireland are much more detailed and nuanced regarding the responsibility of providers. Part of that responsibility involves reflecting on the impact on the person presenting to them of the decisions they take. The provisions on conscientious objection are contained in the same section as the provisions on equality and social inclusion. One of the risks of focusing on the way conscientious objection is presented in the law is, as Ms Spillane highlighted, that there could be a situation like that in Italy whereby people categorise themselves and their medical students as objectors. It is not good enough that they would never think about that again as a doctor. There needs to be education and, as Ms Spillane noted, values clarification and further training for those who are not providing the service. Moreover, there need to be opportunities and a responsibility to reflect on the impact on women of non-provision. If a doctor is categorised at an early stage, he or she will have to decategorise himself or herself and there is a risk people will be locked into their decision.

Deputy Neasa Hourigan: I would love to return to the data issue and to hear more about that because I am always asking about that but my time is limited. Is the existence of groups or agencies that might give incorrect information a problem or a barrier at the moment? We sometimes term them “rogue” pregnancy agencies.

Dr. Caitriona Henchion: It is always difficult to find out about that because if they are successful, we do not see those people. That is one problem with trying to gather those data. We certainly have encountered people who have attended agencies they thought were abortion-providing agencies. They have been brought in for medical appointments, had scans and been told various information about their scans but have been provided with no reports. It is only over time that they have realised that actually, nothing was going to happen and no progress was being made. When they tried to get any of that medical information in order to transfer their care elsewhere, they have not had any assistance with that. Depending on when we end up seeing them, we might say that gestationally they require a scan, and those details could quite easily be at odds with the report they were given earlier. It is definitely an issue we come

across, although not very often. Luckily, women are quite clued in to the issue and recognise the signs that something is not right earlier than they might have in the past, when there was so much secrecy. We tend to see them on time, therefore, although it is difficult to know because if they are not on time, we may not see them at all.

Deputy Bríd Smith: I thank our guests for their presentations. What jumps out at me is the sense we are almost back to where we were when we started with the eighth amendment. Dr. Henchion stated that 90% of doctors do not provide care. Rather than saying that 10% do, the fact that 90% do not demonstrates the lack of services for women in this country. Moreover, there is a lack of mandatory provision in maternity hospitals. When we remind ourselves of why we had a referendum to repeal the eighth amendment and why we needed to ask people whether they should have the right to have a say over their own health, lives, material futures and so on, a question on which we got a huge majority in favour, we need to look at the legislation in this review and address the issues that are holding us back. Half the population - women and girls - are being held back by this legislation.

Ms Taylor said she thought it was good that socioeconomic reasons were not included in the reasons for which women or girls could seek an abortion, yet when we were dealing with this in committee in the lead-up to the referendum, this was one of the stickiest issues. It was put to a very close vote and it was some other members and I who really pushed it. I would have thought socioeconomic reasons would be very important. When we think about teenagers, migrants, women living with domestic abuse, disabled pregnant people and so on, it disproportionately affects the most vulnerable. Maybe Ms Taylor could address that.

I will ask a few questions in a row. The reason for this is that once I hear the answers, I will have to leave to go to the Dáil to speak. My next question is on the impact of the protests outside abortion providers. Does the panel of presenters here not think the Government is now presiding over a situation in this country where women are still being denied access to essential the healthcare for which people overwhelmingly voted because of anti-choice zealots and religious zealots in the main? How urgently must that be addressed? I would have thought that was one of the most urgent and important issues we have to deal with, along with the question of conscientious objection being allowed to block women from accessing abortion care. We just had some discussion on conscientious objection. However, do we know from the research carried out by the National Women's Council or by the family planning services how much the criminalisation of abortion acts as a chill factor, rather than the conscientious objection? If a doctor or a practitioner thought, "Well, if I am challenged on that I could potentially face 14 years in prison", how does that chill factor impact on the non-delivery of services?

I have another question about the scans and the delays women are experiencing because they are not able to get a scan on time. Is there any evidence that is connected to the fact the scanning services have been outsourced by the HSE to a private company? Is there any evidence, or am I just barking up the wrong tree, to suggest there is a discrimination against women in maternity services on those grounds?

My last question relates to the two ancillary recommendations of the citizens' assembly. They arose from the joint Oireachtas committee before repeal was voted on. One of them has been partially acted on while the other has not been acted on at all. One is the provision of free contraception to all those of sexual activity age. That has been partially acted on, but not fully. The other relates to the introduction of a non-ethos-based sex education programme at school. These were looked at and recommended to be implemented because, as is evidenced all over Europe, including in Britain and Holland, where the facilities of free contraception and a non-

ethos-based sex education programme exist, the level of crisis pregnancies is reduced. Could the panel please comment on those questions?

Ms Maeve Taylor: I am very happy to clarify my comments on the socioeconomic grounds. My point was that we would not want to see in law specific socioeconomic grounds, so that one would have a 12-week gestation limit, and then women would have to make a case for abortion on the basis of socioeconomic need. The gestation limit excludes those in particular who have pressing socioeconomic need for abortion care over 12 weeks. We need to remove the 12-week limit, so that rather than having a situation where somebody would have to plead for an abortion on the basis of their particular case, they would be able to request abortion without having to justify their decision, the same as in the current situation before 12 weeks. We know from the international data that most women present well before 12 weeks. However, in those cases where a pregnancy becomes a crisis after 12 weeks, it is important women have access to care. They should not need to justify that on socioeconomic grounds. There simply should not be a gestation limit that makes it an issue.

On the issue of safety zones, I agree completely with Deputy Bríd Smith. The protests outside healthcare providers are instances of targeted harassment of women who need healthcare, as well as of providers. Those who carry out those protests know the Irish Family Planning Association, IFPA, will not change its policy on delivering abortion care. They tend to target the hospitals and smaller providers. This is particularly difficult for providers who are living close to their practices and living within the communities, such as those outside Dublin and in smaller towns and areas. There is a need for action on that.

I will pass to Dr. Henchion to talk more about the chilling factor and access to scanning. I thank the Deputy for raising the issue of the ancillary recommendations, which brings us back to the issue of unintended pregnancy as the critical factor here. At the end of March, we supported the launch of a report by the United Nations sexual and reproductive health agency, UNFPA. This report was called, *Seeing the unseen: the case for action in the neglected crisis of unintended pregnancy*. Empowering people to have the means to prevent pregnancy through education and information and through access to contraception care are critical. I will now pass to Dr. Henchion for more on the contraception, the scanning issue and the chilling factor.

