Report 2019-2025

TERMINATION OF PREGNANCY SERVICES IN IRELAND

HSE

National Women & Infants Health Programme

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Language Used

While this progress report reflects the language found in the Health (Regulation of Termination of Pregnancy) Act 2018, it aims to clarify its contents. For example, the Act uses the words “woman/women”; while it is primarily cisgender women who experience pregnancy, this guide refers to laws that affect anyone who can become pregnant, including transgender and non-binary (TGNB) people.

The Act uses the term “termination of pregnancy”. In this guide, “termination of pregnancy” and “abortion” are both used; sometimes “fetus” and/or “baby” are used, acknowledging that people may prefer one term over the other, with valid and different reasons for these preferences. Healthcare professionals should be guided by the language that people prefer.

List of Acronyms and Abbreviations

CAF	Clinical Advisory Forum
CCO	Chief Clinical Officer
CPG	Clinical Practice Guideline
D&E	Dilation and Evacuation
DDG	Data Governance Group
DOH	Department of Health
EMA	Early Medical Abortion
EPU	Early Pregnancy Unit
GP	General Practitioner
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
MDT(M)	Multidisciplinary Team (Meeting)
MFM	Maternal Fetal Medicine
MOC	Model of Care
MTOP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NPEC	National Perinatal Epidemiological Centre
NWIHP	National Women and Infants Health Programme
PPI	Public and Patient Involvement
RCPI	Royal College of Physicians of Ireland
SIG	Service Improvement Group
STOP	Surgical Termination of Pregnancy
TOP	Termination of Pregnancy
TOPFA	Termination of Pregnancy for Fetal Anomaly

Message from the Clinical Lead for Termination of Pregnancy Services

Dr Aoife Mullally
National Lead for Termination of Pregnancy Services

I am pleased to present the HSEs first report with regards to the provision of termination of pregnancy services within Ireland's secondary care system since 2019.

Termination of Pregnancy became legal in Ireland on the 20th December 2018, when the Health (Regulation of Termination of Pregnancy) Act 2018 was enacted. Provision of termination of pregnancy services commenced across primary and secondary care in January 2019. The legalisation of termination of pregnancy within the parameters set out in the Act, required a huge mindset shift within the healthcare environment. Six years on, the termination of pregnancy service has evolved and is largely acknowledged as a routine and normal part of healthcare provision.

From 2019 to 2025, a substantial volume of work was carried out within the Termination of Pregnancy service, particularly in the following areas:

- An increase in maternity units providing medical termination services under section 12 of the Act from ten maternity units in 2019 to nineteen maternity units in 2025. Additionally, there is an increase in maternity units providing elective surgical termination of pregnancy (STOP) and manual vacuum aspiration (MVA).
- An increase in contract holders in primary care providing early medical abortion (EMA) under section 12 of the Act from three hundred and ten contract holders in 2019 to four hundred and eighty contract holders in 2025.
- The establishment of the Service Improvement Group (SIG) and its continued work in implementing the recommendations set out in the two service reviews conducted in 2022.
- The launch of the national data collection system in collaboration with colleagues in National Perinatal Epidemiological Centre (NPEC).
- The establishment of the monthly peer-to-peer meetings where service providers can meet, share experiences and discuss clinical challenges.
- The development of a Guideline for the 'Investigation and Management of Complications of early termination of pregnancy, as well as the commissioning for the development of further national clinical guidelines for termination of pregnancy.

Termination of Pregnancy services are now an essential component of our healthcare system. In a global climate where reproductive rights are increasingly under pressure, safeguarding and sustaining these important services must remain a priority to ensure that people can continue to access the care that they need and are legally entitled to. I look forward to continuing to lead the service in 2026 and building on the important foundations now in place.

Message from the Clinical Director for The National Women and Infants Health Programme

Dr Cliona Murphy
Clinical Director for The National Women and Infants Health Programme

The Health Service Executive (HSE) remains firmly committed to the delivery of high-quality, safe abortion care across both acute and community settings.

On behalf of the National Women and Infants Health Programme (NWIHP), I would like to sincerely acknowledge the Clinical Lead for this service, Dr Aoife Mullally, whose dedication, diligence and unwavering commitment continue to be exemplary. Her leadership has been instrumental in striving to ensure that every woman receives compassionate, timely and appropriate care and support.

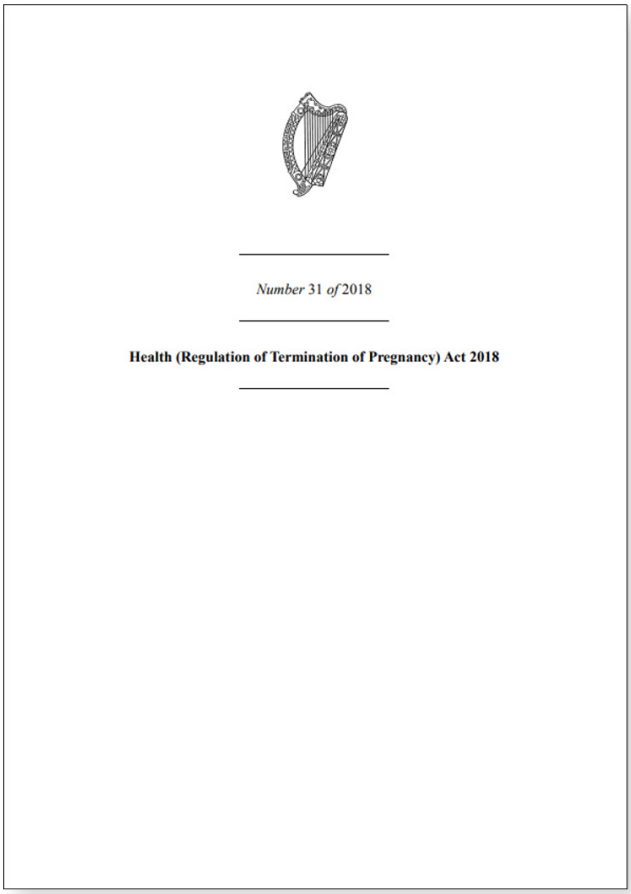
Over the past six years, the service has undergone significant development and advancement. This report outlines the breadth of this progress and the collective efforts that have strengthened service delivery nationwide.

NWIHP remains steadfast in its commitment to initiatives that enhance quality and safety across maternity services. I am proud of the substantial achievements realised across our maternity sites and of the strong collaboration demonstrated by service providers throughout this period. My colleagues have detailed many of these developments in the report, reflecting the shared commitment to continuous improvement. We will continue to work to support and further enhance the service, ensuring it remains an integral component of women's healthcare.

It is recognised that one in four pregnancies worldwide ends in a termination, making it one of the most common medical procedures experienced by women of reproductive age. Safe, high-quality termination of pregnancy care is therefore an essential element of the healthcare services we provide. As we look ahead, our focus turns to planning the next phase of termination of pregnancy services. The service will continue to evolve in response to changes within the health system and the needs of the population, with a sustained emphasis on evidence-based, equitable and woman-centred care.

TERMINATION OF PREGNANCY REGULATORY AND CLINICAL FRAMEWORK

This section provides an overview of the regulatory and guidance framework governing termination of pregnancy (TOP) services. It outlines the legislative context and the Clinical Guidance that underpin service delivery.



Number 31 *of* 2018

Health (Regulation of Termination of Pregnancy) Act 2018

1.1 Legislation overview

The Health (Regulation of Termination of Pregnancy) Act 2018 [1] was passed by the Houses of the Oireachtas on 13th December 2018 and signed into law by the President on 20th December 2018. It paved the way for the introduction of the service for termination of pregnancy from January 2019.

The legislation permits termination of pregnancy to be carried out in the following circumstances:

- Section 9 of the Act, where there is a risk to the life or of serious harm to the health of the pregnant woman;
- Section 10 of the Act, where there is a risk to life or health in an emergency situation;
- Section 11 of the Act, where there is a condition present which is likely to lead to the death of the fetus either before or within 28 days of birth; and
- Section 12 of the Act, without restriction up to 12 weeks of pregnancy.

1.2. Governance

In 2019, termination of pregnancy services were established under the Governance of the National Women and Infants Health Programme. In 2020, a Clinical Lead for Termination of Pregnancy was appointed following which a National Clinical Advisory Forum was established.

1 https://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/pdf

Between 2019 and 2025, governance arrangements for termination of pregnancy services were further strengthened through several key developments, including:

- the appointment of an NWIHP/ICGP Women's Health GP Lead;
- the appointment of Clinical Leads and a coordinator within each service;
- the establishment of a Service Improvement Group; and
- the establishment of a monthly peer-to-peer group.

Following the restructuring of the HSE into Regional Health Authorities (RHAs) in 2024, maternity units were reorganised in line with new regional RHA boundaries, supported by Regional Executive Officers (REOs) and Senior Management Teams. Existing clinical networks were retained, with adaptations for hospitals that were realigned to different RHAs. As termination of pregnancy services are now embedded within routine clinical practice, responsibility for service delivery rests with the RHAs.

NWIHP will continue to work closely with local and regional personnel to support the delivery of Termination of Pregnancy services and will provide strategic leadership, performance monitoring and quality oversight for Termination of Pregnancy Services nationally.

The National Contracts Office, together with National Primary Care Reimbursement Scheme, provides support in relation to contractual arrangements with General Practitioners, as independent contractors, for the delivery of termination of pregnancy services under Section 12 of the Health (Regulation of Termination of Pregnancy) Act 2018.

The My Options service, delivered through the HSE Sexual Health Programme, is responsible for providing information, support, and counselling to women experiencing an unplanned pregnancy.

The diagram below illustrates how these stakeholders work together:

Department of Health
Governing Body / Policy Maker

HSE
Ireland's public health and social care service.

PERFORMANCE DELIVERY / STRATEGIC PLANNING

National Women and Infants Health Programme

- National Clinical Lead for TOP
- NWIHP / ICGP Womens Health GP Lead

Responsible for defining priorities, goals, and long-term vision. Ensuring nationally consistant policies, processes, and implementing legislative requirements

OPERATIONAL MANAGEMENT

Regional Health Authority

HSE Sexual Health Programme
My Options

- Service Provider
- Clinical Lead
- Secondary Care
- TOP Coordinator
- Primary Care / Women's Health Clinics
- Contract Holders

Responsible for delivering termination of pregnancy services, Implementing internal controls, identifying, assessing, and mitigating risks, and ensuring operational compliance.

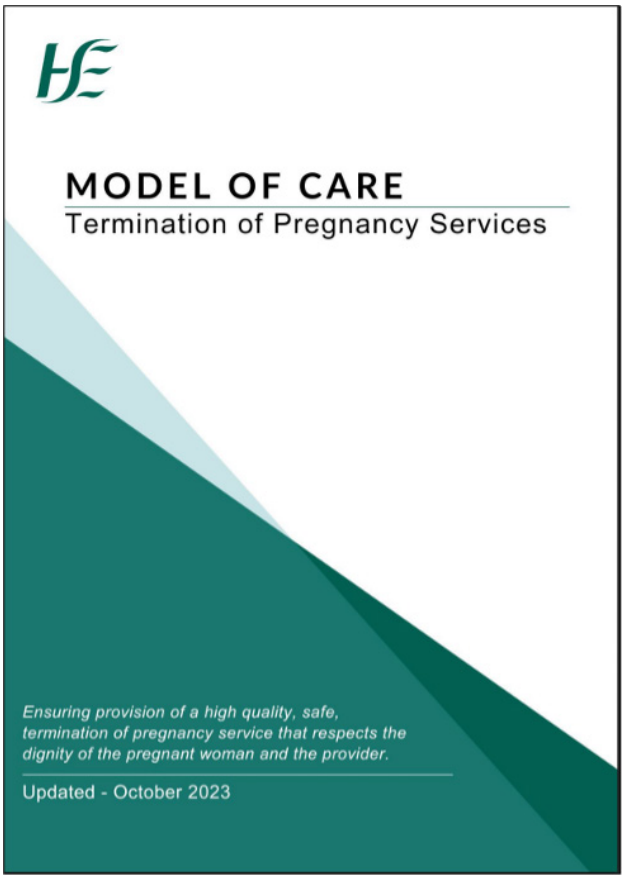
ADMINISTRATION

HSE Primary Care Reimbursement Scheme

HSE Contracts Office

Responsible for delivering termination of pregnancy services, Implementing internal controls, identifying, assessing, and mitigating risks, and ensuring operational compliance.

1.3 Model of Care



The Model of Care (MOC) for termination of pregnancy services came into effect in January 2019, following the enactment and commencement of the Health (Regulation of Termination of Pregnancy) Act 2018.

The initial Model of Care was revised during the COVID-19 public health emergency to allow for remote consultation. This enabled the service to continue while reducing the number of face-to–face consultations and minimising the risk to healthcare providers and patients.

