SERVICE PROVIDER PERSPECTIVES AND EXPERIENCES OF THE HEALTH [REGULATION OF TERMINATION OF PREGNANCY] ACT 2018

This report was produced for the Department of Health under section 7 of the Health [Regulation of Termination of Pregnancy] Act 2018
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Above all, our thanks go to the anonymous participants of this study and health providers working in the Republic of Ireland.

Abbreviations

ARC	Abortion Rights Campaign
ASN	Abortion Support Network
CAF	Clinical Advisory Forum
CHO	Community Health Organisation
EMA	Early Medical Abortion
FFA	Fatal Fetal Anomaly
FMS	Fetal Medicine Specialist
GMS	General Medical Scheme
GP	General Practitioner
HSE	Health Service Executive
IOG	Institute of Obstetrics and Gynaecology
ICGP	Irish College of General Practitioners
MVA	Manual Vacuum Aspiration
MOC	Model of Care
MDT	Multi-Disciplinary Team
NWIHP	National Women and Infants Health Programme
NWC	National Women's Council
NCHD	Non-Consultant Hospital Doctor
OBGYN	Obstetrician and Gynaecologist
ONMSD	Office of Nursing and Midwifery Services Directory
PPSN	Personal Public Service Number
PLDPA	Protection of Life During Pregnancy Act
RMOC	Remote Model of Care
RCSI	Royal College of Surgeons Ireland
START	Southern Taskforce on Abortion and Reproductive Topics
STOP	Surgical Termination of Pregnancy
TOP	Termination of Pregnancy
UnPAC	Unplanned Pregnancy and Abortion Care study
WHC	Women's Health Clinics/Centres
WHO	World Health Organization

Executive Summary

Background

The 2018 referendum to repeal Article 40.3.3 of the constitution - the Eighth Amendment - led to a near-total redesign of abortion care in Ireland. From 1 January 2019, a vastly expanded termination of pregnancy service was implemented. The service was integrated by design, involving the input of healthcare professionals and managers in primary, secondary, and acute care, alongside leading Women's Health Centres (WHCs), in the drafting of interim guidelines and delivery of services to patients. The pre-existing Sexual Health and Crisis Pregnancy information service was partially replaced by a new service, MyOptions, which was established to provide contact details for general practitioners (GPs) registered with the Health Service Executive (HSE) as termination of pregnancy providers. MyOptions also offered non-directive counselling on unplanned pregnancy and clinical advice from nurses.

The new programme of termination of pregnancy services was outlined in a four-pathway Model of Care (MOC) designed in consultation with the Institute of Obstetricians and Gynaecologists (IOG), the HSE, WHCs, and the Irish Council of General Practitioners (ICGP) in late 2018. The initial MOC included

- A ‘community’ pathway, led by primary care (registered GPs and WHCs), for medication abortion under 8-weeks and 6-days gestation;
- An early pregnancy pathway in acute care for pregnancies between 9-weeks and 11-weeks and 6-days using medicines or surgical termination of pregnancy (manual vacuum aspiration in ambulatory gynaecological settings was added by individual hospitals);
- A surgical termination of pregnancy in acute maternity care for pregnancies over 12-weeks' gestation for section 9 ‘risk to life or health’; and

- A surgical termination of pregnancy in acute maternal-fetal care for pregnancies over 12-weeks' gestation for section 11 ‘condition likely to lead to death of the fetus’.

In response to the Covid-19 pandemic, a fifth remote pathway for termination of pregnancy in the community using telemedicine was added in 2020.

Under section 7 of the Health [Regulation of Termination of Pregnancy] Act 2018, the Department of Health committed to a review of the implementation of the Act after three years of service provision. In December 2021, the Department confirmed that the review would have three components:

- A review of service user experiences
- A review of service providers’ experiences
- A public consultation

This report represents the findings of service providers’ experiences of providing termination of pregnancy services in Ireland from January 2019. This work was commissioned by the Department of Health and was carried out by Dr Deirdre Duffy[1], Manchester Metropolitan University (Principal Investigator) with the support of Dr Lorraine Grimes, Maynooth University (Senior Research Associate), Ms Bethany Jay, Manchester Metropolitan University (Graduate Research Assistant) and Mr Jack Callan, Maynooth University (Graduate Research Assistant).

Research was carried out between April 2022 to September 2022. This report was submitted to Marie O'Shea, the Independent Chair of the Review of Termination of Pregnancy, and the Department of Health Bioethics Unit in September 2022. Following internal review, this final version was submitted in November 2022.

Research Objectives and Methodology

The research, as commissioned by the Department of Health, had six key objectives:

[1] Dr Duffy moved to Lancaster University during the finalisation of the report.

1. Examine the arrangements put in place to implement the Act including, but not confined to, the following:
    a. Service provision in the community setting
    b. Service provision in the acute hospital setting;
2. Gather and analyse data from service provider stakeholders to describe their experiences and observations on the operation of services under the Act, in order to provide a comprehensive description of providing services/service provision under the Act;
3. Assess the impact of the Act's operation on access to termination of pregnancy services in this country, taking into account the level of service provision before commencement of the Act. This includes providing figures on Irish women accessing termination in this country and in other jurisdictions, service provision in Ireland in comparison with service provision in other countries in Europe or beyond, and any other factors which may be relevant;
4. Identify any difficulties in providing services expressed by stakeholders which are associated with provisions in the Act.Highlight possible solutions to address any such difficulties, for example, approaches taken in other countries, as appropriate;
5. Assess from the service provision perspective the extent to which the Act's objectives have not been achieved and make recommendations to address barriers, if any, uncovered in that regard; and
6. Explore and weigh the evidence for and against any proposed changes to the Health Act 2018 from the service provider perspective. Provide conclusions based on the research findings, and draft suggestions on appropriate follow-up measures, if necessary.

The study was commissioned based on a Realist Evaluation design using desktop, secondary data and primary, qualitative data. Qualitative data was collected from health professionals in interviews between June and July 2022.

Following a mid-project meeting with the Chair and discussions with the Department of Health regarding the need for additional data collection from GPs (who provide the majority of termination

of pregnancy services), a quantitative survey component was added. Survey data was collected between the end of July and September 2022. As a mid-project addition, there are limitations to this component (outlined in this Report). However, the data collected provides additional evidence relating to primary care. It is advisable to expand on this data through a more substantial GP study with a longer timescale.