Dr. Caitriona Henchion: I will comment first on the scanning issue. Overall, it is one of those issues that depends on geography. Where you are in the country depends on what way your scans are going to be provided, as well as who is going to provide them. In some parts of the country, the maternity unit will provide scans and the doctor will contact them. In Dublin and some other parts of the country, it is outsourced to a private company. The contract that company has is supposed to be that it will provide those scans within that three-day waiting time. It is not supposed to impose an additional delay. Whereas that might work a lot of the time, there will be delays some of the time. Everywhere has had staffing issues because of the pandemic, so that may be part of it. It is not something I could say was either clearly discriminatory or against accessibility or allowing access to abortion. It is set up specifically to allow access to abortion. We have a dedicated referral pathway into this company, which is separate from the general pathway in order to get timely appointments. However, it happens sometimes that there are delays. That can be delay of maybe up to a week. That can negatively impact on women in this time-sensitive service. There are occasionally delays and that is definitely true. It is difficult but we are not given any information as to what the cause the delay is. It can be a difficult experience for women when that happens. In some cases, if we were to go along with that and wait for the scan, it could potentially put women over the legal limit. In the cases

where you would be concerned, you might then contact your local hospital.

Like many issues in relation to the operation of this service, it puts an undue amount of pressure on providers to go way above and beyond what they would normally be expected to do in order to try to make sure the service works for women. There could be several calls in a day about one person, which might not be based on medical need. They might not be because that person is really sick but, rather, they are based on the law and on the fact that if you do not get on to somebody today, that person is going to miss a deadline. That is taking up time that should not be needed to be taken up.

Similarly, the administrative burden falls completely on the providers, who have to do additional certification documents and notification documents. Nobody would mind doing those things, if they were going to provide good data. However, the only data they seem to be interested in finding is the Irish Medical Council number of the doctor who is doing the providing. There is no useful information about the demographic of women who are attending for abortion on the notification forms. I hope that answers the Deputy's questions on scanning.

I have talked about the chilling effect of the criminal sanctions enough at this stage, so I might pass over.

Ms Orla O'Connor: I would like to come in on two or three of Deputy Bríd Smith's questions, the first of which is on the issue of safe access zones. This legislation has been promised and there is cross-party support for it. We think it needs to be moved without delay. We are concerned by the delay in bringing it forward. In part answer to the Deputy's question, it is hard to know the combination of factors leading to the poor coverage we have. We certainly believe, and we know from some evidence from the Southern Taskgroup On Abortion and Reproductive Topics, START, for example, that GPs, particularly in rural areas, are concerned about opening and about protests. This would remove that, and we believe it would assist in broadening the coverage.

To turn to the issue raised on the ancillary recommendations, which are important, I will say something about sex education. This has been the subject of many discussions and debates in the Oireachtas. It is also part of what will be included in the third strategy on gender-based violence. At this point, it is without doubt that we need a comprehensive sex education programme in primary and secondary schools that is obligatory for schools and is part of the core curriculum. It is unfortunate that it is one of the areas getting left behind. In the view of the National Women's Council, it is key for women's health and for wider issue concerning women's equality. Ms Ryan will discuss contraception.

Ms Alana Ryan: The roll-out of free contraception is a very welcome move and it needs to be extended across the whole of the reproductive age range. We also need to focus attention on thinking about how the roll-out to those aged 17 to 25 can be delivered in such a way that everyone can benefit from it. Part of this is thinking about the network provider. GPs and women's health clinics should be used. We should also think about the potential role of pharmacies. In other jurisdictions oral contraceptives are available without prescription via pharmacies. They are trusted local community-based health care facilities. It would be incumbent on us to consider whether there is a role for pharmacists to play if we are to reach all who could benefit from this, especially when they safely deliver the emergency contraceptive as it is. It would be a good care pathway for them to be able to provide regular contraception consultation as they provide emergency contraception as it stands.

Deputy Bernard J. Durkan: I welcome our guests and thank them for the information they made available and for making a positive contribution to the debate. I speak as a former member of the committee, as other speakers have, that dealt with this matter in the context of identifying what that committee tried to do four years ago. It was based on the absolute need to ensure that the full range of medical supports and services were available to women throughout pregnancy for whatever duration and whether it was a crisis pregnancy, an unwanted pregnancy or whatever. It was felt that by doing what was done in the manner in which it was done at the time, the service was going to be provided in the way in which the legislation intended.

I listened with interest to what was said on the need to extend the 12-week period. The previous committee looked at this and an attempt was made to provide services on average and on par with what was available in the rest of Europe. Some countries differ. Some are more advanced than Ireland and some are not. We have to look at the efficacy of the legislation that was passed. Who is not providing the service as required and dictated by the legislation at the time and as approved by the people? We must remember that we had to have at the back of our minds at all times the fact the people had the right to approve or reject it. The best we could do at the time was try to ensure the level of the legislation was sufficient to meet the requirements of women.

I strongly support the point on the absence of robust data. We need this as a matter of urgency. Deputy Brid Smith referred to some of the recommendations that were made for which we do not seem to have evidence. For example, I do not know whether a comprehensive level of sex education is being made available in schools. I am not sure changing legislation will improve it but we need to put it in place and it needs to be done as a matter of urgency.

I am more than a little concerned about national coverage. The findings at the time, after exhaustive exchanges of views between the various stakeholders, was that national coverage in respect of women's health during pregnancy is essential if we are to address the issues concerned. If the availability of support services for women's health has changed since then we need to know urgently about the reasons. We need to have cold hard factual evidence to back up the situation. For example, we need to know how many women are forced to go abroad for terminations of pregnancies and we need to know the reasons for this. By "we", I mean legislators need to know this. The legislators have to stand over this afterwards. Whatever is done has to stand up to scrutiny and stand up to Opposition appraisal. It has the right to appraise it but it has to happen this way.

There is also need to try to ensure the level of data being made available addresses the concerns of the committee from four years ago. Points were raised at the time, all in good faith, by various people and practitioners. It was planned that some practitioners, for personal reasons, would refuse to get involved in the provision of services. I recognise that, but it does not in any way absolve us from the need and obligation to provide health services for women who are pregnant and have a right to them. I was one of the first people in the country to support the introduction of the legislation on the protection of life during pregnancy, which was groundbreaking at the time. The waiting period was kept as it was for reasons that have been referred to already. It has been acknowledged that some women seeking a discontinuation of pregnancy may change their minds. People do change their minds. It was from a health point of view that it was thought that people wanting to terminate pregnancies immediately should have a waiting period because they may think differently. This arose from some of the evidence submitted to the committee during the course of the interviews whereby some people were full of remorse afterwards. It was not the majority of people but it was some people. In order to address this

issue, it was put into the legislation to ensure the highest level of care was made available to women, for or against as the case maybe.