In 2021, the Department of Health requested the HSE to revisit the Model of Care to review its operation and consider whether the blended Model of Care for termination of pregnancy services, should be retained as the enduring Model of Care for the service. The review concluded that incorporating remote consultation as part of the termination of pregnancy service is considered safe, effective and acceptable to both service users and providers.

In May 2022, the Chief Medical Officer (CMO) in the Department of Health requested that the Model of Care be revised to implement the use of remote consultation as per the findings of the review. The revised Model of Care for Termination of Pregnancy Services (2023) [2] was jointly approved by the HSE's Chief Clinical Officer and Minister for Health in 2023 and published on the HSE website.

1.4. Clinical Guidelines

The National Clinical Guidelines in Maternity & Gynaecology are a current programme of work agreed between the NWIHP, the Institute of Obstetricians and Gynaecologists (IOG) and the Royal College of Physicians of Ireland (RCPI) and established in 2021.

Prior to this, in 2018 and at the request of the Department of Health, the RCPI/IOG were asked to develop clinical guidance for termination of pregnancy services. A number of multidisciplinary working groups were convened to collate the evidence and develop a suite of clinical guidelines for healthcare providers with regard to termination of

2 https://about.hse.ie/hcp-publications/hcp-termination-of-pregnancy-services-model-of-care/

pregnancy. These included:

- Interim Clinical Guidance Termination of Pregnancy under 12 Weeks (2018)[3]
- Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy (2019)[4]
- Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed during Pregnancy: Termination of Pregnancy (2018, and updated in 2020)[5]

As part of the work of the National Clinical Guideline Programme Team (GPT), work is underway to develop new updated clinical guidelines for termination of pregnancy services.

The first guideline in this series was published in 2023. The National Clinical Guideline for the 'Investigation and Management of Complications of Early Termination of Pregnancy'[6]. The purpose of this Guideline was to develop and provide a comprehensive evidence-based guidance to improve the management of women who experience complications during or after early termination of pregnancy. This Guideline is intended for all healthcare professionals (including doctors, midwives and nurses), particularly those in both primary and secondary care services who are involved in the care of women who have undergone a termination of pregnancy. The focus of this Guideline is complications relating to early termination of pregnancy (Section 12 of the Health (Regulation of Termination of Pregnancy) Act 2018).

A Quick Summary Document [7] and a Plain Language Summary [8] was published to accompany the Guideline.

Other relevant guidelines commissioned and due for update by the GPT in 2026 include:

- Termination of Pregnancy for fetal anomaly (Section 11);
- Early termination of Pregnancy (Section 12);
- Perinatal Palliative Care.

3. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/IOG_National%20Clinical%20Guidelines_Interim%20Clinical%20Guidance%20Termination%20of%20Pregnancy%20Under%2012%20Weeks_2018.pdf
4. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/IOG_National%20Clinical%20Guidelines_Risk%20to%20Life%20or%20Health%20of%20Pregnant%20Woman%20in%20Termination%20of%20Pregnancy_2019.pdf
5. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/IOG_National%20Clinical%20Guidelines_Pathway%20for%20management%20of%20FFA%20andor%20life%20limiting%20conditions%20diagnosed%20during%20pregnancy_2020.pdf
6. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/2023/Full%20guidelines/IOG_NCG_Investigation%20Management%20Complications%20Early%20Termination%20of%20Pregnancy_2023.pdf?ver=mUxHFi9G4KVAgij_Ip7SGg%3d%3d
7. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/2023/Quick%20Summary%20documents/IOG_NCG_Investigation%20and%20Management%20of%20Complications%20of%20Early%20Termination%20of%20Pregnancy_QSD_2023.pdf
8. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/2023/Plain%20Language%20Document/IOG_NCG_Investigation_Management%20of%20Complications%20of%20Early%20Termination%20Pregnancy_PLS_2023.pdf

TERMINATION OF PREGNANCY SERVICE PROVISION

Termination of Pregnancy Services in Ireland are provided by:

- a GP that provides abortion services;
- Family Planning Clinics;
- Women's Health Clinics; and,
- Maternity Hospitals/Units

Where and how a termination of pregnancy service is provided is dependent on the gestation of the pregnancy.

Up to 9 weeks gestation

9 weeks of pregnancy means 69 days since the first day of the woman's last period (9 weeks + 6 days)

A medical termination of pregnancy can be provided at the following:

- GP surgery that provides abortion services
- Family planning clinic that provides abortion services
- Women's health clinic that provides abortion services
- A Maternity Hospital

10 to 12 weeks gestation

12 weeks of pregnancy means 84 days since the first day of the woman's last period (12 weeks + 0 days)

The hospital provides a termination of pregnancy via the following methods:

- Medical Termination
- Surgical Termination
- Surgical Termination via MVA

From 12 weeks gestation

Maternity units provide termination of pregnancy under Sections 9, 10 and 11 of the Health Act.

2.1. Service Access

Expanded termination of pregnancy services under the Health (Regulation of Termination of Pregnancy) Act 2018 were introduced with effect from 1st January 2019. It is Government policy that termination of pregnancy services provided under the 2018 Act should be available across all nineteen maternity hospitals nationally. This objective has now been achieved, with all nineteen maternity units providing termination of pregnancy services. In parallel, there has been a sustained increase in the number of General Practitioners participating in the provision of termination of pregnancy services in the community, further strengthening access and supporting a geographically distributed model of care.

The expansion of service provision has been supported and enabled through dedicated funding allocations. This investment has facilitated the recruitment of key personnel, including local clinical leads and service coordinators.

NWIHP would like to acknowledge and thank the Minister for Health, along with Department of Health colleagues in the Maternity and Gynaecology Policy Unit, the Women's Health Taskforce and the Bioethics Unit for their continued support, and sustained investment in the development and enhancement of termination of pregnancy services nationally.

Maternity unit service expansion

The below table demonstrates the progression/rollout of termination of pregnancy services across the nineteen maternity units:

Month	2019	2020	2021*	2022	2023	2024	2025
Medical Terminations	10/19	10/19	10/19	11/19	17/19	17/19	19/19
Surgical Terminations	5/19	5/19	5/19	5/19	6/19	7/19	8/19
Manual Vacuum Aspiration	1/19	1/19	2/19	2/19	3/19	3/19	5/19

Table 1

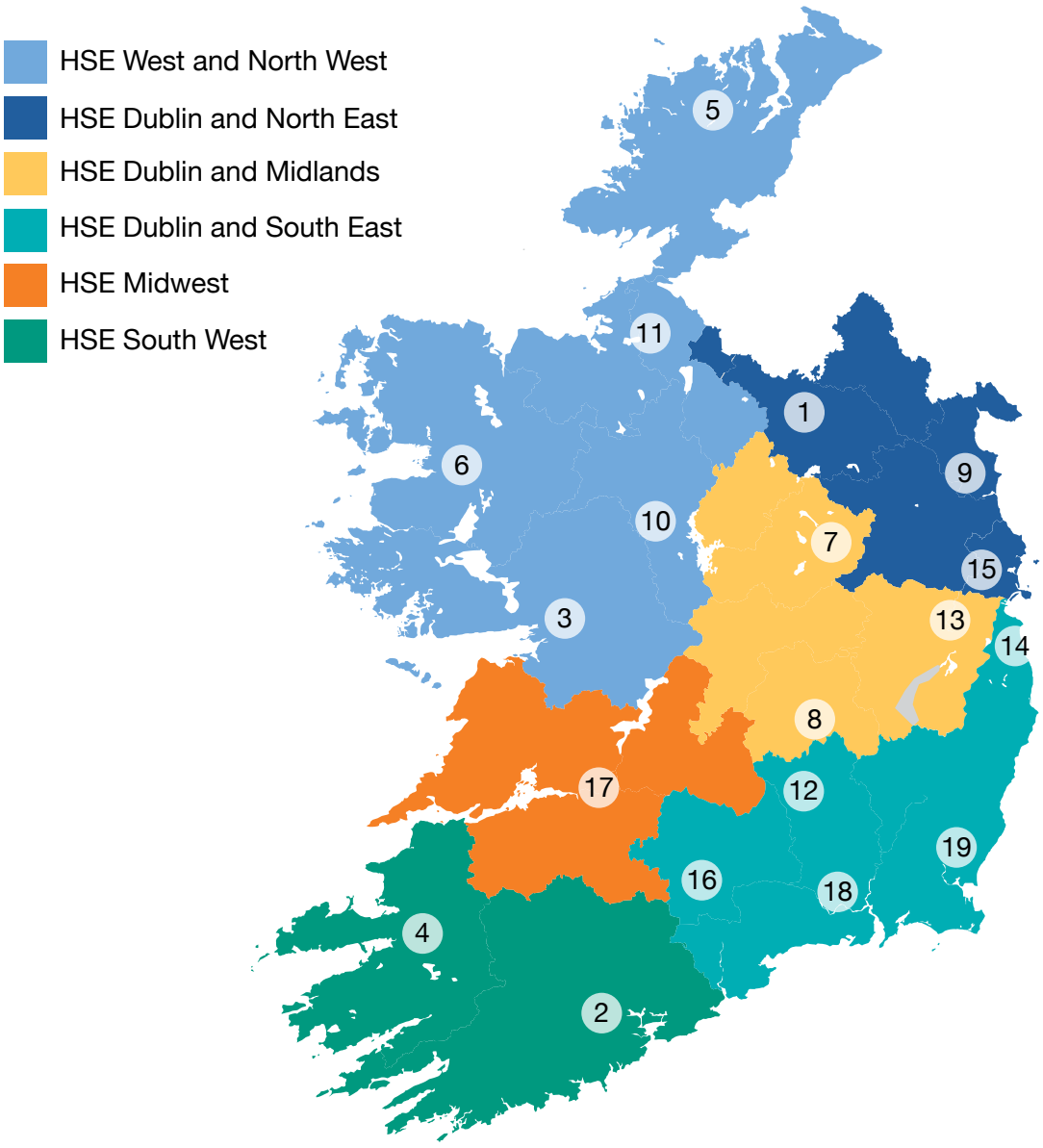
The table below illustrates current Termination of Pregnancy Service Provision across all nineteen maternity units. Including medical, surgical and manual vacuum aspiration, across the nineteen maternity units:

	Maternity Unit /Hospital	TOP Services Provided
1	Cavan General Hospital	Medical and Surgical
2	Cork University Maternity Hospital	Medical, Surgical and MVA
3	Galway University Hospital	Medical and Surgical
4	Kerry General Hospital	Medical
5	Letterkenny University Hospital	Medical
6	Mayo University Hospital	Medical, Surgical and MVA
7	Midlands Regional Hospital Mullingar	Medical
8	Midlands Regional Hospital Portlaoise	Medical
9	Our Lady of Lourdes Hospital Drogheda	Medical and Surgical
10	Portiuncula University Hospital	Medical and Surgical
11	Sligo General Hospital	Medical
12	St Luke's Hospital Kilkenny	Medical
13	The Coombe Hospital	Medical, Surgical and MVA
14	The National Maternity Hospital	Medical and Surgical
15	The Rotunda Hospital	Medical, Surgical and MVA
16	Tipperary General Hospital	Medical
17	University Maternity Hospital Limerick	Medical
18	Waterford University Hospital	Medical
19	Wexford General Hospital	Medical

Table 2 *the current spread of termination of pregnancy services*

All nineteen maternity services provide for surgical termination of pregnancy in an emergency. Difficulties experienced by the remaining ten sites in providing elective surgical terminations include theatre access and personnel.

The current geographical spread of the provision of these services can be seen in the map below:



1. Cavan General Hospital
2. Cork University Maternity Hospital
3. Galway University Hospital
4. Kerry General Hospital
5. Letterkenny University Hospital
6. Mayo University Hospital
7. Midlands Regional Hospital Mullingar
8. Midlands Regional Hospital Portlaoise
9. Our Lady of Lourdes Hospital Drogheda
10. Portiuncula University Hospital
11. Sligo General Hospital
12. St Luke's Hospital Kilkenny
13. The Coombe Hospital
14. The National Maternity Hospital
15. The Rotunda Hospital
16. Tipperary General Hospital
17. University Maternity Hospital Limerick
18. Waterford University Hospital
19. Wexford General Hospital

General Practice service expansion

The table below details the number of contract holders delivering termination of pregnancy services 2019-2025. As more than one GP may be associated with each contract, the total number of GPs providing this service is likely higher.

	2019	2020	2021	2022	2023	2024	2025
GP providers	281	329	342	368	401	430	483

As displayed in the table, there has been incremental increases in the numbers of primary care providers nationally. There is currently a reasonable geographic distribution of GPs offering termination of pregnancy services nationwide. Ensuring equitable access across the country, particularly in rural and underserved areas, continues to be a key priority.