Ethical approval for the research was granted by Maynooth University and Manchester Metropolitan University.

Note on secondary data

All secondary data included in this report, including data provided by the Health Service Executive regarding the number of providers, was correct at time of original submission (October 2022).

Key findings

Overall, the research shows that the introduction and implementation of termination of pregnancy services have had a range of outcomes for health services, the health professions, and individual health workers. These outcomes are closely connected to the mechanisms used to implement services as well as the context of implementation.

The infographic below identifies the outcomes of the Act's implementation observable in primary and secondary data, the activities/mechanisms that health professionals have used to achieve these outcomes and the contextual factors which allow or undermine these mechanisms.

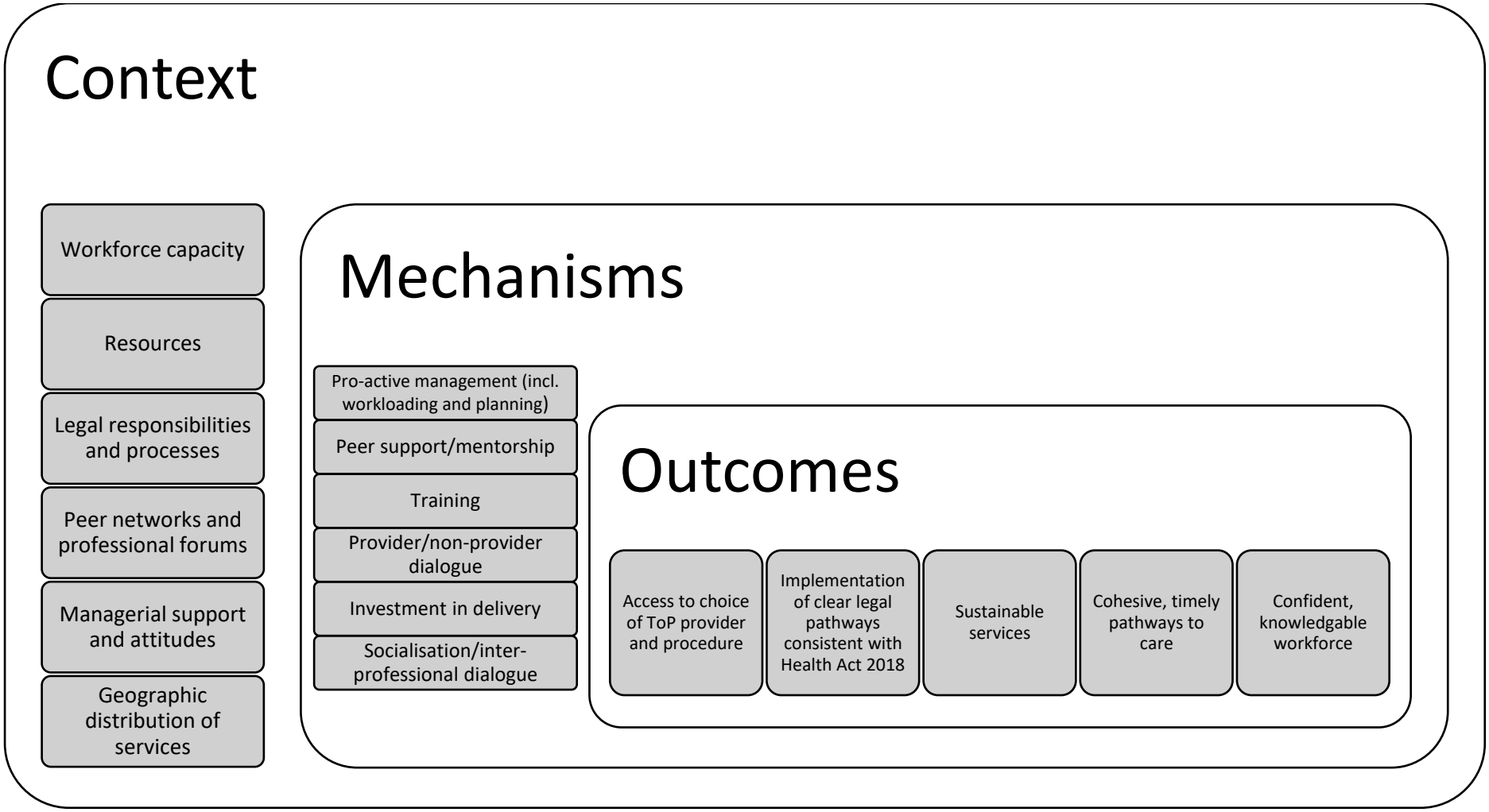

Figure 1: Representation of key findings

Recommendations and Key messages

Primary, secondary and desktop analysis underlined several key summative positive messages for policymakers and health service managers. These include:

- The number of people travelling for termination of pregnancy at an early gestation has decreased significantly since the introduction of services;
- Where providers have been able to meaningfully engage in training and provided with adequate peer-support, they have developed greater confidence and knowledge;
- Pro-active management of workforce, workload, and infrastructure has strengthened access to a choice of termination of pregnancy services and facilitated the development of a sustainable, excellent service;
- Multidisciplinary early abortion services in acute settings, who co-ordinate referral to hospital, have dedicated consultant support, and trained midwife sonographers strengthen access; and
- The development of services has been led by a cohort of committed providers in primary and secondary care.

However, the service provider evidence highlighted numerous areas of concern. This included, but is not limited to:

- Inconsistent access to termination of pregnancy services nationally;
- Inadequate provision for or access to surgical termination of pregnancy due to lack of resources;
- Inconsistent engagement with or identification of non-providing staff by managers;
- Staff shortages and burnout;
- The impact of criminalisation and lack of recognition of the complexity of cases falling under Section11 and Section 9 (for mental health grounds);

- The impact of gestational limits for Section 12 and lack of provision for care for patients who had commenced, but not completed, termination of pregnancy before 12-weeks. In particular, providers identified the problem of service users 'timing out' of legally permissible care;
- The impact of the mandatory three-day wait on the above mentioned ‘timing out’ problem;
- The burden of responsibility, including administrative responsibility, of the Act and problems this created for service sustainability;
- The relationship between providing and non-providing staff and the potential for workplace isolation and conflict;
- The barriers to care facing already marginalised communities, such as the homeless community and migrants in direct provision;
- The underdevelopment of resources at a local level resulting in all services being delivered by small groups of staff with no cover or contingency;
- The absence of clear guidance on, training for, or monitoring of multidisciplinary team (MDT) members resulting in MDTs operating as additional, not legally required, barriers; and The lack of guidance on review procedures where a termination application has been refused.

