

DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 23 Meán Fómhair 2026

Wednesday, 23 September 2026

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:

Colm Burke,	Manus Boyle,
Michael Cahill,	Maria Byrne,
Sorca Clarke,	Tom Clonan,
David Cullinane,	Teresa Costello.
Martin Daly,	
Pádraig O'Sullivan,	
Peter Roche,	
Marie Sherlock.	

I láthair / In attendance: Deputies Grace Boland, Ruth Coppinger and Peadar Tóibín and Senators Lorraine Clifford-Lee, Sharon Keogan, Rónán Mullen, Sarah O'Reilly and Patricia Stephenson.

Teachta / Deputy Pádraig Rice sa Chathaoir / in the Chair.

Gnó an Chomhchoiste - Business of Joint Committee

An Cathaoirleach: I call the meeting to order. We will briefly go into private session.

Chuaigh an comhchoiste isteach i seisiún príobháideach ar 9.31 a.m., cuireadh an suí ar fionraí ar 9.42 a.m. agus cuireadh tús leis arís i seisiún poiblí ar 9.44 a.m.

The joint committee went into private session at 9.31 a.m., suspended at 9.42 a.m. and resumed in public session at 9.44 a.m.

Health (Abolition of Three Day Wait Rule) (Amendment) Bill 2026: Discussion (Resumed)

An Cathaoirleach: Good morning. We have received apologies from Senator Nicole Ryan, who is on maternity leave.

I remind members of the constitutional requirement that they must be physically present within the confines of the Leinster House complex in order to participate in public meetings. I will not permit a member to participate where he or she is not adhering to this constitutional requirement. Therefore, any member who attempts to participate from outside the precincts will be asked to leave the meeting. In this regard, I ask any members partaking via Microsoft Teams to confirm, prior to making their contributions, that they are on the grounds of the Leinster House campus.

Last week, the committee commenced the detailed scrutiny of the Health (Abolition of Three Day Wait Rule) (Amendment) Bill 2026. This is a Private Members' Bill sponsored by Deputy Cullinane of Sinn Féin. The committee has been asked to examine the issue from a legal and policy perspective and to report on the process. The select committee will then make a recommendation to the Dáil on whether the Bill should proceed to Committee Stage.

Last week, we had witnesses from the Irish College of General Practitioners, ICGP. Today, we have representatives from the Department of Health and the HSE to help us consider this from both a legal and policy perspective. As we noted last week, there is a diverse range of views on this issue, some of which are deeply held. I ask all members contributing to the debate today to be respectful of our witnesses and respectful of the invitation we have given them to give their expert opinion from the legal and policy perspective.

This week, we continue our scrutiny. To assist the committee, I welcome from the Department of Health Professor Mary Horgan, Chief Medical Officer, Ms Pamela Carter, principal officer, Mr. David Noonan, principal officer, and Ms Caitriona Mason, assistant principal officer. From the HSE, I welcome Dr. Cliona Murphy, clinical director for the national women and infants health programme, and Dr. Aoife Mullally, national clinical lead on termination of pregnancy.

I wish to read out a note on privilege. Witnesses are reminded of the long-standing parliamentary practice that they should not criticise or make charges against a person or entity by name or in such a way as to make him, her or it identifiable or otherwise engage in speech that may be regarded as damaging to the good name of a person or entity. Therefore, if witnesses' 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.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

To commence today's proceedings, I invite Professor Horgan to make the opening remarks on behalf of the Department of Health.

Professor Mary Horgan: I thank the committee for inviting us here today. I welcome the opportunity to discuss the Health (Abolition of Three Day Wait Rule) (Amendment) Bill 2026.

Improving healthcare for women is an important priority for the Government and the Department. In this context, we are committed to ensuring safe, equitable and timely access to termination of pregnancy services for those who need them. There have been considerable and ongoing developments in terms of increasing access to these services, and these will be outlined in detail by my colleagues from the HSE.

There has been substantial investment in the wider area of women's health, with additional dedicated funding of €180 million provided since 2020. This has resulted in initiatives including the free contraception scheme, specialist menopause clinics, and additional see-and-treat ambulatory gynaecology clinics, to name but a few.

This morning, at the committee's invitation, we are here to address the legal and policy implications of the Health (Abolition of Three Day Wait Rule) (Amendment) Bill 2026. As members are aware, the purpose of the Bill is to abolish the mandatory three-day waiting period for termination in early pregnancy. At the outset, I would like to say that I fully understand that there are different views on this issue. This is, as I am sure all agree, a very sensitive and emotive issue and, for some, a deeply personal matter. I also speak for my colleagues when I say that we fully respect all views. I assure the committee that, in considering this particular issue and other related issues, we have listened and continue to listen, and we welcome respectful debate and take account of all perspectives and information available.

The Health (Regulation of Termination of Pregnancy) Act 2018 was signed into law on 20 December 2018. Expanded termination of pregnancy services have been available since 1 January 2019. The Act allows termination to be carried out in cases where there is a risk to the life or of serious harm to the health of the pregnant woman; where there is a condition present that is likely to lead to the death of the foetus either before or within 28 days of birth; and without restriction up to 12 weeks of pregnancy.

The vast majority of terminations take place under section 12 of the Act. It is estimated that approximately 98% of terminations performed between 2019 and 2025 were under section 12. Most of these were performed in the community. To avail of a termination under section 12 of the Act, a woman must be no more than 12 weeks pregnant and undergo two consultations with a medical practitioner.

At the first consultation, the doctor will certify that the pregnancy is under the 12-week limit. A period of at least three days must then lapse before the termination can take place. The Bill, if passed, will remove the mandatory requirement for a wait of at least three days between the first and second consultations. Currently, the model of care for termination of pregnancy in the

community, national clinical guidelines, service configuration and public information materials are all based on the operation of the three-day waiting period. Moreover, the process by which GPs claim reimbursement for providing the service, set down in SI 598 of 2018, is also predicated on the requirement of two consultations. The above would have to be amended or altered in consultation with the relevant stakeholders, should the requirement for a three-day wait be removed. My colleagues from the HSE will address the operational implications of the Bill.

The arguments for and against the removal of the mandatory three-day waiting period have been the subject of discussion and consideration in the Oireachtas and the public domain. Those in favour of abolishing the mandatory waiting period say it contradicts patient autonomy and informed consent principles. The fact that the law assumes people need time to reconsider is seen as paternalistic and patronising. The point has also been made that the wait and the need for multiple appointments creates practical, logistical difficulties, including time off work, travel and childcare. These difficulties often have a disproportionate impact on vulnerable groups and can lead to timing out or going beyond the 12-week limit in certain instances. I am aware these issues were raised at last week's committee meeting when representatives of the ICGP appeared before it. Those in favour of retaining the mandatory waiting period point to the fact that it formed part of assurances given to the Irish people prior to the repeal of the eighth amendment. It has also been said that it is of value to some women and that many other countries have a similar requirement. This is certainly true.

The key challenge in coming to a decision on the Bill is to find the appropriate balance between protective measures and compassionate, timely access to healthcare. The Government is aware there is a broad range of sincerely held opinions on the removal of the three-day wait and, accordingly, has allowed a conscience vote on this Bill. The Government continues to be committed to engaging constructively with Sinn Féin to ensure the legislation is as robust as possible and that there are no unintended consequences. Government has further committed to ensuring that should this Bill be passed, the option of a reflection period remains available to those who choose to avail of it. In most areas of healthcare, informed consent is based on a patient's capacity, understanding and voluntary decision-making rather than a prescribed waiting period. Therefore, the requirement for a three-day mandatory waiting period is primarily a policy choice and continuous assessment of policies is vital as societal attitudes and healthcare evidence evolve over time.

The Department was asked to consider the legal implications of the PMB. I can confirm the Department engaged with the Office of the Attorney General. The objective was to ensure the Bill, as drafted, was robust and to determine what, if any, amendments may need to be considered. This of course would be a matter for Committee Stage, if that arises. However, to assist the committee in its current deliberations, the most significant consideration is that any potential changes in the policy or legislation would need to ensure and provide for a reflection period, should a woman wish to avail of it. As was discussed previously at this committee, and as I understand it, the premise of the PMB is to remove the mandatory element of the waiting period. It is a matter for the committee to decide on how this Bill progresses and is ultimately a matter for the Oireachtas to determine whether the requirement for a mandatory three-day wait period is removed from the legislation.

As officials, our role is to respect the scrutiny process. We will continue to engage with this committee, the HSE and stakeholders to implement whatever decision is made and the outcome of the democratic process. My colleagues and I are happy to contribute to that process here this morning and answer any questions members of the committee may have. I thank them.

An Cathaoirleach: I thank Professor Horgan. I now invite Dr. Murphy to make her opening remarks on behalf of the HSE.

Dr. Cliona Murphy: Good morning, Chair and members of the committee. I am the clinical director of the national women and infants health programme, NWIHP. I thank the committee for the invitation to join its meeting this morning to discuss termination of pregnancy services, and in particular, the mandatory three-day waiting period provided for under the Health (Regulation of Termination of Pregnancy) Act. I welcome the committee's consideration of this important issue. I am joined by my colleague Dr. Aoife Mullally, national clinical lead for termination of pregnancy services.

Since the commencement of the current legislative framework in 2019, termination of pregnancy services has evolved into an integrated and integral part of women's healthcare. Safe, high-quality termination of pregnancy care is an essential element of the healthcare services we provide, and we remain committed to ensuring women can access these services in a timely, safe and equitable manner. There has been important progress in the provision of termination of pregnancy services nationally. The number of units providing these services increased from ten in 2019 to 19 in 2025, each with designated clinical leads and termination of pregnancy service co-ordinators. In primary care, the number of GP providers holding contracts has increased from 281 in 2019 to 498 currently.

Governance has also been strengthened through the national women and infants health programme, NWIHP, and the national termination of pregnancy service improvement group. Substantial work is under way on education and training, audit and data collection, guideline revision and the development of patient information resources, including the recently published Termination of Pregnancy - Guide to the 2018 Legislation and Termination of Pregnancy for Fetal Anomaly, which provides support, information and guidance to women and families considering a termination of pregnancy for foetal anomaly. These developments reflect the significant work undertaken by the HSE, healthcare professionals and service providers to establish and expand termination of pregnancy services across the country. This work extends beyond access alone, encompassing the delivery of safe, accessible and high-quality care underpinned by strong clinical governance, evidence-based practice, education and training, quality improvement, robust data and audit and clear, accessible information and support for women and their families. Together, these elements are central to ensuring services are delivered consistently and safely within the legislative and clinical framework.

Under current legislation, termination of pregnancy is a legal entitlement. The HSE's role is to support the delivery of services within the agreed legislative and policy framework, working with healthcare professionals, service providers and relevant colleagues across the system to ensure that women receive appropriate information, care and support throughout their care pathway. As the service continues to develop, the HSE also brings operational and clinical experience to its engagement with the Department of Health and other relevant stakeholders, supporting the implementation of agreed policy and contributing to the continued development and improvement of services.

Today, the committee is considering the operation and implications of the mandatory three-day waiting period. At the outset, I would like to state that any decision on the potential removal of the three-day waiting period is a matter for policy and, ultimately, for the Oireachtas. However, from a clinical and operational perspective, the HSE has no fundamental objection to its removal. The current model of care for termination of pregnancy services has been developed and implemented within the existing legislative framework, including the mandatory period. As a result, appointment scheduling, referral pathways, workforce planning, service configuration and administration have developed around this requirement. Any change would therefore require some consideration and planning to ensure the transition is managed effectively and that services continue to operate safely and consistently.