The figures outlined in the table above relate specifically to those who hold a contract for provision of TOP services in primary care, however it is important to note that all GPs, including those who do not provide termination of pregnancy services (whether due to conscientious objection or other reasons), have a legal and ethical duty to ensure that a patient's access to care is not delayed.

2.2. Department of Health: Reports on Notifications in accordance with Section 20 of the Health Act.

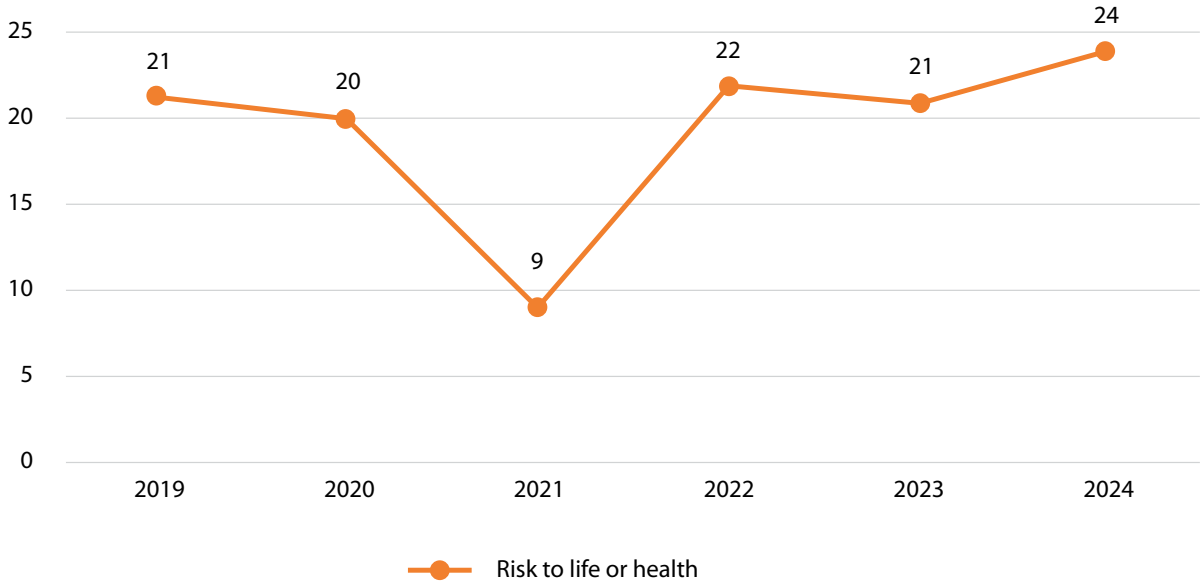
Section 20 of the Act of 2018 provides for a notification system[9] in relation to all terminations of pregnancy carried out under the legislation. Specifically, it requires that the Minister for Health be notified of each termination of pregnancy no later than 28 days after it has been carried out. It also requires the Minister to prepare a report on the notifications received during the immediately preceding year not later than 30th June in each year and to lay it before the Houses of the Oireachtas.

2.2.1.Terminations of pregnancy by section of the Act 2019-2024

The tables and visuals below set out information received by the Minister for Health, and published in the annual notifications reports, on the number of terminations carried out under each relevant section of the legislation, for the period 2019-2024.

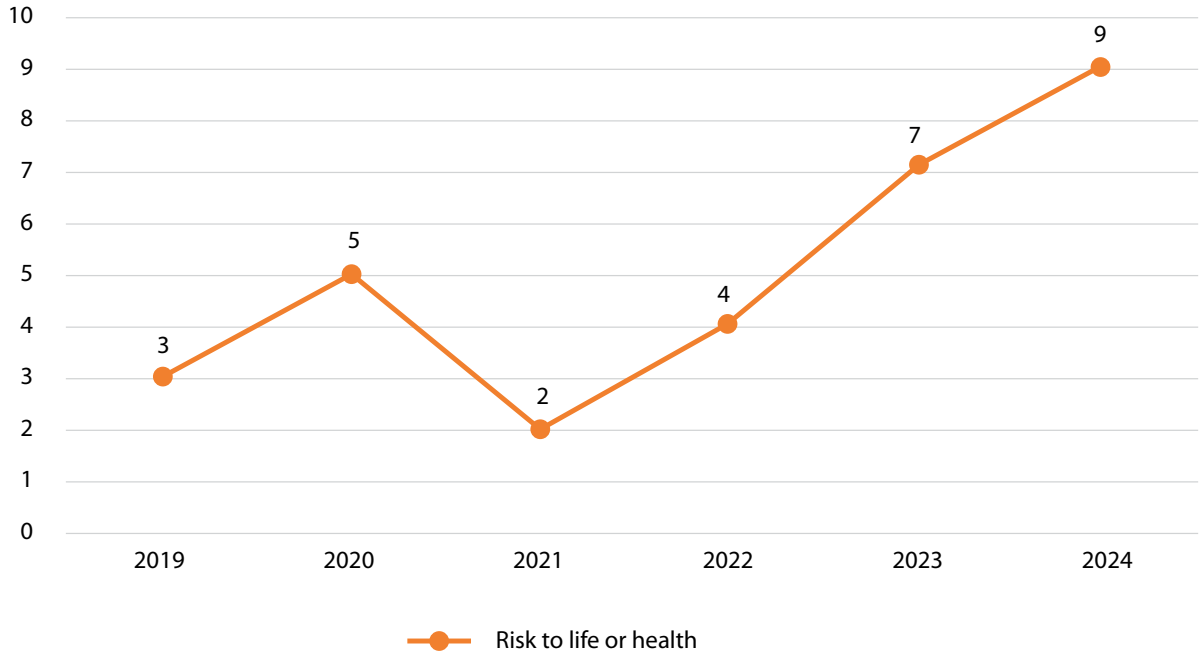
9. https://www.gov.ie/en/publications/?q=notifications&organisation=Department+of+Health

Section 9 Notifications 2019-2024.



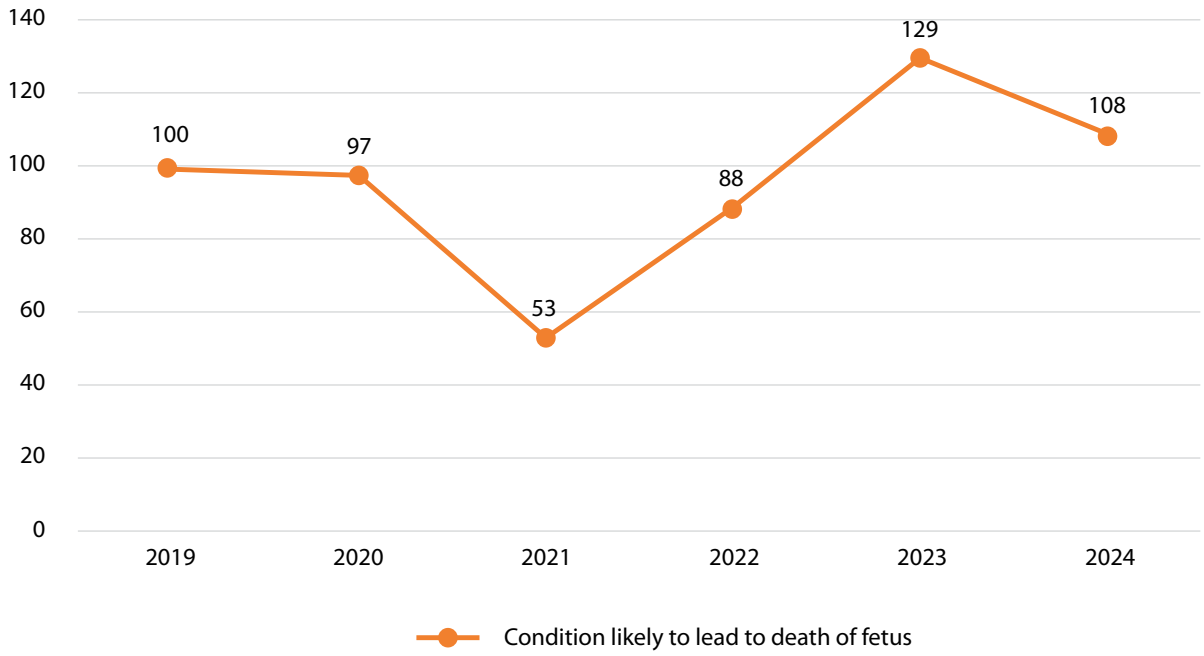
Source: Department of Health, Annual Notifications Reports

Section 10 Notifications 2019-2024.



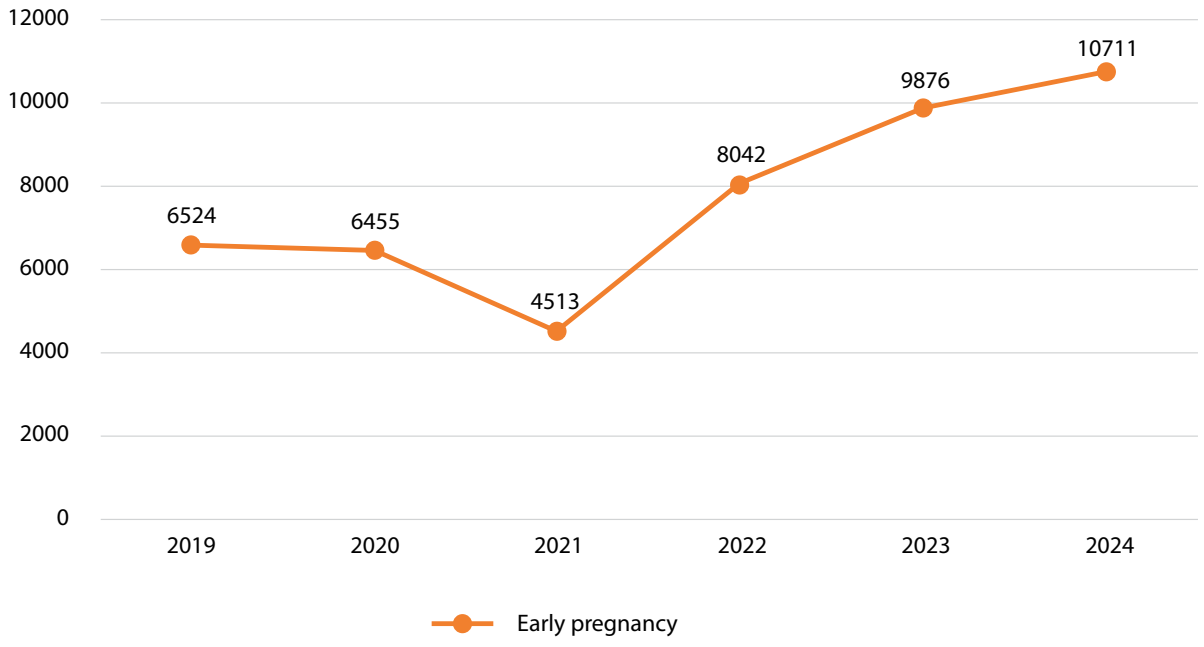
Source: Department of Health, Annual Notifications Reports

Section 11 Notifications 2019-2024



Source: Department of Health, Annual Notifications Reports

Section 12 Notifications 2019-2024



Source: Department of Health, Annual Notifications Reports

2.2.2. Terminations of pregnancy by month 2019-2024

The table and visual below sets out the number of terminations of pregnancy notified to the Minister for Health and published in the annual notifications report, by month in which the termination of pregnancy was carried out, for the period 2019-2024.

Month	2019	2020	2021*	2022	2023	2024	Total
January	625	709	628*	783	878	1056	4,679
February	490	552	493*	651	683	820	3,689
March	508	654	405*	751	874	873	4,065
April	538	639	289*	712	762	941	3,881
May	580	520	100*	597	902	967	3,666
June	533	510	103*	642	866	852	3,506
July	602	605	157*	487	866	952	3,669
August	530	516	142*	606	810	849	3,453
September	506	541	488*	706	836	857	3,934
October	545	490	521*	659	777	854	3,846
November	548	456	630*	749	804	904	4,091
December	592	327	559*	752	817	835	3,882
No date received	69	58	62*	61	158	92	500
Total	6,666	6,577	4,577*	8,156	10,033	10,852	46,861

Source: Department of Health, Annual Notifications Reports *Table 3*

Please note that the DOH published a Supplementary note[10] for the dataset collected in 2022. The overall notifications reported to the Minister for 2021* are substantially lower than observed in the first two annual reports. This precipitous fall in notifications coincides with the criminal cyber-attack on the HSE.

10. https://assets.gov.ie/static/documents/supplementary-note-to-be-read-in-conjunction-with-the-2021-annual-report.pdf

2.2.3.Terminations of pregnancy by county/place of residence 2019-2024

The table below sets out information on the number of terminations of pregnancy notified to the Minister and published in the annual notifications report, by the woman's county of residence, or place of residence (where the woman resides outside of the State), for the period 2019-2024.