We need to identify precisely the amount of travel abroad and the reasons for it. We need to look at the chill factor. This also applies in other countries, including the UK. Its inclusion is being criticised. The Irish legislation is pitched somewhere in the middle ground, but we need more information as to how it has progressed over the past three to four years. We need hard evidence. That evidence must involve a careful assessment of all that has happened in the past couple of years in order to ensure that in the context of whatever decisions are made, we improve matters. We are going to change the legislation, which was not anticipated in the review. The review was supposed to identify the cause or causes of what might impede the provision of first-class healthcare and support for pregnant women throughout the country, in all circumstances, not by virtue of the fact they are far from where services are available but to try to ensure, insofar as we could, that such services be made available full stop. We have the obligation as legislators to do that for now and in the future. I do not want to delay the meeting but the issue of national coverage is one that needs to be dealt with as a matter of urgency.

The other issue is I do not think it was ever intended that women would have to justify their need for healthcare. There were reasons other than those for needing to ensure that the legislation was not as progressive as that in some countries but not as restrictive as that in others. It is essential that the highest possible level of medical care be made available, whether it involves medical abortion or surgical abortion. A lot depended on the degree to which these issues were teased out by the previous committee when the people came to vote. Legislators have to rely on public support for whatever we legislate for at any particular time and that will still continue.

Chairman: Does Ms Spillane or anyone else want to respond?

Ms Alison Spillane: I will respond to the point about data collection. The availability of surgical abortions was also mentioned. Perhaps Dr. Henchion would like to come in on that. The point about data speaks to the need to reform not only operational issues relating to abortion access but also the law itself in the form of the 2018 Act. Data collection requirements are set out under section 20 of the Act. This provision does not give us any useful public health data on the delivery of abortion care. It exceptionalises abortion and stigmatises the people who provide that care. The requirement under that section - I am sure members are familiar with this - is that every abortion that takes place in this country must be notified directly to the Minister for Health within 28 days of its occurrence. That is absolutely absurd and it is not an appropriate way to collect data on essential healthcare. It does not happen with any other health procedure, such as heart and lung transplants. Should we notify the Minister every time we carry out a cervical screen or insert a coil? It is not an appropriate way to collect data in healthcare.

Such data does not, of course, provide any identifying information about the women who access care but, on every single notification, the doctor who provided care must supply his or her medical council registration number. What message does that send to providers? We have talked a lot about conscience, non-provision and the lack of geographical coverage. What message does that send to healthcare providers other than, "We are watching you"? It is absolutely not appropriate. Instead, we need a provision that requires the HSE to publish an annual statistical report relating to trends in service delivery. We do not need to set out in legislation what types of data we collect, but the type of information that might be useful includes the age profile of women accessing care, the gestation stage they are presenting at and the uptake of contraception. This information is critical to informing service delivery and safeguarding abortion care into the future. The current provision is not fit for purpose. It is not appropriate to collect data

about abortion in this way.

Dr. Caitriona Henchion: I am trying to remember what Ms Spillane asked me to come in on.

Ms Alison Spillane: Surgical abortions.

Dr. Caitriona Henchion: That is again an availability issue. Many people assume that when somebody is in that nine-to-12 week bracket and gets referred to hospital that she automatically gets the option of a surgical abortion. That is not the case. It depends on what location she is referred to. Some maternity units that are providing services do not actually have access to provide surgical abortion. It can be particularly problematic for women, let us say, who have had a very difficult experience, either with a previous medical abortion or maybe a miscarriage, and are very anxious about the procedure or, again, are very worried about the prospect of failure, which would be higher with medical rather than surgical abortion.

The other issue I want to address relates to that of the youthfulness of the three days in respect of women potentially changing their minds. A significant amount of evidence shows there is no medical basis for the three days' wait. It is not just the fact of having a waiting period. It is the fact the waiting period is mandated in law to a specific length of time that is totally inflexible and does not take anything into account regarding a woman's circumstances. As I said, these things relate to the availability of referral services and the fact that in certain cases three days means at least a week because, for example, there might not be another hospital clinic until the end of that week. It may also be the fact that a woman, for example, only has support from a partner at weekends so, again, three days becomes seven days since she cannot come back for the appointment on a Monday or Tuesday because there is nobody to mind her children. It is all of those things. It is the inflexibility of it, apart from the principle of it, that is problematic.

This issue should also come under the general principles of good, informed consent. If we get such consent, somebody who is uncertain should then feel comfortable in saying "I don't know". My experience is that those people do say "I don't know", and when they are given the information, they very clearly say, "I am still not quite sure what I'm going to do". I say to them that it is absolutely fine if they need more time, that if they are six or seven weeks pregnant, for example, they have more time, they do not have to come after three days, they can come next week or the end of next week and, if it runs a bit longer, we can refer them to hospital. We go through all of that with people. They do not need to be told they must wait. It is up to good practitioners to make sure that if people need to wait, they get that opportunity. It is not for the law to decide how long it should be for a woman to decide she is still sure about the decision she was already sure about three days ago.

Ms Maeve Taylor: On Deputy Durkan's point about the Joint Committee on the Eighth Amendment of the Constitution, that was one of the high points of the Oireachtas in recent years. It was an extraordinary process. The attention and detailed listening that happened during that process where Members listened to medical experts, civil society organisations and women who had experiences of being denied abortion care, and assessed and scrutinised international evidence, was impressive and phenomenal. Those of us who followed the citizens' assembly saw the Oireachtas go through a detailed process after that. Anyone who was on that committee should be very proud of the work it did, the report it produced and the result it had, but we cannot ignore what we know now. We have had three years of understanding how the law is operating in practice. The purpose of the review is to look at the operation of the law. The evidence is showing that the law is getting in the way of the good operation of abortion care

services that the committee aimed to produce.

There is a responsibility on the Oireachtas to deeply consider the evidence we now have, namely, Irish data, the experience of Irish healthcare providers and international guidance - there is new guidance from the WHO - and to have an ongoing and monitoring review so we are gradually supporting the mainstreaming of abortion care into healthcare and the destigmatisation of reproductive healthcare generally. It is a very important role into the future. The job is not done yet.

Senator Annie Hoey: I thank all the representatives for their hard work on this issue in the run-up to the referendum, in the subsequent monitoring of abortion provision in Ireland, in ensuring that we have such provision, and providing the critical advocacy we needed in this area over the past three years. I have to agree that we have had three years of understanding how it can operate. Many of the flaws the representatives highlighted were potentially picked up on three years ago. We kind of knew this was going to happen. I hope, therefore, we do not waste this opportunity to fix these issues because that means we will have gone through two rounds where we will not have put in place best practice in the first instance or, in this case, tried to amend the situation.

