An Roinn Sláinte
Department of Health

Public Consultation to Inform the Review of the Operation of the Termination of Pregnancy Act

Review

Undertaken by M-CO on behalf of the Department of Health

Introduction

Background to this review

On May 25th, 2018, a referendum repealed the Eighth Amendment to the Irish Constitution, which had "acknowledged the right to life of the unborn with due regard to the equal right to life of the mother" [1].

In December of that year the Regulation of Termination of Pregnancy Bill was signed into law. This established a legal framework for termination of pregnancy. It permits 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, including in an emergency; where there is a condition present which 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.

Section 7 of the Health (Regulation of Termination of Pregnancy) Act 2018 provides that a review of the operation of the Act be carried out by the Minister for Health. The review clause was included in the 2018 Act in order to facilitate monitoring of the operation of the legislation in practice, as well as of the delivery of services in the area.

The Review commenced in line with statutory and Government commitments in December 2021. The Review comprises of 2 main phases. As part of the first phase of the review, information, and evidence on the operation of the Act is being collected from women who use the service, from service providers, and from the public, through a public consultation.

Between 8th December 2021 and1 April 2022, the Department of Health facilitated a public consultation to seek the views of the public on the operation of the Health (Regulation of Termination of Pregnancy) Act 2018.

This report outlines the wide range of views and perspectives submitted through this public consultation. The responses are grouped into themes that are most relevant to the review of the Health (Regulation of Termination of Pregnancy) Act 2018 ("the Act").

This report along with all other relevant research, information and material inputting into the review is being considered by the Independent Chair of the Review.

On behalf of the Chair and the Minister, the Department wishes to acknowledge and thank everyone who took the time to engage with this consultation process.

[1] Eighth Amendment of the Constitution Act, 1983. Republic of Ireland. Oireachtas. Health (Regulation of Termination of Pregnancy) Act 2018. https://www.oireachtas.ie/en/bills/bill/2018/105/?tab=bill-text)/

Methodology

Following a process of data anonymisation, a "mixed-methods sequential explanatory" methodology was applied. This combines an initial quantitative analysis of responses to the closed ended questions followed by a thematic analysis of the open ended questions.

This outlines ***what*** people said in relation to the consultation questions, as well as understanding ***why*** they said it. This is critical as there will be various interpretations underpinning the answers people give to the closed ended questions.

Thematic analysis identifies, analyses and reports patterns (themes) within qualitative and unstructured data. A theme or pattern is something important within the data that relates to the overarching consultation questions. In the context of this consultation this method presented several key benefits. The primary benefit of thematic analysis is that it allows the final interpretation to be understood by a diverse group of stakeholders (e.g. Policy makers, advocacy groups, service users, service providers).

These stages often involve iteratively relating back to the original consultation questions, the data and wider information in order to produce a concise report of the analysis.

Some other principles of our approach include:

- Data is analysed without any moderation
- All data is given equal attention without prejudice and bias is controlled
- The coding is thorough, accurate and comprehensive
- Data is synthesised rather than merely paraphrased (but not ranked)

Submissions received

Submissions to the consultation were accepted in several formats, those submitted online through a survey form, by email as an attachment (PDF or Microsoft Word document) to the Department of Health, or by post to the Department of Health

Each submission was assigned a unique reference code by the Department. This code was a letter followed by 4 numbers.

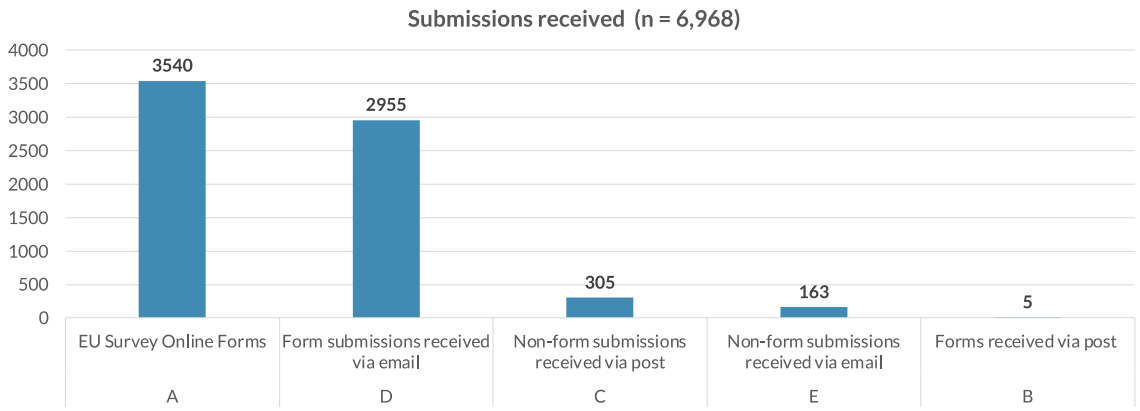
The Letter referred to a grouping of the submissions by the following formats:

- **Forms:** Submissions received in the requested survey format.
- **Non-forms:** Submissions that address a select number of questions in the survey, however they did not provide their submission in the format of the consultation questionnaire.
- **Bulk submissions:** A number of submissions received were identical and likely drafted on behalf of an organisation and submitted multiple times by separate individuals. Each of these were accounted for. If a unique commentary is attached to a bulk submission, this is flagged in the spreadsheet to ensure that it is appropriately reviewed.

When bulk submissions were included, there were 6,968 submissions received and reviewed as part consultation process.

The Department of Health ensured that all data protection obligations were met by removing all personal and identifiable data from submissions. Personal data means any information about a living person, where that person either is identified or could be identified.

Special attention was also be given to ensure that there was no sensitive personal data retained that are deemed 'special categories'; as these are subject to additional protection under GDPR. Following the process of anonymisation through redaction, the posted or scanned submissions were converted to machine readable formats to assist in data analysis.

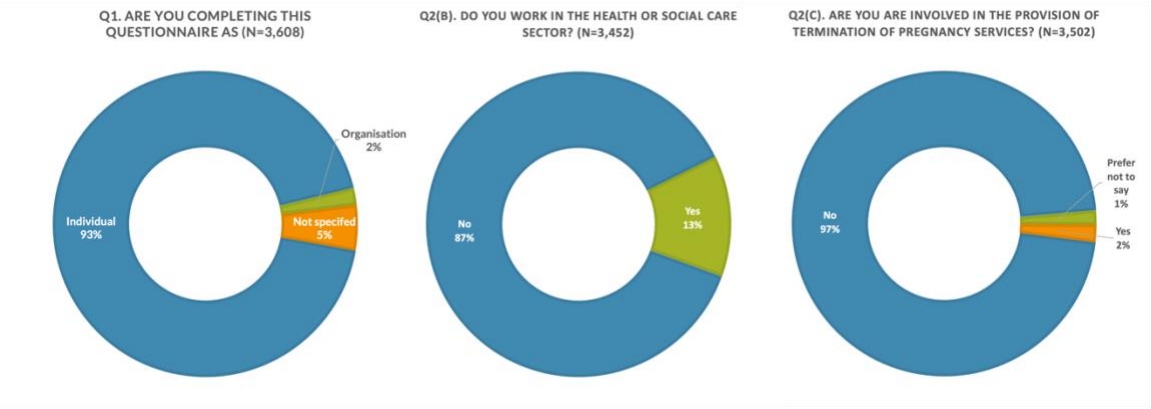


Sample overview

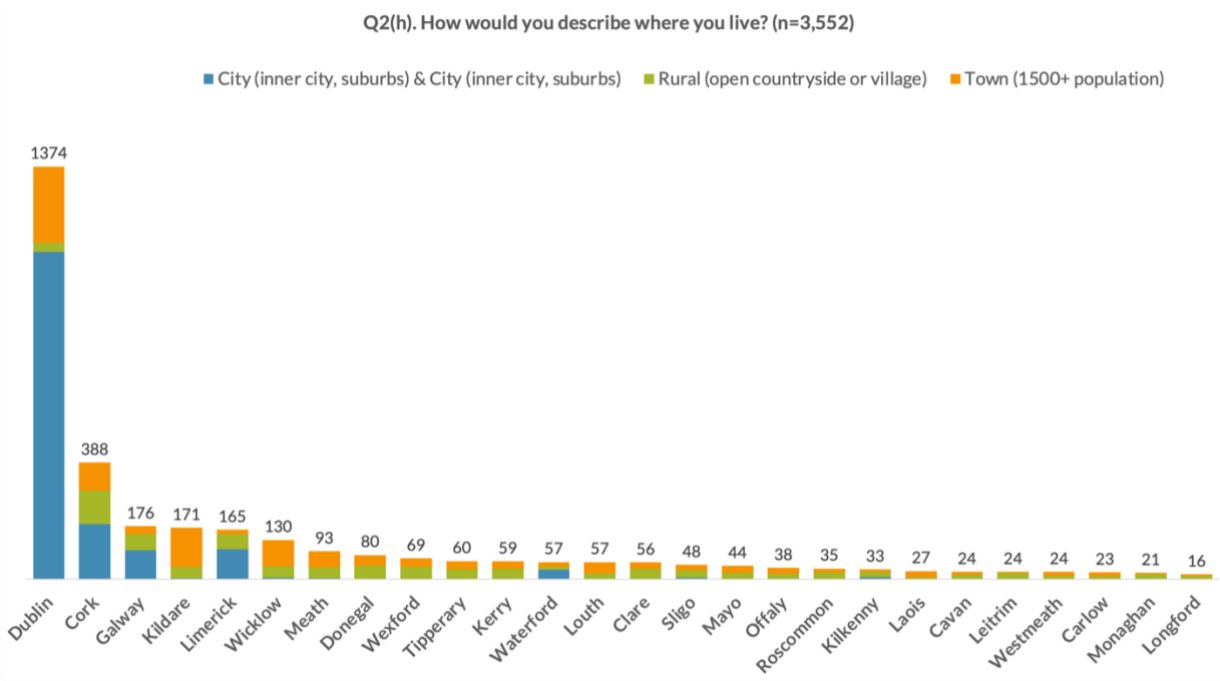
93% responded as individuals with 87% being from outside the health and social care sectors.