From a clinical perspective, the HSE's position is that there is no clinical requirement for a mandatory three-day waiting period or for any period beyond the time necessary for a woman to consider and absorb the information provided as part of the consultation and informed consent process. However, there is an important distinction between removing a mandatory waiting period and removing the opportunity for reflection. Some women may value additional time to consider their decision and that opportunity should remain available to them. Removing a mandatory waiting period would not mean every woman would necessarily proceed to treatment on the day of consultation. The timing of care would continue to depend on the individual woman's circumstances, clinical assessment, service arrangements and, importantly, her own wishes. What would change is that additional time for reflection would be available as a matter of choice rather than imposed as a mandatory requirement. This is consistent with a more flexible, patient-centred approach based on informed consent, autonomy and individualised decision-making. It also recognises that women accessing abortion services will have different circumstances, needs and preferences.

The HSE has not undertaken a dedicated review of service user feedback specifically on the mandatory waiting period. However, the evidence available from the Unplanned Pregnancy and Abortion Care, UnPAC, study and other research supports consideration of greater flexibility within the existing model of care.

The UnPAC study commissioned as part of the review of the Health (Regulation of Termination of Pregnancy) Act explored the experiences of individuals accessing abortion services under section 12 of the Act. The study found that the mandatory waiting period was a recurring feature of discussions across the majority of interviews. Participants expressed a range of views. Some regarded the waiting period as a procedural requirement that had to be navigated, while others experienced it as a barrier or unnecessary delay. Very few participants considered the waiting period to have been beneficial to their own decision-making process, although some acknowledged that other women might value additional time for reflection.

The study found support for a more flexible approach, where women could access treatment without a mandatory waiting period while retaining the option of additional consultation where this was desired and agreed with the provider. The UnPAC report noted that women are generally clear on their decision and are anxious for timely access, which is at odds with the mandatory three-day waiting period.

Mandatory waiting is not a universal feature of abortion care internationally. Several jurisdictions, including France and the Netherlands, have recently moved away from mandatory periods towards a reliance on standard informed consent processes. Importantly,

the WHO safe abortion guidance also recommends against mandatory waiting periods, identifying them as potential barriers to access and recognition of women as competent decision-makers.

At the same time, removal of the mandatory waiting period would require some consideration of practical implications. The existing pathway operates through separate stages of assessment, certification and treatment. A revised model would need to provide clarity on how the stages would operate, including whether assessment and treatment could take place during the same consultation, how appointments would be scheduled and how an optional period of reflection could be accommodated for women who wish to take additional time.

As is the case across other areas of healthcare, we believe women should have the opportunity to take additional time for reflection where they wish to do so. We do not consider that there is a clinical rationale for a mandatory three-day waiting period where a woman has made an informed decision to proceed. Again, that does not mean that a termination would necessarily take place on the same day, as the timing of care will continue to depend on the individual woman's circumstances, clinical assessment, service arrangements and wishes. The key distinction is the opportunity for additional reflection should be available to a woman who wants it rather than imposed as a mandatory requirement on every woman.

The HSE will continue to support the delivery of safe and accessible and high-quality termination of pregnancy services within the agreed legislative and policy framework, working closely with the Department of Health, policy units and relevant stakeholders and bringing the operational and clinical expense of the health service to ongoing policy consideration. I thank the committee for its time.

An Cathaoirleach: I thank Dr. Murphy. We will move to questions from members. We have an agreed rota based on party size. Each member is given eight minutes. We take a break of five minutes halfway through the list and then resume with the remaining committee members. Any additional time left will be divided equally among those who are not committee members but who are here. I have taken names as members have arrived for that list. This is the highest attendance we have had at the health committee and therefore time for additional members at the end may be quite short. We will try to get everybody in, but we will conclude at 12.30 p.m. because there is another committee meeting after this one. I ask everybody to be respectful of time because it will be tight and to try to keep to their time as much as possible.

Deputy Martin Daly: I thank the witnesses for coming before the committee and for their statements. We start with the premise of the Bill. There is reference in the HSE to a legal entitlement. Women are entitled also to have the highest quality service delivered by well-trained professionals in the health service. That is important to note. I ask the witnesses to comment on whether there is there any scientific, medical or clinical rationale for a mandatory three-day wait between consultation and procurement of a termination.

Professor Mary Horgan: There is no medical reason for a mandatory wait.

Dr. Cliona Murphy: There is no medical reason. There is plenty of research that shows that women have made a considered decision before approaching a doctor. There is a lot of information available on *myoptions.ie*. Experience would show that women have discussed this with their partners and close confidants and have come to a considered decision before meeting a doctor. There are situations where people need additional time in most instances. In

other countries with a 72-hour waiting period, it led to a longer time before accessing care. The evidence would suggest that those women were not conflicted when they presented.

Deputy Martin Daly: What is Dr. Mullally's view?

Dr. Aoife Mullally: I agree with my colleagues. We have overwhelming evidence against waiting periods from the World Health Organization abortion care guidelines published in 2025, which was a meta analysis of 33 scientific studies. I will go through some of those in some detail.

Of the 33 studies, seven showed that mandatory waiting periods contributed to abortion delays by increasing the time from counselling to the abortion appointment and contributing to logistical difficulties in accessing care. That effect is magnified when two visits are required, as with our current model. There are seven studies that show mandatory waiting periods do not contribute to any changes in abortion rights, unintended pregnancy or birth rates in general. One study showed that, among minors, mandatory waiting periods are associated with an increased risk of reporting of an unwanted birth. Some 18 studies reported that mandatory waiting periods contributed to financial and emotional costs, such as logistical burdens, emotional stress, financial cost, travel time and out of state travel.

For most women, mandatory waiting periods do not impact their certainty in abortion decision. As an abortion care provider, that is something I see very clearly when I meet women. Waiting periods do not align with WHO recommendations, human rights standards and modern clinical practice. As doctors, we are used to dealing with the concept of informed consent all of the time. We are very much used to dealing with patients who exhibit signs of indecision and uncertainty. We are very aware of the concept.

Deputy Martin Daly: I would like to put some specific questions to the witnesses on some of the issues raised. Can Dr. Mullally confirm the natural rate of spontaneous abortion or miscarriage in the first 12 weeks of pregnancy? Is it in the order of 30%?

Dr. Aoife Mullally: It is between 20% and 25%, depending on the age of the woman and various different factors.

Deputy Martin Daly: Working from the premise that it is a legal right for a woman to have an abortion in this country under the legislation, there is a dearth of providers in certain parts of the country, which means there are considerable travel and logistical issues for women. I refer to women in lower income groups who are vulnerable, perhaps financially, or are in controlling or coercive relationships where it is difficult for them to share with a partner what is going on. Is there published research to show that those women are disproportionately affected by a mandatory wait?

Dr. Aoife Mullally: Yes, that is absolutely correct. There is, and that was included in the WHO guidance. We know that vulnerable and marginalised women already experience difficulties accessing healthcare and, more importantly, have poorer health outcomes. They will be more affected by any mandatory waiting period, whether it is three days or any other number of days.

Deputy Martin Daly: I would be aware in practice that in the west of Ireland women have to travel two or three hours to find a provider. They may have inadequate public transport and

issues around resources. I wanted to know what the published research found, rather than relying on hearsay.

On healthcare in general, we trust people to make their own decisions. I note in both documents submitted to the committee that informed consent is based on patients' capacity, understanding and voluntary decision-making rather than a prescribed waiting time. Is there any other area of healthcare, other than in the case of minors, where mandatory wait times are imposed?

Dr. Aoife Mullally: There is not. It is worth noting that healthcare is becoming increasingly complex and people make very complex decisions about their own health every day in collaboration with their medical practitioners. We do not impose mandatory waiting periods on any other decisions.

Deputy Martin Daly: I am short on time. The area of reflection is really important. I think there is general agreement that there should be a period of reflection if the woman wants reflection. Around the whole area of a mandatory period of reflection, my experience would be that people have already reflected on this situation before they come to a doctor. What does the evidence show?

Dr. Aoife Mullally: That is certainly true. The women interviewed and surveyed in depth in the Unplanned Pregnancy and Abortion Care, UnPAC, study, would certainly say that. It is important that there is a period of reflection allowed for within any amended model of care, but that is consistent with any other area of healthcare.

Deputy Martin Daly: What the published evidence is saying is that there is no clinical, medical or scientific reason for a mandatory three-day period of reflection, that reflection is good but it does not need to be mandatory, that women have already reflected before they present to a doctor and have the opportunity to voluntarily reflect on this case in conjunction with the provider, and that there is no real basis for the mandatory aspect of it in science. This is a political policy decision, respecting people's personal views on that.

Deputy David Cullinane: I welcome all our witnesses. The witnesses here from the Department and the HSE are here on behalf of those bodies to give either a Department or a HSE perspective and not any individual perspectives. Is that the case?

Dr. Clíona Murphy: Yes.

Deputy David Cullinane: I just wanted that clarified first. As the author of the Bill, it is important for me to set some context. I said at the last session that I respect there are different opinions on this issue. There are different opinions on the issue of abortion. I am very respectful of the fact that there are different opinions. However, the purpose and intent of this Bill are very clear. I need to state that again because there is an impression being given by some that this Bill seeks to remove any option of reflection for women, which is not the case. This Bill proposes to remove the mandatory element, or forcing women to wait, as opposed to what I would describe as an individualised approach which would be based on the circumstances of the woman, and each woman would be different and come at this differently. It is about individualised care and pathways. There still would be, and has to be, a time for reflection because if a woman arrives at a decision to have an abortion, it has to be at a time of her choosing.

I want to put that to the HSE. Is it the view of the HSE representatives that, notwithstanding this Bill removing the mandatory element, it is important for that reflection part and the individualised nature of that to be retained? Is that the view of the HSE?

Dr. Cliona Murphy: Absolutely. Termination of pregnancy services should be like the rest of women's healthcare. We have situations where women can have a procedure on the same day when it is properly explained, but some of those women may choose to have it done on another day because it does not suit, whether it is a biopsy or some type of scan. We deal with this all the time. It is not a matter of one size fits all; it is what suits a particular individual at that point in time. The same is true for minor surgical procedures. There may be options of having them in a short timeframe but if the person is not ready, there are arrangements made for that. Doctors, midwives and nurses are well aware of that and tailor services accordingly.

Deputy David Cullinane: I put the same question to the Department.

Professor Mary Horgan: When it comes to delivery of healthcare, it is patient-centred and, in this case, it is woman-centred. It is important that as a principle or objective the option of a reflection period remains available to those who wish for it. Not everyone thinks the same. Not every woman wants things done the same way. Our job as clinicians, and certainly from the Department's point of view, is to respect that ability to have the option to reflect.

Deputy David Cullinane: I think the HSE referenced seven studies that identified financial and emotional issues for some women because of the mandatory element of the three-day wait. Some of those are international studies. There were also issues in relation to access. We heard from the Irish College of General Practitioners, ICGP, last week that it can be a barrier to accessing services for some women. Is that accepted?

Dr. Aoife Mullally: I think that is correct, yes.

Deputy David Cullinane: If it was the case that the Bill was passed and the mandatory element of the three-day wait was removed, obviously there would still be an option for reflection. That may not be three days. For some women it might be a week, two weeks or three weeks. It is obviously up to each individual woman. However, in circumstances where the mandatory element only is removed, do witnesses foresee any difficulties or impediments for women in those circumstances?