County	2019	2020	2021	2022	2023	2024	Total
Carlow	74	56	46	54	89	80	399
Cavan	77	107	70	116	123	119	612
Clare	73	83	82	118	177	178	711
Cork	606	645	408	734	873	957	4,223
Donegal	127	128	90	169	249	285	1,048
Dublin	2,493	2,414	1,618	3,005	3,645	4,125	17,300
Galway	280	274	206	354	446	507	2,067
Kerry	48	110	103	189	254	262	966
Kildare	295	264	165	318	429	436	1,907
Kilkenny	96	83	64	131	134	166	674
Laois	79	60	46	107	129	140	561
Leitrim	27	28	22	48	47	49	221
Limerick	226	278	186	377	423	441	1,931
Longford	47	52	41	61	76	81	358
Louth	213	220	160	301	330	333	1,557
Mayo	111	105	83	124	179	218	820
Meath	252	240	169	270	317	359	1,607
Monaghan	36	54	46	57	47	78	318
Offaly	67	67	49	80	133	141	537
Roscommon	43	53	38	77	98	66	375
Sligo	59	60	54	88	104	140	505
Tipperary	174	161	128	226	240	245	1,174
Waterford	149	158	124	206	258	281	1,176
Westmeath	104	108	76	122	174	171	755
Wexford	165	159	147	203	236	258	1,168
Wicklow	138	141	145	151	245	266	1,086
Northern Ireland	67	36	5	12	9	8	137
Other	15	8	2	5	7	12	49
No place received	525	425	204	453	535	450	2,592
Total	6,666	6,577	4,557	8,156	10,033	10,852	46,841

Table 4 *number of terminations of pregnancy notified to the Minister and published in the annual notifications report*

The observed increase in the annual number and rate of terminations of pregnancy in Ireland, is mirrored in many developed countries, including England, Wales and Scotland, as documented in official government statistics [11, 12]. In England and Wales, the age-standardised abortion rate rose to its highest level on record in 2023, with 277,970 terminations reported, an 11% increase compared with 2022, and increases seen across all age groups. In Scotland, official termination statistics also show a 10% rise in the number of terminations in 2023 compared with 2022, with increases in rates among multiple age cohorts.

There is likely to be a range of inter-related factors behind these trends including: improved access to termination of pregnancy services, economic pressures such as the cost-of-living crisis and financial insecurity. Demographic shifts are also recognised as associated with changing patterns of terminations.

2.2.4. Requests for Review of Relevant Medical Opinion

Under Section 13 of the Health Act 2018, where a medical practitioner determines that a case does not meet the criteria for a lawful termination of pregnancy, a pregnant woman, or a person acting on her behalf, may make an application to the HSE for a independent review of the decision made.

Sections 14-17 of the Health Act 2018 calls for the establishment of review panel and a review committee in order to review the decision.

As per Section 18, the HSE prepares and submits to the Minister of Health a report not later than 30 June in each year, on the operation of reviews under this Part in the immediately preceding year. The Health (Regulation of Termination of Pregnancy) Act 2018, reports on Reviews are published on the Department of Health Website.

The governance and responsibility for conduct of formal clinical reviews of medical opinions, under Section 13 of the Health Regulation of Termination of Pregnancy Act 2018, formally transferred to the National Women and Infants Health Programme (NWIHP) in 2021. Prior to this, under the Protection of Life During Pregnancy Act 2013, the responsibility for the conduct of reviews, resided with the HSE's Quality Improvement Division.

A summary of Reviews 2019-2024 is provided below:

2019: 0 reviews

- There were no applications for a Review in 2019.

2020: 2 reviews.

- Both Reviews were sought under the circumstances referred to in Section (11) of the Act

One of the applications was found to have met the requirements for a termination of

11. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2023/abortion-statistics-commentary-england-and-wales-2023
12. https://publichealthscotland.scot/publications/termination-of-pregnancy-statistics/termination-of-pregnancy-statistics-year-ending-december-2025/

pregnancy and one did not meet the requirements

2021: 1 review.

- The Review was sought under the circumstances referred to in Section (11) of the Act
- The application was found to have met the requirements for a termination of pregnancy.

2022: 2 reviews (4 were received with 2 applications subsequently withdrawn).

- Both Reviews were sought under the circumstances referred to in Section (11) of the Act
- One of the applications was found to have met the requirements for a termination of pregnancy and one did not meet the requirements.

2023: 2 reviews.

- One Review was sought under the circumstances referred to in Section (9) of the Act.
- One Review was sought under the circumstances referred to in Section (11) of the Act.
- Both of the applications were found to have met the requirements for a termination of pregnancy.

2024: 3 reviews.

- All three reviews were sought under the circumstances referred to in Section (11) of the Act.
- One of the applications was found to have met the requirements for a termination of pregnancy and two did not meet the requirements.

2.3. HSE National Monitoring and Data Collection for Termination of Pregnancy (TOP) Services

Until recently, there was no formalised or systematic national mechanism for the monitoring and evaluation of termination of pregnancy services. Data collection was primarily undertaken through the aforementioned statutory notification process as required under the Act. While this process fulfilled legal reporting obligations, it did not provide a comprehensive framework for service evaluation, quality assurance, or workforce planning.

Following the findings and recommendations of two national reviews of termination of pregnancy services, the O'Shea Review and the Regan Review (Link to the section in this report - page 30), NWIHP, in partnership with the National Perinatal Epidemiology Centre (NPEC), developed a national electronic data collection system for termination of pregnancy services.

The system is initially focused on hospital-based termination of pregnancy services and is designed to support clinical governance, service planning, and continuous quality improvement.

The national dataset captures the following information:

- Patient demographics including age, obstetric history (e.g. previous pregnancies), contraception use, and previous termination of pregnancy;
- The relevant section of the Act under which the termination was carried out (e.g. Sections 9, 10, 11, or 12);
- Mode of termination of pregnancy;
- Gestational age at the time of the procedure;
- Post termination of pregnancy complications and related care;
- Hospital presentations following early medical abortion (EMA) provided in the community, or following a termination of pregnancy carried out outside the jurisdiction.

Importantly, the system does not collect any patient-identifiable information. All data are anonymised and managed in accordance with national data protection and governance standards.

A dedicated termination of pregnancy Data Governance Group (DGG) has been established to oversee the system and to ensure that data are appropriately collected, analysed and reported on.

Preliminary data have been reported from pilot sites and are presented below. It is important to note the following when interpreting these figures:

- The data represent a subset collected from fourteen sites providing termination of pregnancy services that participated in the pilot phase of the project;
- The dataset pertains exclusively to Hospital based termination of pregnancy carried out under Section 12 of the Act;
- The timeframe covered is May to December 2024;
- The metrics presented are intended to illustrate the type of information that will be collated and reported nationally and to demonstrate the functionality and capability of the system.

A programme of work is underway to ensure that all nineteen maternity units are represented within the national dataset. As national coverage expands and data completeness improves, additional metrics and analyses will be incorporated into future termination of pregnancy service reports. Work is also scheduled to commence in 2026 to explore the development of a similar national data collection framework for termination of pregnancy services delivered in primary care settings, with the aim of establishing a comprehensive, whole-system view of termination of pregnancy service provision.

2.3.1. Section 12 Hospital Metrics

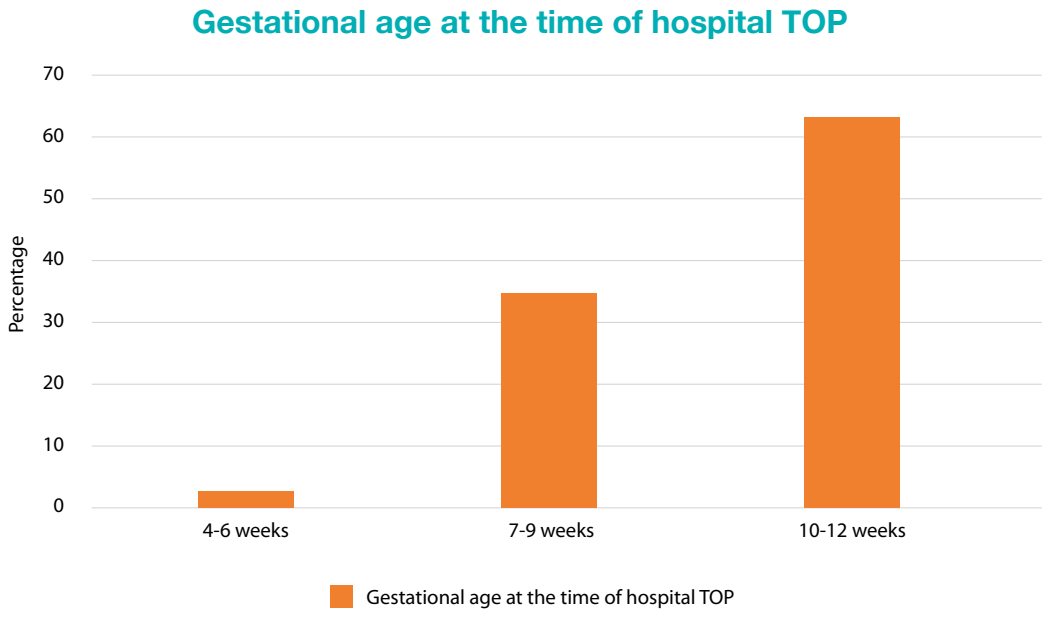
Fourteen of the country's nineteen maternity sites submitted data related to 305 women that underwent termination of pregnancy under section 12 in hospital during May-December 2024. Their clinical characteristics are detailed in the table below.

Clinical characteristic	Category	n (%)
Type of termination of pregnancy	Medical [1]	247 (81.0%)
	Surgical	58 (19.0%)
Gestational age at the time of hospital TOP [2]	4-6 weeks	7 (2.3%)
	7-9 weeks	107 (35.2%)
	10-12 weeks	190 (62.5%)
Days from GP referral to review in secondary care TOP services pre TOP [3]	0-2 days	104 (36.5%)
	3-5 days	133 (46.7%)
	6-8 days	40 (14.0%)
	9-24 days	8 (2.8%)

1. Includes 21 cases given Mifepristone in hospital and Misoprostol at home;
2. Not recorded for one case;
3. Not recorded for 20 cases.

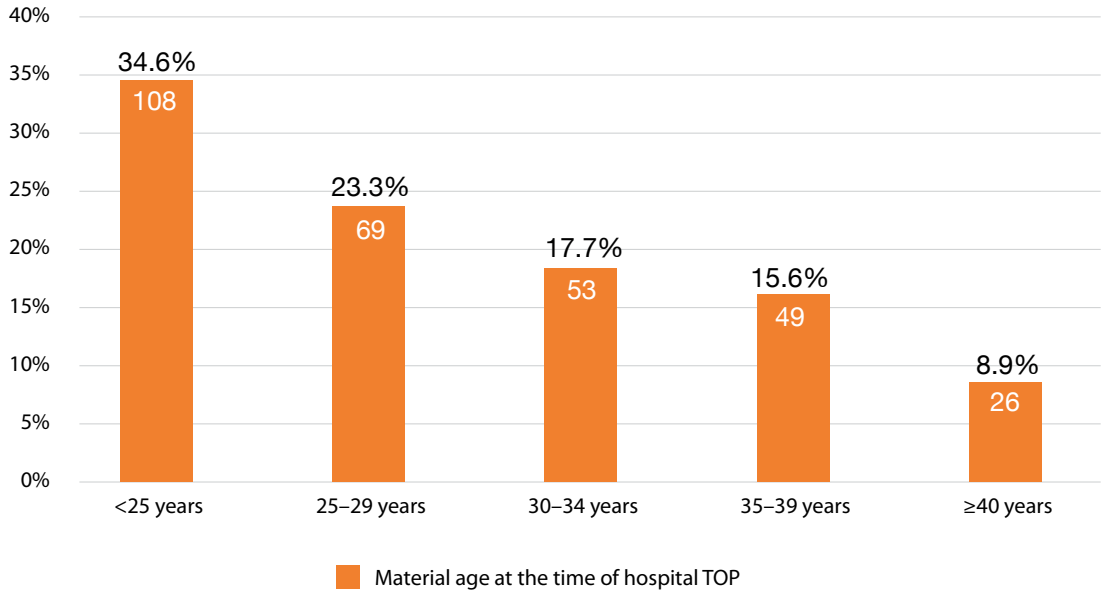
Table 5

The vast majority of the cases involved medical termination of pregnancy. Almost two thirds had a gestational age of 10-12 weeks at the time of the termination of pregnancy (illustrated in the chart below). The review in secondary care took place within five days of referral for 83% of the women and 16% presented with a pre-existing medical comorbidity.