Of those that identified the type of organisation they were responding on behalf of (n=65), 23% were solely volunteer/not for profit groups and 22% were solely advocacy and special interest groups.

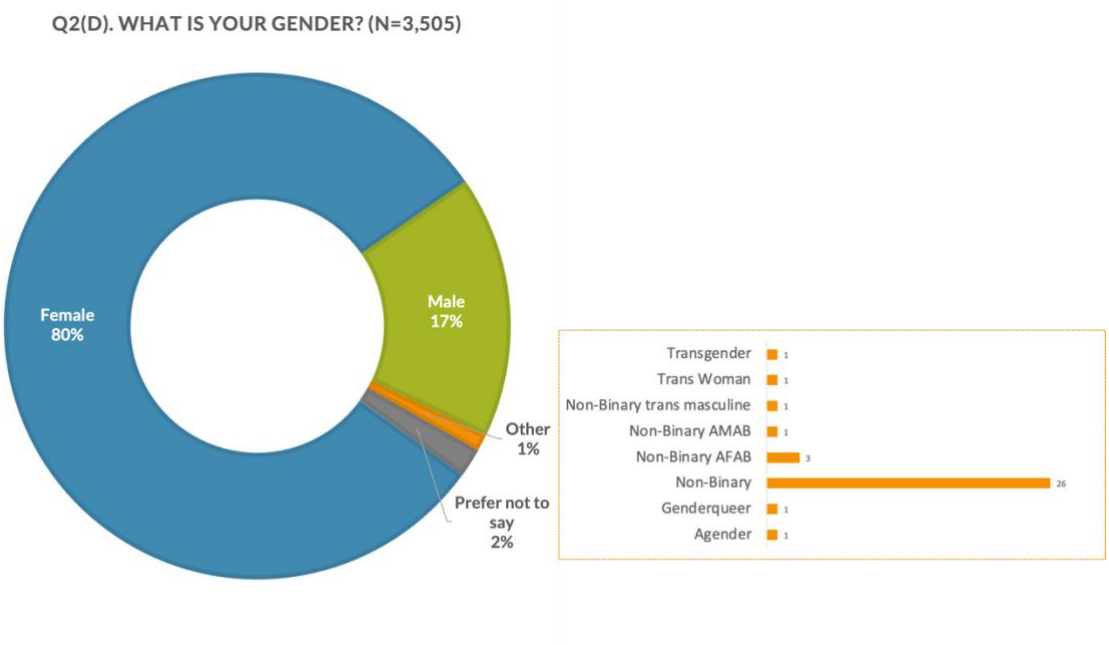
Only 2% of people that responded were involved in the provision of pregnancy services.

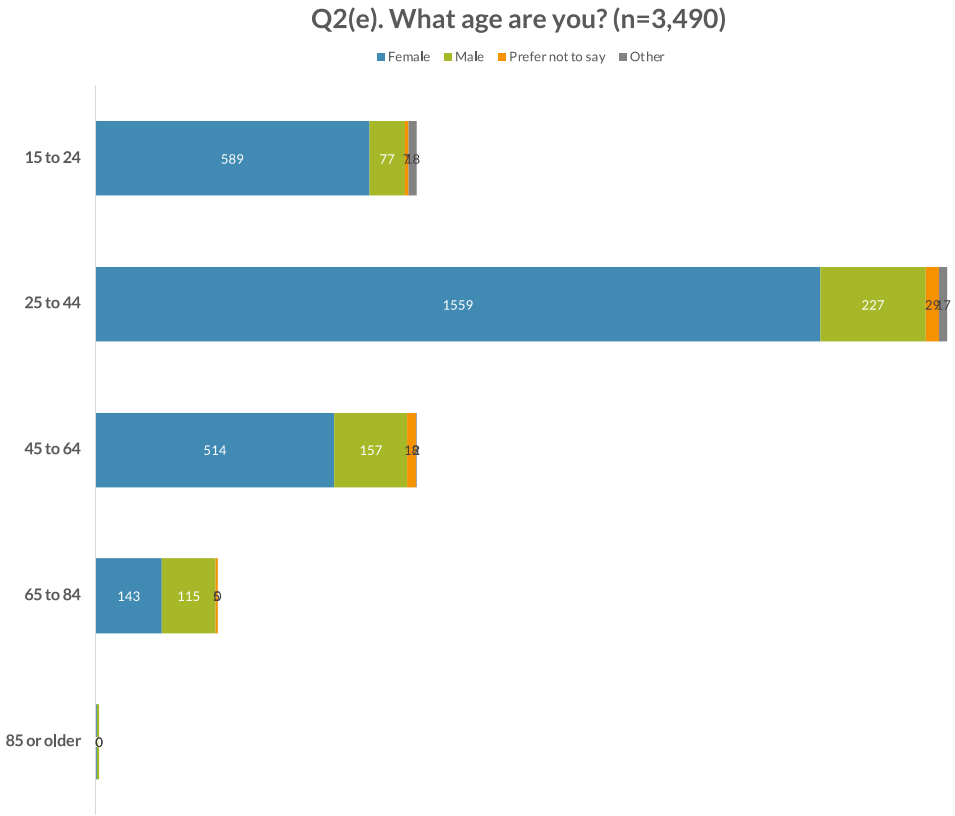


77% of those that responded were from cities and towns. This is a small under representation of people living in rural areas.



80% of those that responded identified as female and 48% were between the ages of 25 and 44.

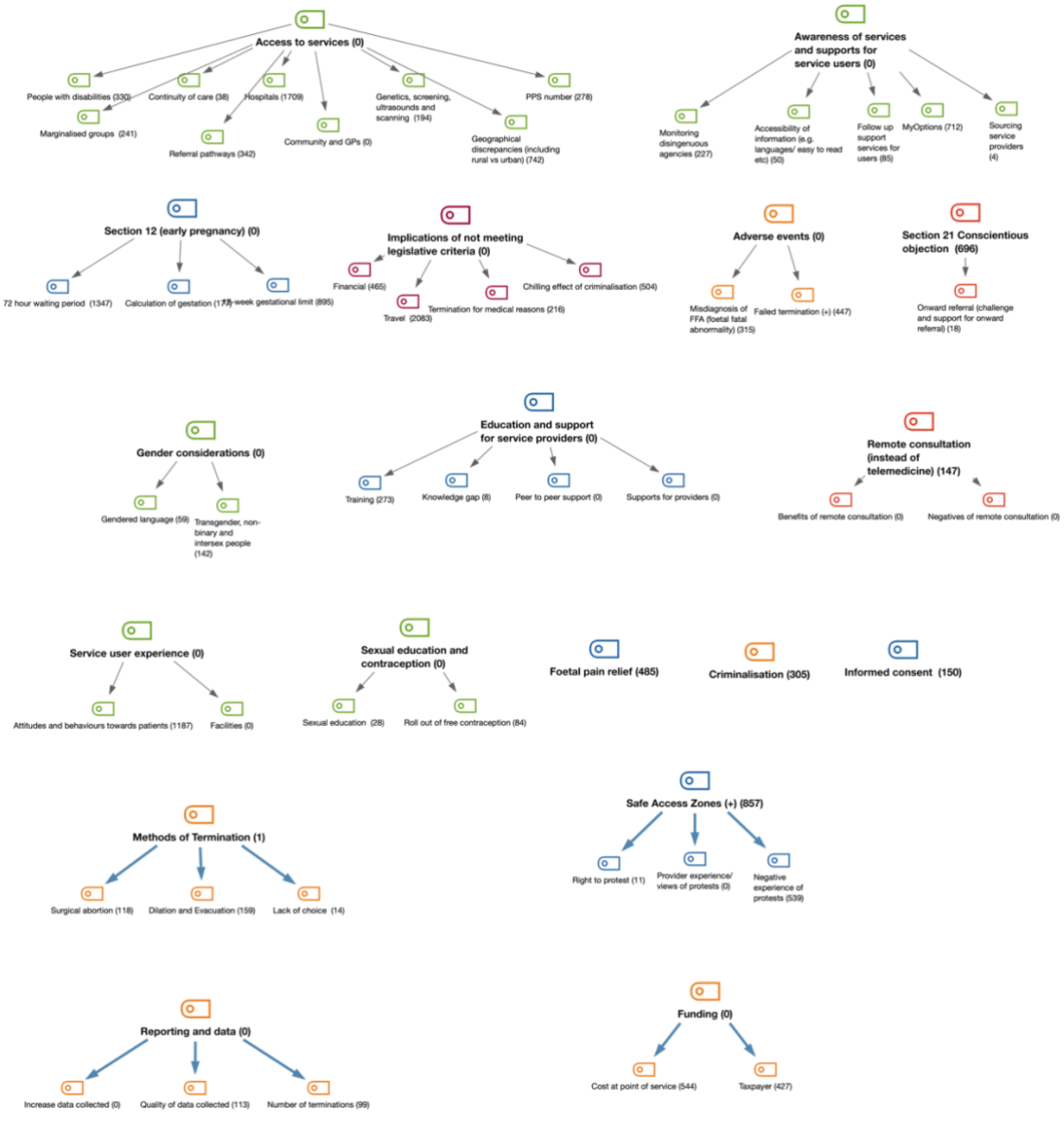




Thematic map

This is a map of the code system used to analyse the qualitative data (open ended questions). This codes system was developed in 2 phases. A randomised selection of responses were read by the research team and initial codes developed.

This initial set of codes was then reviewed by Department of Health and updated to reflect the language of the Act. This coding system was further refined through the write up of the data. No codes were removed but some were merged for clarity.



Findings

This public consultation was an opportunity for the public, health care professionals, representative and campaign groups and individuals to share their personal and organisational views on the functioning of the Act.

The survey questions were framed in a functional way to determine what has and what has not worked. This resulted in a range of polarising perspectives.

Given that this was the first opportunity to feed back to the Department of Health on the functioning of the Act, people often repeated their concerns and issues across the various questions.

While the findings include a range of polarising views loosely distinguishable between "opposing" and "supporting" cohorts, there is a spectrum of views and interrelationships between these.

As a result, this report does not differentiate between these cohorts but the differing rationale behind responses will be apparent.