Dr. Cliona Murphy: If the wait was removed there would be some operational issues for the HSE-----

Deputy David Cullinane: I am asking about women accessing services.

Dr. Cliona Murphy: I do not think so. Whatever pathways are appropriate can be arranged. GPs know their patients well and how they are delivering the service. I think new pathways will be determined for those women. The people most affected by the mandatory element are often people who have a legal right but may time out of services because of the three-day wait and those in very straitened circumstances who may have already taken eight or ten days to present to a doctor because of financial circumstances. Removing the mandatory wait will----

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Deputy David Cullinane: Is there any evidence to suggest that, because of the mandatory element of the three-day wait, women who presented and were clear in their view then changed their minds after that three-day period? Are there any published data available to answer that?

Dr. Clíona Murphy: There is no published evidence. There is published evidence of longitudinal studies of people with regard to abortion care and the level of regret is low and the overwhelming sense is of relief. That is in published studies.

Deputy David Cullinane: I will turn to the Department. The Attorney General examined the Bill. As the author of the Bill, I did meet with the Department and I know there are a number of technical amendments proposed. Aside from that, the Department said there was no legal, constitutional or even policy impediments to prevent the passage of the Bill. I think the argument, essentially, is that it is a matter for the Oireachtas but the Attorney General does not see any practical, legal, constitutional or other reason the Bill would not pass. Is that correct?

Professor Mary Horgan: Yes. The Department has already consulted with the Office of the Attorney General and, while the legal advice is privileged, a number of minor issues were identified. These relate to the Title of the Bill and some small technical rewording. These could be appropriately addressed, if that is the decision of the committee.

Deputy David Cullinane: To make a point from my perspective in conclusion, I am respectful of different opinions but there must be an honesty about what is being proposed and also the evidence which has been presented, certainly by any clinicians who have come forward giving the views of representative bodies before the committee, that there is no clinical or medical reason for the mandatory element to remain. In fact, they said there are barriers to access and that is in proven and published reports which looked at this. I want to make the point as the author of the Bill that I do not want any woman to feel rushed in making a decision. Each woman will come at this from their own perspective. This is about choice. Sometimes women can feel patronised when they are told a mandatory three-day wait has to remain in place. That is wrong. Obviously, I support a reflection period and that is important as well. What I am hearing from the Department and the HSE is that will of course remain and if this Bill passes, of course, a woman will arrive at making the decision at a time of her choosing and then the pathway is individualised. That is the most sensible, best and most caring way to deal with this issue. I will leave it at that.

Deputy Colm Burke: I thank Professor Horgan and Dr. Murphy for their very good presentations and for giving a very balanced view on this issue. I appreciate that very much.

In relation to people attending their first appointment, there is a view that people have their minds already made up that they want to proceed with a termination. My understanding, however, is that over 10,000 women did not return for the second consultation. Is that not evidence, in its own light, that people do not have their minds fully made up if as many as 10,000 did not come back for a second consultation?

Dr. Clíona Murphy: An assumption is being made there that those who have not returned for the second consultation have not proceeded. In fact, reasons for not coming back for the second consultation could be going to another doctor and referring on to the hospital, so they are not counted in the same dataset as such. There is also the rate of miscarriage. As the Deputy said, some will continue. The published evidence, however, with regard to continuing would be the Irish Family Planning Association, IFPA, data which showed that 1.8% continue with

the pregnancy. We have no evidence to say that the mandatory element is what has caused people to continue.

Deputy Colm Burke: Regarding the figures being quoted to us, we do not have detailed research in relation to any sample of those 10,000 people in real terms.

Dr. Cliona Murphy: This is a sample from the Irish Family Planning Association five-year dataset of anonymised clinical data, and 98% continued with abortion care and 1.8% continued with the pregnancy. That is data from a large provider.

Deputy Colm Burke: It is still an issue that is being raised. The evidence is that 10,000 people who attended a first consultation did not come back to the same medical practitioner for their second consultation.

Dr. Cliona Murphy: Yes, but what I am saying is that it does not mean that they did not continue with care. They may have gone to another doctor, or they may not have. They may have gone into a hospital.

Deputy Colm Burke: There is not detailed analysis of all of that in real terms, however. No detailed analysis has been done by the HSE of that.

Dr. Cliona Murphy: We are currently doing a data collection on the hospital data, and then there will be a secondary roll-out-----

Deputy Colm Burke: Up to this, there has been no detailed analysis of that figure.

Dr. Cliona Murphy: Not of the 10,000, but I am giving the Deputy a subset of the 10,000, which is 2,466.

Deputy Colm Burke: Just on the issue in relation to the report produced in 2022, that had interviews with 59 women. It was for a period from when the legislation came into effect on 1 January 2019, so it was a very short time. No major research project has been done by the HSE since that 2022 report.

Dr. Cliona Murphy: The HSE has done a lot of work on the operational side-----

Deputy Colm Burke: I know, but no major research document has been done since 2022, and that document was in relation to interviews with 59 women.

Dr. Cliona Murphy: We have been doing a lot of work regarding clinical guidance and other aspects of operational-----

Deputy Colm Burke: I fully accept that but I am just saying that one of the arguments being put forward is that no major research has been done by the HSE since 2022, and that report was done at a time when, in fairness, the process and the availability of termination services had only been in existence for two years. We had a very short timeframe. What could we have learned if we had done further research taking into account the fact that the process had been in place for six or seven years?

The second thing I want to touch on is that medical practitioners have advised me that they find the three-day reflection period protective of them as medical practitioners as well. If they feel that somebody is under pressure to go ahead with a termination, the fact that they can tell them they will have to come back in three days makes the medical practitioner feel very much

protected by having that safety mechanism in place. I am not sure if Dr. Murphy has heard of that being said by medical practitioners.

Dr. Cliona Murphy: No, I have not had that view expressed to me. The ICGP, in a session last week, did not express that view from its members. I ask Dr. Mullally to comment on whether she has heard that view expressed.

Dr. Aoife Mullally: I think most medical practitioners feel that a period of reflection is useful for many women, and it is important that this is about the woman and not about safeguarding the practitioner *per se*.

Deputy Colm Burke: I accept that.

Dr. Aoife Mullally: The international evidence shows that medical practitioners feel that mandatory waiting periods are not useful. The service providers stream of the UNPAC study was very strong on the fact that medical practitioners did not feel that the mandatory nature of the period, in itself, was useful.

Deputy Colm Burke: Turning to the issue of international practice, both witnesses acknowledged that many countries have a mandatory waiting time. It is seven days in one country and six days in another, while it is three in other countries. Quite a number of countries are the same as Ireland and have that mandatory time period, so Ireland is not on its own in regard to this issue. I think Professor Horgan referred to the fact that two countries have reviewed it. Obviously, however, a number of countries have the same view that a mandatory time period is helpful rather than it being discretionary.

Dr. Aoife Mullally: With respect, those mandatory waiting periods similar to Ireland's were policy decisions rather than clinical decisions. Since the WHO guidance was produced in 2025, five countries have moved away from mandatory. France, the Netherlands, North Macedonia, Spain and Luxembourg have dropped their mandatory waiting periods. The international trend is very much away from imposing mandatory waiting periods.

Deputy Colm Burke: A number of countries in Europe still have a mandatory time period. however.

Dr. Aoife Mullally: There are-----

Deputy Colm Burke: Ireland is not standing on its own.

Dr. Aoife Mullally: -----but policy changes slowly and I suspect, as I said, the trend is towards removing mandatory waiting periods. That is very clear.

Dr. Cliona Murphy: I will add that it is also not based on clinical grounds in those countries. Portugal, which has a three-day wait similar to us, also has considerable barriers to access, including geography and conscientious objection. In Italy, which has a seven-day waiting period, there is some discretion there with regard to the doctor, but the country actually has very poor access for women. There are different elements in different countries. There is an abortion care atlas which shows that Ireland scores 66% in comparison with other EU countries such as France, which would score 85%, and Denmark, which would score 78%.

An Cathaoirleach: I thank Dr. Murphy. The next slot is mine. I thank the witnesses very much for their evidence and submissions. They are very detailed and clear. I will pick up on

some of the questions Deputy Burke was putting because I do not think the witnesses were given adequate time to answer them in relation to the IFPA study. Will they tell us a bit more about that?

Dr. Cliona Murphy: The study from the IFPA was a five-year one, and 85% were under eight weeks and 15% were between eight and ten weeks. There was follow-up with more than 2,500 women, and 1.9% continued with a pregnancy. It is a very firm dataset for this country.

An Cathaoirleach: In other words, 98% of people continued.

Dr. Cliona Murphy: Yes, exactly.

An Cathaoirleach: It is very clear published data from the IFPA from a large sample size. Are there any other thoughts in relation to this aspect? The evidence is very clear.

Dr. Aoife Mullally: It is very clear, and, as I said, I do not want to speak from a personal point of view as a provider, but I have been leading a service for six years. I see the women who come in to me. I see the degrees of certainty and uncertainty around clinical decisions. My colleagues and I, including those in general practice, are very aware of the need for periods of reflection. Women often come back multiple times because they are undecided, and the models of care allow for that and providers allow for that. It is important to stress that doctors do not rush women into decisions. We are aware of the gravity of these decisions and the consequences. We stick by the pillars of informed consent, patient autonomy and maintaining the patient at the centre of the conversation at all times.

An Cathaoirleach: Would Dr. Mullally see this continuing?

If this legislative change is made, would you see it continuing that time would be allowed and people could make a decision in their own way?

Dr. Aoife Mullally: Correct.

An Cathaoirleach: Last week we heard from the ICGP, which said that the mandatory three-day wait is not medically necessary. The HSE has now confirmed this position saying there is no clinical requirement for it. Is it the HSE's view that not only is the mandatory waiting period clinically unnecessary, but this model delays treatment and is in fact suboptimal?

Dr. Cliona Murphy: As I said, for some women early on in pregnancy, it may not make too much of a difference, particularly if they have financial means. We know that it affects those in more straitened circumstances, those who have to arrange childcare, etc., and those in more marginalised communities. Certainly, it has a higher impact on those who are closer to timing out. The combination of our strict 12-week cut-off and the three-day wait impacts some women, perhaps including those who, through no fault of their own, found out about their pregnancy later. There are still people who are not aware of the legislation. It affects such people disproportionately. Medical practitioners can do nothing in that situation.

An Cathaoirleach: This law is resulting in people timing out and also having a disproportionate impact on some of the most disadvantaged groups who are socially, economically and geographically marginalised. Is that correct?

Dr. Cliona Murphy: Yes.

An Cathaoirleach: A change in the law would have a benefit for those cohorts.

Dr. Cliona Murphy: Yes.

An Cathaoirleach: The My Options service was mentioned. Is it not the case that the HSE already provides services which ensure that the system of reflection is embedded within the system, such as the My Options service?

Dr. Cliona Murphy: Yes, absolutely. It is called My Options because it is not that somebody starts immediately to make an appointment. They have the option for counselling and there is information. The first step is actually thinking about it, having to go on to the My Options website and getting the information on what GP is available. There are a number of steps a woman has to go through before she gets the appointment with the GP. In the vast majority of cases, we are not talking about somebody who is finding out they are pregnant on the day and talking to the GP for that first consultation. A number of steps have to be taken by the woman first.

An Cathaoirleach: Tell us a bit more about the My Options service and how it supports reflection.