Taken as a whole, the evidence collected, analysed, and presented in this report shows that, three years following the introduction of services, progress is uneven. Access to care is unequal. Whether health professionals can ensure the provision of services in accordance with the wishes of the electorate and intentions of the Act depends on where they work, who they work with, who they work for, and what section of the Act their work sits under. As one provider stated, it is a "postcode lottery" and some health professionals still see provision of termination of pregnancy services as an "indulgence".

The management and engagement with non-providing healthcare practitioners is concerning. The decision not to provide is not always due to conscientious objection. Workload is a critical factor in primary and secondary care. Non-providers play a critical role in ensuring legal pathways are clearly implemented and that patients can access care in a timely manner. The findings of this study indicate that, in some contexts, providing and non-providers are disconnected from each other. The data presented in this report points to the emergence of a 'parallel' non-providing health service.

1 Overview of report

To meet the research objectives, the research was divided into two work programmes. **Work programme one** had two aims:

i. Assess the impact of the Act's operation on abortion access in the Republic of Ireland and on abortion travel
ii. Identify evidence gaps to guide primary data collection

Work programme 1 was desk-based and involved:

- A scoping exercise and synthesis of existing published data on the challenges and experience of implementing and accessing the new programme of termination of pregnancy services since January 2019;
- The collation of data on the organisation of services; and
- The collation of data on the provision of termination of pregnancy services under the Act and access to termination of pregnancy by Irish residents in other jurisdictions ('abortion travel')

Work programme 2 involved a Realist Evaluation of the operation and achievements of the Act from the perspective of health professionals in primary and acute care. The Realist Evaluation used primary qualitative data collected through semi-structured interviews with health professionals and health service managers. It also drew on published secondary research identified in work programme one.

The report follows the RAMESES II reporting guidelines for Realist Evaluation reporting as developed by Wong et al (2016). Consistent with this guideline, the report provides: a brief summary of the methodology; a scoping review of literature; a synthesis of desktop data; an outline of primary research design and collection methods; details of 'in-project' adjustments; and retroductive analysis of research data focusing on detailing and connecting programme participants perspectives on how

experienced outcomes were achieved, under which conditions (context), and through what means (mechanisms). In this study 'programme participants' are health professionals and health service managers.

2 Methodology

2.1 Realist Evaluation

The study was designed to focus on stakeholder and service provider perspectives of what works in services implemented since January 2019. Having regard to the research objectives, 'working' was defined as:

- The existence of cohesive pathways for the timely delivery of abortion care under all sections of the Act;
- A reduction in the number of women accessing abortion services outside the State ('abortion travel') or through extrajudicial means (i.e. importing abortion pills);
- The existence of equitable access, including the availability on a geographic basis;
- The successful and sustainable development of abortion services in community and acute care settings.

The study adopted a realistic evaluative approach. Realistic evaluation is a methodological framework for assessing the operation of programmes through asking **"what works, for whom, under what circumstances and when?"** (Pawson and Tilley, 2001). Realist Evaluation aims to establish, from the perspective of those at the front line of programmes, what contributes to the achievement, or limited achievement, of intended outcomes. The contributions include contextual factors and on-the-ground activities and practices ('mechanisms'). For this study we focused on five key intended outcome areas:

1. Developing a confident, knowledgeable termination of pregnancy workforce;
2. Implementing clear legal pathways to care consistent with the aims of the Act;
3. Ensuring equal access to a choice of termination of pregnancy services;
4. Establishing cohesive, timely patient journeys to care inside the State;
5. Establishing a sustainable termination of pregnancy service.

These outcome areas were selected as they combined the research objectives indicated in the Department of Health tender advertisement and international guidance, particularly the World Health Organization (WHO) guidance, on excellence in abortion care.

Realist Evaluation involves developing and refining evidence-based explanations for whether, how, and under what circumstances outcomes are achieved or not achieved. These explanations (context-mechanism-outcome chains or programme theories) are developed through repeated analyses of data, in-project adjustments to question or topic guides, discussions within the research team, and seeking feedback.

3 Scoping review and desktop research synthesis

3.1 Scoping Review

Our literature review combined a SPIDER literature synthesis and 'pearl gathering' strategy. The scoping review had two purposes. First to identify gaps in evidence, including population gaps (i.e. which health professional groups were less prominent in the evidence base). Addressing these gaps would inform the primary data collection approach, particularly the sampling strategy, and meet research objectives two through six. Second the review would help identify key evidence-based findings in relation to difficulties in providing services identified by health professionals and stakeholders (research objectives four and five).

SPIDER is a systematic review method involving the retrieval and collation of evidence. (Cooke, et al., 2012) Papers are coded in a six-point framework: Sample, Population, Intervention, Design, Evaluation and Results. In the context of this review, the intervention is the introduction of the new programme of termination of pregnancy services. 'Pearl gathering' involves identifying and collating published research by moving outwards from specific, known articles.

We undertook involved systematic searches on two databases, PubMed and CINAHL, using the terms 'Ireland', 'Health services' and 'Termination of Pregnancy' with the Boolean operator AND. We also truncated the search terms to include variations, for example 'Republic of Ireland' and 'Health providers'.

The searches retrieved fifteen individual peer-reviewed papers and commentary pieces by healthcare providers. Through 'pearl gathering', a further four papers were identified, including two reports. Only research papers published after 2019, focused on the Republic of Ireland, based on applied primary research (qualitative, quantitative, and mixed-method) with health providers and/or service users were included in the final review. After discounting papers which did not meet the inclusion criteria, we were left with fifteen research outputs connected to nine individual research

studies (Table 1). It is worth noting that we discounted commentary papers and editorials from the SPIDER analysis as, even though some of these were authored by healthcare providers, they did not meet the inclusion criteria. We have referenced these papers, 'grey literature' (ie. government reports), and broader literature in the discussion section of this report.