Across both cohorts, the arguments rested largely on three broad areas:

- **the promise, spirit, and wording of the legislation;**
- **the forms of implementation, and;**
- **clinical guidance;**

Within these argument areas, as this report shows, there were a number of specific issues put forward and these will provide substantial qualitative data for the independent review panel to reflect upon.

Within each cohort a combination of arguments were found. This ranged from:

- **Personal testimony highlighting direct experience of accessing termination of pregnancy services;**
- **Indirect testimony where people used the experience of others such as friends and family to frame their view;**
- **Indirect experiences based on media or social media;**
- **Detailed analysis of sections of the Act with reference to published research and literature, and;**
- **Emotive argument and personal opinion-based assertion.**

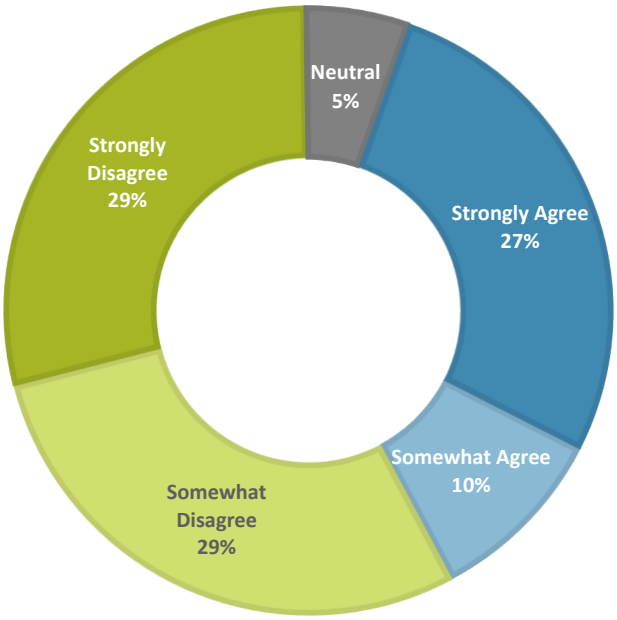
The purpose of this report is to provide a thematic analysis of what participants said, and not to evaluate their views for accuracy or correctness.

To what extent do you agree that the Act has achieved what it set out to do?

Question three asked to what extent people agree the Health (Regulation of Termination of Pregnancy) Act 2018 has achieved the policy aims. Of those that replied to this question (N = 3,475), 61% disagreed that it had achieved "what it set out to do" and only 31% agreed.

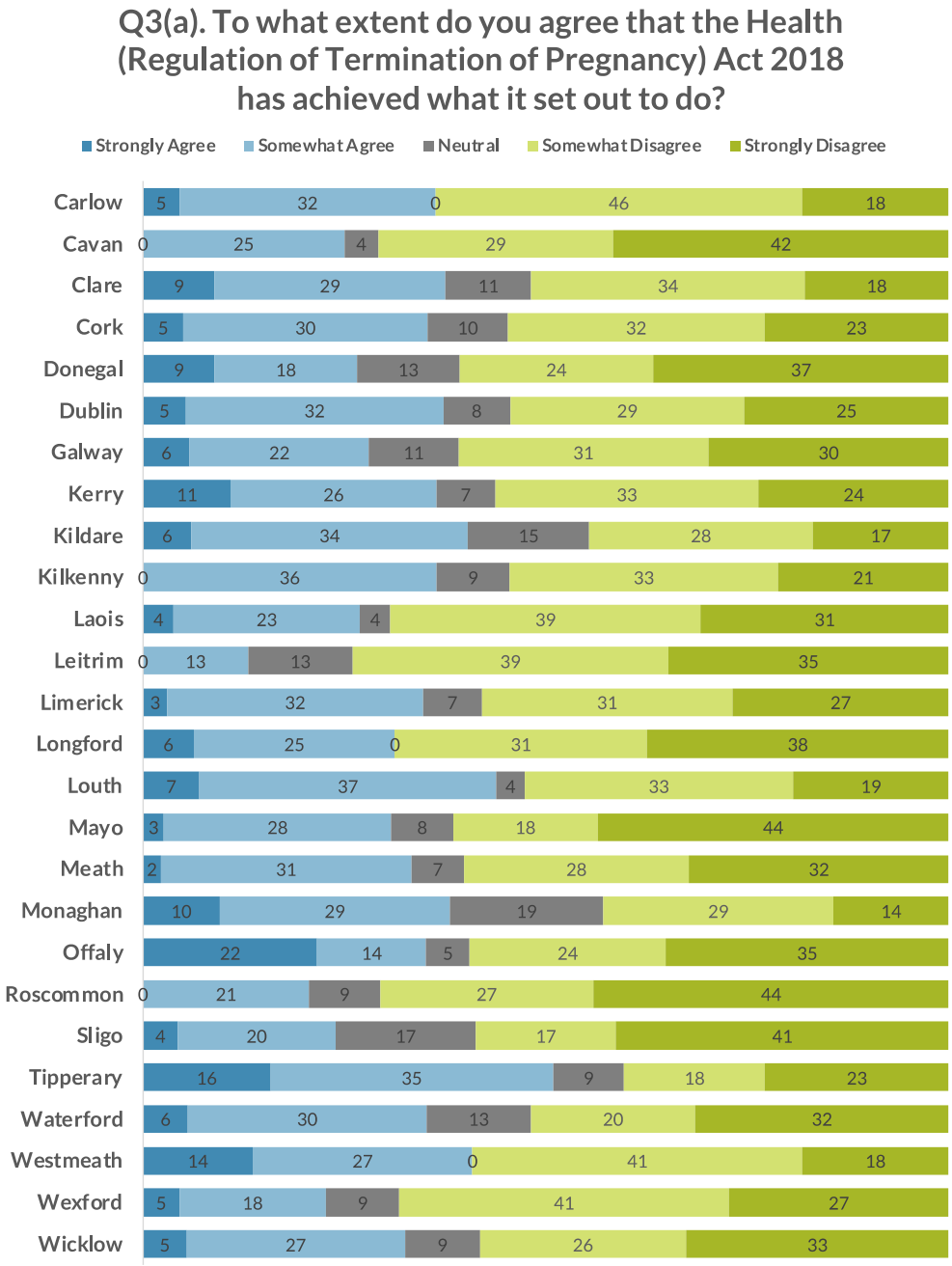
This question was very broad and elicited a wide range of perspectives that will be outlined later in the report. At a high level, the disagreement is grounded in the Act having "gone too far" in terms of the increase in terminations or the Act not having "gone far enough" in terms of consistency, quality and scale of services offered.

Q3(A). TO WHAT EXTENT DO YOU AGREE THAT THE HEALTH (REGULATION OF TERMINATION OF PREGNANCY) ACT 2018 HAS ACHIEVED WHAT IT SET OUT TO DO? (N=3,475)



When viewed at a county level we see that some report higher levels of strong disagreement and disagreement in general.

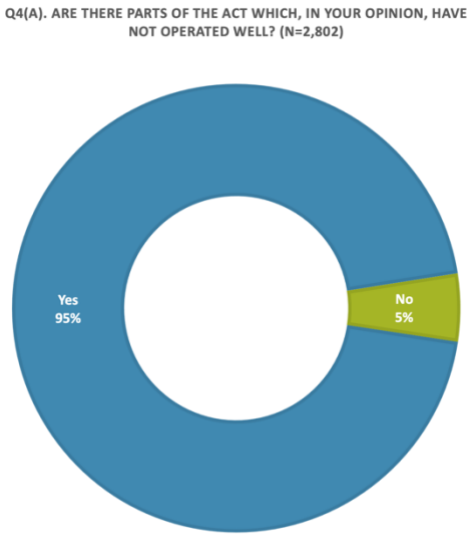
The sample sizes from some counties is low so should not be reported as representative.

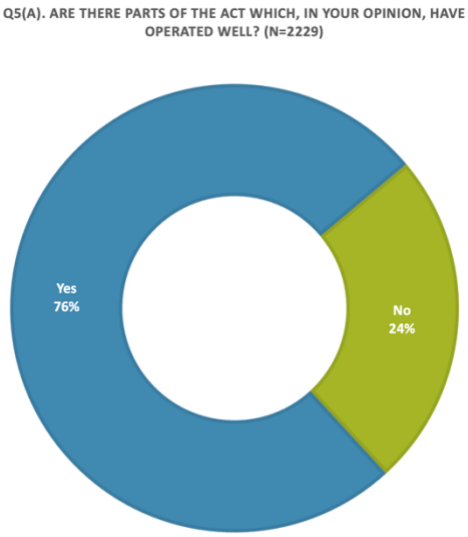


Are there parts of the Act which, in your opinion, have or have not operated well?

Question four asked if there were “parts” of the Act that have not operated well. Of those that replied to this question in the (N = 2,802), 95% suggested there were parts of the Act that had not operated well and only 5% disagreed with the statement.

Question five asked if there were “parts” of the Act that have operated well. Of those that replied to this question in the (N = 2,229), 76% suggested there were parts of the Act that had operated well and only 24% disagreed with the question.





In terms of the dominant themes in the open ended responses to this question, the key issues that people felt were not working well included:

- Access to Services
- Implications of not meeting legislative criteria
- Section 12 - Early Pregnancy
- Section 22 - Conscientious Objection
- Service user experience
- Adverse events

*Inner ring presents high level themes and outer ring includes sub themes

Overview of open ended comments

The following pages present the analysis of the consultation responses against the themes outlined in the thematic map (page 8). These are presented alphabetically so as to not infer any prioritisation.

Each page has a title that shows the top level theme in bold. If there is sub theme this is included below. There are two columns that present the combined responses across both primary cohorts in terms of what has worked well and what has not worked well.

The lists are not inferring priority and largely reflect the ordering of issues raised within the responses.

Access to Services / Continuity of Care

The issue of continuity of care was primarily framed as an issue of coordination between services for individual patients.

There was recognition in the responses that the transfer of medical records such as medical history and diagnostic test results between Health Care Professionals (HCP), particularly between jurisdictions, can often be inadequate.