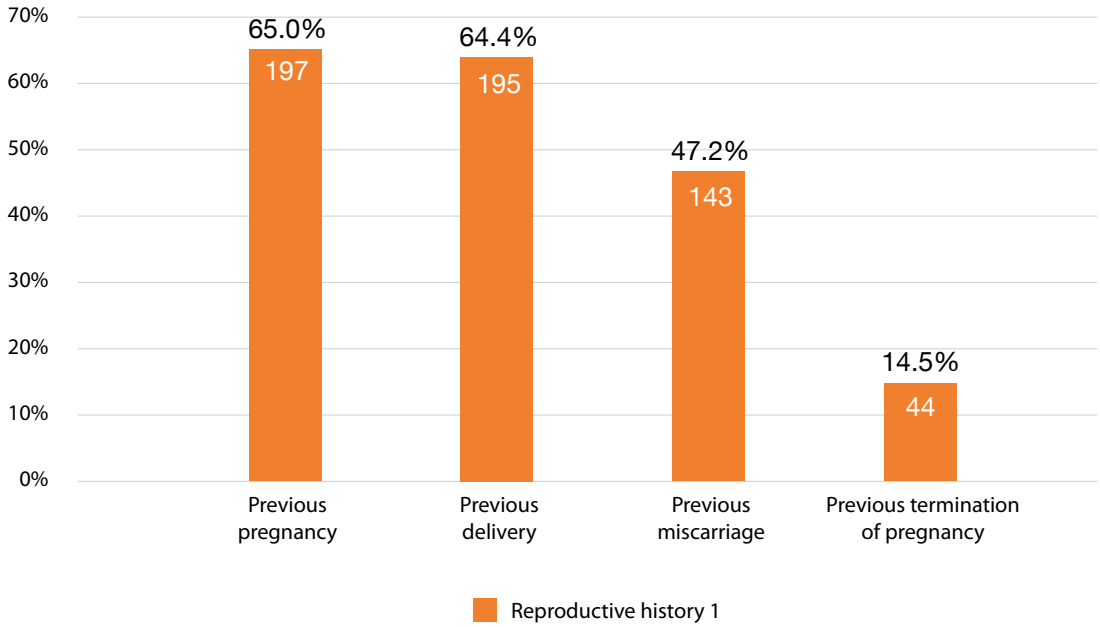


Most of the women were aged less than 30 years – 35% aged less than 25 years and 23% aged 25-29 years (detailed and illustrated in the table and chart below). Two thirds of the women had a previous pregnancy, and almost all of these women had given birth. Almost half of the women had experienced a previous miscarriage and 15% had a previous TOP.

Material age at the time of hospital TOP



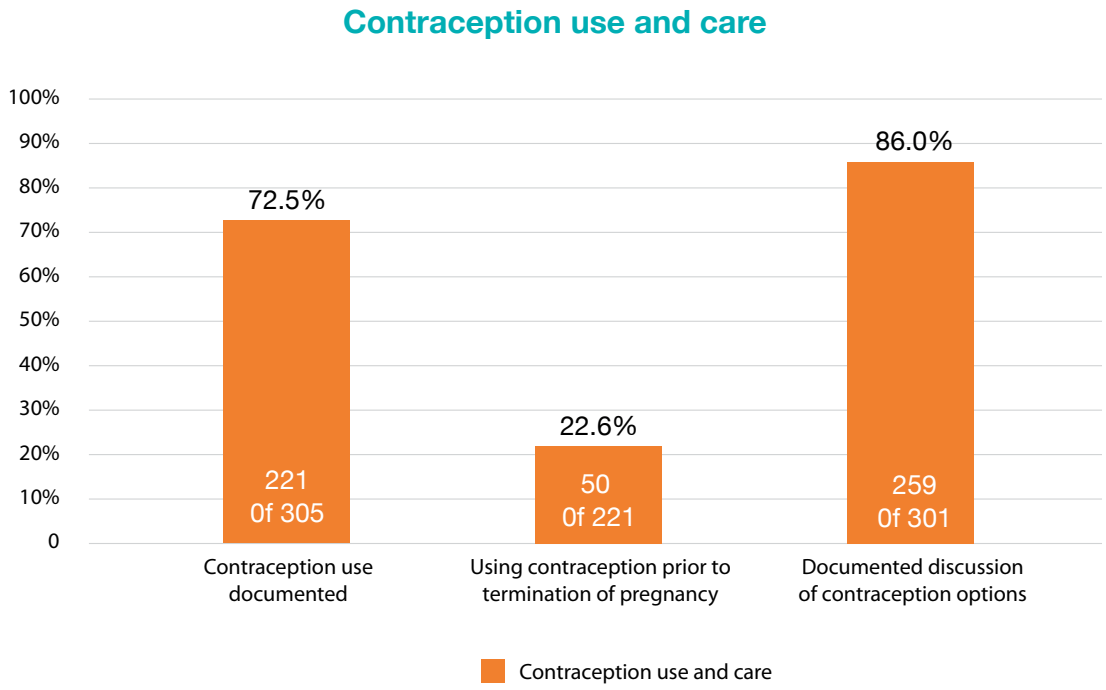
Reproductive history [1]



1 Not recorded for two cases

Contraception

Contraception use was documented for almost three quarters of the women, and of these women 23% had been using contraception prior to the termination of pregnancy. For almost 90% of all the women, it was documented that a discussion of contraception options took place.



Medical termination of pregnancy

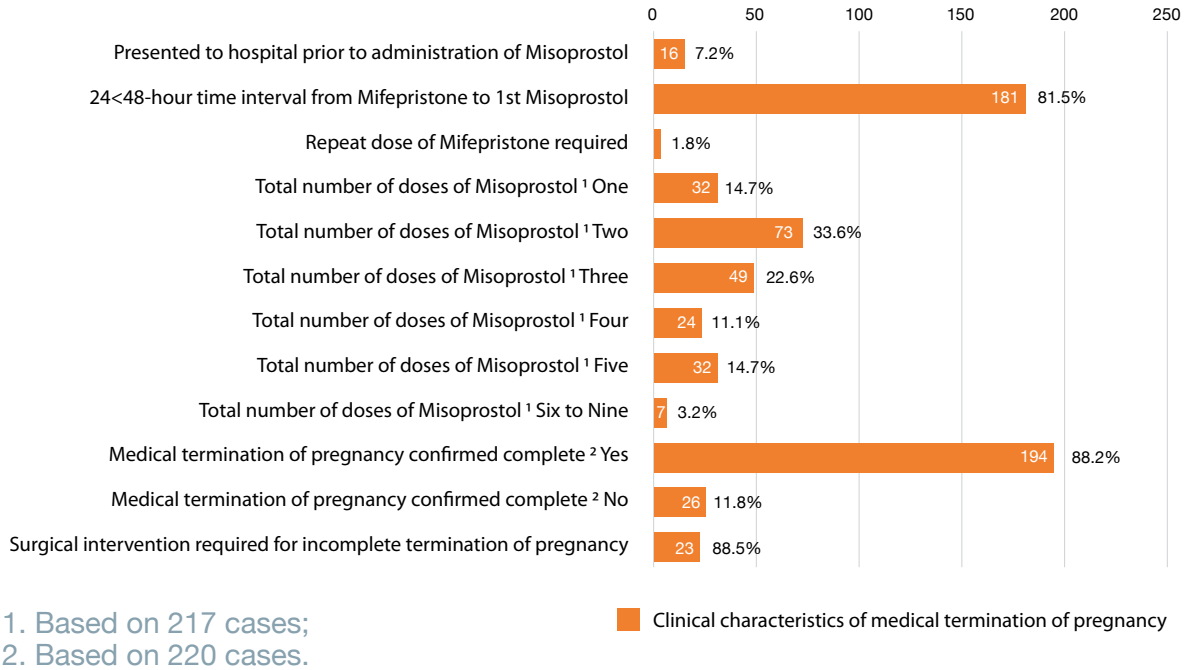
Among the 247 cases of medical termination of pregnancy, 21 involved the woman taking misoprostol at home (early medical abortion) following hospital review. Of the other 226 hospital cases, detailed information of the procedure was available for 222 cases (see table below).

In 7% of cases, the woman presented to hospital before administration of misoprostol. For the vast majority of cases, the time interval from administration of mifepristone to the first dose of misoprostol was between 24 and 48 hours. Very rarely was a repeat dose of mifepristone required for an unsuccessful medical termination of pregnancy. Fifteen percent of the women received a single dose of misoprostol and one third received two doses, while 29% received at least four doses.

In almost 90% of cases, the medical termination of pregnancy was confirmed as complete. Of the 26 incomplete cases, 23 required surgical intervention while the other three cases were managed medically.

The average time in hospital before termination was complete was 10.6 hours (based on 208 cases) and the average post-delivery time in hospital was 9.5 hours (based on 198 cases).

Clinical characteristics of medical termination of pregnancy



1. Based on 217 cases;
2. Based on 220 cases.

Surgical termination of pregnancy

Ninety percent of the 58 surgical termination of pregnancy cases were performed in theatre and the vast majority involved general anaesthetic, prophylactic antibiotics and electric vacuum aspiration. Almost all of the surgical termination of pregnancies were conducted by a consultant, used ultrasound guidance and had no acute complications.

The average time in hospital before termination was complete was 3.6 hours (based on 55 cases) and the average post-delivery time in hospital was 5.8 hours (based on 56 cases).

Clinical characteristics of surgical termination of pregnancy	Category	n (%)
Location	Theatre Outpatient clinic	52 (89.7%) 6 (10.3%)
Anaesthetic [1]	General Local	50 (89.3%) 6 (10.7%)
Prophylactic antibiotics [2]	Yes No	52 (91.2%) 5 (8.8%)
Surgical method [3]	Electric vacuum aspiration Manual vacuum aspiration Dilation and Curettage	48 (85.7%) 6 (10.7%) 2 (3.6%)

Clinical characteristics of surgical termination of pregnancy	Category	n (%)
Grade of operator	Consultant Specialist/Senior Registrar	55 (94.8%) 3 (5.2%)
Ultrasound guidance used	Yes No	55 (94.8%) 3 (5.2%)
Acute surgical complications	Yes No	2 (3.4%) 56 (96.6%)

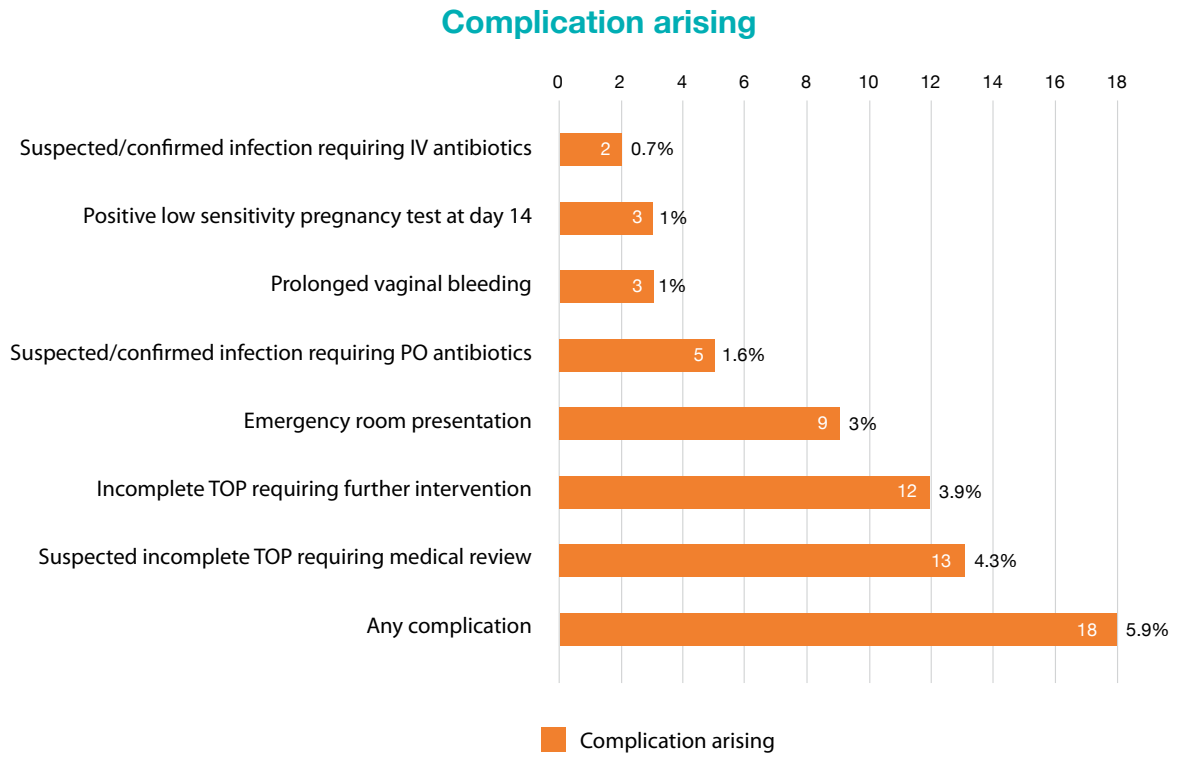
1.Not recorded for two cases;
2. Not recorded for one case;
3. Not recorded for two cases.