I am astonished that so many maternity hospitals are not providing care. For an entire institution not to be providing care seems to go far beyond what was envisaged regarding conscientious objection, with individuals not being forced into doing something they do not want to do. To have full-blown maternity hospitals not offering care is not in keeping with what was envisaged. I ask for some comments on that.

One of the witnesses referred to the provision of care. The people not providing it are not just conscientious objectors. This has come up in recent months with some GPs I have spoken to, both in public debates and privately, whereby they have said they do not have the capacity to do it. I ask the witnesses to tease that out. Dr. Henchion mentioned that not every GP offers every service. From some of the people I have spoken to, my understanding is that they were not providing it because they did not have the capacity to do it. This does not apply to all. Some GP practices are pointing patients to other GPs offering the service, which puts enormous pressure on a small number of GPs, in particular those in remote areas who have to deal with it all. I know that not all GPs offer all services, but it would be incredible if it was 90% of GPs. If it was mix of conscientious objection and just not being able to do it, I cannot think of any other service that would have 90% saying they could not do it for whatever reason.

We know that the three-day wait forces a medically unnecessary delay. I already know the answer to this. As far as I am aware, for no other procedure is a person required to wait three days. People may get a major diagnosis and need to take time to consider their care options. Am I correct in stating that there is nowhere in medicine where there is a required mandatory, legally bound three-day wait for any care? We all know the answer to that. I just want to confirm it.

I do not work in this area, but the 28-day mortality clause seems highly complex and difficult to work out. We would all agree that it is not right or fair to force families to face that. It puts the doctor in the situation of saying that it could be 29 days and therefore the pregnancy must proceed. As an outsider looking in, it seems impossible for a doctor to make a call on the matter. I ask the witnesses to elaborate on that.

Many people have found that telemedicine works very well. It has been a very positive

development. From the witnesses' perspective, how has telemedicine been working? I do not want to pose a leading question, but we all know where I stand on the value and necessity of telemedicine. We were at the launch of the UNFPA. There is a local conversation on telemedicine, but particularly here in Ireland regarding this.

The WHO recommends an abortion-on-request model as best medical practice. I ask the witnesses to explain for the sake of the people listening in why that is the best model. If this is the best practice, why are we not doing it?

Ms Maeve Taylor: Ms Spillane and Dr. Henchion also wish to come in. I thank the Senator for her questions. She asked about the definition of foetal anomaly and the 28-day limit. Professor Keelin O'Donoghue and her colleagues would be the best people to talk about this. They have done some really important research on it. Regarding the review of provisions within the legislation, Deputy Colm Burke pointed out earlier that it is extremely odd that only one review of a decision about foetal anomaly had taken place and asked whether that was functioning. That is not unrelated to the definition and the ticking clock that we have repeatedly talked about.

Our director of counselling, Róisín Venables, who is in the Gallery, has spoken about the decision-making process of people who have received the diagnosis of foetal anomaly. The clock starts ticking. Doctors need to do scans to determine the diagnosis and to make a determination of whether a foetus is likely to survive more than 28 days. That is not at clear-cut diagnosis, and very often there are multiple serious anomalies. In some cases, women or couples have travelled to the UK and a doctor there has said that it fell within the definition of foetal anomaly. That is extremely difficult for people.

This point was made to the Oireachtas joint committee and the citizens' assembly many times. It is putting a bright line into law where clinicians are looking at a statute rather than following the normal professional guidance on how to treat a case. That determination must be made in line with the law rather than in consultation with a pregnant woman about her views because her views do not come into that determination. That is critical to the determination of risk in any other circumstances. The reason more people may not be looking for reviews under the law of decisions on the nature of a foetal anomaly is because the clock is ticking and they need to make a decision to travel to the UK for an earlier intervention rather than wait and potentially be told it will not happen here.

The WHO advocates for abortion on request for all the reasons we have heard. The law gets in the way of timely access. It gets in the way of good exercise of medical ethics, informed consent and clinical discretion. It stigmatises women. As Dr. Henchion said, there is no other procedure in respect of which the law gets discussed so much. It keeps abortion at the margins of healthcare in ways that are not good for health. It makes things more difficult for women and forces providers to police and be gatekeepers of the three-day waiting limit, to police and be gatekeepers of the gestation limit, to police and be gatekeepers of the definition of foetal anomaly and risk to health which is also very limiting and we see very few cases reported under that ground.

Having a criminal provision in the background simply makes it difficult and cumbersome. It creates added time burdens and added administrative burdens. It uses up healthcare resources on the part of the provider. It causes stress, anxiety, delay and stigma to women for no health benefit. It does nothing to change the picture of abortion access. We know this from all the previous discussions. When the law is in the picture it forces difficult decisions on women on where and how they will access abortion, not whether. It forces women into later abortions by

waiting.

The WHO guidelines set out that the approach to law should not start with criminal sanctions and then work in enabling provisions, which is essentially what the Act does because it was based on the Protection of Life During Pregnancy Act, which was the enabling provision of the eighth amendment. We are using that model, which was published in March 2018, before the extent of the public support for repeal of the eighth amendment was made clear through the referendum. The WHO is advocating that laws should be based on principles of rights and access and they should place responsibilities on the State, which already exist. They should be reflecting the responsibilities that already exist on the State.

Deputy Hourigan mentioned that the UN Committee on Economic, Social and Cultural Rights had raised the issue of abortion in Ireland in its list of issues. There are obligations on the public sector in Irish law. There are obligations on healthcare providers according to their duty and their ethics. The WHO believes that the law should be enabling access and should be protecting access to the service. We need to protect the good elements which we mentioned in the opening statement of funding by the State for abortion and abortions on request without requirement to justify a decision, which are really important principles. The law should be like the laws in places like the state of Victoria in Australia, which has one of the model laws and which starts with rights-based provisions. The law in Spain similarly starts with the rights-based provisions and then goes into the fact that the law is designed to enable access rather than to restrict and criminalise. That only causes harm, delay, stress and stigma.

Ms Orla O'Connor: I reiterate what Ms Taylor said; we completely agree with all of that. One of the things I said earlier in terms of that whole 28-day piece is that termination for medical reasons is a critical issue for women and for our members. They have raised this matter consistently. It is the impact it has in the moment but also the message that it sends to people and couples who are in that situation. It really is a critical area for change in this review.