This can result in poor communication between HCPs and patients accessing services. It was recognised that this can negatively impact the person accessing abortion services, both emotionally and physically. It can also bring an additional financial burden.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Women were forced to travel to UK due to narrow criteria around legal access regarding fatal foetal anomalies (FFA) in Ireland. Sensitivity around transfer of care to UK and the lack of a defined pathway of referral can lead to incomplete transfer of records and difficulty accessing services in a timely manner. Costs associated with travel place huge burden on those accessing abortion services, alongside the emotional and physical impact. Legal obligation to refer onwards not always being adhered to in a timely manner or at all.	There were almost no responses that indicated what was working well in terms of Continuity of Care. However, there was some anecdotal testimony of individual HCPs assisting with the sensitive and compassionate transfer of care to UK.

Access to Services / Genetic screening, ultrasound, and scanning

The responses addressing access to genetic screening, ultrasound and scanning services highlighted clear points of tension between the various cohorts.

This is due to the necessity of accessing these services as a first step in the abortion journey and their role and impact on clinical and personal decision making.

The concerns were focussed around;

- poor resourcing of services impacting negatively on a person's experience when accessing the service;
- poor resourcing of the services leading to inequitable access;
- lack of equitable timely access to clinical genetics and associated counselling;
- potential misdiagnosis of FFA leading to termination of healthy foetuses.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
There is a need for better quality assurance around ultrasound scanning in order to minimise incorrect calculation of gestational age due to scanning technique or lack of operator experience. Women with irregular cycles are at a disadvantage with strict time limits where every day counts. There is seen to be limited access to ultrasound scans nationally, limits equitable access and provision. Some held view that through misdiagnosis of FFA healthy foetuses are often terminated, and late term abortions are common.	Some of the key issues that **are working** in relation to Continuity of Care raised throughout the consultation responses include: Access to dating scans for appropriate calculation of gestational age is important for timely access to abortion services, this is more available in urban settings where a higher proportion of providers are offering abortion services. Women accessing abortion services via large tertiary referral hospitals have better and earlier access to ultrasound scanning and genetic testing where required.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
The lack of equitable access to clinical genetics and associated counselling is seen to be driven by: • Lack of clarity around definition of FFA, definitive agreement necessary as multi-disciplinary team decisions can be altered by genetic results; • Complexity of genetic issues with limited number of experienced staff to interpret; • Lag time and delay in obtaining results can often mean that women must travel to UK. Among these responses there is a perception of little or no support for woman to continue pregnancy leading to abuse of vulnerable and weak in society ("preborn baby"). Anecdotal evidence presented of HCPs reporting large amount of late term failed procedures.	

Access to Services / Geographical discrepancies

The responses addressing geographical discrepancies were almost exclusively negative and were often linked to wider concerns about access to services. There is a broad recognition that the geographic distribution of services is poor, and services are concentrated in urban areas and sparse in rural regions. The primary concerns focussed on the relatively low numbers of GPs (12%) and Hospitals (55%) currently providing termination of pregnancy services. The issue of safe access zones was also dominant when considering hospital access.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
National training required for all health care professionals in order to provide better access to abortion services for those who chose to access services. There is a need for clear national referral pathways – several responses indicated that pathways are blocked by issues such as conscientious objection. Given that it is a national abortion service, yet many counties do not have a single medical practitioner offering abortion services, the safe provision of access must be extended to all counties. Increase in number of GPs in rural areas to meet basic levels of demand. Only 55% of hospitals and 12 % of GPs are currently providing abortion services which has a disproportionate effect on rural women[2]. 3 day wait further impacts this – added logistical and financial burden given that	Provision of telemedicine services during the pandemic worked well especially for vulnerable and marginalised groups given that remote consultations removed the barrier of travel resulting in improved access to services. Suggestion that this telemedicine option is vital to preserve.

[2] As of 14 June 2022, after the consultation closing date, there were 413 termination of pregnancy providers in the community. This includes 403 GP contractors and 10 women's health services contractors.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
many counties have zero access to services.	
Need to monitor conscientious objection and make onwards referral mandatory as per Irish Medical Council guidelines.	

Access to Services / Hospitals

The responses addressing access to hospital care were linked to the broader area of access to abortion services in general. There was wide recognition that the geographic distribution of services is poor, and services are concentrated in urban areas and sparse in rural regions with only just over 50% of hospitals currently providing abortion services. The issue of safe access zones was also dominant when considering hospital access.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Many submissions felt that the lack of safe access zones was a glaring omission from the Act and should be protected legally given that protests can be distressing for both staff and patients. Currently only 10 of the 19 eligible hospitals in Ireland are providing abortion care with many respondents stating that the reasons why need to be better understood. Responses were questioning if this is due to lack of adequate training or more to do with conscientious objection. The Act mandates that all terminations between 9-12 weeks gestation takes place in hospitals and better information is needed as to why this is warranted. It was felt that this is discriminatory to rural patients due to unequal access and is not in line with international best practice. Hospitals are also excluding trainees from providing abortion services which further perpetuates stigma. It was suggested that dedicated public clinics to provide abortion services that are separate to maternity hospitals would be important in providing sensitive compassionate care for women.	Some submissions felt that the right to peaceful protest should be respected with no real need for safe access zones, even if only one life is saved.

Access to Service / Marginalised groups, People with disabilities, PPSN Requirements

The responses outlined a range of issues related to marginalised groups such as those living with disability, migrant groups, travellers, asylum seekers, and people experiencing homelessness.

The responses broadly indicated that the state has a duty of care for all people living in Ireland to provide safe and equitable access to abortion services, regardless of citizenship status, without requiring a PPS number or medical card

Given that it is a time sensitive treatment with short treatment window – safe equitable access is essential considering that travel after 12 weeks is often a huge barrier for undocumented migrants and other vulnerable groups.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Access to information in multiple languages including Irish Sign Language and access to interpreters is extremely limited. 3 day wait is a significant barrier to marginalised groups and more widely creates logistical and financial difficulty. Current legislation does not fit an 'access for all' ethos as rural and vulnerable find service difficult to access. Some responses suggested that disingenuous agencies disproportionately targeting vulnerable groups. A number of responses highlighted in UK 90% of pregnancies diagnosed with a certain disability are terminated, this is a horrific message to send to people living with disabilities.	Telemedicine during pandemic should be retained as provided more equitable access for vulnerable groups

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Irish society gives attention to equality but facilitating the legal lethal discrimination of disabled babies is in direct conflict to this – there is no time limit for abortion done on disability grounds and it is often done to full term. The requirement for PPS number to access free abortion is seen by a number of people that responded to create a bureaucratic barrier for many.	

Access to Services / Referral pathways

The responses to the consultation highlighted several issues in relation to Referral Pathways.

A key issue framing responses about referral pathways was the fact that many Termination for Medical Reasons (TFMR) cases do not fall within the legally permissible criteria for abortion, leading to many people accessing abortion services abroad.

This can lead to considerable financial costs and additional emotional and physical burden. Of those that highlighted this challenge in particular, there was an emphasis on the need to provide clear referral pathways to abortion providers outside the State. This call for clear referral pathways was particularly emphasised for people who receive a diagnosis of fatal foetal anomaly.

The issue around referral pathways was flagged by many respondents. The establishment of clear referral pathways that are not influenced by conscientious objection is vital.

Additionally, data on refusal of care and onwards referral should be published, thereby establishing a clear reporting system to identify gaps in service provision.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Responses suggested that conscientious objection is being used as a tool to instigate complete refusal of care with regular failure to provide timely onward referral. Concern was raised about a failure to collect useful data on abortion provision. This includes no monitoring of conscientious objection and timeliness of referrals. Responses suggested that lack of HCPs trained in abortion care is a significant barrier to safe and comprehensive provision.	There were no significant responses that indicated what was working well in terms of referral pathways

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Section 22 right to conscientious objection conflicts with obligatory referral which facilitates abortions, there is a need to remove mandatory referral for HCPs who are conscientious objectors. Health Service Executive MyOptions functioning as an abortion referral service – obligation to provide more options to support and retain pregnancy. Some responses requested investigation to ensure parents not pressurised into abortion and felt that remote consultations pose risk to vulnerable women susceptible to pressure.	

Adverse events / Failed termination

Responses that referred to failed termination almost exclusively highlighted situations arising with the twelve week limit, limited access to surgical abortion and cases of failed medical abortion that require a repeat course of treatment. In these situations, responses highlighted the need to travel to complete abortion care.

Some responses highlighted unreferenced cases of failed late term abortions where pain relief is not administered, leading to distress to mother and baby.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
A number of responses indicated that approximately 2% of medical abortions fail but that access to surgical procedures is limited. Repeat procedures are often outside gestation windows and are subsequently forced to travel. Respondents highlighted the need for patients in such situations to be allowed to complete their abortion treatment in Ireland, where it was initiated, even if they fall outside the 12 week window. Some respondents felt that Dilatation & Evacuation abortions should be banned in all cases. Some respondents highlighted anecdotal cases of failed late term abortions in Irish hospitals where foetuses are left to die.	There were no significant responses that indicated what was working well in terms of failed terminations.

Adverse events / FFA (Fatal Foetal Anomaly)

Responses that raised the issue of FFA (fatal foetal anomaly) were almost exclusively in relation to the risks arising from misdiagnosis leading to an abortion as well as timely diagnosis of such conditions.

A high profile 2019 case of misdiagnosis leading to an abortion that was reported in the media was raised frequently by those highlighting these concerns.

The topic of timely diagnosis of FFA was raised by many respondents with the arbitrary 28 day survival cut off a major pressure point. Additionally there was contention around the definition of FFA and the quantification of what constitutes a fatal diagnosis.

Issues around termination on grounds of genetic issues or potential disability were raised by respondents alongside the issue of misdiagnosis.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Responses indicated that the FFA 28-day survival cut-off, means it is often difficult for HCPs to agree on exact criteria as the definition is open to interpretation. Because of this, a number of responses outlined the need for more clearly defined criteria and wider timeframe. "HCPs are left debating how long a terminal baby may survive with complete disregard to quality of life or mental health of the mother". The requirement for two practitioners to agree on termination under section 11 can be distressing. Certification of FFA is complex and the current law is too restrictive.	There were no significant responses that indicated what was working well in terms of adverse events/FFA.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
The claim that as a society we value differently abled people is in direct conflict with permitting termination associated with a genetic diagnosis or a FFA. Some responses suggested that misdiagnosis leads to wrongful killing of preborn. Suggestion that HIQA would investigate all adverse events relating to misdiagnosis of FFA, considering the precedence set by the baby C controversy.	