Reference	**Study descriptor**
Mishtal, J., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Chavkin, W., Duffy, D., Favier, M., Horgan, P., Murphy, M. and Lavelanet, A. F. (2022) 'Abortion policy implementation in Ireland: Lessons from the community model of care.' Scott, J. (ed.) *PLOS ONE*, 17(5) p. e0264494.	WHO barriers and facilitators study
Duffy, D., Mishtal, J., Grimes, L., Reeves, K., Chakravarty, D., Stifani, B., Chavkin, W., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. (2022What are the informational barriers and facilitators to abortion care? Patient Journey Analysis of abortion access under new services in the Republic of Ireland. *Social Science and Medicine – Population Health,* 19. p. 101132	WHO barriers and facilitators study
O'Shaughnessy, E., O'Donoghue, K. and Leitao, S. (2021) 'Termination of pregnancy: Staff knowledge and training.' *Sexual & Reproductive Healthcare*, 28, p. 100613.	Single-site staff knowledge
Power, S., Meaney, S. and O'Donoghue, K. (2021) 'Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study.' *BJOG: An International Journal of Obstetrics & Gynaecology*, 128(4) pp. 676–684.	FMS experience
Stifani, B. M., Mishtal, J., Chavkin, W., Reeves, K., Grimes, L., Chakravarty, D., Duffy, D., Murphy, M., Horgan, T., Favier, M. and Lavelanet, A. (2022) 'Abortion policy implementation in Ireland: successes and challenges in the establishment of hospital-based services.' *SSM - Qualitative Research in Health*, 2, p. 100090.	WHO barriers and facilitators
Mac Donncha, C., Brohan, J. and O'Brien, B. (2020) 'Conscientious objection to provision of anaesthesia for termination of pregnancy amongst anaesthesiologists in the Republic of Ireland.' *British Journal of Anaesthesia*, 124(3) pp. e115–e116.	Anaesthesiologists
Dempsey, B., Favier, M., Mullally, A., and Higgins, M. F., (2021) 'Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland.' *Contraception*, 104(4) pp. 414–419.	Health providers stigma study

O'Shaughnessy, E., Leitao, S., Russell, N., O'Donoghue, K., 'Termination of pregnancy services: a year in review in a tertiary maternity hospital', *British Medical Journal: Sex & Reproductive Health*, April (2021).	Tertiary site review
Grimes, L., O'Shaughnessy, A., Roth, R., Carnegie, A., & Duffy, D. (2022). Analysing MyOptions: experiences of Ireland's abortion and information Services. BMJ Sexual and Reproductive Health. https://doi.org/10.1136/bmjsrh-2021-201424.	ARC My Options study
Hayes-Ryan, D. Meaney, S. Byrne, S. Ramphul, M. O'Dwyer, V. Cooley, S. (2021) 'Women's experience of Manual Vacuum Aspiration: An Irish perspective', European Journal of Obstetrics & Gynecology and Reproductive Biology 266 (2021) 114–118	MVA study
Conlon, C. Antosik-Parsons, K. Butler, É. 'Unplanned Pregnancy and Abortion Care (UnPAC) Study', HSE Health and Wellbeing, Strategy and Research, July 2022.	UnPAC
ARC & Grimes, L. (2021). Too many barriers: Experiences of abortion in Ireland after Repeal. https://www.abortionrightscampaign.ie/facts/research/ (accessed 24 March 2022).	ARC report
Horgan P, Thompson M, Harte K, Gee R. Termination of pregnancy services in Irish general practice from January 2019 to June 2019. Contraception. 2021 Nov;104(5):502-505. doi: 10.1016/j.contraception.2021.05.021. Epub 2021 Jun 10. PMID: 34118270.	GP case review
Spillane, A., Taylor, M., Henchion, C., Venables, R., & Conlon, C. (2021). Early abortion care during the COVID-19 public health emergency in Ireland: Implications for law, policy, and service delivery. International Journal of Gynecology & Obstetrics, 154(2), 379-384. https://doi.org/10.1002/ijgo.13720.	Telemedicine review
O'Connor R, O'Doherty J, O'Mahony M, Spain E. Knowledge and attitudes of Irish GPs towards abortion following its legalisation: a cross-sectional study. BJGP Open. 2019 Dec 10;3(4) doi:10.3399/bjgpopen19X101669	GP knowledge and training
Kennedy S, Accessing Abortion in Ireland: Meeting the needs of every woman, National Women's Council, 2021	

Table 1: List of sources

3.1.1 Gaps in literature

Using SPIDER as a literature synthesis framework we were able to establish evidentiary and population gaps. As the tabulated Sample, Population, and Design synthesis (Table 2) illustrates most studies were qualitative and included GPs, obstetricians, and gynaecologists. Three studies included all clinical staff, midwives, and nurses. One study focused solely on anaesthesiologists; one focused solely on fetal medicine specialists. Four studies focused in whole or in part on service user

experiences. The minimum sample in studies was 12, the maximum was 475. One study was based on analysis of case reports.

Reference	Sample	Population	Design
MacDonncha et al, 2019	109 anaesthesiologists	Anaesthesiologists	Survey
Dempsey et al, 2021	156 members of START and Hospital Providers groups	GPs, OBGYNs, midwives	Survey
O'Shaughnessy et al, 2021 (a)	133 clinical staff from one hospital	Hospital staff	Survey
O'Shaughnessy et al, 2021 (b)	42 ToP service users from one hospital	Service users	Semi-structured interview
Power et al, 2021	12 fetal medicine specialists	Fetal medical specialists (medics)	Focus groups
Mishtal et al, 2022; Stifani et al, 2022; Duffy et al, 2022	109 hospital and GP providers, key informants, and service users	Hospital staff and members of START GP group	Semi-structured interviews
Grimes et al, 2021; ARC and Grimes, 2021	402 service users	Service users	Survey
Conlon et al, 2022	58 service users	Service users	Semi-structured interviews
Hayes-Ryan et al, 2021	19 service users	Service users	Semi-structured interviews
Stifani et al, 2022	109 OBGYN non-consultant hospital doctors	NCHD medics	Survey
Horgan et al, 2021	475 service users	Service users	Chart review
O'Connor et al, 2019	222 GPs	GPs	Survey

Table 2: Sample, Population and Design literature synthesis

3.2 Core research themes

These published reports were analysed thematically, with a focus on synthesising key findings across this secondary dataset. Research findings reported in this research focused on the following seven key areas: (i) provider/service user views of the community and remote model(s) of care; (ii) MyOptions; (iii) provider training and knowledge; (iv) experiences of being a provider; (v) availability of services; (vi) patient experiences of care; and (vii) provider and service user views of the challenges of the Act.