Ms Alison Spillane: I will respond quickly to the Senator's comment about telemedicine, which has been a really positive innovation in abortion care since the establishment of services. Dr. Henchion might want to speak to our day-to-day experience of delivering it, but I want to mention that early on in the introduction of telemedicine, we sought feedback from our clients because it was a new mode of service delivery. The feedback we received was overwhelmingly positive that women like accessing care in this manner. They identified several general advantages and very few or no disadvantages to accessing care. For many women, it means that it minimises the burden of having to take time off work or education. Certainly, at the time this research was conducted in summer 2020, many people also reported that it minimised the risks associated with the Covid-19 pandemic, as one would expect. Women felt it enabled them to access care sooner. Others cited that they felt it gave them more privacy and reduced burdens in terms of arranging childcare. The provision of abortion by telemedicine is supported by really strong international evidence. Really importantly, that evidence base has increased during the pandemic thanks to a major study coming out of England and Wales. It is working well from our experience. It is a positive enhancement of abortion care and should certainly be retained into the long term.

Dr. Caitriona Henchion: I will mention two things on telemedicine, the first of which is to point out that it is not restricted to abortion care. Telemedicine has been widely used since the pandemic particularly. I would like to say it was really good to see that the HSE very proactively came out at the beginning of the pandemic to make sure that even though there is a restriction in the law saying the woman must be examined, it felt that in the emergency, we could actually

still use telemedicine in these situations and still make an estimation of gestation in good faith or refer for a scan without physically having to see every person since it was not going to be safe to do so. The really clear message was that abortion is the same as all other healthcare and that the abortion providers could act in the same way when providing this service as every other service. That was really good.

The other thing, to be clear for people, is that I would not like anybody to get the impression that telemedicine is somehow a reducing of a service to women. It is actually a huge extra amount of work for the provider to make sure that all of the information is being transmitted during the consultation because we so often rely on body language when looking at someone to see whether they look confused and get everything we say. Much more effort goes into those consultations. We put a lot of extra resources into making sure we had little links put into text messages, which we could send in order that people could click and read extra information. We had little video clips showing them what to expect in their packs. We would have already had information sheets and one pagers for people on how to take their medication at home, advice on what to expect and emergency contact numbers. We made sure all of those went either by email or text.

A proper package has to be put together in order to have good telemedicine. That is when we will get really good results. We have to also be open for business. We have to actually realise that it is not going to suit everybody. Some people have no privacy at home and need to get out of it to actually be able to have a confidential conversation. Some will just physically feel uncomfortable. People could be deaf. People will not always be able to do telemedicine. We need to be very flexible about and also say, yes, we had this conversation over the phone but our door is open. If a person has this or that issue, we want that person to come in and feel that they are welcome to do so. We do not actually provide it in a vacuum where people feel they do not know where the service is and where they can go.

Senator Frances Black: I welcome our witnesses and thank them for their phenomenal work on this issue. My first question is to Ms O'Connor and Ms Ryan of the NWC. In her submission, Ms O'Connor looked at the interpretation of health and the consequences of it in abortion care. She cited that of the 6,577 abortions provided in 2020, just 20 procedures were carried out due to risk to life or health. This would signal an issue we have with how we interpret this definition. Could the witnesses say a little bit about that? How do they suggest we rectify this?

Ms Alana Ryan: It goes back to the points made earlier around gestational limits and the need to bring the model in line with the WHO guidance. In practice, what we have is that after 12 weeks, there is a requirement to demonstrate why a person needs care based on very narrow grounds whether they are the definition of health and risk to health or fatal foetal anomalies. It is why us, the IFPA and many others in this field are advocating for a move away from those kinds of rigid criteria and instead towards a model that is based on the doctor-patient relationship that allows abortion on request without the gestational limit, which does not have an evidence base and which the WHO recommends against. To be clear, we disagree with having a model of care that requires the service user to demonstrate meeting very narrow criteria and which really inhibits that person's agency in this whole process.

Senator Frances Black: The submission looked at the issues that the criteria relating to PPS numbers impose for undocumented people looking for abortion care. Apart from removing these criteria, how does the NWC think we can support undocumented people in achieving abortion care? Can we implement safeguards that would protect them from any fear of engag-

ing with State services? I want to get the witnesses' thoughts on that.

Ms Alana Ryan: I can speak a little about that. It comes back to My Options and really ensuring that from the very first point of access with the service, it is inclusive and designed with diversity of needs in mind. We have a great range of interpretation services being provided through My Options at the moment but there is still additional work which could be done to make sure that it is inclusive of everyone. At the moment, if a person has English as an additional language, that person sometimes requires a friend or family member to call on their behalf. That is one way in which the privacy of the service user is impacted. It might be a particular issue for undocumented people who have English as an additional language. We should be thinking from the very beginning about the additional challenges people on the margins are facing from the very first point of access.

Going back to the points around coverage, if a person is in a rural area that does not have a GP service robustly in place or lives in a direct provision centre and does not have a PPS number yet or, indeed, a medical card, that person will face challenges trying to use public transport to get to a provider. It really speaks to the need to think about the coverage issue very seriously if we are to meet the needs of everyone, particularly those who may have additional barriers to transport as well as language challenges.

Senator Frances Black: I thank Ms Ryan.

Turning to the IFPA, in the context of the experiences of women in rural areas versus urban areas, the geographic disparities and disparities in care are very worrying. The representatives from the IFPA mentioned that in most cases, and in the absence of locally accessible care, the only option women might have is home self-management of medical abortion. Will our guests say a little more about that and what it means? How has that affected, for example, victims of domestic abuse or women who do not have safe home environments? Will our guests expand on that? They touched on that issue a little; perhaps they would expand further.

Ms Maeve Taylor: I thank the Senator. Home self-management is the general model of care. Women attend a doctor and receive the abortion medication. The first medication is usually taken in the presence of the doctor and the second is taken at home. If women are receiving care fully remotely, they receive a self-care pack and take both medications at home. That is the general access model. Of course, the point we are making is that for many women home is not a suitable environment to self-manage an abortion. Home can be a place that a woman is sharing. Perhaps she is sharing with a number of people. She may even be sharing a bedroom. Home may also mean a place with a coercive or violent partner. It can be a place where one simply has no privacy. These packs are also not suitable for homeless people who may be living in various kinds of unsuitable accommodation. Many people in such situations would prefer a surgical abortion to a medical abortion. Medical abortions are currently the predominant treatment available. For most women, surgical abortion is only offered when there is a clinical indication of it being necessary rather than when there is a preference or a reason linked to their socioeconomic situation.

Dr. Caitriona Henchion: The Senator asked for clarification on the meaning of home self-management. The situation is the same as it was prior to the referendum to repeal the eighth amendment. In certain circumstances, there are people who still have to travel. That can be very difficult for them. Even if it means travelling to Dublin rather than to the UK, the women concerned are still having to travel, which means, for example, that they are not going to be there to collect their kids from school and that they must tell somebody else because they have

to make arrangements in that regard.

Telemedicine is an advantage because only one attendance is required and women only need to make contingency arrangements once rather than twice. It is, however, difficult for women who are coming from a distant location for many reasons. Such women do not feel that the option is open to drop back into that provider if there is a problem. They may be faced with a choice to attend a local maternity unit where they know there are no services being provided and where they might potentially face stigma. That is another part of the issue.