Awareness of services and supports for service users / Information, follow up, service providers, disingenuous agencies, and MyOptions

There were a variety of views on the awareness of services and supports for service users. There was a general view that information about termination of pregnancy, how to access the procedures and relevant supports that are available is not always well known. This is especially important for vulnerable groups.

MyOptions is the national free helpline where women and pregnant people looking for an abortion can call and receive the name and phone number to specific providers near them, as well as free and confidential information and counselling to people experiencing an unplanned pregnancy.

Although some people are still unaware of this service, service users have reported positive experiences of MyOptions. More could be done to both to publicise the MyOptions helpline and make it more accessible and suited to people's needs.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Treatment of patients accessing service was flagged as concerning with many reports and personal testimonies of refusal of care and lack of respect submitted. No national database to track service provision by location, type etc. and currently there is no way to monitor conscientious objection, refusal of care or onward referral. This was flagged as a serious barrier to safe, equitable access. The issue of right to access services without risk of harassment was raised alongside the issue of unregulated rogue crisis pregnancy agencies. Multiple reports of disingenuous agencies targeting vulnerable women to misinform and obstruct access were submitted.	Abortion is now legal in many cases but widely inaccessible to many. Telemedicine is vital to vulnerable groups and should be retained post pandemic. It is positive that those who access abortion under 12 weeks' gestation are able to do so without having to provide a reason. The Act seems to function for those who realise they are pregnant very early and have the resources to enable them to plan for an abortion with haste.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
The regulation and sanction of such agencies was flagged alongside the establishment of safe access zones. Call for free post abortion counselling and follow up care was raised, citing that its omission is a current limitation to the service. Some respondents felt that the easy availability of the morning after pill in pharmacies is not screened properly and that women should be made to consider their choice more thoroughly and that all options should be explored. Others felt that the freedom of conscience of HCPs to refuse to provide care and referral is not respected – doctors who are conscientious objectors should not be obliged to refer patients. It was also suggested that the HSE MyOptions service is not offering pro-life alternatives.	

Criminalisation

The issues of criminalisation was addressed through a number of perspectives, including impacts on service providers, service provision and people accessing services. The factors and Actions that lead to criminality and the possibility of up to 14 years imprisonment was discussed almost exclusively in negative terms.

A number of responses suggested that full decriminalisation is necessary so that any medical professional that initiates a termination during early pregnancy, but the termination fails, they should be legally able to complete the termination even if beyond the 12 week period.

Criminalisation clause is seen to be counterproductive if a licensed professional involved. Criminalisation of providers and prescriptive time limits for FFA is forcing women abroad and undermining clinical judgement and professional expertise of providers.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Respondents suggested that full decriminalisation is vital. The current narrow time limits are perceived as unrealistic and paternalistic. This includes the 3 day wait which is seen as demeaning to patients and medically unnecessary. Many accounts describe how the criminalisation of providers leaves them wary of providing care, given that the maximum sentence is 14 years if a termination was provided outside the specific terms of the Act. The current ambiguous legal definitions around FFA and risk to health are causing providers to interpret law over cautiously to avoid risk of prosecution.	There were no significant responses that indicated what was working well in terms of criminalisation

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
There is a perception that the criminalisation clause is counterproductive given that licensed professionals are involved and it only goes to intimidate both patients and providers. Chilling effect of criminalisation forces women abroad leaving financial, logistical, social, emotional, and physical impact and often providers adopt a conservative approach for fear of legal repercussions. Inclusion of a post birth time limit where diagnosis may lead to death within 28 days of FFA can force practitioners to err on the side of caution to protect from prosecution.	

Education & Support for Service Providers

The provision of Education & Support for Service Providers was primarily addressed through three related primary perspectives. The first being to build capacity across clinical staff, the second being to improve the experience of people accessing services and the third being to reduce stigma within the healthcare system by ensuring training is inclusive and expansive.

There were also several responses that suggested that education should be opt-in and that the principles of conscientious objection be extended to all those working in healthcare settings (not just clinical staff) and to those entering healthcare training.

Of those that wanted to increase capacity among clinical staff, the focus was on continuing professional development in all areas of healthcare, improving the accuracy of FFA diagnosis, increasing the number of ultrasound providers, and improving the accuracy of scans.

A number of responses outlined the need for wider training such as values clarification training, anti-racism training. A common view held was that this training should be extended to the wide range of HCPs whose work intersects with abortion services.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Disproportionate effect on rural women as insufficient access to service due to lack of training. There should be a national list of every GP (who take medical cards) fully trained and able to provide service in order to provide true access for all. Exclusion of trainees from providing abortion services in hospitals perpetuates stigma and prevents relevant training and exposure. Better clarity and training on FFA management – language and information provided is vital alongside sensitivity, compassion, and privacy.	Comprehensive training of healthcare workers in selected hospitals was described which ensures that women who receive a diagnosis of a FFA are treated with sensitivity and are given full information about the diagnosis in language and forms they can understand. Positive testimony around privacy and confidentiality and the provision of support and timely healthcare was also reported.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Create a GP Abortion Liaison Officer role in every county who is appropriately trained to signpost and advise on provision of abortion care Some responses suggested that the freedom of conscience/conscientious objection for HCP's must be respected and should not impact on their role or tenure and should be broadened to all staff (not just clinical). There is seen to be a lack of trained HCPs a significant barrier and international evidence suggests nurses and midwives can safely provide early medical abortion. Clinician supervision important but wider knowledge to increase provision by nurses would improve access. Lack of knowledge or preparation for practicalities of abortion process and association complications for both staff and patients. Act should have a broader scope – emphasis on women's health at all stages and educate staff in this. Mandatory national training for all providers – lack of trained HCPs is a significant barrier to safe equitable delivery of abortion services. GP trained in every town to provide safe equitable access for all to crisis pregnancy counselling and unbiased care.	

Foetal Pain Relief

The issue around foetal pain relief was raised, particularly with respect to later term abortions and the belief that unborn babies feel pain and are left to die if born alive with no comfort care being provided.

A number of responses felt that the Act does not allow for precautionary pain relief. It was suggested that the state investigate all late term abortions.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
State should mandate pain relief of foetus during termination and require care given to all babies born alive. "It is my understanding that unborn children are undergoing late term abortions with no pain relief, this is inhumane and cruel". Mandatory pain relief for foetus and care for babies born alive. Legislation does not prohibit explicit targeting of foetus because of a non-life-threatening condition e.g. T21, gender etc. Extend 3 day wait to 5 days to facilitate comprehension of brevity of situation, force women to think about what they are doing. Preborn feel pain from 8 weeks and the lack of pain relief during termination is barbaric. Doctors should be encouraged to administer abortion pill reversal where mothers are regretful.	There were no significant responses that indicated what was working well in terms of foetal pain relief.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?

Funding

The responses in relation to the funding of abortion services highlighted a number of clear tensions between those that opposed the Act and those that feel the implementation of the Act has not gone as far as expected. In a general sense there were those that:

- opposed outright the use of tax to fund abortion services
- wanted funding allocated to pro-life advisory services
- wanted abortion services to be free for all citizens

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
A number of responses suggested that it should be mandatory for all public hospitals and all GP's to provide free legal healthcare to all patients including pregnant people wanting to access abortion. A number of responses were concerned that their taxes were used to fund abortion services that they were opposed to. Additionally they raised queries in relation to the medical card scheme logic. Public Hospitals are state funded so why are only just over 50% providing abortion care. Some respondents called for the provision in equal measure of support services to facilitate women who would prefer to keep their babies, if abortion services are to be provided free of charge, then financial support should equally be offered to allow mothers afford to keep their babies.	Abortion care should be free safe and legal with equitable access for all- expand access to those with no PPS and other vulnerable groups.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
There was a view among some responses that Ireland should stop worrying about people who will never support abortion in any circumstances, the vocal minority. Instead we should provide care for those seeking abortions by decriminalising abortion and providing free safe, legal, and total access for anyone who requests, without restrictions.	

Gender Considerations

A number of responses highlighted how the 2018 Act does not use gender-inclusive language.

Among these responses, there is a recognition that transgender, non-binary, and intersex people also need access to abortion services and that the language of the Act should reflect this.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Some responses suggested that gendered language of the Act does not consider trans, non-binary and intersex people. These responses typically suggested that to protect rights of all people accessing service these responses suggest that the Act use language such as “pregnant person/people” so that rights of transgender, non-binary and intersex people are explicitly stated.	Some responses suggested that the language of the Act should not be changed.

Implications of Not Meeting Legislative Criteria / Chilling effect of criminalisation

As mentioned previously, the responses relating to criminalisation were almost exclusively viewed in negative terms. There were no clear references to the framing of criminalisation in the Act (e.g. up to 14 years imprisonment) among those that opposed abortion.

The chilling effect of criminalisation was often framed as an interrelated issue. For example, the view that the criteria for pregnant people to receive a diagnosis of a fatal foetal anomaly are too narrow and this combined with the "chilling effect" of criminalisation impacts negatively on service delivery. This is then seen to have negative consequences such as people having to travel abroad for abortion services.

The negative perspectives included reducing the term of imprisonment through to full decriminalisation.

In a number of cases, those arguing for decriminalisation referenced the desire to bring Ireland in line with recommendations of the European Court of Human Rights, the World Health Organisation, and the United Nations.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
There was concern that HCPs providing abortion services outside of strict criteria set out in Act are potentially criminally liable and could face imprisonment. Some of these responses felt that the criminal offences provisions undermine HCPs clinical judgement and professional expertise, and they also perpetuates stigma. FFA criteria very strict – hard cases need sensitivity and compassion. Chilling effect surrounds doctors making the decision as they fear calling it "wrong" and facing consequences.	There were no significant responses that indicated what was working well in terms of criminalisation.

Implications of Not Meeting Legislative Criteria / Financial

Responses outlined the financial impacts arising from the implementation of the Act. In the first instance this related to the cost differential between abortion services compared to GP led pregnancy care (indications that this was €450 compared to €250).