3.2.1.1 Provider views of the community and remote model(s) of care

The community and remote model of care were identified as particularly successful by GPs and WHCs. (Mishtal et al, 2022) A chart review of 475 patients across 27 GP surgeries found that the vast majority were able to access care through community settings. (Horgan et al, 2021) The Unplanned Pregnancy and Abortion Care (UnPAC) study found that the remote model of care has increased accessibility of the abortion care service, particularly benefitting people in rural areas or parts of the country where the coverage of GP or WHC providers might be limited. (Conlon et al. 2022) Many others have also noted that the introduction of telemedicine made access to abortion easier for them as it has reduced the need for travel and increased individuals' privacy. (Conlon et al. 2022, Grimes & ARC, 2021; Kennedy, 2021; Mishtal 2020)

The UnPAC study analysed data from Women on Web, an online international abortion provider through the postal service. It found that people contacting Women on Web demonstrated a preference for the perceived privacy and comfort afforded by telemedicine services which suggests a role for continued provision of remote services locally. (Conlon et al. 2022)

3.2.1.2 My Options

The My Options information and nursing helpline were commended by some providers and service users as a useful contact for facilitating access to care and addressing 'out of hours' patient queries. The WHO study found that MyOptions is 'one of the more successful strategies facilitating

access to care'. (Mishtal, 2022) From a sample of twelve interviewees, service users reported 'overwhelmingly positive experiences when interacting with MyOptions'. (Mishtal et al. 2022) However, it was noted that many other interviewees were 'unaware of or could not remember that it was the national referral service in Ireland' but concluded that 'once women contacted the helpline, their experience was generally positive and led to a swift referral to a viable provider.' (Mishtal, 2022)

Among the UnPAC study participants, there was a general consensus that My Options was accessible and the website was informative, but for some the website was unclear. (Conlon et la. 2022) They found that stigma attached to abortion for some women encompassed a sense of shame that made them hesitant about calling the helpline. (Conlon et al. 2022) The My Options 24-hour nurse helpline was assessed positively by participants in the study. However, the UnPAC study found that there was a good sense of general awareness of My Options among people who had grown up or lived for some time, in Ireland. Conlon et al (2022) argued that My Options as the sole source of information on GP providers removes any onus or responsibility on actors across wider services to be knowledgeable about, willing to discuss, and willing to refer women seeking abortion into the care pathway for abortion services.

Some respondents in the ARC survey who used MyOptions described the helpline as useful and compassionate. In contrast, some respondents noted a lack of clarity from MyOptions about the scope of its service and a lack of information on accessing abortion after 12-weeks. (Grimes & ARC, 2021) Respondents reported frustration that the service did not arrange appointments, explaining that having to contact GPs themselves was stressful and time-consuming, as was GPs' refusal to provide care or refer to a willing provider. (Grimes & ARC, 2021)

In an article based on the ARC findings, it concluded that MyOptions primarily benefits abortion-seekers whose pregnancies are under 12-weeks and who are comfortable contacting a GP themselves. (Grimes, et al, 2021) It also argued that because MyOptions does not arrange

appointments for abortion-seekers, it places the burden on individuals to contact providers and creates a risk of encountering anti-choice GPs or rogue agencies, or 'timing out' of the legal window to access care. (Grimes, et al, 2021)

3.2.1.3 Provider training and knowledge

A survey carried out in 2021, found that knowledge of termination of pregnancy legislation, guidelines, methods and complications is lacking amongst hospital staff. (O'Shaughnessy, O'Donoghue & Leitao, 2021) Most respondents (88%) had not received clinical training prior to the implementation of TOP services, and 94% wanted to receive more training (Ibid). They noted that at one maternity hospital, the service relies on a small number of consultants, which raises concerns about its sustainability. (O'Shaughnessy et al., 2021a). Stifani et al's (2022b) study of non-consultant hospital doctors (NCHDs) indicates that there is an interest among trainees to expand their knowledge of and participation in termination of pregnancy care. Only 61.8% of respondents to the researchers' survey of NCHDs reported participation in abortion care and only 25.5% reported performing surgical procedures. More than 75% of respondents stated they would like to receive more training in all clinical skills related to termination of pregnancy. 67.6% of respondents would be willing to provide a termination in all circumstances allowed by law.

Stifani et al (2022a) also advise that clinical leaders should clarify with all staff the roles and ethical obligations of conscientious objectors in accordance with local laws and regulations. The study found that many respondents did participate in a series of values clarification workshops which were almost universally described as 'highly valuable'. Respondents expressed the need for more workshops for a wide range of staff, and that these should be carried out during staff working hours. (Stifani, 2022)

3.2.1.4 Experience of being a provider

Literature reported positive and negative experiences of being a provider. A study of 156 hospital doctors and GPs found that, while providers themselves found their work fulfilling, more than one in six doctors providing termination services said they have experienced a 'verbal threat or attack' since abortion was introduced in Ireland in 2019. (Dempsey et al., 2021) This study found that Irish doctors suffered fewer verbal or physical attacks than their international counterparts and those in hospital- and clinic-based practises experienced higher levels of stigma and threatening behaviour than community-based GPs. (Dempsey et al., 2021) They suggested this might be because hospital physicians were more likely to be involved in carrying out later-gestation abortions. It concluded that despite widespread public support for the expansion of abortion services in Ireland, stigma was still present. The study found that there were 'difficulties in providing abortion care as part of a team…where feelings of disapproval and disrespect from colleagues, as well as resistance and conflict were noted'. (Dempsey et al. 2021)

Power et al. also noted 'teamwork conflict' within fatal fetal anomaly (FFA) diagnosis and described meetings discussing complex cases as 'divisive'. (Power et al, 2021) Power states that a good working relationship with multi-disciplinary team members is 'essential' to providing good quality care. (Ibid)