Dr. Cliona Murphy: I will let Dr. Mullally answer this.

Dr. Aoife Mullally: My Options is a service that was initially funded by the sexual health and crisis pregnancy programme in the HSE. It is a free helpline and a webchat service that women can contact. It provides signposting to abortion care, but also provides supports for women who choose to continue with the pregnancy and signposting towards particular supports or agencies they might need. If a woman has decided to proceed with a termination of pregnancy, My Options will give her the contact details of a number of providers in her local area. Some women may choose to go further afield and My Options will give them the contact details of providers in another locality, if that is what they choose. It also provides counselling after an abortion and provides a nurse-led phone line for women who are experiencing symptoms or complications they may be concerned about.

An Cathaoirleach: So there are services in place that support reflection and decision-making, and, as the title of the service says, the options that are available to them.

Dr. Aoife Mullally: Correct.

An Cathaoirleach: Regarding the changes that may be made if the legislation progresses, I understand that GPs currently receive three payments in relation to providing terminations free of charge: for the first visit, for termination aftercare, and then for aftercare if the termination takes place in a hospital. If the Bill is passed, is it the Department's intention to continue offering up to three free-of-charge consultations to accommodate service users who would prefer not to proceed on their initial visit?

Professor Mary Horgan: Should the Bill progress, our job is to look at that with our colleagues in primary care to see how we can best support that and to maintain the payment that allows women who are at the centre of all this to access care should they want that period of reflection.

An Cathaoirleach: It is likely that a similar model will exist in that multiple visits may be provided free of charge. Is that correct?

Professor Mary Horgan: Yes, it is likely that will happen.

An Cathaoirleach: That will continue to support the period of reflection if people want to come back multiple times in order to support that decision-making process. As mentioned this morning, last week the ICGP confirmed that the mandatory wait was pushing some women into requiring hospital-based abortion care because they timed out of community-based abortion care. Do you think that pushing women into more complex secondary pathways serves them in any way?

Dr. Aoife Mullally: Absolutely not. It is important to note that women experience more complications and physical symptoms at increasing gestations. There is also a lot less flexibility around abortion in a hospital setting where the woman has to be managed as an inpatient, rather than being able to self-manage their own care at home in an environment with supportive partners or people around them.

An Cathaoirleach: Where possible, it is preferable to accommodate terminations in primary care where it can be self-managed, rather than in more hospital-based care. This change to the law would support that-----

Professor Mary Horgan: Correct.

An Cathaoirleach: -----by ensuring fewer people are timed out and requiring hospital-based care.

Professor Mary Horgan: Exactly.

An Cathaoirleach: Would it also be true to say that forcing people into hospital-based care creates an additional burden on the health service, with people requiring inpatient services and, as you say, the care sometimes becoming more complex?

Dr. Aoife Mullally: We should really be focusing on the woman. This is a very small volume of work that is carried out in maternity services. The resources and personnel are there to look after women but it is really about the woman.

An Cathaoirleach: It is preferable to put treatment in the community and in primary care.

Dr. Aoife Mullally: Exactly.

Deputy Marie Sherlock: I thank the witnesses for being here today. I am very conscious that these are deeply sensitive issues for many people here for a variety of reasons. When I look around and see how full the room is, I hope we will have this level of commitment when we talk about other women's health issues during the lifetime of the committee. It is really striking that on other days we have very few people here and then on this issue of termination of pregnancy, we have a full house. I hope that continues.

I want to say thanks for both presentations today, for their clarity and frankness in showing that there is no clinical indication for the mandatory three-day wait and that, by extension, it is a policy or administrative fix as opposed to considering the three-day wait as anything else. The witnesses referred to the impact on women who are in any form of disadvantage, for example with regard to being able to access their GP. We know that some people cannot do so in a timely fashion, and have to wait a considerable time. They could be disadvantaged because of their location, because of where they work or because of culture or language barriers. There

is a variety of issues which present difficulties for women accessing a GP and then of course having to come three days later. I thank the witnesses for their frankness with regards to that.

I want to ask about data collection, which is a source of enormous frustration for me, notwithstanding that we have fantastic data from the IFPA. Being honest, that data is not trusted by some people sitting in this room and by others out there. It falls to the State and the Department to ensure we have the data of women's experiences of the system in place. As I understand, the ADAPT study commenced last year. When is it likely to be published? What is the further plan? Will there be ongoing data collection of women's experiences? This will be really important in dispelling the many myths that are out there about why women do not come back after three days.

Professor Mary Horgan: That study is data collection that has started in general practice that the committee would have heard about last week. Other data collection is of course really important. The service is provided by the HSE and Dr. Murphy has already outlined plans for it so she might be able to expand on it. I agree that data collection is really important. It is not about data; it is about the woman and the experience. We do that for many other services, particularly women's services, which have expanded, so that we can get information from the lived experience of the women who use the services in order to best modify the services as informed by the feedback. Dr. Murphy might be able to expand on the plans for that.

Dr. Cliona Murphy: The HSE has published data on abortion services this year.

That was the first time there was published data. As I explained earlier, in the initial roll-out there was a focus on operationalising, guidelines, etc. There needed to be a time period. We knew that the Department was collating a limited dataset. There is obviously some sensitivity around place and identifiable features, etc. We are now doing data collection focusing on the hospital side with the REDCap system. There will be roll-out to GP collection. I might ask Dr. Mullally to comment further.

Dr. Aoife Mullally: National data collection was piloted approximately two years ago. All units are now submitting data to that and we think we will have a complete dataset at the end of this year. That is really focusing on the quality of the service being provided and includes safety metrics, complications and access issues. Obviously, patient experience is an important part of the service and the HSE is currently considering a patient experience survey on pregnancy loss and pregnancy endings across all of those contexts.

Primary care is certainly more challenging because you are talking about almost 500 individual practitioners or contract holders. It is about finding a way of collecting data that all of those practices can incorporate into their daily work. That is something we are considering rolling out. We understand the importance of having a complete dataset from a quality point of view.

Deputy Marie Sherlock: I thank Dr. Mullally. In no other element of healthcare do we have such levels of judgment as to why people make decisions. That is why the data is so important.

I want to ask about informed consent. Whatever the medical procedure, people do not understand what happens in the case of informed consent. I say that in order to then ask about cases where a doctor takes the view that somebody needs to reflect on their decision. How does that conversation play out?

Dr. Aoife Mullally: Informed consent is a two-way collaboration between the doctor and the patient, and it is underpinned by the concepts of choice and autonomy. One of the issues with mandatory waiting periods is that it removes some of that autonomy from the patient. If patients are uncertain about any healthcare decision, it is picked up by the doctor. We can question patients on whether they are sure of their decision, if there are any other questions they want to ask, if they want to involve a support person in the conversation, or if they need written information or time for reflection. That is the same in all areas of healthcare. It is something that we are trained to do and that we learn to do with experience.

Deputy Marie Sherlock: We know that our primary care system is largely private. Unless you have a medical card, you have to pay. If you are in the hospital system, it is public. Cost is obviously a significant barrier to accessing GPs. I will pick up on an earlier question. If we are to see this Bill pass, as I hope, and move to the removal of the three-day wait, there will have to be significant reform of the schedule of payments to a GP. It is critically important that cost would not be a barrier to a woman coming back or feeling that she has to go through with a process there and then. I hear from Professor Horgan that some of that work has commenced but she might go into a little more detail about how she thinks that should play out.

Professor Mary Horgan: Incorporation of the reflection time is really important. Some women need that; others do not. However, that of course would be a component of the fee schedule should the committee decide that is the way to go. It is important that a woman is supported regardless of whether she opts to go ahead or wants that period of reflection, which, as has been pointed out, could be three days or longer. Women do not all think the same way.

Senator Tom Clonan: I thank the witnesses for giving us their time this morning. Like Deputy Sherlock, I note the large number of non-members of the committee. I welcome all of my colleagues. It reflects the strongly held moral perspectives that people have around the overarching issue here.

In a previous life, I taught moral philosophy for over a decade. One of the questions that we have as a species is what is the difference between morals and ethics. I understand that on the one hand, there are people who have a very legitimately held set of strong beliefs and views around an issue and at the other end of the spectrum, there are people who hold equally legitimate views that are strongly held on a moral basis. The purpose of ethics, and what differentiates them from morality, is the ability to reconcile different moral perspectives. That is where ethics lies. Trying to approach and achieve an ethical outcome relies on reason. Ethics rely on reason, justice and balance. I thank the witnesses for the detail they have given us. It certainly assists me in arriving at what I would consider to be an ethical view on the issue.

I have a couple of questions. I will leave it open and let the witnesses volunteer if they wish to try to answer. In the absence of any clinical reasons for a mandatory or prescribed period of reflection, as medical professionals who are in this area and have a deep knowledge of it, why do the witnesses think that a mandatory or prescribed period of reflection was recommended?

Dr. Aoife Mullally: It was a policy decision at the time. I have no other real answer for that.

Senator Tom Clonan: Does Dr. Mullally have any subjective view as to why a mandatory period of reflection was recommended?

Dr. Aoife Mullally: I do not.

Dr. Clíona Murphy: It was not a recommendation from the citizens' assembly, as far as I recall. We are here to give evidence from the HSE and not our personal opinions.

Senator Tom Clonan: It is an opinion based on the depth of the witnesses' professional experience. Apart from women, is there any other category of citizen for whom a mandatory period of reflection is prescribed in relation to any medical or life decision?

Dr. Aoife Mullally: Not that I am aware of.

Senator Tom Clonan: Is there any jurisdiction outside of the Republic where a mandatory period of reflection is imposed on any category of citizen in relation to a health or life decision?

Dr. Aoife Mullally: I am not familiar with healthcare provision in all other jurisdictions, but aside from abortion care, again, not that I am aware of.

Senator Tom Clonan: In the absence of a clinical reason and in the absence of any kind of intellectual rationale for a mandatory or prescribed period of reflection, is it ideological?

Dr. Aoife Mullally: I could not comment on the ideology around it.

Senator Tom Clonan: Is it a paternalistic view of women that they require a mandatory period of reflection?

Dr. Aoife Mullally: That has certainly been suggested, yes.

Professor Mary Horgan: My understanding is that it was a legal safeguard put in at the time. Everyone around here will appreciate that this was a brand-new service that came on foot of the repeal of the amendment. It was put in at that time as a safeguard. As I outlined, the service is embedded so-----

Senator Tom Clonan: When Professor Horgan says it was a "safeguard", in what sense does she mean it? What was it to safeguard?

Professor Mary Horgan: It was to safeguard the amendment that was brought in. It was a brand-new service.

Senator Tom Clonan: Does the professor mean it was like a speed ramp to compulsorily slow down people's decision-making process?

Professor Mary Horgan: I am not aware that that was the cause, but it was a policy decision at the time.

Senator Tom Clonan: What would the rationale be? When the professor says "safeguard", what does she mean by it?

Professor Mary Horgan: It was in the context of a new service that was being rolled out and had different opinions, as has been alluded to already.

Senator Tom Clonan: Medicine is a learning environment and an iterative process. It is evidence-based, research-led and research-informed, so it is constantly changing and there are new and novel treatments and interventions all the time.

Is there any other medical intervention, innovation, procedure or therapy for which a prescribed or compulsory period of reflection is imposed just on women?

Professor Mary Horgan: Not that I am aware of.