This then extended to the uneven distribution of financial burdens on people in rural areas, those from marginalised groups and those who have to travel outside the state to access abortion services.

In particular, responses highlighted the additional burden on those travelling due to a FFA diagnosis.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
A number of responses outlined how the implementation of the Act resulted in financial burden, particularly for rural and marginalised groups. Financial cost of access where GP service is not accessible or does not exist. The 3 day waiting period impacts this further. There were suggestions that a reform of Clinical Care pathways is needed to ensure more equitable access with all costs covered by State. The cost differential between abortion services compared to GP led pregnancy care was raised with some questioning why more money was being allocated to terminating pregnancies than to providing antenatal care. Cost of travel to UK for FFA or other complex cases is often prohibitive.	There were no significant responses that indicated what was working well in terms of financial impact.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Abortion is free but contraception costs money. Suggestion that there should be legislative provision for alternative to abortion – package of supplies that a pregnant person considering abortion can access- alternative route to termination. Increased government funding to support pregnancy to continue.	

Implications of Not Meeting Legislative Criteria / TFMR

Responses that raised the issue of termination for medical reasons (TFMR) were almost exclusively in relation to the complications around diagnosis and the same risks as outlined in the responses to FFA.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
The multidisciplinary team approach (sign off by 2 medical practitioners) is strict and the consensus often difficult to achieve. Women forced to travel for TFMR but would be better served with safe, local, and compassionate care in Ireland. 12 week limit too strict and access to care at home is vital, better access to family support and follow up care. Severe versus fatal anomalies are very hard to distinguish, which adds undue stress to patient and HCP. If forced to travel due to Sect 11 the State should cover costs. FFA already stressful and difficult without burden of travel Significant problems with access post 12 weeks for TFMR, criteria needs to be widened. Wrong to abort for medical reasons or suspicion of abnormality. Misdiagnosis causes the unnecessary killing of an unborn child as was the case with Baby C.	There were no significant responses that indicated what was working well in terms of TFMR.

Implications of Not Meeting Legislative Criteria / Travel

Travel was one of the most dominant issues discussed throughout the survey responses. It is an emotive topic with a number of issues leading to and caused by the need to travel for a termination of pregnancy.

A number of responses spoke about the factors leading to travel such as:

- overly restrictive definitions in the legislation
- restrictive criteria for pregnant people who receive a diagnosis of fatal foetal anomaly
- the effect of criminalisation

There was a broad consensus on the problem of hundreds of people living in Ireland having to continue to travel abroad for abortion services.

There were several personal and indirect testimonies that outlined the impact on the individual. These included the stressful and traumatising effects of having to travel, the inability to grieve properly following a termination for medical reasons, being separated from family and friends. For some, the issue of travel is a signal that abortion services is not fully integrated into the Irish healthcare system.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Services should be provided locally, travel to other jurisdictions or to other services places an undue burden. Not being able to grieve properly due to travel can be stressful and traumatising. Restrictive criteria for legal access to abortion post 12 weeks needs to be reviewed.	There were no significant responses that indicated what was working well in terms of travel.

Informed Consent

The issue of informed consent was discussed from a range of perspectives. In particular, those from the opposing cohort were concerned that there is a lack of public information on the alternatives to abortion or the likely impacts on those that have an abortion. They feel this is counter to informed consent. On the other hand, a number of responses suggested that informed consent should be a mechanism for empowerment

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
MyOptions does not provide sufficient information on alternatives to abortion and so is providing inadequate information. Some responses indicated that lack of informed consent was forcing women into termination. Women should be protected from pressure to terminate. It should be their choice after all options are made clear and limits of prenatal testing should be clearer. How can women give informed consent when full facts are withheld especially with regards to pain relief and alternatives to abortion. Consent of pregnant person should be central in the legislation. The reliance on HCP opinion brings possibility of not agreeing in good faith and bringing opinion rather than medical facts to the decision. Some responses indicated that remote “home abortions” pose serious risk and fully informed consent is not guaranteed.	3 day wait saves lives and assists true consent. 3 day wait should be extended to better inform and educated women about their alternatives to abortion.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Full options and informed consent is not being followed – long term physical and psychological effects are not being explained.	

Methods of Termination / Dilation and Evacuation, Lack of choice, Surgical abortion

Responses in relation to the methods of termination were divided between concerns about a lack of choice, limitations on access and the emotive response to certain procedures.

A number of responses expressed concern that there is a lack of hospitals providing surgical abortion with the result being medical abortion is the most frequently discussed option but possibly not the most appropriate choice in some cases.

Some responses suggested that certain procedures such as Dilation and Evacuation should be restricted or banned.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Surgical methods are rapid and more supportive emotionally for women. Responses suggested that wider access to this treatment would be in the better interest of women. Medical abortion at home can be more traumatic in some instances and follow up support is vital. Some responses suggest that surgical abortions should be prohibited, late term Dilation and Evacuation on Irish soil is seen to be a cruel procedure with no pain relief for babies, survivors left to die. Failed early medical abortion with 2% chance of repeat treatment required, which may then require travel as 12 week limit has been exceeded.	There were no significant responses that indicated what was working well in terms of methods of termination.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Surgical abortion should be more widely available in Ireland with better access in the community in specialised clinics. Lack of hospitals willing to provide surgical abortion means that medical abortion is often the main option discussed. This has an impact on timing as the 12 week limit is seen by some to be too strict. In conflict with international best practise there is a lack of choice over type, medical or surgical, due to limited service.	

Remote Consultation

The implementation of remote consultation (e.g. telemedicine) for abortion services during the COVID-19 pandemic was broadly seen as being successful.

Remote consultation was seen to have removed barriers to care (e.g. those living rurally, people with disability) and there were various levels of acceptability expressed for patients and providers. This included both direct and indirect experiences.

These views highlighted the potential for remote consultation to increase equity of access. This includes both pre and post abortion counselling.

Concerns were raised in relation to perceived risks associated with Remote Consultation. These responses primarily expressed concern in relation to medical abortion ("abortion pills") at home.

Some respondents shared the view of the WHO that remote consultation (telemedicine) for termination of pregnancies is safe when supported by a hospital or health care professional such as a GP.

Across the responses there was a lack of clarity on whether Remote Consultation will remain in place after the pandemic.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Access nationally is poor especially in rural areas – One in ten GP's plus only just over 50% of hospitals offer abortion services – 2 out of every 3 terminations for FFA need to travel due to strict criteria. Telemedicine abortions pose serious risk to women – home abortions need to end as women pressurised into having an abortion. Better access to post abortion counselling either remote or in person – current provision is not standardised, investment in this area is required.	Remote provision of care during the pandemic was hugely beneficial as it provided access to safe and effective early medical abortion. Remote Consultation / telemedicine has provided more equitable access to care especially for vulnerable and marginalised groups. My Options is a good service however the introduction of a booking facility would be helpful for marginalised/rural women.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
	Remote consultation can eradicate barriers of geographical provision and delays – WHO considered telemedicine abortions safe, especially with GP and hospital input. Remote Consultation has improved access for the disabled community and should be maintained. 3 day wait and in person consultations will save lives – remote consultation should end immediately.

Reporting and data / Number of terminations, Quality of data collected

The issue of data quality was discussed from a number of different perspectives. Some responses indicated the need to improve data collection and reporting as detailed statistics can assist Government in service provision and service planning.

Better quality data can also help inform the public about the effectiveness of the Act.

It was notable how different statistics were used to make points throughout the survey with differing levels of referencing to research or government statistics.

Some responses indicated the need to improve data collection and reporting Need to keep detailed statistics to assist Government in service provision development.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
There should be mandatory reporting of denial of services, conscientious objections and onward referrals. Some respondents felt that the number of reported terminations in the first 2 years of the operation of the Act was not in keeping with the governments promise of rare, safe, and legal abortion. They felt a 70% increase is not a rare occurrence and called for a full investigation.	There were no significant responses that indicated what was working well in terms of reporting and data.

Safe Access Zones / Negative experience of protests

While the national conversation and policy position around safe access zones has advanced since the public consultation was undertaken, the responses to the survey in relation to Safe Access Zones highlighted two distinct views. On the one hand, some people felt that the right to protest or hold vigils should not be infringed and on the other hand many viewed Safe Access Zones as essential for the provision of safe, respectful access to services.

Through a combination of personal testimony and perceived effects, the responses highlighted a number of impacts that protests and vigils have had on both people accessing services and service providers.

There was a sense that Safe Access Zones were "promised" in 2018 but have not yet been enacted in legislation.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Protests outside clinics are seen to be very distressing for potential service users and should be banned. There was a large level of concern that these protests were not likely to change the mind of the person seeking a termination, but caused undue stress, and interfered with the privacy of service users. The impact on service providers was also described particularly in smaller towns and rural settings where protests and associated stigma may impact the provision of safe abortion services.	Some people felt that the right to protest and freely assemble in a public place should not be impinged or restricted. Right to peaceful protests should be protected – countless lives have been saved globally

Section 12 / 12-week gestational limit

The responses in relation to the 12 week gestation limit were mostly concerned with the following key issues; narrow timeline for women accessing services in rural areas or vulnerable situations, tight gestational limit for those who have a delay in confirmation of pregnancy and delays around genetic testing results.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Among those that responded, the 12 week gestational limit is seen to be particularly challenging if there is a delay in confirmation of pregnancy due to irregular periods, disability, lack of familiarity with the health service or inadequate access to GP or healthcare system. The provision of abortion after 10 weeks gestation can be problematic as hospitals may not have regular availability of TOP clinics and the person may not be offered a surgical option within the 12 week window. There can be a delay between attending a GP and being referred onto the hospital system if surgical termination is required, and a call for more robust referral pathways could help this issue given that only 12% of GPs and 50% of hospitals are participating in providing abortion services nationally. In many instances of FFA there may not be a diagnosis until well after 12 weeks due to insufficient equitable access to genetic testing and clinical diagnostics nationally, many examples of personal testimony were submitted detailing the associated trauma of having to go overseas for termination.	There were a number of personal testimonies from those who sought an early medical abortion in an area that was serviced well with GPs providing abortion services. Many reported a service that is working well for straightforward cases.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
There needs to be clear information and support for those with FFA diagnosis post 12 weeks gestation and how they can access termination services.	