3.2.1.5 Availability of services

Analysis also revealed multiple barriers to local access including sparse coverage of providers, especially in rural areas, and some continued reticence in discussing abortion with a GP due to concerns about stigma and confidentiality (Conlon et al. 2022). The WHO study outlined that capacity, limited staffing, workload burden, and inadequate facilities acted as a barrier to establishing termination of pregnancy (ToP) care in Irish hospital settings (Stifani et al. 2022). The limited access to surgical abortion has been outlined by many researchers to date. (Mishtal 2020; Stifani 2020; Grimes & ARC 2021) The WHO reported that second-trimester surgical abortion

(dilation & evacuation) is not available anywhere as this is not part of training in Ireland. Even for first-trimester cases, most respondents acknowledged that hospitals that offer uterine aspiration as an initial option are rare. (Stifani, 2022) One provider said that she does routinely provides manual vacuum aspiration (MVA) in an ambulatory setting however, the service was new at the time of the interview and primarily reserved for patients with retained products after a medical abortion. (Stifani, 2022) The WHO concluded that although surgical abortion can be performed under local anaesthesia in ambulatory settings, which eliminates the need for theatre and anaesthesia staff, this is rarely done in Ireland.

The research studies also connected the availability of services with issues of sustainability and burnout. For example, O'Shaughnessey et al (2021) recorded a small proportion of hospital consultants participated in ToP care at one hospital, with two providing care for over half the cohort. This study concluded that a service run by such a small number of physicians is unsustainable. Dempsey et al's (2021) study also investigated the relationship between stigma and burnout. They found that while greater experience of stigma will likely have negative impacts, 'it is reasonable that Irish providers who experience greater stigma are not at increased risk of burnout given that the majority dedicate very little time to providing abortion care.' They point out that in the wake of the referendum, Irish providers may feel 'a renewed sense of purpose…which may have protected against burnout.' They caution that 'this sense of purpose may diminish as we move further away from the support of the referendum and as providers continue to gain experience.'

3.2.1.6 Patient experiences of care

The WHO study typically reported positive experiences from service users with community abortion providers. (Mishtal, et al. 2022) Some of the challenges arising from the research were: unclear or slow referral pathways from the GP to hospitals; non-providing GPs responsible for unreliable referrals and obstruction; and unreliable referral pathways for ultrasound scans. Data from service users whose patient journey progresses to secondary care in Ireland describe the

patient journey in largely positive terms but found the movement to secondary care complicated and confusing. (Duffy, Mishtal, et al. 2022)

Similarly, the Abortion Rights Campaign (ARC) study also outlined long waits between GP to hospital care, between GP to scan referral and obstruction and delay from non-providing GPs. (Grimes & ARC, 2021) The UnPAC study also found that referral to My Options or a providing GP by non-providing GP practices was not the norm. (Conlon et al. 2022) In addition, there is uneven access to abortion for migrants and geographically, there is an uneven distribution of services which leads to a significant impact on service users. (Mishtal et al. 2020; ARC report 2021; Kennedy, 2021). In evaluating hospital abortion care in the UNPAC study, was largely positive. Many commented on the staff, describing them as “helpful”, “caring”, “fantastic”, “excellent”, and “lovely”. Although one person felt less favourably about aspects of the care. (Conlon et al. 2022). Research pointed out that the location of the service within maternity settings is a major issue. The UnPAC research concluded that the location of services within maternity settings was disconcerting for some who encountered pregnant women and babies. (Conlon et al. 2022)

3.2.1.7 Provider views of the challenges of the Act

Both GPs and service users believed that the mandatory three-day wait is unnecessary and can lead to delays. (Mishtal et al. 2020) The ARC study outlines the negative impact of the three-day wait on service users psychologically and in some cases, is the reason for travel overseas because of 'timing-out'. (Grimes & ARC, 2021) The UnPAC study found that very few participants considered the three-day wait to be of any personal benefit to them. (Conlon et al. 2022) Research by medical practitioners also stated that the negative impact of the waiting period describing it as '"presumptive and patronising", as it suggests pregnant people are not certain of their decision.' (Mullaly et al., 2020). As Alison Spillane argues, 'if a patient needs more time to think through their options, they are able to voice that decision for themselves.’ (Spillane et al., 2021).

Power et al's (2021) study of fetal medicine specialists found challenges with the interpretation of the legislation (Power et al, 2021). In this study, half of the fetal medicine specialists expressed 'uncertainty' regarding a diagnosis as fatal. Participants identified that 'there is never any certainty' when death will occur, as it depends on an individual's 'definition' of fatal. (Power et al. 2021).

Data from medics in primary and secondary care highlights the challenges of the gestational limits and the resultant requirement for precise gestational dating. Organising dating scans was underlined as a key barrier to termination of pregnancy care by primary providers in the WHO study (Mishtal et al, 2022; Duffy et al, 2022). In other studies, medics argued that there has been no guidance on how to manage a failed termination (O'Shaughnessy, Leitao, Russell, et al. 2021) resulting in confusion among clinicians regarding the legal permissibility of care for those whose termination had commenced, but not completed, prior to 12-weeks gestation. O'Shaughnessey et al (2021) reported women who presented between 11- and 12-weeks' gestation (16/42, 38.1%) pose particular challenges as ToP must be completed prior to the 12-weeks legal limit. This can be difficult at weekends if a participating consultant is not present in the hospital.

3.3 Desktop synthesis

3.3.1 Development of services

The expanded termination of pregnancy services initially included a four-pathway model of care (MOC). This was expanded in response to the Covid-19 pandemic in 2020 when an additional remote model of care (RMOC) for care in the community was implemented. Services are delivered through primary care (general practice and women's health centres) and acute (maternity) care. The MOC and RMOC used early medication abortion (EMA) and surgical termination of pregnancy (STOP). A small number of hospitals offer early gestation termination of pregnancy using manual vacuum aspiration (MVA) in ambulatory settings.

A dedicated information service, My Options, was launched in 2019. My Options was designed to: (i) offer non-directive counselling (replacing the pre-existing Sexual Health and Crisis Pregnancy counselling services); (ii) facilitate patient journeys to abortion services while protecting the identity of GPs registered with the service as termination of pregnancy providers; and (iii) provide a readily available health information hotline for clinical queries from the public (this is staffed by nurses).