Table 6

Complications

Of the 305 Section 12 TOPs, the observed risk of complication arising within six weeks of discharge from hospital was 6% (n=18 cases) The complications experienced related to possible incomplete TOP, infection, and bleeding, and some women experienced multiple complications.

The table below summarises the types of complications observed. It is important to note that several cases involved more than one complication, therefore, the total number of complications reported does not correspond to the number of individual cases.



OPERATIONAL REVIEWS AND THE SERVICE IMPROVEMENT GROUP

Reviewing a newly established health service is essential to ensure it delivers safe, high-quality, and effective care. Most importantly, systematic review supports continuous improvement, enabling the service to evolve and better meet the needs of the population.

There have been two National reviews conducted to date with regards to termination of pregnancy in Ireland.

3.1. The Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018

Section 7 of the Act provides that a review of the operation of the Act be carried out by the Minister for Health no later than three years after service commencement. The Review commenced in 2022 and The Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018[12] was published in 2023.

The review produced a series of recommendations, some operational in nature and others proposing legislative change. The Legislative recommendations were referred to the Joint Committee on Health for consideration, while operational recommendations were forwarded to the HSE for implementation.

12. https://www.gov.ie/en/department-of-health/publications/the-independent-review-of-the-operation-of-the-health-regulation-of-termination-of-pregnancy-act-2018/

3.2. The Review of the Safety and Operation of Section 11 of the Health (Regulation of Termination of Pregnancy) Act 2018

This Review was commissioned by the CCO in 2022 to identify what is required to enhance provision of termination of pregnancy under Section 11, and the 'Review of the Safety and Operation of the Section 11 of the Health (Regulation of Termination of Pregnancy) Act 2018' was published in 2023

The review produced a series of recommendations on the structures and supports required to enhance termination of pregnancy services, as provided under Section 11 of the Health Regulation of Termination of Pregnancy Act 2018. The process for the implementation of these recommendations will be discussed later in this section.

3.3. National Termination of Pregnancy Service Improvement Group

Following the two Reviews outlined above, a National Termination of Pregnancy Service Improvement Group (SIG) was established. This multidisciplinary group, which includes clinicians, allied health professionals, service users, and advocacy groups, was established in January 2024 to support the implementation of the recommendations. A number of workstreams are being progressed under the remit of the Termination of Pregnancy Service Improvement Group. These include:

Early Pregnancy Workstream

Overview:

This work stream is chaired by Dr Deirdre Hayes-Ryan and Dr Caitriona Henchion and focuses on early pregnancy ultrasound, specifically the availability and accessibility of early pregnancy ultrasound scanning, referral pathways, quality of routine ultrasound, and a service evaluation of early pregnancy care. The aim is to establish the extent and nature of provision of early pregnancy ultrasound services and undertake an anonymised audit of ultrasound scans provided in maternity units as well as those provided by private contractors.

Key Developments:

A national audit was conducted which identified some inconsistencies in scan reporting across EPUs and private providers. In response, a standardised scan report template was introduced, now part of the National Clinical Guideline on First Trimester Miscarriage[13] which was published in 2025.

A broader EPU baseline audit conducted in 2025 assessed the resources and capacity in place across maternity units nationally in relation to early pregnancy care. The audit identified variations between services and highlighted the need for national minimum standards to support consistent and equitable care.

13. https://www.rcpi.ie/Portals/0/Document%20Repository/Institute%20of%20Obstetricians%20and%20Gynaecologists/National%20Clinical%20Guidelines/2025/Full%20Guidelines/IOG_HSE_NCPG_First%20Trimester%20Miscarriage_2025.pdf

Building on these findings, work is currently underway to develop national minimum standards for EPUs. This aims to ensure that all women have access to consistent services, equitable access to care and a uniform standard of care across EPUs nationally.

Section 12 Workstream – Management Pathways

Overview:

This workstream is Chaired by Dr Aoife Mullally and Dr Ciara McCarthy and focuses on reviewing and improving access to early pregnancy termination of pregnancy services under Section 12, strengthening care pathways between primary care and hospital services, enhancing opportunities for peer to peer support and professional engagement, expanding education and training, and updating relevant national clinical guidelines.

Key Developments

Service Access - When the Review of the Health (Regulation of Termination of Pregnancy) Act 2018 was commissioned in Q4 2021, only 10 of the 19 maternity units were providing termination of pregnancy services. Following sustained engagement at local, maternity network and regional levels, all 19 units now provide termination of pregnancy services nationally. In addition, the number of primary care contract holders delivering termination services has increased incrementally from 342 in 2021 to 483 in 2025. As more than one GP may be associated with each contract, the total number of GPs providing this service is likely higher.

Model of Care - In 2020, as part of public health measures introduced in response to COVID-19, the Department of Health and the Health Service Executive (HSE) established arrangements to enable remote provision of early pregnancy termination services. In September 2021, the Department requested the HSE's National Women and Infants Health Programme (NWIHP) to review the operation of the revised Model of Care. The review concluded that incorporating remote consultation is safe, effective and acceptable. In 2023, the revised model[14] of care was approved by the HSE and Department of Health as the enduring model of care for early pregnancy termination services.

While the Model of Care allows for remote consultation, in general, early medical termination of pregnancy is provided by in-person or a blend of in-person and remote consultation. Fully remote provision is not routine and is only provided in extenuating circumstances, using clinical judgement and putting appropriate safeguards in place.

Clinical Guidelines - Work is underway to update the National Clinical Guideline for Early Pregnancy Termination of Pregnancy. A writing group, led by the National Clinical Lead, is progressing this work with completion targeted for 2026.

14. https://about.hse.ie/hcp-publications/hcp-termination-of-pregnancy-services-model-of-care/

Surgical Termination of Pregnancy and MVA Workstream

Overview:

This workstream is Chaired by Dr Aoife Mullally and Dr Cliona Murphy focuses on expanding the availability of choice of method of termination in hospital settings, including Surgical Termination of Pregnancy (STOP) and manual vacuum aspiration (MVA).

Key Developments:

An audit of service provision, including the availability of choice of method of termination, has been carried out across relevant hospital sites. While there has been a modest increase in the number of sites providing STOP and MVA, some challenges do remain. Ability to provide STOP as a matter of choice, can often depend on availability of theatre space, trained staff and local service arrangements.

Training on techniques such as Manual Vacuum Aspiration (MVA) is ongoing. However, expanding the choice of termination methods across all sites will take considerable time as many units face competing demands on theatre availability, limited access to trained staff and the need to prioritise immediate clinical risks.

Prenatal Screening Workstream

Overview:

This workstream is Chaired by Prof Keelin O'Donoghue and Dr Emma McCann and focuses on the development of a comprehensive prenatal screening programme for aneuploidy. It will review published evidence, drawing on data from Ireland and relevant professional networks, to inform best practice. A stakeholder forum will be convened, incorporating patient and public involvement (PPI), ethical and legal representatives, interest groups, maternal–fetal medicine specialists, sonographers, and laboratory experts, to ensure broad consultation and guidance. An open public consultation will also be considered to gather input on proposed models of screening. In parallel, health economics analyses, costing assessments, and laboratory services input will be undertaken to evaluate the feasibility and sustainability of the proposed screening approaches. The workstream will culminate in the development of a full, evidence-informed proposal for the implementation of a national prenatal screening programme for aneuploidy.

Key Developments:

The National Review Group, established to examine and improve the safety and management of termination services under Section 11 of the Health (Regulation of Termination of Pregnancy) Act 2018, identified the need for a literature review to assess gaps in services and contextualise findings from the service evaluation. This review was conducted in late 2022 and updated in early 2023 using targeted keywords. It focused

on high-quality evidence, including systematic and scoping reviews, national audits, cohort studies, randomised controlled trials, clinical guidelines, and professional position statements. It also drew on guidance from key international bodies, including ISUOG, AIUM, RANZCOG, SOGC, NICE, NHS FASP, RCOG, BMUS, and FIGO.

The review covered: fetal anomaly screening (including aneuploidy screening, dating scans, and fetal anatomy ultrasound); fetal medicine and termination of pregnancy for fetal anomaly (TOPFA), including care pathways and neonatology; clinical genetics; investigation and follow-up (including perinatal pathology and bereavement care); and professional development.

Separately, to inform future service planning, a national prenatal screening survey was conducted in 2025. This market-sounding exercise examined public awareness, understanding, and attitudes towards non-invasive prenatal screening (NIPS) in Ireland. Its findings and recommendations will inform the development of public information materials and future proposals for consideration by the Department of Health and HSE leadership.

Fetal Medicine Workstream

Overview:

This workstream is Chaired by Prof. John Morrison and Prof. Keelin O'Donoghue and focuses on the development and standardisation of fetal medicine services across network and centre levels. It will establish a model of care, including agreed standards for staffing and skill mix, with clear guidance on referrals and procedural responsibilities. Standardised referral templates, pathways, and information resources will be developed and agreed to ensure consistency and quality of care. An annual audit and reporting framework will be implemented across all units, specifying responsibilities, scope, and reporting destinations. All relevant paperwork for Section 11 will be reviewed and updated, including multidisciplinary team (MDT) proformas, consent forms, and referral documentation. A guideline on termination for fetal anomaly will be developed, while collaboration with the Pregnancy Loss Research Group will support the development and review of termination of pregnancy for fetal anomaly (TOPFA) and relevant legislation information booklets. An agreed list of information sites and resources will be established, and a comprehensive assessment of existing fetal anomaly resources will be conducted to inform future development. Finally, standards for prenatal diagnosis of the most common and clinically significant treatable conditions will be considered and incorporated into the service framework.

Key Developments:

A Fetal Medicine Study Day featuring world-leading experts was hosted at University College Cork in September 2024. The event, which was attended by over two hundred delegates, was hosted by the Pregnancy Loss Research Group, in collaboration with the International Fetal Medicine & Surgery Society (IFMSS) and RCSI, with support from

the Health Research Board. The specialist information sessions included Termination of Pregnancy for Fetal Anomalies and a panel discussion of Legislation and Clinical Practice, Clinical Presentations and Complex Cases, Decision Making and Clinical Challenges closed out the event.

Under the leadership of the National Clinical Lead for National Clinical Guidelines (Obstetrics and Gynaecology), drafting of a new National Clinical Guideline on Termination of Pregnancy in cases of Fetal Anomaly, is underway. Concurrently, work is progressing on the development of a suite of patient information booklets addressing all aspects of pregnancy loss, including termination of pregnancy. This suite will include a dedicated booklet on Termination of Pregnancy for Fetal Anomaly.

These resources are being developed collaboratively by the NWIHP and the Pregnancy Loss Research Group (PLRG), with input from key stakeholders, including individuals with lived experience of Termination of Pregnancy for Fetal Anomaly, as well as healthcare professionals.

Audit and Data Collection Workstream

Overview:

This workstream is chaired by Dr Deirdre Hayes Ryan and Dr Caitriona Henchion and focuses on the development and implementation of a comprehensive data collection and audit mechanism across both primary and secondary care settings. The project will capture data on Termination of Pregnancy in Early pregnancy (Section 12); Termination of pregnancy where there present a condition likely to lead to death of the fetus (Section 11); Termination of pregnancy where there is a Risk to life or Health (Section 9); and Termination of pregnancy where there is a Risk to Life or Health in an emergency (Section 10). Initially focusing on Hospital services, Section 2.3.1, presented earlier in this report, provides an overview of provisional data relating to selected hospital metrics.

National data collection and reporting mechanisms are being co-designed with input from the National Perinatal Epidemiology Centre (NPEC), termination of pregnancy providers, fetal medicine specialists, and other relevant stakeholders to ensure methodological robustness and practical relevance.

In addition, this workstream will include a review of the current inclusion and reporting of termination of pregnancy within the National Perinatal Mortality Report and broader national audit frameworks, with a view to identifying opportunities to enhance reporting practices and optimise the use of collected data.

Key Developments:

Efforts to standardise data collection across all termination of pregnancy service sites continued through the implementation of a national electronic data collection system and a new termination of pregnancy Proforma. Several units began data entry, with

full national rollout expected in 2026.

A dedicated Data Governance Group was established in 2025 to oversee data quality and use.

Education and Training Workstream

Overview:

This workstream is Chaired by Ms Fiona Hanrahan and Dr Ciara McCarthy and focuses on the review and development of education and training related to pregnancy loss and termination of pregnancy in Ireland, in collaboration with the Pregnancy Loss Research Group (PLRG). The review will assess current education and training programmes, identifying gaps and opportunities for enhancement. Peer support and case discussion mechanisms will be explored, including the feasibility of regular group meetings or network-based sessions. A peer support platform will be developed to connect early pregnancy care teams across community and hospital settings, with a dedicated website to facilitate access. Additionally, collaboration with the RCPI Education & Training lead will support the development of a fetal medicine Higher Specialist Training (HST) course or workshop, ensuring standardised, high-quality training for clinical staff.