Section 12 / 3 day waiting period

The responses in relation to the mandatory 72-hour waiting period elicited a narrow range of polarising responses, from removing the wait all together through to retaining or extending it further.

For those that opposed the 3 day waiting period the arguments were typically framed around the lack of clear medical necessity and number of responses indicated that it was contrary to "international best practice".

In these arguments, it was outlined that the 3 day waiting period delays the overall process and can impact on later access to care but that it can have a delegitimising effect on people seeking abortions.

On the other hand some felt that the 3 day waiting period was a period of reflection where people could receive additional support and advice, particularly in relation to not progressing to an abortion.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Some responses felt that the 3 day waiting period was not women centred or grounded in any clinical evidence, but rather made the difficult decision of terminating a pregnancy even more challenging and distressing. At a practical level the 3 day waiting period effectively reduces the already tight window that exists for women to access legal termination. 3 day wait removes agency and absence of providers of surgical abortion causes undue stress – inequality of access. Too many barriers to safe and timely care, 3 day wait, 12 week limit and lack of access in some areas.	For some the 3 day wait was perceived to be working well as it provided time to allow women to think through their options and reconsider terminating their pregnancies. There was a suggestion by some respondents that this waiting period be extended further to 5 days to allow for sufficient time to consider alternatives to terminating a pregnancy.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?

Section 12 / Calculation of Gestation

Accurate calculation of gestation is essential for access to abortion services.

Ultrasound scanning is used to correctly date a pregnancy and is generally performed in the first trimester by a qualified HCP.

Respondents noted that timely access to dating scans for accurate calculation of gestation can impact access to abortion service.

The main issues raised around calculation of gestation were, lack of timely equitable access to dating scans and the impact on the 12 week cut off for accessing services.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Under the Act, an abortion is only available upon request if the person is no more than 12 weeks pregnant. There are many instances where women fall outside this limited criteria due to incorrect dating of pregnancy. Calculation of gestation can sometimes be inaccurate based on whether it is done by a GP or within hospital services. Suggestion that there should be clarification on permissible access to service within the 12 week window, should it be that gestational age used refers to the initiation of the procedure or completion of the procedure? Some respondents suggest that the 12 week cut off should be based on when the woman first presents, in order to allow for delays in the health system.	It is positive that those who access abortion under 12 weeks' gestation are able to do so without having to provide a reason. The Act seems to function for those who realise they are pregnant very early and have the resources to enable them to make arrangements for an abortion with haste.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Suggestion that an ultrasound always be used to provide an accurate calculation of the gestation of the foetus and base the legality of termination on this basis. Challenge of calculating gestation for telemedicine or remote consultations was flagged.	

Section 21 / Conscientious objection

The responses in relation to conscientious objection were broadly debited between those that consider it a barrier to access and those that think it is a principle to uphold.

A key tension in the responses is that the Act requires that those who opt to not provide abortion services transfer the person seeking services "as soon as may be" yet this is not always happening.

There was concern among a number of responses that the poor geographic distribution of services and the lack of a defined timeframe for referral, can ultimately delay, or prevent care.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
The right to conscientious objection was seen by some as limiting options for those in areas where there was a high level of non-participation by GPs, effectively limiting access to care. Others felt that the legislation did not give enough scope for medical staff to express their opinion – Section 22 with regard to conscientious objection is in the legislation but in its current form it does not provide genuine freedom of conscience to GPs as it obliges them to refer on. The question was also raised about a patients' rights if a HCP refuses them care.	There were also responses that held the view that conscientious objection is a fundamental aspect of the Act and should be maintained.

Service User Experience / Attitudes and behaviour towards patients

There were a number of personal testimonies that provided direct insight into the experience of people accessing abortion services in Ireland. The personal testimonies typically outlined different negative experiences at different stages of abortion services received from interactions with GPs through to Maternity Hospitals. A number of responses provided insights into the experience of friends, partners, and family members.

The experience presented ranged from direct experience of refusal of care due to conscientious objection through to service provision that lacked empathy or was hostile or aggressive. There was recognition in these responses that some of the experience in this context was created as a result of the legislation as well as existing attitudes.

Another issue raised in relation to attitudes and behaviours towards patients was stigma, both perceived and experienced. Some personal testimonies mentioned the need to normalise abortion services through visible information in healthcare settings.

A number of responses dealt with the post-termination counselling services. Some service providers indicated that an increased number of people accessing these services is indicative of a gradual decline in stigma.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	**Are there parts of the Act which, in your opinion, HAVE operated well?**
Where services were available, they were seen as being accessible for those within the 12 week limit- this was largely based on the WHO survey rather than personal experience. Personal testimony mostly focused on the difficulty of delayed diagnosis of FFA and the associated difficulties with being given a timely diagnosis. The 28 day rule was seen as not allowing for nuance or practical implementation given the dynamic reality of clinical diagnoses.	There were no significant responses that indicated what was working well in terms of attitudes and behaviour towards patients but there was recognition that changes, such as an increase in numbers accessing counselling, is a positive signal.

Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Service users are being treated in maternity settings and are being mixed in with other women, who may be giving birth – and there was an expectation of better options. There needs to be a clear role for the social worker when the case is based on FFA. Counselling needs to focus on the emotional experience of the woman and not just on the physical health issues of the foetus.	

Sexual education and contraception

Responses in relation to sexual education and contraception highlighted a number of interrelated views. This included the expansion of sexual education and provision of widespread affordable or free contraception

These responses were typically framed as a rights-based point of view or as a key mechanism to limit unplanned or 'unwanted' pregnancies

There was support for having better sexual education, and free contraception as part of the full range of care provided.

There were differing views on what forms of contraception should be included.

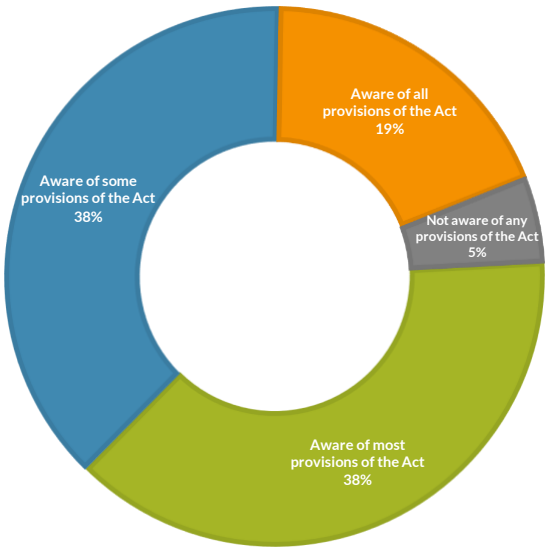
Are there parts of the Act which, in your opinion, HAVE NOT operated well?	Are there parts of the Act which, in your opinion, HAVE operated well?
Some viewed that the part of the Act that promised better access to sexual education and affordable education has not been delivered. For some this is key to reducing the need for abortion, and for others this is part of basic rights for females to have bodily autonomy. Some approach free contraception as a rights-based issue, while others see it as important for reducing unwanted pregnancies and the need for termination. The content of sex education was discussed, with agreement on information that supports the avoidance of unwanted pregnancy.	There were no significant responses that indicated what was working well in terms of sexual education and contraception

Awareness of the Act prior to responding to the consultation

Prior to this consultation what was your awareness of the Act?

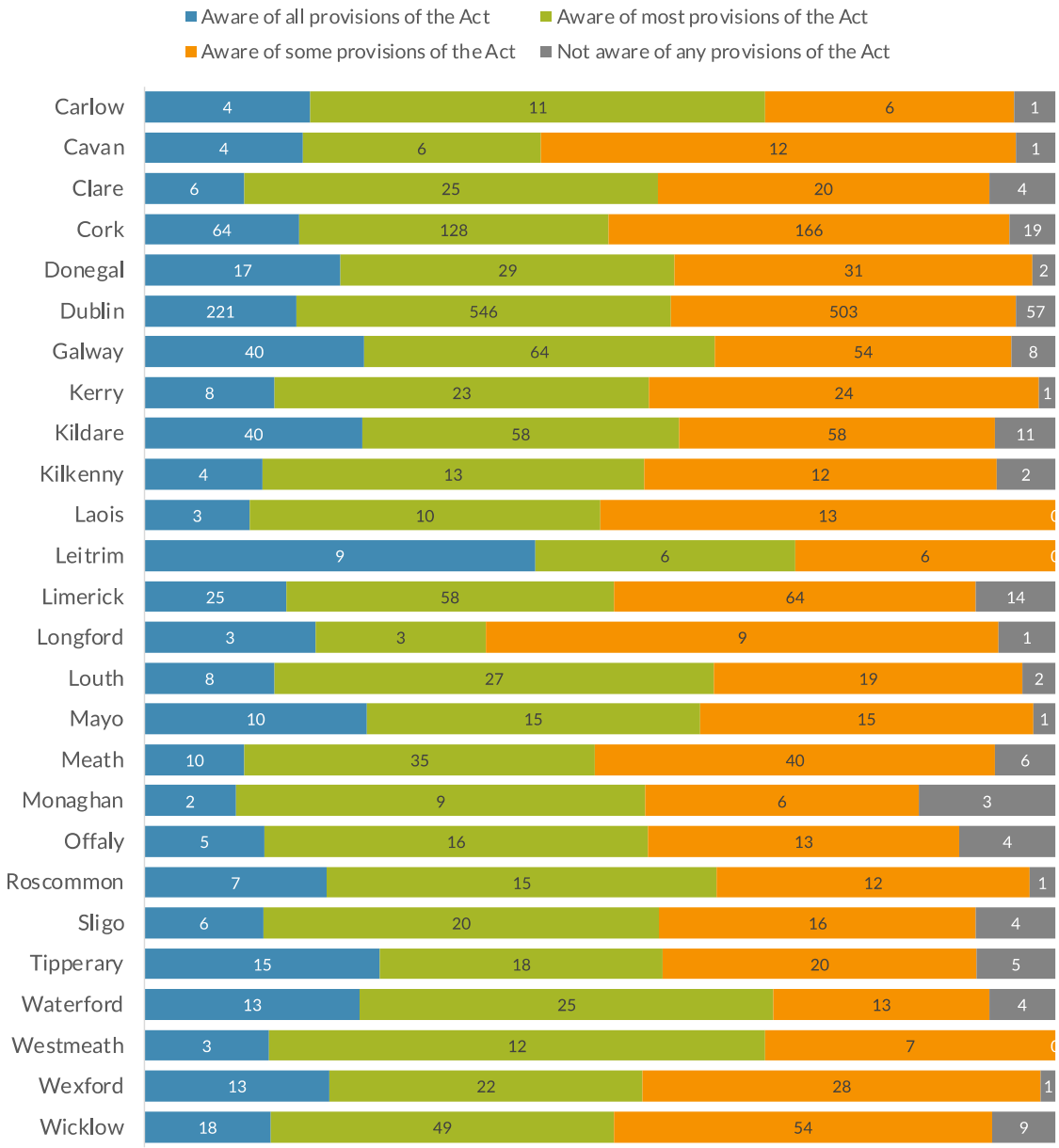
Question eight asked if people were aware of the Act prior to completing the consultation. Only 5% (n=177) indicated that they were not aware of any provisions of the Act.