Senator Tom Clonan: There are no such safeguards in any other branch of medicine or, indeed, in any other branch of human life - in all of the activities. What would the witnesses say about the rationale for imposing a compulsory or mandatory period of reflection? I am all for reflection. At the age we are at now, we have all had to make decisions, including complex medical decisions, and reflection is a good thing. I also believe, like the moral philosophers, that dialogue, engagement and discussion are very important. However, where does the *a priori* assumption come from that women, as a specific category of citizens, require that a mandatory period must be compulsorily imposed upon them in law to make a decision in relation to a medical issue, or to a moral, philosophical, intellectual or any other aspect of Irish life?

Dr. Aoife Mullally: Our experience is within the clinical and operational sphere rather than legal or policy making, so it is very difficult to answer that question.

Senator Tom Clonan: I would put it to the witnesses that there is no such thing. It is the compulsory, mandatory, prescribed component of this. I cannot understand why that would be applied to women and girls, as a category of citizen, and to no other individual. In the 30 seconds remaining - this is like "Just a Minute", the 30-second quiz - can anybody tell me where they think the origins of the compulsory or mandatory nature of this period of reflection comes from?

Dr. Cliona Murphy: It is possibly to try to prevent regret. I think that is the idea in people's minds.

Senator Tom Clonan: That is why we have cooling-off periods in contracts and for all sorts of things. Where is this mandatorily or compulsorily applied to any other category of citizen?

Professor Mary Horgan: It was at a point in time. It was put in as a policy decision to-----

Senator Tom Clonan: I thank the witnesses for their patience.

An Cathaoirleach: Thank you. I suggest that we take a quick break and resume in five minutes. Is that agreed? Agreed.

Cuireadh an suí ar fionraí ar 10.53 a.m. agus cuireadh tús leis arís ar 10.57 a.m.

Sitting suspended at 10.53 a.m. and resumed at 10.57 a.m.

Deputy Michael Cahill: So far, it has been pretty much one-way traffic in this debate on this very important, sensitive and emotive issue. As I said on the last day, most of the members here are lay people and we need to be fully informed. We need to hear both sides of the debate.

In the statement, the witnesses say they have no fundamental objection to the removal of the three-day wait and that it is not based on any new evidence. That has been presented to the committee. It remains the case that before arriving at that position, the HSE had not consulted with the 10,000-plus women who went for their first abortion appointments and did not return after the waiting period had elapsed. The witnesses can correct me if I am wrong. I believe that we need to get witnesses on all sides in here, including GPs and women who have been through this and who can speak of their experience regarding the value of the three-day wait. I believe we also need to give a little bit of time because this is something that cannot be rushed.

People have their own lives and their own work to carry out and they need some bit of time to be able to reorganise in order to be able to attend. Dr. Murphy can correct me if I am wrong, but I am concerned about the level of research carried out by the HSE on this most important issue. I feel very uncomfortable because we are due to make a huge decision that could very well be exceptionally controversial - it has been in the past - and I would like a more balanced debate going forward, a Chathaoirligh.

An Cathaoirleach: I thank the Deputy. Does anyone wish to respond to the remarks made by the Deputy?

Dr. Cliona Murphy: On the point about hearing from women who have not continued, in some cases following up women who do not wish to be contacted could be an invasion of privacy. We would not ordinarily do that for people who are not in our health service any more. I understand what the Deputy is talking about and that he would like to know more about their thoughts, etc., but it is a difficult one when they are not enrolled in a study. Privacy is really important to people going through this process. In this particular issue, sometimes these women will only disclose to their closest confidantes. That is really important with regard to the follow-up. I totally understand where the Deputy is coming from.

Deputy Michael Cahill: There are women out there who would be prepared to come forward.

An Cathaoirleach: We agreed this morning at the private meeting that we would have an additional session next week – the first half of next week's meeting – to hear from two medical practitioners, GPs, who have an opposing view. They do not share the view presented last week by the ICGP. There will be another session with those who have an opposing view from a medical perspective. That was agreed by the committee this morning.

Deputy Michael Cahill: In relation to that, for people who would not be able to arrange at short notice to come in here, can we give them a second opportunity?

An Cathaoirleach: We have agreed the witnesses this morning in the private meeting, as proposed by Deputy Cahill's colleague, Deputy O'Sullivan from Fianna Fáil. That was agreed this morning and discussed yesterday at the private meeting at length. I am not proposing to relitigate that. It was agreed by the committee this morning.

The next slot is for Sinn Féin, Deputy Clarke.

Deputy Sorca Clarke: I thank our guests this morning for coming in and for giving the committee their time and their expertise in the roles that they hold.

I want to go back to the figure of 10,000 women who do not present for a second appointment after the initial assessment with the GP. My opinion when it comes to medical services is I should be able to talk to my GP about anything when I have an appointment. I can discuss and make a decision in my own time to do that.

I want to ask a very specific question. From what the witnesses said about the data from the IFPA's five-year study that 98% of women who continued with termination services, is it, in their opinion, a sound or unsound assumption that the difference for those 2% of women was the three-day mandatory waiting period?

Dr. Cliona Murphy: There is no evidence to say that the mandatory part of it was the key element. International studies would also concur that the mandatory element was not felt to be helpful by women in those circumstances.

Deputy Sorca Clarke: It was simply a woman receiving information and exercising free choice on whether to proceed with the termination of the pregnancy. Is that a reasonable statement to make?

Dr. Cliona Murphy: It is reasonable but we do not know for certain.

Deputy Sorca Clarke: I can accept that. I think that is a problem. We should know how much women want to engage with a process. Where there is a gap of data, there then comes the opportunity for less-than-accurate information to be put out into the public domain, which does nobody any favours.

I want to look at the situation around other countries that have mandatory waiting times. I ask the witnesses to please correct me if I am wrong, but as of today, that is a very small minority. It is actually one third of European countries, and it is a decreasing minority also. Out of the 43 European countries, two thirds do not have a mandatory waiting period. Am I correct?

Dr. Cliona Murphy: Yes. Just eight EU countries. In wider Europe, it may be more. Russia, Belarus, Armenia - those types of country that have very different health systems to ours. Those that are a bit closer to our health system do not have mandatory waiting periods. Some of those also have barriers to access, geographic inequity, so they are not necessarily the models we have been aiming for. Obviously, there are things to be learned from other countries.

Deputy Sorca Clarke: Absolutely. Am I correct in saying the number of countries that continue to have mandatory waiting times is decreasing, and did decrease specifically after that 2025 WHO report?

Dr. Cliona Murphy: It has been decreasing and there have been some other changes in their legislation with regard to their cut-off with some increase in their cut-off as well.

Deputy Sorca Clarke: From the witnesses' professional experience between when this service started to be delivered seven years ago up until the point where the WHO report came out in 2025, were the findings of that report a surprise or news to them or did the report reflect the learnings in the provision of services since the service was introduced?

Dr. Aoife Mullally: I do not think it was a surprise. Previous WHO guidance documents had also included studies that showed that mandatory waiting periods were not evidence based. There was no clinical rationale for them. They were harmful for some women. Certainly in relation to the women that my colleagues and myself have looked after over the last seven years, I have not heard from those women or from the voices of my colleagues that that mandatory waiting period has been helpful. Some women certainly see it as removing their autonomy, heightening stress and the emotional response around it. That was well highlighted in the unplanned pregnancy and abortion care, UnPAC, study.

Deputy Sorca Clarke: My opinion around the mandatory wait time is that it fails to recognise a woman's ability, capability and, most likely, probability of already having had a period of reflection. There is no recognition of the thoughts or the conversations that happen

outside of a visit to a GP that are just as important, and may actually be more important for some women. I find the three-day wait limits, and almost restricts, the value that is placed on a woman's ability to think for herself. That does not sit easy with me.

I represent a rural constituency where there are challenges in accessing services. I have to say that has decreased in recent years but that was certainly an issue at the start.

I have a lot of constituents who do not come from very affluent areas and would not have financial resources. I have a question about the poorer health outcomes for women from disadvantaged backgrounds that the witnesses mentioned. There was talk of the current reimbursement process for GPs. Let us say this Bill passes and a woman decides that she does want to have a second or third appointment with her GP before she is happy in her decision-making process. Would the HSE and the Department have any opinion on any changes to that statutory reimbursement scheme for GPs? I would not like to see us removing one barrier and then replacing it with another, the other being a financial barrier.

Dr. Clíona Murphy: I think there is agreement that whatever the legislation, if it changes, every effort will be made so that the provision of care is woman centred. Details could be worked out.

Professor Mary Horgan: We feel very strongly about this. I will pass over to my colleague, Mr. Noonan, in primary care.

Mr. David Noonan: The fee payment structures will reflect the model of care that is developed. Depending on what happens with the legislation and where the model of care recommends the ability to have several consultations, that would be reflected in the fees. The intention of establishing the fees is to facilitate the service and not to be any kind of blockage toward it.

Deputy Sorca Clarke: Should this Bill be passed, what would need to happen between it passing and the Minister being in a position to commence it? What additional work do the HSE or the Department need to undertake in order that all of the relevant changes would be made before the Minister would be in a position to commence the legislation?

Professor Mary Horgan: It is important to note that the model of care may need to change, depending on the decision of the committee. That is paramount, because it is the woman who is attending the service who needs to be looked after. That change in the model of care is both essential and a priority. I am not sure if Dr. Murphy wants to add anything.

Dr. Clíona Murphy: With regard to implementation, if there were any changes, any of the work that needs to be done would be done without undue delay. There would be an excellent working relationship-----

Deputy Sorca Clarke: Would we be talking days, weeks or months?

Dr. Clíona Murphy: I could not put a time on it. The important thing would be to get it right.

An Cathaoirleach: Other members might pick this up. We can come back to it.

Deputy Peter Roche: I thank the witnesses for taking the time to have this discussion with us. We discussed the Bill with the Irish College of General Practitioners, ICGP, last week. That discussion was both informative and beneficial.

I will not hide my position. I am vehemently opposed to abolishing the three-day wait. I do not want to bore people, but I will repeat what I said last week. When people talk about percentages, reference is made to the 1.8% of women who continued with their pregnancies. Earlier, one of the witnesses mentioned something which I suggested last week, namely that from 2019 to 2024, 10,500 women did not return for a second visit. I repeat what I said last week: it is fair to assume that of those pregnancies, some miscarried and some chose other options, but that a huge number of children attending national school today are as a consequence of women not going back for the second visit. An educated guess would be that thousands of children are alive and well today as a consequence of their mums making the decision not to go back. We can try to dispute that all we like, but 10,500 is quite a high number.

Based on what we see and read, there is compelling information to the effect that almost 56% of the general public do not want this tampered with. They want the *status quo* to remain. The referendum took place in 2018. A huge cohort of people decided that this was the right thing to do. We made the provision for termination but we put this safeguard in place. One of the witnesses mentioned that this was done almost to prevent regret, and that is why the legislation was formulated at that point. It was sensible to legislate for this.

Senator Clonan touched on this earlier. Those who support removing the three-day waiting period argue that no other procedure in general practice is subject to a mandatory wait. The question I have probably goes a little further than Senator Clonan's. Is there any other procedure in general practice whose direct and intended purpose is to end life? I hasten to add that there probably is not, but I am asking the question of the witnesses.

Professor Mary Horgan: Not that I am aware of.

Deputy Peter Roche: We tend to want to inform ourselves more about what is being presented. Forgive me if my next question is inappropriate. The HSE pays GPs substantially more for carrying out abortions, with the three-day wait, than it does, for example, those who are involved in the caring for the mother and baby during pregnancy and delivery. I cannot understand how that is the case. A figure of €450 has been mentioned. Why is that the case? Who arrived at that figure? That is what I am trying to get at.