Key Developments:

In recognition of the need for a structured mechanism for information sharing, discussion, peer support, and collective advocacy among Termination of Pregnancy providers nationally, monthly peer-to-peer meetings have been established. These meetings are chaired by the National Clinical Lead for Termination of Pregnancy and bring together hospital-based clinical leads and midwife coordinators.

In addition, biannual multidisciplinary Termination of Pregnancy study days are facilitated by the Centre of Midwifery Education (CME). These include values clarification workshops and are delivered on a national basis. While the CME is based in the Coombe Hospital, it serves all three Dublin maternity hospitals and supports nationwide education initiatives. Since 2020, a total of 541 participants have attended these study days. The Irish College of General Practitioners also provides regular training for new early medical abortion (EMA) providers, along with refresher training sessions for existing practitioners.

HSE Workplace Policies (Conscientious Objection & Conscientious Provision) Workstream

Overview:

This workstream focuses on the review and analysis of frameworks governing conscientious objection within healthcare settings. It will include a scoping review of

national workplace policies, with particular attention to their application in healthcare environments, to identify existing practices and inform policy development. A review of relevant legislation will be undertaken to ensure alignment with statutory requirements and professional obligations. In addition, HSE documentation relating to interview protocols will be examined to support consistency, transparency, and good governance in the management of conscientious objection across the health service.

Key Developments:

Work is to commence in this workstream in 2026, in collaboration with external expertise.

Leadership Models and Health Systems Workstream

Overview:

This workstream focuses on the development and evaluation of leadership models and health system frameworks within early pregnancy and fetal medicine services. It will review the role of the multidisciplinary team meeting (MDTM) in termination of pregnancy for fetal anomaly (TOPFA) care, including consideration of a survey and assessment of current working arrangements in fetal medicine centres. The workstream will explore the working relationships between neonatology and fetal medicine teams to identify opportunities for enhanced collaboration and integration. The overarching aim is to support effective team leadership, peer support, research engagement, and the development of provider networks within abortion and early pregnancy care services.

Key Developments:

Work is to commence in this workstream in 2026.

Maternal Health and Section 9 Workstream

Overview:

This workstream focuses on maternal health in the context of Section 9 care. A guideline development group will be convened to produce a Clinical Practice Guideline for Section 9 termination of pregnancy. A working group(s), incorporating expertise from perinatal psychiatry and maternal–fetal medicine (MFM), will be established to provide clinical oversight and ensure multidisciplinary input. The workstream will also consider the development of a guideline addressing pre-viable preterm rupture of membranes (PRPOM), supporting evidence-based, standardised care for complex maternal health scenarios.

Key Developments:

Work is to commence in this workstream in 2026

REFLECTIONS FROM SERVICE PROVIDERS AND SERVICE USERS

As outlined in Section 1.2. the provision of termination of Pregnancy services involves multiple collaborators. The sections below reflect the experiences of collaborators who are members of the National Termination of Pregnancy Service Improvement Group in delivering termination of pregnancy services, as well as those who support families who have received a fatal or severe fetal diagnosis during pregnancy.

4.1. LMC Bereavement Support

LMC Bereavement Support (formally Leanbh Mo Chroi) is a Charity organisation who provide non-directive practical information, advice and support to anyone considering their options, including ending a pregnancy for a medical reason. It is run by peer supporters who have all received a fatal or severe diagnosis during pregnancy. We support parents from across the country in many different hospitals and with many different diagnoses so we get to hear a range of experiences. Some of our parents are able to access a TOPFA (termination of pregnancy for fetal anomoly) here in Ireland but many fall outside the legislation and have to travel abroad, mainly the UK, to access one.

From our parents' experiences, a few things stand out for them. On the positive side, those who were referred to the bereavement midwives or fetal medicine midwives in the hospital found them excellent to deal with and could not speak highly enough about the care they received with them. They appreciated that cold cots, coffins and urns were arranged without them having to think of any of it, although not everyone was offered this. Hand/foot prints were given where possible. For those that had follow on care, they were given a 6-week check-up and many were offered counselling. Referrals to geneticists and genetic counsellors were offered if the condition warranted. Nearly all said that for subsequent pregnancies they were offered extra scans and testing if needed which they found very reassuring.

While some families supported by LMC described compassionate and well-coordinated care, others experienced significant inconsistencies and failings in the information, support, and follow-up they received. These differing experiences highlight an important opportunity to strengthen and standardise care pathways so that all families, regardless of where they attend, can access the same high standard of support during what is already an exceptionally difficult and traumatic time.

A recurring theme was the variability in care both between hospitals and, at times, within the same hospital. Some parents were automatically connected with bereavement teams, provided with clear procedural information, and offered appropriate follow-up supports. Others described fragmented communication between healthcare providers,

no post-termination follow-up, no PHN involvement, and difficulties accessing mental health services. Long waiting times for psychological support and lack of follow on care further compounded distress for some families.

Communication and access to timely information emerge as key areas requiring continued focus. Some families experienced difficulties in receiving clear and compassionate counselling from the outset regarding the provisions of the TOP Act, including eligibility criteria, the Independent Review of Relevant Medical Decision process, and the supports available should they continue the pregnancy or not meet the criteria for a TOPFA in Ireland. Ensuring that all families are fully informed of their options and available supports would help them feel more supported and confident in their decision-making.

Families identified the lack of preparation for the practical and emotional realities that follow diagnosis and termination and emphasised the need for comprehensive guidance around labour, postnatal recovery, autopsy discussions, and what to expect physically and emotionally following a termination, particularly those experiencing a first pregnancy and delivery. Some families felt that automatic referral pathways to mental health supports following diagnosis would provide an important layer of early intervention and ongoing care.

The physical hospital environment was another area identified for improvement. Many parents described the distress of spending time in shared maternity settings alongside expectant families and newborn babies during admissions, scans, while delivering their babies and after birth. Consideration of quieter pathways through hospitals, including alternative entrances or access to more private spaces where possible, could help reduce additional emotional stress at an already vulnerable time.

Many families spoke very positively about the care they received and described healthcare professionals who provided empathetic, person-centred support during an incredibly difficult period. However, for those that did not have a positive experience, introducing consistent and standardised pathways, checklists, and multidisciplinary supports for families receiving a life-limiting or complex diagnosis in pregnancy and strengthening coordination and communication between hospital services, GPs, and community supports is essential to improve continuity of care. This will ensure that every family receives timely information, compassionate communication, coordinated aftercare, and equitable access to emotional and practical supports, regardless of where they access care.

4.2. Irish Family Planning Association (IFPA)

On January 1st, 2019, the IFPA commenced providing abortion services. We set up a client-centred service that incorporates information provision, medical consultation and the offer of specialist counselling to any person who wishes to avail of it. As expected with a relatively new service, uptake has increased year on year, in line with

the growth in access to this service nationally since its introduction.

Since the beginning we have focused on strengthening our staff's ability to deliver high-quality, client-centred care. The World Health Organisation delivered values clarification training to all IFPA staff.

We recognised the importance of our administrative team as the first point of contact for service users. Today, clients frequently commend our reception team for providing helpful information in a clear and friendly manner, with many highlighting the importance of the first interaction in allaying their concerns or fears. The reception team's understanding of the model of care—the critical gestational limits for access to abortion and requirement for hospital referral—is essential to the safe operation of the service. Their empathy and kindness are instrumental in creating a welcoming and destigmatised service for all. A 2023 redesign of our clinic waiting rooms to create spaces which promote reproductive autonomy and rights has further enhanced clients' experience of care.

Since January 2019, the IFPA has trained several doctors in abortion provision who are now providing abortion care in general practice settings in Dublin and beyond. Our midwifery team also play a crucial role in supporting women who have concerns or complications following abortion or who need additional follow-up.

Our specialist pregnancy counselling service evolved considerably following the introduction of legal abortion services. The need for counselling among clients from migrant communities is reflected in the significant increase in requests for interpreters. Our counselling service is now more focused on people in exceptionally difficult circumstances, whether for medical, personal, financial or societal reasons. Indeed, clients frequently refer to financial insecurity as a factor in their decision not to parent.

While most clients who present seeking abortion can access care, some fall outside the eligibility criteria of the legislation –leaving them no option but to parent against their wishes or seek services outside Ireland.

Our counsellors provide assistance with navigating alternative pathways to care, which can involve intensive engagement and collaboration with other agencies to overcome the financial, logistical and procedural barriers which are particularly onerous on people who have disabilities, migrant women, young people and those in strained economic circumstances.

A continuing barrier to providing the highest attainable standard of abortion care is the mandatory waiting period. In 2021 the IFPA began conducting an annual analysis of anonymised abortion service data. Our four-year data set (2021-24) show a consistent finding: 98% of IFPA clients who were subjected to the imposed delay of a mandatory waiting period proceeded to have an abortion. Our data insights are in line with the views and experiences of leading medical experts, and of the World Health Organisation, that an enforced waiting period before abortion care is unjustifiable,

demeaning and patronising. There is nothing in our data to indicate that the enforced three-day wait influences decisions about pregnancy.

In conclusion, abortion care is fully embedded within the IFPA's services. The integration of the service into primary care settings has led to significant normalisation of abortion and reduction of stigma. It is notable now that people seeking abortion are more likely to have support in their family and friends, compared to pre-legalisation.

4.3. Dublin Well Woman Centre

In May 2018 the Irish electorate voted by referendum to allow for the introduction of safe and legal abortion services. The resulting Health (Regulation of Termination of Pregnancy) Act, 2018 came into effect on January 1st 2019.

The Autumn of 2018 saw hospital and community-based healthcare professionals along with Dept of Health and HSE officials develop a Model of Care to establish guidelines for a service never before available in the country.

The Dublin Well Woman Centre has long been an advocate for women's reproductive rights. Over the years we have provided pre and post counselling services and post abortion medical check-ups for women who accessed abortion services outside Ireland. Legalising abortion under twelve weeks of pregnancy and providing the vast majority of these abortions in the community has made an enormous difference.

We are able to provide this service free of charge to the woman. There is a requirement for two consultations at least three days apart but then she can take the medication in her own setting and have easy access to any medical follow up she may need. Hospital referral is not required if the pregnancy is under nine weeks. There are very few medical conditions that require referral but these are screened for at the initial assessment.

A follow up telephone call is made two weeks later to ensure that the woman has no lasting side effects from the medication and her low sensitivity pregnancy test is negative. She may already have discussed contraception during her Early Medical Abortion (EMA) consults but if not, arrangements can be made for a further consult if she wishes.

During the introduction of the service in 2019 we referred almost all women for a dating scan. Review of the results showed that women were accurately dating their pregnancy so referrals for scans were reserved for cases where there was uncertainty around dates. This coincided with a change to the initial haematology requirement to test everyone over 7 weeks gestation for Rhesus status.

At the time of setting up the Model of Care the consensus amongst the Haematologists consulted was that any woman who was Rhesus negative and over seven weeks pregnant would need an anti D shot to avoid possible rhesus issues in future

pregnancies. This requirement was dropped when the guidelines internationally were changed but initially we were taking bloods on anyone potentially over 7 weeks of pregnancy, sending the samples to the nearest maternity hospital and referring women for anti D vaccine to that hospital within 48 hours of the abortion.

The Covid pandemic saw in person medical services of all kinds reduced where possible. This led to another change in the Model of Care to allow the consultations to be done by telephone instead of clinic visits. Post pandemic we reverted to all second appointments being in the clinic but the woman can choose to have the first consult either in clinic or by telephone. Supporting documentation advice and information is emailed to her.

Three quarters of EMA services are taken up by women who give a Dublin address and surrounding counties account for most of the remainder. However, we have seen women from every county in Ireland.

The service has become more streamlined since it started. No blood tests are needed, referrals for scans are usually not necessary, and when they are the patient is seen and the scan report received within three days, the majority of abortions happen in the community with hospital referrals rare. Communication with the hospitals is straightforward.

Women still have access to our counselling services where needed. We provide information on all forms of contraception during the EMA consults or at a third follow up consult if preferred. The offer of contraception advice is always there and the majority of women availing of the EMA service are eligible for the Free Contraception Scheme should they wish to avail of it at a later date.

4.4. HSE Sexual Health Programme

Unplanned pregnancy counselling and supports

Following the introduction of termination of pregnancy services, the My Options service was established in 2019. It is funded by the HSE Sexual Health Programme (SHP). My Options is accessible through a free dedicated phone line and web chat service operating for anyone affected by an unplanned pregnancy. It provides contact information for GPs that provide abortion services; offers counselling and listening support; signposts to services; and provides a 24/7 nursing service for women during or after an abortion.