On the non-documented issue, Ms Ryan is right that there is a barrier there in terms of language difficulty. The simple black-and-white fact is that there is no way for a doctor to be reimbursed for providing that service if the patient has no personal public service, PPS, number. Many doctors will simply not be able to provide the service because it is not sustainable to provide lengthy consultations for free. Those women are being excluded unless they have money which in almost all cases, they do not. It is not all about women who are in direct provision or that sort of setting. There are students who have been in this country for a year but who do not have PPS numbers. When this kind of situation arises, they have no way to access services. It is not only one demographic that is affected. People should be clear that there are several areas in which this happens. There needs to be a pathway for the provision of this care if we want women who are resident here to be entitled to it, regardless of their circumstances.

Ms Alison Spillane: I will make two additional points. The first relates to the supports for women in those circumstances. Since before the introduction of legal abortion and currently, the HSE does fund organisations such as the IFPA to provide specialist pregnancy counselling. It is through that specialist counselling that we hear about many of the barriers women face. Counselling can be useful for women to work through the particular stresses and anxieties of the unintended pregnancy but also of the delays involved and having to go through the waiting period. It can help women to deal with the stress of being excluded by the law or of finding the gestation limit has excluded them from care completely. Many women are not aware of the availability of pregnancy counselling. Among the clients of our pregnancy counselling service are minors who need to access abortion care, women in direct provision and students. Our clients include people who lack PPS numbers. To clarify, the IFPA provides care to people without PPS numbers. That is currently a cost we absorb. That is not sustainable into the long term and there needs to be a system whereby there is a clear mechanism and transparency about reimbursement in order that providers are in a position to offer care and are not put in the position of denying it because of the reimbursement issue and a lack of clarity.

Senator Frances Black: It is shocking to think that a doctor, friend or family member could still face a 14-year prison sentence for helping someone access an abortion. The reality is that the Irish people voted for abortion to be a healthcare issue and not a criminal act. Unfortunately, the Act still criminalises anyone who assists a pregnant person to obtain an abortion outside of the provisions of the Act with a penalty of up to 14 years' imprisonment. Are there many, or any, other countries in which abortion is decriminalised? Do our guests think that decriminalisation would help to reduce the stigma relating to abortion?

Ms Alison Spillane: We do think it would contribute to the reduction of abortion stigma. As we said in our opening statement, we feel that the framing of the Act is wrong and that abortion is permissible in only a limited set of circumstances. That is entirely the wrong frame within which to legislate for access to healthcare.

The Senator asked specifically about the situation in other countries. I know it is decrimi-

nalised in Canada. There were also recent reforms in South Korea and New Zealand. I will prepare a note on that topic and send it to the committee after the meeting, if that is okay.

Senator Frances Black: That would be great. Criminalisation could impact a partner or a parent who might order abortion pills. As we all know, that happened to the mother of a young teenager. She was charged in that respect and the case is ongoing in Northern Ireland. The likely result will be that medical professionals will interpret the law conservatively and patients will be denied care. I highlight that issue. I thank our guests for their comprehensive statements.

Ms Alana Ryan: I will mention another group affected by the issue relating to PPS numbers. This ties into what the Senator just said about Northern Ireland. Women who are travelling from Northern Ireland in the absence of services must bear the cost not only of the travel into the Republic and the cost of childcare but also the cost of the procedure because such women do not have a PPS number. Given the absolute lack of provision in Northern Ireland and the fact that a postcode lottery defines whether a woman is in a healthcare area that is providing the limited service available, we have an obligation to provide care for that group of women. Dealing with the issue around PPS numbers would also have an impact by providing support for women in Northern Ireland who need care and cannot access it in that jurisdiction.

Senator Seán Kyne: I was a Member of the Oireachtas at the time of the passing of the Protection of Life in Pregnancy Act 2013 and the Health (Regulation of Termination of Pregnancy) Act 2018. As we approach the ten-year anniversary of the Protection of Life in Pregnancy Act, it is clear how far we have come in terms of the provision of services and how far things have moved in the past decade. It is clear that the debate in 2013 was an important precursor to the successful repeal of the eighth amendment because, having been a Deputy, then I recall the level of debate and engagement I had with constituents regarding the legislation.

I welcome all our guests. I wish to play devil's advocate a little, and I hope they understand that. As somebody who voted "Yes" in the referendum, I still think it is important to reflect on some of the issues those of an alternative view might have. Are there data on the three-day wait period and on how many women might have changed their minds prior to abortions or, indeed, how many may have harmed themselves as a result of not receiving timely access?

Ms Orla O'Connor: Not to my knowledge, although the IFPA may have some. On the data question, what is important is the research I mentioned that was commissioned by the HSE and carried out by Dr. Catherine Conlon. Within that, will be details on the experiences of women. Within that, it will be our understanding part of that experience is that three-day wait period puts an undue stress on people. It is something we believe is not necessary.

Senator Seán Kyne: I thank Ms O'Connor. Similarly, Dr. Henchion answered a question on telemedicine. We received an amount of correspondence expressing the view that telemedicine, as opposed to direct, face-to-face contact, is a lesser service. Dr. Henchion has answered on that comprehensively, but she may wish to comment further. Playing devil's advocate again, a referendum was put to the people and reassurances were provided and a comprehensive set of regulations were legislated for based on the legislation for a 12-week limit and the three-day wait period I have mentioned. What do our guests say to people who say a referendum was put, these were reassurances that were provided and to look again at those would go against the spirit of that referendum.

Ms Maeve Taylor: As we have said, we were in a certain context in 2018. At that time there was only knowledge of abortion provision in cases or risk to life. The only legal framework

available was the Protection of Life During Pregnancy Act. I agree with the Senator that the Act and the debates around it and its enactment were really important in the process of reform. Prior to the Act, no legislative effect had ever been given to the X case. We had the eighth amendment and a Supreme Court case. There was no legislation, regulations or anything in guidance that clarified for healthcare practitioners what they should do in those cases. For that reason, the IFPA supported three women to take a case to the European Court of Human Rights, namely, the A, B and C case. The Protection of Life During Pregnancy Act was enacted as part of the process to give effect to the ruling in the A, B and C case to give legislative clarity to the X case. That was a requirement, as members know, of the A, B and C case. However, once that Act was passed and in operation, a completely different conversation about abortion in Ireland happened because it liberated healthcare providers to talk about what that provision was like and really name the barriers.