Dr. Aoife Mullally: We cannot comment on contract negotiations or fees that were arrived at. That is outside our clinical remit.

Deputy Peter Roche: It is fair to say that what I am saying is based on fact.

Dr. Cliona Murphy: The current mother and baby scheme is being renegotiated because it is historical and is being updated as a result. The scheme for termination of pregnancy is more recent, so it involves a different fee structure.

Deputy Peter Roche: I read in Professor Horgan's report, which states that there has been substantial investment in the wider area of women's health. That is really welcome. Additional dedicated funding of €180 million has been provided since 2020. Why do I read that there has been no increase in funding for maternity and infant care since 2013? Am I reading it right or is that something which-----

Professor Mary Horgan: This is beyond ambit of the reason we were asked to come here today.

Deputy Peter Roche: It is a reasonable question, is it not?

Professor Mary Horgan: It is not within the ambit of why we were invited here today. The discussion is about the mandatory three-day wait.

Deputy Peter Roche: I have issue with that, because there has been no or little investment in maternity and infant care since 2013. Maybe if there was more investment, we might not be having this debate.

Dr. Clíona Murphy: An awful lot has been put into maternity and infant services of late. I might just give the example of postnatal care. We heard from many women that they felt that the postnatal period was a little neglected and that they did not have enough support for breastfeeding or social support over that period. Once they left the hospital, they felt a little on their own. There has been a roll-out of a large number of postnatal hubs. Many of them are close to home in more rural areas, so women do not have to trek to hospitals. There is a really supportive environment. There is definite evidence that we have listened to what women and families say they need and that we are trying to support them.

Professor Mary Horgan: It is important to highlight that about €180 million has been put into women's health since 2020. That is across the entire span of women's health.

Deputy Peter Roche: I thank the witnesses. With regard to the comment that was made earlier about the number of extra people who are present, that is because this is a very emotive and sensitive subject which needs to be considered fully.

Deputy Pádraig O'Sullivan: I welcome the witnesses. The figure of 10,000 has been quoted quite a lot in public discourse over the past while. As I understand it, that data emerged in the reply to a parliamentary question and that the information was provided by the HSE. Some of the witnesses are here on behalf of the HSE.

To an extent, we are refuting the data. I suppose there is subdivision, and we are trying to say that a percentage of it might be attributable to this or that reason. There are myriad reasons. This supports the points made by Deputies Burke and Sherlock about the fundamental importance of the HSE, as the health service provider, above any other organisation providing data. I am a bit uncomfortable with some of the data that has been provided or with the surveys done by certain cohorts. Some of these have been part-funded by international organisations and so on. I would much rather have a complete dataset verified by the HSE that everybody can stand over. We would then not have these debates about whether the data is acceptable or whether this or that reason is legitimate. It would provide clarity above all else. Can the HSE officials reiterate what the intention is? This has been in place as a service since 2019, which is a long time. Can they provide an indication as to when we are likely to see a full dataset? I may follow up on this question.

Dr. Aoife Mullally: We published a report on termination of pregnancy services earlier this year. It was the first annual report published. There was a sample of the data being collected in primary care within that report. The report is in the public domain. It is on the HSE website. The next annual report, which will be published next year, will have a more complete dataset.

Deputy Pádraig O'Sullivan: I do not want samples. I want a complete dataset. That is the point I am trying to make. I can point to a START Ireland survey that was done a number of years ago on the 12 weeks and on the window narrowing for people to avail of services the closer they get to 12 weeks. The representatives from the ICGP stated last week that this was one of the fundamental reasons for the removal of the waiting period. I would like a statistical breakdown of how that is a determining factor in the ultimate decision that people actually make in order to see how crucial that narrowing of the window is as an ultimate determinant of the decision. These decisions are not taken lightly. Does anybody else want to talk about the data before I move on to the next question?

Professor Mary Horgan: Data is collected by the people who provide the service. Given that it is a relatively new service, work is being done on that, as outlined by Dr Murphy and Dr Mullally.

Deputy Pádraig O'Sullivan: The service was introduced in 2019. From the HSE's perspective, it is still a relatively new service. However, seven years is a significant period.

Dr. Cliona Murphy: A lot of work has been done operationally in that time, rather than going out to ask people the reasons for not coming back. With regard to that particular point about the three-day wait, we have only been asked in recent times to come in to talk about it. The data that is being collected forms a more comprehensive suite rather than on that particular issue.

Deputy Pádraig O'Sullivan: I hope this will inform data in the future.

Dr. Cliona Murphy: Absolutely.

Deputy Pádraig O'Sullivan: It is important where women are making a decision. The ICGP stated last week that the tighter they come to the 12 weeks, the greater the say in people's decision-making the three-day wait has and called for its removal. We should have data on how important it is rated on a scale of people's decisions and whether it is the ultimate decision-making factor, if that makes sense.

Dr. Aoife Mullally: What the Deputy is really talking about is patient experience surveys rather than data collection. That is an entirely different piece of work.

Deputy Pádraig O'Sullivan: I would argue that both are very important.

Dr. Aoife Mullally: Agreed.

Deputy Pádraig O'Sullivan: That leads me to my second question. Does the HSE conduct interviews when people use the service as to their experience, even if it was qualitative rather than quantitative in nature?

Dr. Aoife Mullally: We are considering a patient experience survey based on all pregnancy loss and pregnancy endings.

Deputy Pádraig O'Sullivan: Considering it.

Dr. Aoife Mullally: Considering.

Deputy Pádraig O'Sullivan: Is that for next year?

Dr. Aoife Mullally: I cannot give the Deputy a timeline.

Deputy Pádraig O'Sullivan: Who makes that decision? Is it Dr. Mullally? Is it the HSE?

Dr. Aoife Mullally: It is not myself. It is done within the national women and infants programme.

Deputy Pádraig O'Sullivan: Does Dr. Mullally agree that it would be helpful to have the experience of patients?

Dr. Aoife Mullally: All patient experience surveys are helpful and they guide us with regard to future planning, care provision and how we can improve the services for women within the entire context of women's health.

Deputy Pádraig O'Sullivan: My final question is about the voluntary reflection period. Let us say that the Bill passes and that the reflection period becomes voluntary. Do the witnesses foresee any implementation issues or any kind of additional administrative burden? Do they think it will be pretty seamless? Would it require extra resourcing?

Dr. Clíona Murphy: There would be work required, obviously. It is important that when there is any change in process, time is given to proper implementation. There was a massive change in 2018 and preparing for 2019. The health service did that and put the work in. If this is passed, we will do the appropriate work with an implementation group and so on.

Deputy Pádraig O'Sullivan: Does Dr. Murphy foresee that it would require additional spending and resources from the HSE?

Dr. Clíona Murphy: I will not comment on resources, but we are pretty resourceful within the HSE, with those who are employed in the agency putting the work. We would see it as part of our remit. I am not sure that it would require----

Deputy Pádraig O'Sullivan: Going back to the voluntary element, is there any suggestion on the part of the HSE as to how that would be monitored? If the Bill is passed, is the HSE considering monitoring how it would be implemented in terms of the decision-making element?

Dr. Aoife Mullally: That is not something we are considering at the moment because, as I said, the Bill has not been passed. We would wait for the Bill to either pass or not before we would consider that.

Senator Teresa Costello: I thank the witnesses for being here. I have found last week and this week very emotional. I cannot help but feel there is a lack of humanity in all of this, on both sides, for people who are for and against. People who are for the removal of the three-day wait are not listening to people who are against it. People who want to keep the three-day wait are nearly pontificating, and there is no thought of the lives of the people after the birth of the child. I have not really heard much consideration of or talk about what happens to a child after they are born, the lives they have to live or the acknowledgement of women who do not receive any maintenance or emotional or financial support from the fathers. I do believe abortion is a necessary part of women's healthcare. I was not particularly in favour of the removal of the three-day mandatory reflection period.

In the whole discussion, maybe this is just how I work, but I feel humans are being forgotten about. It is like an argument about a point. That is just how I feel. Maybe I am not getting how I feel across properly. Just for women, if this Bill is passed, is the HSE going to monitor how many women avail of a waiting period? If the mandatory three-day wait is kept, will that prevent people from having abortions? If so, would the witnesses be saying that anybody who avails of a three-day wait period is actually disrupting their access to an abortion?

I was in the Seanad so I missed the reference to the Attorney General. The Department officials mentioned that they had consulted with the Office of the Attorney General. Can they outline the specific legal risks or potential unintended consequences that were raised?

I think it was said that last year was the first time there was annual report. Why did it take from 2018 for it to produce an annual report for the first time?

Dr. Aoife Mullally: The vast majority of resources and efforts in the first couple of years went into implementation, which was slow across secondary care, the quality of the service and resourcing the service itself. Initially the only reports we had were based on the annual notifications which the Senator will be aware of. They gave some information but a limited amount of information. It became very clear that what we needed to quality-assure the service was a robust data collection system where we could look at safety metrics, access and various other metrics. That is why the data collection roll-out began.

Senator Teresa Costello: I also asked about the Attorney General's advice.

Dr. Aoife Mullally: I will ask my colleague Ms Carter to speak to that.

Ms Pamela Carter: I can confirm that we engaged with the Office of the Attorney General. Obviously it is subject to legal privilege so I will not divulge the exact details and exact nature of the amendment that would apply. That would be a matter for Committee Stage. However, our objective was to ensure that we would avoid any unintended consequences of the Bill and to ensure that the reflection and the option of a reflection period was preserved. Based on the legal advice we received, it was confirmed that would be the case. I think there was a general consensus-----

Senator Teresa Costello: But the HSE cannot say the unintended consequences that it may have identified?

Ms Pamela Carter: The unintended consequences of the wording as drafted in the Bill would be that it would in any way prevent a woman from an optional reflection period. An amendment that we would propose, subject to Government approval, would be to ensure that would not be the case and the reflection period would be preserved.

Senator Teresa Costello: Will the witnesses explain how, if the Bill is passed, the appointment schedule would differ?

Dr. Aoife Mullally: That will very much depend on the woman in question. Some women will need a period of reflection. They may need a longer period of reflection and they may need several in-person visits either with their GP or with hospital and other women will not. We cannot describe a one-size-fits-all model. It will depend on the woman's needs and the clinical needs around that particular pregnancy.

Senator Teresa Costello: For a woman who has her mind made up and does not want to avail of the waiting period, what would the appointment schedule look like?

Dr. Aoife Mullally: At the moment, the vast majority of terminations take place in primary care so I might describe that journey as it is at the moment. The woman makes contact with a GP. She often has a phone call before the first visit so the first visit can sometimes comprise two patient contacts. During the first visit, the doctor certifies that the pregnancy is less than 12 weeks' gestation. The woman is given written information. She is given verbal information. Any questions she has are addressed. Sometimes there is a need for blood tests or an ultrasound. Sometimes infection screening is carried out. After the three-day period - sometimes it is more, depending on weekends and bank holidays - the woman comes back. At that visit, the initial medication is given to the woman with follow-up medication given to take at home. That is what happens in primary care.

If the Bill is passed, I do not foresee that model looking hugely different except that some women - I think it will be a small number but I stress that I think that is the case; I do not know - will take the medication on the first visit, having availed of the information through My Options, the information on the website and possibly having availed of a phone call with their GP beforehand. Then, they have the option of the follow-up visit with their GP for follow-up contraception and any questions they have afterwards.