Beginning in late 2018, the HSE and healthcare professional bodies rolled-out training related to abortion and termination of pregnancy care under the new service programme. This training was designed for primary care, acute care, and midwifery and nursing. Primary care training was designed and has been led by the Irish Council General Practitioners (ICGP) in conjunction with the Southern Taskforce for Abortion and Reproductive Topics (START). Midwives and nursing staff training was delivered through the pre-existing Masterclasses of Supporting an Unplanned Pregnancy held at Maynooth University developed under the HSE Sexual Health and Crisis Pregnancy Programme prior to 2018. The Institute of Obstetricians and Gynaecologists (IOG), collaborating with the WHO, also held 'values clarification' training and information sessions for healthcare workers in late 2018 and early 2019 (Annual Report, National Women and Infants Health Programme, 2019).

3.3.2 Organisation of services

3.3.2.1 Management

The National Women and Infants Health Programme (NWHIP) assumed responsibility for the implementation and management of termination of pregnancy services as part of the National Maternity Strategy *Safer Better Healthcare*.

Interim guidelines were developed by the IOG between late 2018 and mid-2019. The ICGP also produced guidelines for its members. The interim guidelines on the care pathway for termination of pregnancy in cases of fatal fetal anomaly and/or life-limiting condition likely to lead to fetal demise or death within 28-days post-partum were updated in 2020 by the IOG Fetal Medicine Working Group.

Following the Act's implementation, the National Consent Policy and Code of Professional Ethics for Medical Professionals were amended to reflect the obligations of health professionals under the new legislation. The Code also outlined the parameters of conscientious objection and confirmed the obligation to refer.

A National Clinical Lead post was approved in 2019. Dr Aoife Mullally was recruited to the post in late 2019. The Clinical Lead chairs the national Clinical Advisory Forum (CAF) which includes representatives from NWHIP, HSE Acute Strategy and Planning, HSE Primary Care Strategy and Planning, Irish Family Planning Association (IFPA), the HSE Sexual Health and Crisis Pregnancy Programme, WellWoman, the National Women's Council, the IOG, the ICGP, the START, and the five largest maternity hospitals. The CAF also includes national Directors of Midwifery and Practice Nursing representation. The CAF meets three times annually. The CAF coordinates the development of training and is currently leading in ensuring quality assessment of services.

3.3.2.2 Primary care

Under the Health Act 2018, access to termination of pregnancy services is free of charge to those with a Personal Public Service number (PPSN). General practitioners who have registered through the General Medical Scheme (GMS) lead the primary care 'community' model for early

medical abortion under-10 weeks' gestation (dated from the first date of last menstrual period). Most terminations are recorded as Section 12 applications. Although the interim guidelines for fetal anomaly/life-limited condition states that applications under Section 11 may be provided through primary care where medically appropriate to do so.

GPs can provide, and be reimbursed for, ToP care through the GMS if they hold a ToP service contract with the HSE. ToP care does not include referral to another provider. GPs are not compelled to provide ToP care and are entitled to exercise a conscientious objection; GPs are not entitled to refuse to refer. The Code of Ethics for Professional Practice 2019 states that referral and handover must be timely and direct.

Data provided by the HSE (Figures 2 and 3) indicate that the number of registered GP providers has increased since January 2019 implementation. That said, primary care coverage is geographically uneven. Fewer GP contracts are recorded in the south-east, north-west, midlands, and border counties than elsewhere.

At first sight, the figures point to inadequate provision outside of cities. However, there are important issues that need to be recognised when interpreting this data. First, these are the number of contracts per GP surgery and it is not clear how many GPs are providing care under 'surgery contracts'. The qualitative research component indicated that, in some instances, multiple providers were operating under a single 'surgery contract'. Similarly, qualitative data indicates that some GPs only provide to previously registered patients. Even when a contract is recorded, services may not be available to all ToP care seekers.

Second, we were not provided with sub-national population data for each of the community health organisations (CHOs) the reported contracts fall within. The HSE established nine CHOs as a means of ensuring that provision matched population-level need. Some of the CHOs map directly onto counties; others cut across county boundaries. Without the precise location of surgery

contracts or details on the number of individual GPs at contract-holding surgeries, it is impossible to gauge whether there is sufficient provision to meet local need.