It was in the process of discussion of the A, B and C case and of the Protection of Life During Pregnancy Act that healthcare providers came before the Oireachtas and later the citizens' assembly and talked about the difficulties of working in an environment where the law was in the consultation between a woman and her doctor and the bright line between life and health, the policing of that by healthcare professionals, the ethical and clinical difficulties that brought about and then the impact on women of denial of care. That was thrashed out after the enactment of the legislation, and, in the context of the enactment, in a way we had not seen before. This was because there was clinical knowledge and it was much more in the open. We had doctors coming before the joint committee in 2017 giving evidence about what it was like and what the Act's impact on the operation of services was. That is the position we are in again, whereas in 2018, during the referendum campaign, a general scheme was produced that March that was very much modelled on the structure of the Protection of Life During Pregnancy Act but allowing for abortion in much wider circumstances. That was published before the extent of public support for repeal of the eighth amendment was known.

Following on from that, as lawmakers, Members of the Oireachtas have a responsibility to learn from the evidence of the impact of the law on the operation of services. From the evidence, it is very clear it does. Once Dr. Conlon's report and the other piece of research into the experience of providers are published, as well as the evidence presented to the committee today through various submissions and when the committee hears more from hospital doctors and GPs, especially in rural areas, the evidence will show that the operation of services is negatively impacted by over-restriction in the law. There is too much law in the law. The gestation limit acts to exclude women who need abortion care from a necessary health service and forces them into exile. That is something people very explicitly voted against in 2018. That is very much what was in most people's minds when they were voting. There is a responsibility on legislators to learn from the evidence and be confident in the evidence that will be presented in the review but to take responsibility for changing the law if the law is frustrating access and frustrating what people voted for.

Senator Seán Kyne: I thank Ms Taylor. On geographical cover, the referendum result was obviously hugely in favour of the proposition and that was across geographic areas as well. Clearly, as has been mentioned, Dublin, Cork, Limerick, Galway and Wicklow have adequate and good cover of provision of services. In other areas and counties it is less so. It was part of the debate that many people would not wish to access services that are very local to them, especially if they are from a small community or small rural area. Notwithstanding the population advantage the large cities have, is there evidence people are accessing those services from rural areas partly because they must but also partly because they wish to have that level of anonym-

ity?

Ms Alana Ryan: The evidence collected by Dr. Lorraine Grimes and the Abortion Rights Campaign as a survey of service users' experience suggests about 30% of those who responded were travelling four to six hours to access abortion care. I understand the point the Senator is making that maybe going to a city might give people more assurance their need is confidential, is not a matter for discussion and that their privacy is respected. Ultimately, however, when we think about the profile of women who require abortions, many will have children, caring responsibilities, some will not have access to a car and others may be disabled. Nobody wants to be travelling that type of distance to access a key service. That speaks to why we really need to retain telemedicine so that burden of a two-appointment procedure is mitigated and why we need to remove the three-day wait as well, so it is a single appointment. Ultimately, we should be working to a national network of coverage where a woman or pregnant person can attend a local GP practice within her community which is accessible and which offers discreet and confidential care, as one would for any other health reason. No one wants to travel that distance for what is a routine healthcare procedure.

Dr. Caitriona Henchion: Could I add a little to that? If people chose to travel to a city for anonymity or whatever their personal reason is, that is absolutely fine but it should be a choice. It should not be a necessity. If there was less stigma around the provision of abortion, people would not be anxious about attending their local service for it and they would be able to do that. As Ms Ryan said, many people lose much of their anonymity because they have to disclose to others if they are to travel that distance because they need help with childcare and they need time off work as it involves more than a couple of hours. For the vast majority of people, if they were assured of the service being available locally, that would guarantee them far more anonymity.

Senator Seán Kyne: I thank the Chair.

Chairman: On the number of women travelling, the IFPA gave a figure of 200 and referred to data, etc. Does the fact that 200 women were travelling during the pandemic skew the data in respect of women travelling. At one stage, one could not travel down the road and international travel was out. The representatives from the IFPA stated that there are three years of data. How will that skew the data?

Ms Alison Spillane: It is interesting that in 2019, without the pandemic, there were 375 women travelling. That decreased almost by half the following year to 294. We do not know. When the figures for 2021 are published in June, they might give us more of an indication of the extent to which unmet need is continuing. We do not know whether that reduction between 2019 and 2020 was entirely due to the pandemic or whether there were improvements in access locally and nationally.

I might flag as well, in terms of the figures we have around unmet need, data provided by an organisation called Women on Web, which provides online access to telemedicine abortion predominantly in jurisdictions where abortion is illegal or heavily restricted. Between 2019 and 2021, they received more than 700 consultations from women in Ireland. That speaks to remaining barriers around access as well.

Chairman: The figures are stark. One in ten, as one of the members pointed out, means that 90% remain. There are four counties - Dublin, Cork, Galway and Wicklow - where there are some limited services but where there are challenges. There are challenges for GPs, par-

ticularly in rural areas and socioeconomically deprived areas. There are fewer opportunities for people in those areas as well. Has Dr. Henchion any suggestions in that regard? How can we open up services so that people do not have to travel to services such as in Dublin, Galway or Wicklow? I note IFPA's submission, but are there any practical suggestions? Dr. Henchion was talking in terms of the barriers there in respect of those GPs. We could nearly do a session on that alone. Maybe Dr. Henchion might want to comment further on some of those matters

On the other issue, I was not aware of the criteria relating to PPS numbers. That is new to me. What is Dr. Henchion suggesting in respect of that matter? Is she suggesting the use of medical numbers?

Dr. Caitriona Henchion: Students who spend some time in another country, if they do not get what would be the equivalent of a PPS number, they usually get a visitor number or a visitor card. They can use the card to access medical services in that country while they are there. That is one cohort that could be resolved. If, for example, somebody is recently arrived into a country undocumented, that person will still have needs. There has to be a way of providing something, whether it is an area where they are living or something like that, in order to use. It can be a separate channel. It can be a little more difficult to make sure that there are not problems with too many claims, but there has to be a way. There should be a mechanism for those people to be able to still access care.

In terms of GPs, an individual GP might not have an objection but if he or she is in a practice with two others and those two others do not want to provide the service, it is difficult for that one GP who does not have the objection to provide the service because he or she will have concerns about his or her patient coming back on a day he or she is not there with a problem and being met by someone who says that he or she does not provide the service. Sometimes it is a little harder to see. When people talk about entire hospitals or institutions not providing, if one has a relatively small number of obstetricians in a hospital and half of them say "No", that makes it logistically quite difficult to do. In terms of what needs to be done there, it is about resourcing new roles so that one will meet that critical number of staff required to make the service work. It is also about task sharing with midwives and nursing staff to make sure that there are sufficient staff to provide it and about training for all so that everybody is clear that even if they do not want to be involved in providing the procedure, they must treat people with respect and be capable of providing all of the aftercare for complication. As a result, if women go in and are faced with someone who does not provide the service, will not be worried about what that person is going to say and can be confident that everybody in the facility will be able to deal with anybody who has a complication.