Senator Teresa Costello: So there is always a follow-up visit after the abortion takes place.

Dr. Aoife Mullally: A follow-up visit is offered. Some women do not take up that follow-up visit and some women do it on the phone.

An Cathaoirleach: I thank the Senator. We will now move to non-members of the committee. As I said, we have eight listed. The slots will be three minutes each.

Senator Lorraine Clifford-Lee: I thank the witnesses. I really appreciate their time here. It is clear from their submissions that there is no clinical need for the three-day wait. The mandatory waiting period was introduced at the behest of one Member of the Oireachtas and one member of the Cabinet at that time. It was subsequently imposed on all women who have sought abortion services since the service was introduced. Just to be clear, there were no clinical grounds for this. The citizens' assembly did not recommend it. The legislation introduced afterwards recommended a review of the service because it was a new service. That is why the previous health committee, of which I was a member, undertook that review with the assistance of Ms O'Shea and we produced a report. That is why we are here - to move on from that.

I ask Dr. Mullally to clarify the HSE model of care pathway. Is it true that a significant number of women who present to primary care for the first consultation must then be referred to a hospital because they are over the nine-week mark? Is it true that they are then not captured in the data that is collected and that this has given rise to the figure of 10,000?

Dr. Aoife Mullally: There are two parts to that question. I will answer them separately. The vast majority of terminations take place in early pregnancy in primary care. A small number of women are referred to hospital. It is not always before they are over nine weeks. Some women have a preference to attend hospital and some have a background medical condition

that makes it safer for them to avail of abortion care in hospital. Some women attend hospital, where they are looked after within the secondary care or the maternity setting.

The Senator is entirely correct in that women who have their first visit with the GP and then attend hospital are included in the 10,000 or 10,500 women we are all talking about today. Those 10,000 women comprise women who change their minds, which they are fully entitled to do, and continue with their pregnancy with the appropriate support; women referred into the secondary care setting; women who choose to travel to other countries, which they do even when there is not a legal need to do so, particularly when they are not from other countries, and women who have pregnancy loss whether miscarriage or ectopic pregnancy.

Senator Lorraine Clifford-Lee: Does Dr. Mullally agree that healthcare policy should not be frozen in time by a law if it is out of line with the recommendations of the WHO?

Dr. Aoife Mullally: As clinical practitioners, we need to operate under the pillars of evidence-based practice.

Senator Lorraine Clifford-Lee: The WHO has made recommendations since the commencement of the abortion legislation in Ireland.

Dr. Aoife Mullally: I consider its guidance to be very robust.

Senator Lorraine Clifford-Lee: The HSE has already confirmed that the trend in Europe is to move away from mandatory waiting periods. Is that correct?

Dr. Aoife Mullally: That is correct.

Deputy Grace Boland: I thank the Chair as I am not a member of this committee. As Oireachtas Members and legislators, it is very important for us when we are considering healthcare legislation that we listen carefully to the evidence, to the experience of patients and to the advice of healthcare professionals. To me, the central question is not about whether any member of this committee agrees with this form of healthcare - the choice here is about whether there is a legally mandated reflection period versus a reflection period tailored to the individual woman by her and her doctor. That is the basis on which we have to approach this. We know that the WHO says there is no evidence of any benefits from a mandated legal reflection period so I want to approach it the other way. Is there any evidence or research that establishes that there are benefits for women in having a mandated legal reflection period?

Dr. Cliona Murphy: I have not come across any. Some women who reported that there may be benefits were talking about other women. I have not come across evidence that it has helped. Some might talk about the distress of waiting, nausea, vomiting and the stress on finance, etc. I have not seen evidence about positive benefits

Deputy Grace Boland: Does the legal mandatory reflection period disproportionately impact vulnerable women - women experiencing domestic, sexual and gender-based violence, coercive control, poverty, addiction or homelessness?

Do we know that? Do we have evidence to support that?

Dr. Cliona Murphy: We know from multiple studies that these mandatory waiting times affect people in more straitened circumstances. The Deputy mentioned coercive control where people may need to be very careful about their whereabouts and there is a level of secrecy, etc.,

to it. There are also those who are from disadvantaged and marginalised communities and those for whom Ireland is not their country of origin. They find it more difficult to navigate healthcare, transport, etc. It disproportionately affects those and the same has been found in other jurisdictions where there is a mandatory wait. It disproportionately affects the less well-off in society.

Deputy Grace Boland: We are long past, I very much hope, legislating that adult women cannot make up their own minds or are incapable of being informed on all matters, including healthcare. Is Dr. Murphy comfortable that the safeguard in this instance is informed consent between the woman and her healthcare professional?

Dr. Cliona Murphy: Doctors take informed consent very seriously and informing patients--

An Cathaoirleach: Thanks very much. We are just very tight on time so I have to keep the answers short.

Senator Rónán Mullen: I will just mention a few things I find surprising. Maybe the witnesses can tell me at the end if I am wrong to find them surprising. I thought it strange that when Professor Horgan was setting out the reasons for and against keeping the wait, she did not mention what I thought was the obvious reason people are in favour of keeping it, which is the concern that because of the requirement that some women, perhaps including very vulnerable women, might have the opportunity to reflect, which they would not take if there was not the requirement there, they either would not regret their choice or indeed they might go on to have babies that they were happy to have.

I am surprised that there also seemed to be an unwillingness in responding to Senator Clonan's question. There was almost a refusal to utter what the rationale might be for having the three-day requirement, other than that it was a political choice. It was not; it was a welfare choice. This is why I find it strange that the witnesses come in here and tell us there is no clinical basis for saying there should be. They certainly have not given us any clinical basis for saying the waiting period should be removed, but they are a lot less quiet about that.

I find it strange that they point to - I think - 1% of cases, according to the START report, in which women, as a result of the waiting period being required, might go beyond 12 weeks. That is a very small percentage yet the witnesses put considerable emphasis on it. They have come in here showing no interest in doing detailed research on the reasons that 10,000 women did not go ahead with a second appointment. They put out supposition, but the UnPAC report they cite interviewed just 58 women and did not interview a single woman who, as a result of the three-day waiting period being required, did not go ahead with their abortion. Several years on, the witnesses still have no interest in this, beyond putting out supposition that it might be because of miscarriages or it might be because they went to a hospital. With respect, we are not paying the IFPA, which is associated with an international abortion provider, to come up with statistics we can rely on about how many women changed their mind as a result of this required wait. We are paying the witnesses to do so. I find it very strange that the research has not been commissioned-----

An Cathaoirleach: Senator, you have 30 seconds left for a response.

Senator Rónán Mullen: Thank you. I find it very strange that the witnesses would come in here and offer us advice - their advice is tending towards saying we should get rid of the waiting requirement - but they have done no further research to try to understand. I understand there are women in the public domain - I hope the committee will choose to hear from them - who say the requirement for the wait helped them. It is not just that people may choose to wait. Some of the most vulnerable people might benefit from the wait being required, particularly if we value the advice doctors might give them.

An Cathaoirleach: Thank you, Senator. If Members would like a response to their questions - we have invited people here to give us their responses - they should leave time for that. It is respectful of the people we have invited before us that we allow them time to respond to the charges that are made against them and sometimes when they are quite serious charges-----

Senator Rónán Mullen: On a point of order-----

An Cathaoirleach: We are moving on. We are tight on time.

Senator Rónán Mullen: On a point of order, that is fine to say but this is called detailed scrutiny. Some of us have given up our time because this is a life-and-death situation and there are points that need to be put on record arising out of what was said.

An Cathaoirleach: Yes. You made the time and we allocated you the time-----

Senator Rónán Mullen: If you give me time afterwards, I will happily engage further-----

Senator Lorraine Clifford-Lee: Chairman, on a point of order-----

An Cathaoirleach: Order, order.

Senator Rónán Mullen: -----but in the time limit, Chair-----

An Cathaoirleach: Senator Clifford-Lee, you do not have the floor. Senator Mullen, you do not either. We are moving on. We are tight on time. We want to bring all the Members in and there is a long list.

Senator Rónán Mullen: I have made my point.

An Cathaoirleach: Colleagues are waiting to get in and time is running out.

Senator Patricia Stephenson: I thank the witnesses for outlining the whole approach to this. I will pick up on one of the points that was just made. I understand there is a benefit to having primary care as the first point, where possible on a clinical basis, for the individual woman because we always promote primary care over hospital care where we can. That is one of the reasons we would be promoting that for women who are forced out. Obviously over the nine-week gestation period women, through the model of care pathway the witnesses have outlined, then need to go to the hospital, so that is quite clear.

We would love HSE data on this, and I recognise that is coming, but we should not be entirely discounting the IFPA, which I think is 56 years old and has large connections in terms of abortion provision in Ireland. I think the HSE funds the IFPA in that regard as well. To totally discount the data that has been provided over a five-year piece of research would be unwise and completely unhelpful in this situation. Obviously the IFPA has talked about the 1.8%. Everyone is throwing around assumptions on each side, like saying we can assume some

women have miscarriages based on the 20% to 25% of women who experience miscarriages in the first 12 weeks. We can assume some women have to go to hospital because they have timed out of their nine-week gestation period in terms of primary healthcare. We can assume that some women who use the reflection period - which they would have under this legislation; it just would not be mandated - choose to continue with the pregnancy. We can assume some women go overseas. They can go to another GP. We have been told by one member to assume all those babies are now in school. That is something we absolutely cannot assume. While I appreciate that the data on the 1.8% who do not return after three days can be a little vague, I hope the research that comes out of what the witnesses are working on now will answer those questions. We simply cannot discount all the hard work and effort that has been put by the IFPA into its multiple surveys and studies with women who go through this.

I am not looking for a response from the witnesses; I am just trying to summarise some of the points that have come out of this discussion for me. We have spoken about length about how this is the only area of healthcare where women only are mandated to wait before accessing it. We talk about autonomy, informed decision-making, and trusting and believing women. The current legislation does not trust women, and it does not believe them. They are forced into this paternalistic cycle. That is my perspective. It is a political perspective, perhaps. It is a policy-based perspective. Women are forced into this cycle where they have to rely on a paternalistic system for their healthcare and no-one else experiences that.

Senator Sharon Keogan: I thank the witnesses for coming in. I will keep it very simple. I want "Yes" or "No" answers to these questions. If we pass this legislation and completely abolish the reflection period, will the total annual number of abortions in the Republic of Ireland increase? Dr. Mullally?

Dr. Aoife Mullally: There is no evidence that will be the case.

Senator Sharon Keogan: "Yes" or "No".

Dr. Aoife Mullally: No, I do not believe so.

Senator Sharon Keogan: Dr. Murphy?

Dr. Cliona Murphy: I cannot say.

Senator Sharon Keogan: Professor Horgan?

Professor Mary Horgan: We are not removing the reflective period is my understanding from the committees and the Bill.

Senator Sharon Keogan: Thank you. Putting clinical logistics entirely aside, do the witnesses agree that a responsible society should actively implement policy frameworks that seek to encourage births and lower the volume of terminations? That is "Yes" or "No".

Dr. Aoife Mullally: That is not something I can comment on.

Senator Sharon Keogan: Dr. Murphy? It is "Yes" or "No".

Dr. Cliona Murphy: No, it is up to a woman to make an individual choice.