The My Options helpline has received approximately 70,000 calls since its establishment. In 2024, there were 11,767 calls to the My Options helpline. Of those: 10,364 calls related to information seeking on termination of pregnancy services; 1,671 calls provided listening support; 2,774 calls were directed to a Nursing Line

which provides medical advice on termination of pregnancy and 80 counselling calls were made.

A percentage breakdown of these calls can be seen in the chart below.

My Options leaflets and posters are available to order or download in various languages at healthpromotion.ie

The My Options service Freephone helpline is 1800 828 010; Web chat is available at myoptions.ie

In 2024 both the HSE National Women and Infants Health programme and the HSE SHP collaborated with HSE funded Crisis Pregnancy Counselling services to establish if community-based counselling services could be extended to address current unmet and emerging health needs of women. The planning phase commenced for counselling services to extend their remit to other areas including long term infertility, complex menopause and recurrent miscarriage. It is envisaged that the referral pathways established will widen the availability of more comprehensive, integrated women's health supports in the community as outlined in the new National Sexual Health Strategy[15].

15. https://www.gov.ie/en/healthy-ireland/policy-information/national-sexual-health-strategy-2025-2035/

4.5. Irish College of GPs

The Irish College of GPs is committed to the provision of comprehensive, patient-centred women's healthcare. We aim to support our GP members in this regard through the provision of evidence-based, accessible education which is responsive to the changing health needs of women across the life course.

Following the repeal of the Eighth Amendment to the Constitution, the Health (Regulation of Termination of Pregnancy) Act 2018 was enacted on January 1st 2019. Section 12 of this Act allows for termination of pregnancy provided a doctor can certify that in good faith the pregnancy in question is less than 12 weeks gestation.

To operationalise the Act, the HSE commissioned and published a Model of Care for Termination of Pregnancy services. This allows for abortions of up to ten weeks gestation to be managed primarily in general practice via early medical abortion (EMA). This represented a significant shift in the scope of care delivered to that date by GPs and required the rapid rollout of guidance to support early adopting GPs who planned to provide the service from January 2019. To fulfil this need, the Irish College of GPs published interim guidance in December 2018, demonstrating the ability of the College and general practice to respond and adapt rapidly to major legislative and clinical change.

At an individual level, GP providers had to incorporate new clinical pathways and governance into their existing structures in a short period of time. Care is provided via a three-consultation model, which includes eligibility assessment, informed consent, provision of early medical abortion, follow-up and delivery of post-abortion contraception. Embedding this wraparound care within routine general practice provides for timely access to care, reduces travelling time for women, and reduces the stigma associated with accessing abortion care through dedicated abortion clinics.

Since 2019, the EMA service provided in general practice has expanded and evolved. The number of GP contract holders has increased to over 480, with two or more GPs often providing EMA under a single contract. The increased numbers of practices offering EMA has ensured more thorough geographic coverage, albeit not uniformly so.

The COVID-19 pandemic required many areas of healthcare to rapidly adapt, and EMA care was no different. The Model of Care was revised to allow increased use of virtual consultations, which was necessary to ensure access to abortion care for many women. This 'blended' approach, a combination of virtual and in person visits, has been proven to be safe and effective while also acceptable to women, and in 2023 the Model of Care was formally updated to retain this facility.

GP EMA provision is supported via established referral pathways to other services. Women can be referred for non-directive crisis pregnancy and post abortion counselling through the My Options helpline. Clear referral pathways for dating ultrasound have been established, as well as strong links with obstetric/gynaecology colleagues to

facilitate the shared care of women who are unsuitable for community EMA, or who require a higher level of follow-up care.

The Irish College of GPs respects the right to conscientious objection for its members. It also recognises that a spectrum of opinion exists among GPs with regards to abortion care, ranging from conscientious provision to conscientious objection. This is acknowledged along with Medical Council obligations regarding facilitating timely transfer of care. Bearing this in mind, and to support all GPs regardless of their personal position on abortion, the College has developed two separate clinical support documents. The first is a comprehensive document to support GP providers, which evolved from the initial interim support document, and was most recently amended in 2025. The second document is a higher-level overview for non-providing GPs, which focuses on key clinical and ethical areas relating to abortion care in Ireland.

The College have also developed and delivered regular in-person training and updates for new and existing GP EMA providers respectively. These have been comprehensively delivered by the College's network of EMA trainers, providing not only evidence-based clinical information, but important opportunities for reflective practice and peer support.

As with any clinical service, a number of challenges remain, many of which were highlighted in the 2023 O'Shea Report. There are some regional variations in the geographic spread of GP providers, disproportionately affecting women in rural areas. Women from migrant and other disadvantaged communities may also face specific barriers in accessing abortion care. Some GP EMA providers have had protests staged outside their premises, which is not only distressing for the practice staff but may deter women from seeking abortion care or other healthcare services. It is positive that all nineteen maternity units are now providing medical abortion services, but access to surgical abortion and manual vacuum aspiration remains limited in many areas. The development and expansion of these services will create greater choice for women, especially those whose personal circumstances may render them unsuitable for community EMA.

Despite the remaining challenges, abortion care in Ireland has progressed significantly since 2019. GP delivered EMA has been shown to be timely, effective, safe and acceptable to patients and practice staff. It provides for continuity of care in an accessible and patient centred way. Dedicated, resourced data collection at primary care level, in addition to research focussed on EMA in Irish general practice will promote further service improvement. Ongoing provision of education and peer support for GP providers through the Irish College of GPs will be key to ensuring that community based early medical abortion services continue to deliver high-quality, sustainable care, and continue to evolve with changing national and international guidance.

4.6. Secondary Care Provider

Reflection on Termination of Pregnancy Services in Secondary Care in Ireland

The enactment of the Health (Regulation of Termination of Pregnancy) Act 2018 represented a significant milestone in Irish reproductive healthcare. Since the initiation of termination of pregnancy services in secondary care in January 2019, the service has evolved over seven years from one delivered in a context of significant stigma into an integral and routine aspect of obstetric and gynaecological practice.

A key strength of the Irish model has been the early establishment of robust clinical governance structures. National clinical guidance developed by the Institute of Obstetricians and Gynaecologists and the Royal College of Physicians of Ireland, further strengthened by the National Women and Infants Health Programme, has ensured consistency, safety, and adherence to best practice from the outset. This has been complemented by values clarification training supported by the World Health Organization, which has played, and continues to play, a crucial role in preparing healthcare professionals to deliver care in a compassionate, respectful, and non-judgemental manner.

The integration of community and hospital services has been particularly impactful. The national My Options service provides a centralised access point for information and referral, while strong collaboration with general practitioners has led to a steady increase in community providers. Regular GP training, peer support networks, and ongoing engagement have strengthened this interface, ensuring continuity of care for women across settings.

Within secondary care, service delivery has benefited from strong multidisciplinary collaboration and sustained investment in training. Ongoing professional development, supported by the Centre of Nursing and Midwifery Education, alongside structured in-hospital training involving all stakeholders, has enhanced provider competence and confidence, contributing to the development of a sustainable and skilled workforce. The inclusion of NCHDs, GP trainees and medical students in TOP care, now increasingly embedded within undergraduate and postgraduate curricula, reflects the normalisation of abortion care as a core component of reproductive health practice.

The expansion of supportive services has further strengthened the overall provision of care. Administrative teams, clerical staff, and essential hospital support personnel play a critical role in coordinating patient pathways and ensuring the efficient and seamless delivery of the service. Within secondary care, the multidisciplinary team is central to service delivery and includes consultant obstetricians and gynaecologists, the TOP service coordinator, nursing and midwifery staff, ambulatory gynaecology teams, sonographers, and early pregnancy unit staff. Gynaecology ward teams, theatre personnel (including anaesthetists, theatre nurses, and porters), and pharmacists also contribute significantly to safe and effective are delivery. In addition, counselling

and social support services, alongside bereavement and perinatal mental health midwives, provide essential psychological and emotional support to patients and families. Laboratory and mortuary services also play an important role in supporting safe clinical pathways, particularly in cases of fatal foetal anomalies.

Efforts to improve accessibility for migrant communities, including the provision of interpreting services, reflect an increasing commitment to equity in care delivery. Women now have increasing choice between medical and surgical management pathways within secondary care, including manual vacuum aspiration under either local or general anaesthesia. Additionally, the introduction of free contraception services represents an important complementary public health measure, supporting reproductive autonomy and contributing to the reduction of unintended pregnancies.

Collaboration between secondary and tertiary care has also been a critical component of safe and high-quality TOP services, particularly in the context of fatal foetal anomalies and complex maternal medical conditions. In such cases, clear referral pathways and close multidisciplinary communication between secondary maternity units and tertiary foetal medicine and maternal medicine services ensure timely assessment, diagnostic confirmation, and coordinated decision-making. This integrated approach supports comprehensive counselling for women and families and facilitates appropriate planning for both medical and surgical management in complex clinical scenarios, while ensuring psychological and bereavement supports are in place. Overall, this collaboration has strengthened continuity of care across the healthcare system.

Despite these advances, several challenges remain. The mandatory 72-hour waiting period and the legal gestational limit of 12 weeks for abortion on request continue to present practical and ethical complexities, particularly in time-sensitive cases. Operational challenges such as ensuring consistent weekend service provision persist, highlighting the need for ongoing service development and resource allocation.

Overall, since 2019, TOP services in Ireland have undergone significant evolution. There has been an increase in the number of maternity units providing care, alongside a growing cohort of providers skilled in surgical TOP and manual vacuum aspiration. What began as a newly implemented service is now firmly integrated into routine obstetric and gynaecological practice, a service that ensures accessibility, availability, acceptability, and quality of care for its patients.

This transformation reflects not only legislative change but also the commitment of healthcare professionals, the support of management structures, the strength of multidisciplinary collaboration, and a broader societal shift towards recognising reproductive healthcare as an essential component of women's health.

FUTURE FOCUS FOR TERMINATION OF PREGNANCY SERVICES

International research and independent reviews recognise Ireland's model of termination of pregnancy care as a successful expansion of access, delivered through integrated community and hospital pathways. This model is supported by national referral mechanisms such as MyOptions, alongside strong implementation collaboration among policy, clinical and service user stakeholders.

Since the introduction of termination of pregnancy services in 2019, significant progress has been made in expanding access, strengthening clinical pathways, developing multidisciplinary expertise, and improving support for women and families. The experiences reflected in the earlier section demonstrate both the achievements to date and the areas where further improvement is needed. Some of the challenges identified relate to legislative and policy matters that fall beyond the remit of service providers, while others can be addressed through ongoing quality improvement, standardisation of care, enhanced coordination, and workforce development. The HSE remains committed to sustaining the progress that has been achieved, working collaboratively to address remaining gaps, and continuing to improve the quality, accessibility, and consistency of services for women and families. A continuing priority will be the implementation of the Service Improvement Group (SIG) workstream programmes with a focus on further strenghtening governance, clinical quality, service consistency and patient experience across all settings where termination of pregnancy care is delivered.

Work will continue on the further development, completion and implementation of the National Clinical Guidelines for Termination of Pregnancy Services, supporting delivery of safe, effective, consistent and evidence-based care.

The continued rollout and strengthening of the national termination of pregnancy data collection system will remain a priority focus. Expansion of data capture across all secondary care providers will enhance national oversight and support continuous quality improvement. In parallel, work will progress to identify and develop appropriate mechanisms to facilitate structured data collection from community-based termination of pregnancy contract holders, with the aim of achieving a comprehensive dataset spanning both primary and secondary care.

A further priority will be the development and publication of clear, accessible patient information resources. This will include a plain-language explainer of the termination of pregnancy legislation, as well as a dedicated information booklet for cases involving Fatal Fetal Anomaly (FFA). These materials will be informed by comprehensive multidisciplinary input including clinical, legal and policy expertise, alongside meaningful service user engagement to ensure that content is accurate, sensitive, and responsive to the lived experiences of those accessing care.

There will be a sustained focus on delivering opportunities for peer-to-peer engagement, multidisciplinary collaboration and shared learning, including training opportunities and mechanisms to strengthen professional networks across primary and secondary care settings.

Collectively, the above priorities reflect an ongoing commitment to service optimisation and ensuring that termination of pregnancy care continues to be safe, equitable, evidence-based and fully integrated across the health system.

Thanks and Acknowledgements:

To conclude, we would like to extend our sincere thanks to all those who have contributed to this report. We acknowledge the dedication of staff across primary and secondary care who provide Termination of Pregnancy care to women and families on a day-to-day basis. We also thank the Department of Health and its policy units for their continued support and prioritisation of this important service.

We are especially grateful to the members of the National Termination of Pregnancy Service Improvement Group for their commitment to the ongoing development and improvement of services, ensuring they are safe, effective, equitable and accessible.

Finally, we acknowledge the women and families we are privileged to support.

National
Women & Infants
Health Programme