Chairman: I listened to what Dr. Henchion said regarding GP services. Looking the hospital set-up, it is a hierarchical situation involving consultants, etc. The difficulty is that if the senior clinician is in that position, I would imagine there would be an impact. The senior clinician has priority in the context of theatre time. It is also difficult for junior staff to be filling that gap or going against the conscientious objection of that individual. One can imagine the tension and the difficulty that creates within the system.

Dr. Caitriona Henchion: Completely. That is why it is so important to have somebody appointed who can mentor those junior staff in order that the next generation coming through will not face the same issues. That is what one wants to try and do to safeguard the service into the future.

On a question asked earlier, the HSE is continuously making efforts to expand the service.

It is involved in conversations with those hospitals. As far as I am aware, the service started being provided in Sligo hospital recently. Previously, it was not available there. It is slow, but they are trying to engage. Somebody asked if there anything is being done. They are trying to engage in those areas.

Ms Maeve Taylor: I will follow on from that. The PPS number issue is something that the IFPA is engaging with the HSE on. We have raised it with the executive and we can keep the committee informed if there is progress. We are hoping that there will be progress in that area.

On the idea of sustainability and supports into the future, what is clear from everything that has been said today is that the law makes services available and creates a legal framework for availability, but availability is the minimal requirement in order that services can be provided. We need to look at the broader requirements of the right to health, which is that healthcare services, including reproductive healthcare services, should not only be available, they should also be accessible and acceptable to women and of high quality. We need to see removal of the barriers to access but also concerted efforts to build in that accessibility and acceptability, as well as availability and women's right to access care with dignity. These requirements need to be built in institutionally by means of training and structures and, as Dr. Henchion stated, support and mentoring. In addition, the Act does not contain an overarching preamble that deals with values. Something is needed, whether that is a preamble inserted into the Act or a code of practice on reproductive autonomy and access to healthcare according to human rights guidelines. The HSE has been making heroic efforts to ensure availability of services, but there is, however, an overarching responsibility to lift our vision and to think about excellence, quality and sustainability in future. Many structures could be put in place in the health system to do that.

Chairman: The point was made about notifying the Minister after 28 days, which is inappropriate. Also touched on was the issue of safe access. Would the witnesses like to outline some experiences they are aware of? I refer to challenges women are facing in some areas. There is no need to necessarily mention those areas, but I think we would all accept it is wrong and that people should be able to access medical care if they need it. They should not have to go through a gauntlet in doing so, as we have seen in other countries. It is only starting here, and we would all be horrified if it escalated. The people in favour of doing that would pick on what they would term, *mar dhea*, "a success" in one area and then move to another, and so on. Legislation is being brought forward. It is important, however, for any overview of the legislation to consider this aspect, which is one of the areas that must be addressed urgently.

Ms Orla O'Connor: Yes, absolutely. We have certainly heard some of the public reporting on protests outside the National Maternity Hospital. We also know of doctors who have decided not to go ahead with surgeries, on a weekend, for example, because of protests happening outside. We are not that far away from when we had the referendum and we have also spoken a great deal about the stigmatisation of abortion, so of course these protests cause real concern for women. We have said this several times today, but this legislation was promised at the time of the original Act and yet we have had this enormous delay. This legislation must be introduced as speedily as possible because it is part of the frame around the stigmatisation of what is a healthcare service for women.

Ms Alana Ryan: To add to that, this is an area of abortion policy which has significant popular support. Nationally representative data collected in February 2022 show that 85% of the public agree that those providing and accessing abortion services should be protected from threats, harassment and abuse. That is a strong mandate from the public for the introduction of safe access zones. The cross-party Bill, which has been developed and strengthened on every

Stage so far, represents our best opportunity for introducing the legislation in a timely way. As the Bill enters the Dáil, it is incumbent on all our representatives to support it.

Chairman: I call Senator Clifford-Lee, who wishes to come in again.

Senator Lorraine Clifford-Lee: I have several questions about failed early medical abortion. Will the witnesses outline how often failed early medical abortions occur and what the process is for after-care? What harm can this do to people?

Dr. Caitriona Henchion: The rate of failure depends on the exact gestational period, but it varies from approximately 1% under seven weeks to about 2.5% by the time 12 weeks are reached. Therefore, it goes up slightly during that gestational period. In some cases, it is obvious it has occurred because no bleeding has happened and somebody is going to report that quickly. If it were to happen in the community, then we would quickly refer the people concerned to one of the clinics in the maternity units providing care. Those units would be extremely responsive in seeing those people quickly. It is upsetting for people because they thought it was going to be sorted out. This aspect is part of the consent process, though, so people know about it and we are clear with them about it. It is stressful, however, because people might then have to wait for a few days for a hospital appointment.

The real problem comes in cases where people may have this experience slightly earlier than they thought. I refer to situations where people might have had less bleeding than they thought, so then they may be anxious the procedure has failed, when in fact it has been okay. Even more anxiety may be felt in the opposite situation, where people thought they had enough bleeding, but they did not actually lose a pregnancy and it was still there. Therefore, there is this whole aspect of first trying to ascertain whether someone is still pregnant. In a situation where there has been a positive test, the question is whether that is just because of some remaining residual hormone and there is nothing to worry about. Rather than just adopting an approach of telling people it often takes a bit longer for the pregnancy hormones level to fall and that it sounds like everything is fine and we will just do the test again in a week, we are always in the position of saying we cannot really just afford to wait for a week in case we run out of time.

Therefore, we must over-investigate people, whether that involves sending them to the hospital for scans or doing blood tests to check whether their hormone levels are dropping. It means that women are being overstressed and over-investigated. We are constantly going around with these numbers in our heads. For example, if a person had a blood test on Monday, I must ensure I get the result, communicate again and ensure that person comes back in on Thursday. There is nothing wrong with these people. They are perfectly well and healthy, and we should not be having this major concern about what their blood test results are.

Senator Lorraine Clifford-Lee: I thank Dr. Henchion.

Chairman: We have come to the end of this meeting. I do not know if it was as historic as the witnesses thought it might be, but it was a useful discussion. We have covered a large area. I reiterate that if there are areas the witnesses would have liked to have had the opportunity to expand on, but could not because of the nature of the ten-minute slots, they should, by all means, feel free to come back to us in that regard. On that note, I again thank all the witnesses for their comprehensive discussion with the committee.

The joint committee adjourned at 12.27 p.m. until 9.30 a.m. on Wednesday, 4 May 2022.