Q8. PRIOR TO THIS CONSULTATION WHAT WAS YOUR AWARENESS OF THE ACT? (N=3,440)

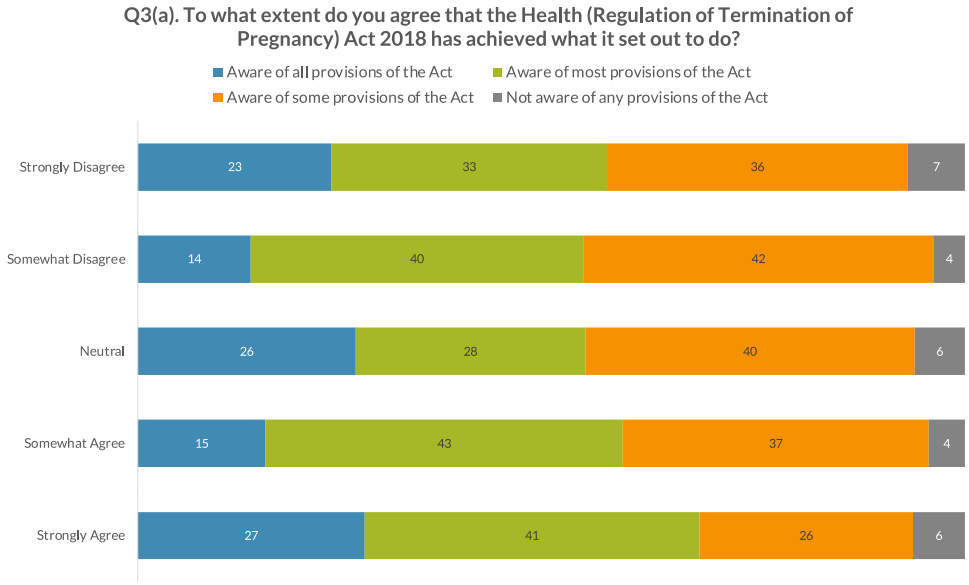


There are varying degrees of awareness at a county level. **The sample sizes from some counties is low so should not be reported as representative.**

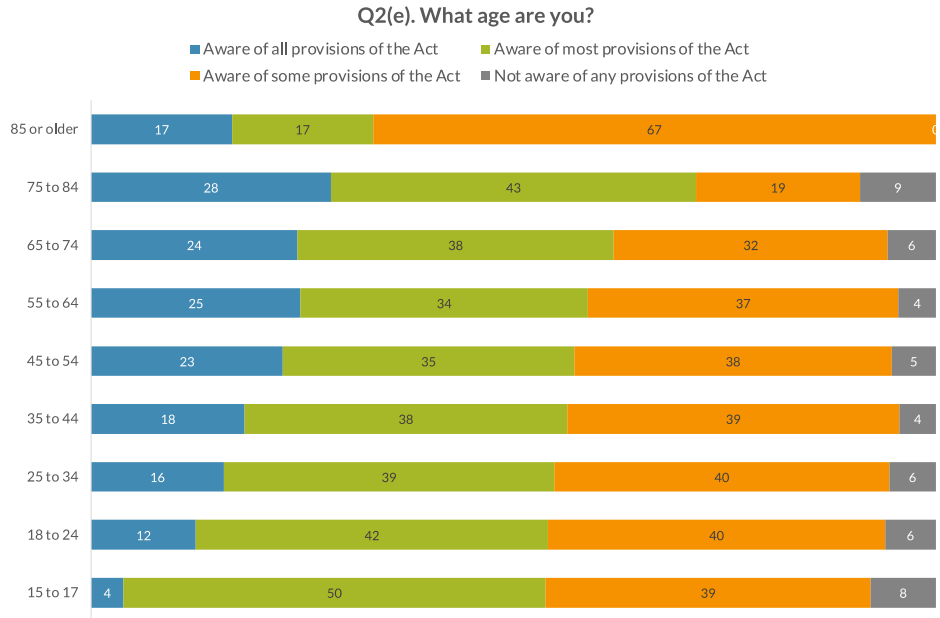
Q8. Prior to this consultation what was your awareness of the Act? (n=3,380)



Those that Agree that that the Act has achieved what it set out to do (n=1,278) report higher levels of awareness of the provisions of the Act.



While there is not significant variance, those between the ages of 45 and 84 report higher levels of awareness of "all provisions of the Act".



Summary and conclusion

This public consultation was an opportunity for the public, health care professionals, representative and campaign groups, and individuals to share their personal and organisational views on the functioning of the Act.

This report outlined the wide range of views and perspectives submitted to the Department of Health and Independent review of the Health (Regulation of Termination of Pregnancy) Act 2018. Given the large number of responses, including detailed written submissions, this report provides a high level overview and a cross section of views across the cohorts of responses.

The detailed review of responses highlighted that while termination of pregnancy and abortion services is a polarising but, rather than it being a binary debate, the report highlights a spectrum of views about the implementation of the Health (Regulation of Termination of Pregnancy) Act 2018.

While there is no evidence in the data gathered of a significant shift in opinion since the commencement of the Act between those that opposed or supported the introduction of the Act, responses indicate that the nature and scope of the public debate is changing.

This is likely to be due to the changes in the social and political context now that the Act is in place. The survey questions were framed in a functional way to determine what has and what has not worked. This framing also partly explains the range of polarising perspectives.

As expected, there are those that remain opposed to the Act and will continue to be. In this opposing cohort there are also those that want changes to the implementation of the Act in such a way as they feel it will achieve their objectives of reducing or eliminating terminations of pregnancy.

Within this cohort, the views range from those that are entirely opposed outright regardless of circumstance through to those that oppose the Act but try to identify touchpoints or entry points in the abortion services journey where different forms of support, information could be provided with the anticipation that this may result in a different choice.

Conversely there are those that support the Act and will continue to do so. Within this cohort, the views range from those that are glad that the Act is in place but have no direct experience of the implementation through to those that feel the Act has not gone far enough in terms of what was hoped for and expected in the lead up to the Act.

This cohort put forward a large number of suggestions or recommendations submitted in relation to improving the practical implementation of safe and effective abortion services in Ireland.

It should be noted that there were responses based on detailed personal testimonies that openly shared experiences of accessing services. These experiences were often traumatic with the negative experiences being exacerbated by the manner in which the Act was being implemented.

The review team want to specifically thank those that shared direct personal stories and let them know due care was given to read, understand and reflect on these experiences during the analysis leading up to this report.

Annexes

Organisations that responded to the consultation

Abortion Access Campaign West

Abortion Rights Campaign

Abortion Working Group, convened by the National Women's Council

Academics Research Team - University of Central Florida, sponsored by the WHO

Action For Choice

Alliance For Choice

Alliance For Choice Derry

Amnesty International

An Rabharta Glas – Green Left

Aontú

Atheist Ireland

BetterMaternityCare Campaign

British Pregnancy Advisory Service (BPAS)

Centre for Disability Law and Policy (CDLP)

CoS Leitrim Cares

Disabled Women Ireland

Doctors for Life

Donegal Pro Life

Doula Association of Ireland

Families Strengthening Families Ireland - T/A Family.ie

Family Solidarity

Fetal Medicine Department, National Maternity Hospital, Dublin.

Fetal Medicine Specialist (FMS) Working Group, Institute of Obstetricians and Gynaecologists, Ireland

Fine Gael Women's Network

Fingal Feminist Network

Galway East for Choice

Galway Feminist Collective

Galway for Life

Galway Pro-Choice

Galway Sexual Health Forum

In Her Shoes - Women of the Eighth

IrelandStandUp

Irish Catholic Association

Irish Catholic Doctors Association

Irish Family Planning Association - IFPA

Irish Second-Level Students Union

Just Transition Greens

Kerry Life and Family

Labour Party

Labour Women

Labour Youth

Leitrim for Choice

Leixlip Pro-Life

Let Them Live Leinster

Life Institute

Limerick Feminist Network

Limerick For Life

Limerick Labour Party

LMC

Marconi Institute

Migrant Rights Centre Ireland

Mná Glasa

NCWWN Clare Women's Network

North Wicklow Together for Choice and Equality

Nurses and Midwives for Life Ireland

One Family

Our Maternity Hospital

People Before Profit

Phoenix Women's Centre

Pro Life Campaign

Queen Mary University of London

ROSA

Sexual Health Centre

Sligo for life

Sligo Pro Life

Social Democrats Limerick City Branch

Solidarity and The Socialist Party

Southern Task Group On Abortion and Reproductive Topics (START)

Spunout

Students for Life

Syro Malabar Catholic Church Community

Termination For Medical Reasons

The Christian Institute

The Dublin Well Woman Centre CLG

The Iona Institute

The National Maternity Hospital

Together for Safety

Mallow and North Cork Pro-Life Organisation

University College Dublin Student's Unions

West Cork Counselling And Support Services

Wicklow Pro-Life

Women Hurt

Women's Aid

Workers' Party