Senator Sharon Keogan: Okay. We have a massive amount of testimony about the minor logistical inconveniences the three-day wait places on a woman's schedule. As policymakers

we must weigh competing interests. Why does this committee place a higher legislative priority on eliminating a minor 72-hour scheduling inconvenience than it does on protecting the thousands of human lives statistically proven to be saved by the very same reflective window? Why are you not putting a more serious emphasis on that?

Dr. Aoife Mullally: As I am not a member of this committee, I cannot comment on what this committee's thought process is.

Senator Sharon Keogan: Well, you are a witness.

Dr. Cliona Murphy: We have just been asked-----

Professor Mary Horgan: It is a matter for the committee.

Dr. Cliona Murphy: Absolutely.

Senator Sharon Keogan: My next question might be relevant to Mr. Noonan. Some years ago, UCC research involved some of his colleagues reporting cases where babies survived abortion procedures. Doctors interviewed described not knowing what to do in those circumstances and finding the experience extremely traumatic. One doctor described getting sick in the corridor after performing an abortion. Whenever information as serious as this emerges, there is total silence from the HSE rather than an open acknowledgement of concerns raised and a clear response on what action is required. The same silence greeted the story that emerged after a reply to a parliamentary question confirmed that a number of babies survived the abortion procedure in Ireland. When it comes to the three-day wait, the HSE and those overseeing abortion provision across Ireland do not hold back from expressing their views. Why is there such an approach and why is it so different? Specifically, how were the findings of the UCC research I just referenced dealt with internally by the HSE? More generally, what support does the HSE provide to healthcare workers who experience trauma after performing or assisting the abortions?

Deputy Ruth Coppinger: I thank the contributors. The reason I gave up my time to be here today is because of the disrespect that came out of last week's committee. I was emailed by a number of people who were disgusted at the disrespect for women and the disrespect for science and research and I was asked whether I would attend. I think I am the only person who was on the eighth amendment committee who is here who participated for the months over which it took place. I think Senator Mullen might also have been on it. To clarify a few things, the eighth amendment committee was dissolved on 20 December 2017 and there was no mention of or vote on a three-day wait period. The legislation appeared in March 2018 with a three-day wait in it, which was never discussed at the committee. There are two words for why it was in there and these are Simon Coveney. It was to get this over the line with the Tánaiste at the time. There has never been a clinical reason for this.

I also want to remind people on the committee that we all have different views but the Oireachtas committee and the country voted for abortion up to 12 weeks without reason needing to be given. Why would you then introduce a mandatory reflection period? The country already agreed we would not question anybody on their reasons up until 12 weeks.

It was reported last week that the anxiety of carrying an unwanted or unplanned pregnancy and having to wait potentially another week for a second appointment with a doctor, and we all know about getting an appointment with a doctor at the weekend, especially in a busy area,

was compared to a hangover. That sort of disrespect is why people were disgusted with this committee last week and it should not be allowed to have this kind of thing said. It should be called out.

For anyone asking about the clinical reasons, there have been umpteen reports where women were interviewed about this. Go and read them. I know some people do not care about how women feel but I remind people how unrepresentative this committee is. There are not many women on it, not many women of childbearing age on it and not many people who will ever have to have an abortion or, indeed, a pregnancy on it. Also, it is very out of touch with the general population. Fianna Fáil and Fine Gael did not support repeal as parties *en masse*. There was division in them over repeal. They do not represent the general population. Just to check people's privilege would be helpful.

I will cite only the one report that has been done. The figure of 10,000 keeps being trotted out. There should definitely be research. The IFPA is funded by the HSE, its clients and the International Planned Parenthood Federation. I do not know how much it gives but they are the three sources of funding.

An Cathaoirleach: Thanks, Deputy.

Deputy Ruth Coppinger: It found that 98% of people went ahead-----

An Cathaoirleach: Time, Deputy.

Deputy Ruth Coppinger: -----and 41% continue the pregnancy. This is a pretty deep study that was done and must be brought in.

An Cathaoirleach: Just as a point for going forward, we do not name people outside of the House by name to make charges against them. It is standard parliamentary practice and the clerk has asked me to restate it. In relation to last week's comments, some of them were challenged by other members in the hearing, for the record.

Deputy Ruth Coppinger: Today, somebody gave an educated guess. We are not here to give educated guesses; we are here to deal with figures.

An Cathaoirleach: I thank Deputy Coppinger for the point she has made.

Senator Sarah O'Reilly: I thank the witnesses for coming before the committee. Much has been made of the mandatory nature of the wait. The three-day wait was a crucial safeguard for women who have contacted me. I know this from people who have contacted me and women who have kept their babies because of the three-day wait. These women have not been mentioned here today and have not been talked about here today, and the witnesses have not talked to them either. Their voices have been left out of the conversation. These are women who have financial difficulties, women who have unplanned crisis pregnancies and women who may want to keep their baby but are scared and need supports. They need that time to reflect.

There is no other decision which involves the taking of life. Someone said earlier today that it should be the same as all other care. I do not believe that. I think it is a huge decision. I think there is no other decision which involves the taking of life. Do the witnesses put any importance on the fact that the three-day wait has saved lives and protected women from possible regret and an irreversible decision? Do they put any weight on that at all?

Dr. Cliona Murphy: The element is the mandatory aspect. Nobody is disputing the fact that consideration and taking time for a decision is something we all in this room agree on. Certainly going forward, those who need extra time and more time to discuss things with their doctor will be facilitated. I have no argument with that.

Senator Sarah O'Reilly: But you will not always know that. Some people who are in shock will think totally differently a week afterwards. That three-day wait is extremely important and there is very little emphasis on it from the witnesses. To go back to the HSE termination of pregnancy services report and the 10,000 women, this report is being trotted out all the time but it has incomplete data. It never got in touch with the women who have evidence of the experience of keeping their babies. We cannot really discuss that. I do not think it is ethical. Earlier Senator Clonan spoke about ethical research and ethical data, but if we completely miss out a whole cohort of the 10,000 women, it cannot be ethical. Deputy Daly was very clear at the last meeting and this meeting that there is no clinical reason and no medical reason. Nobody I know is saying there was a clinical reason or a medical reason.

An Cathaoirleach: Thanks, Senator.

Senator Sarah O'Reilly: It was put in as a safeguard. It was put in to give women time.

An Cathaoirleach: The Senator is now taking time from her colleague.

Deputy Peadar Tóibín: Gabhaim míle buíochas leis na finnétithe as ucht teacht isteach inniu. A question was asked as to whether there is a mandatory wait time for any other health service that they knew of and the witnesses said there was not. Is there not a mandatory wait time for euthanasia or assisted suicide internationally?

Dr. Aoife Mullally: They are not legally allowed-----

Deputy Peadar Tóibín: No, the question was international.

Dr. Aoife Mullally: I am not familiar with those. It is not my area of expertise.

Deputy Peadar Tóibín: There is a mandatory wait time for euthanasia so the answer that you gave was incorrect.

An Cathaoirleach: The question was domestic, I believe.

Deputy Peadar Tóibín: No, it was not, actually, because I remember the question included international examples, so that is important.

Senator Tom Clonan: On a point of order-----

Deputy Peadar Tóibín: I have three minutes.

An Cathaoirleach: We will take the point of order and we will give Deputy Tóibín time.

Senator Tom Clonan: The question I asked was whether there is any mandatory waiting period that is assigned to one category of citizens, that is, women, exclusively. In the case of euthanasia and assisted dying it applies to all categories of citizens. I just want to make that point.

Deputy Peadar Tóibín: I think it is important that there is a mandatory wait time and the reason is because euthanasia and assisted suicide are similar. They are both unique. They are both the intended ending of a human life.

The main element of the evidence here is that there is no clinical reason for the mandatory three-day wait but this committee heard that 80% of abortions were for socioeconomic reasons. They were not for clinical reasons at all. Is a woman who is having an abortion because she is homeless a clinical reason or a socioeconomic reason?

Dr. Aoife Mullally: Those economic reasons feed into healthcare.

Deputy Peadar Tóibín: I have very little time. Is it a medical, clinical or socioeconomic decision?

Dr. Aoife Mullally: The definition of health includes socioeconomic factors.

Deputy Peadar Tóibín: In that situation of homelessness, is the resolution of that worry or stress a woman's ability to be able to find a home and maybe have the confidence that she has somewhere to bring a life into? Poverty, for example, is not a clinical reason. It is a health reason. While the two feed into each other, as Dr. Mullally says, the direct experience of the woman in poverty is the stress that she will not be able to provide for that child if she brings the child into the world. The logic of a three-day mandatory wait in that scenario is not because it is a clinical decision. It is whether she can put in place certain economic supports to be able to empower her to have a positive decision in relation to that.

In relation to coerced abortion, how many coerced abortions are happening in Ireland every year?

Dr. Aoife Mullally: I think coercion is a really important topic.

Deputy Peadar Tóibín: I have 30 seconds.

Dr. Aoife Mullally: There are two separate issues. One is safeguarding women against coercion, and the other is whether a mandatory waiting period actually safeguards women.

Deputy Peadar Tóibín: How many coercive abortions are there in Ireland every year?

Dr. Aoife Mullally: We have had no reports.

Deputy Peadar Tóibín: There has been a prosecution in this case, has there not?

Dr. Aoife Mullally: Yes. I am familiar with that because it is in the public domain. That medication was obtained illegally by the woman's partner. She did not interact with the HSE.

Deputy Peadar Tóibín: Is it easier to prevent a coerced abortion in one or two meetings? Is that person likely to attend a second or third meeting if it is not mandatory and if they are being coerced?

Dr. Aoife Mullally: Doctors are very familiar with the concept of coercion, screening women for coercion and asking women about coercion.

Deputy Peadar Tóibín: In this case, that was not successful.

Dr. Aoife Mullally: That woman did not interact with the HSE.

Deputy Peadar Tóibín: I want to raise an important point with Dr. Murphy. She mentioned that it could be impeding on the privacy of a woman to ask her afterwards had-----

An Cathaoirleach: We have given the Deputy 20 seconds extra.

Deputy Peadar Tóibín: In that case, has the HSE had a woman actually come to it and say she would not speak to it because it infringes on her privacy? We here are listening to those women, but we cannot understand why the HSE will not listen to them.

An Cathaoirleach: I will allow a brief answer before we conclude.

Dr. Cliona Murphy: We are talking about organising research that follows up with people as to why they do not attend appointments. We do not generally do it in other aspects.

Deputy Peadar Tóibín: What about longitudinal studies?

Dr. Cliona Murphy: In other aspects of healthcare where you follow up with somebody who does not attend, and in this particular aspect, there are issues of privacy and being careful about writing out to people. There is a whole different aspect to abortion healthcare that has to be considered.

An Cathaoirleach: Thank you. That concludes the session. I thank the officials in the Department of Health and the HSE for assisting the committee with the scrutiny of the Health (Abolition of the Three Day Wait Rule) (Amendment) Bill 2026. I thank the witnesses for their time, detailed evidence and consideration of this matter. It is greatly appreciated by the committee and is very helpful for our consideration of this important legislation. It is a matter of deep concern to the Oireachtas and, I know, to people at home.

The meeting will adjourn until next Tuesday, 29 September, when we will meet in private session at 3.30 p.m.

Cuireadh an comhchoiste ar athló ar 12.03 p.m. go dtí 9.30 a.m., Dé Céadaoin, an 30 Meán Fómhair 2026.

The joint committee adjourned at 12.03 p.m. until 9.30 a.m. on Wednesday, 30 September 2026.