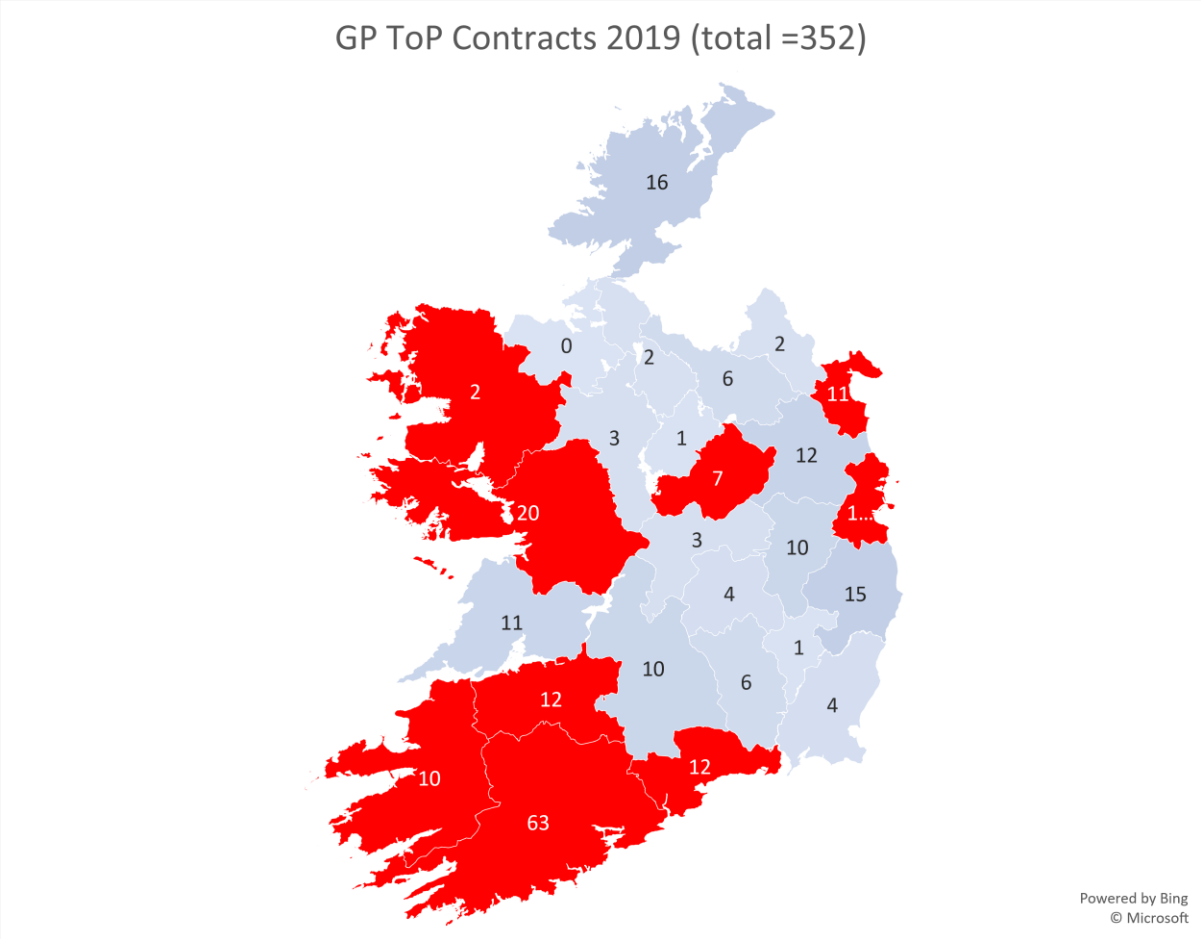

Figure 2: GP Contracts for Termination of Pregnancy by county (2019)

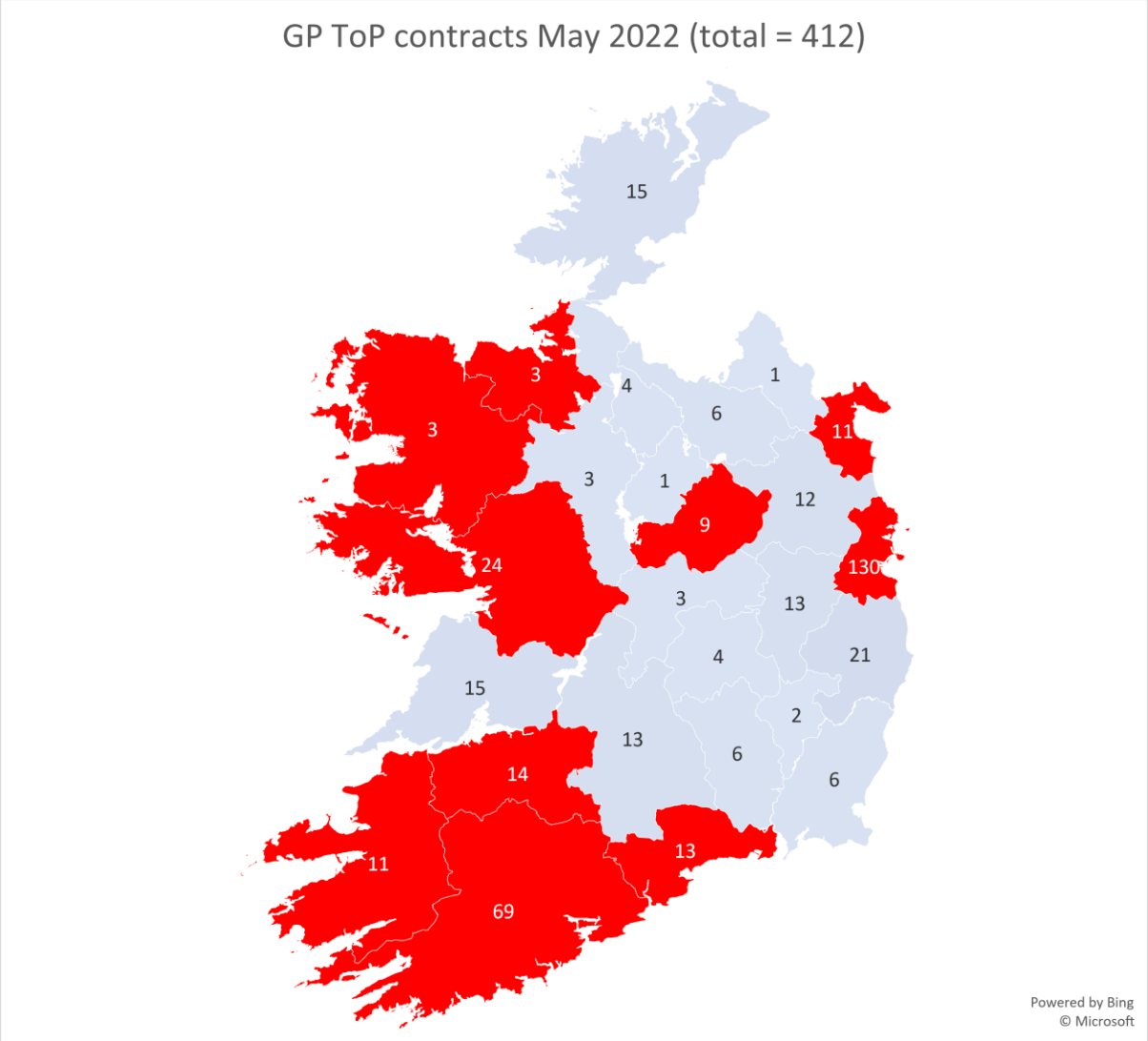

Figure 3: GP Contracts for Termination of Pregnancy by county (2022)

Desktop research also revealed a further provision/coverage issue in relation to primary care. A key component of the new ToP service programme is MyOptions. This was introduced to address access to care by acting as a free, public phone number and online webchat facility for those seeking information about ToP care. Through MyOptions, abortion seekers can receive contact details of providing GPs in their local area. While MyOptions does not make an appointment for service users, it is designed to facilitate access to care.

Under the current agreement, GPs are not obligated to register with MyOptions when they register as ToP providers through the GMS contract. By not registering with MyOptions, GPs are able to limit the number of ToP patients they accept to those who either contact the surgery directly or

existing patients. Data provided by the HSE as part of the review shows that a significant proportion of GPs are not registered with MyOptions. In 2022, of the 412 GPs contracted to provide ToP care, 164 (39.8%) were not registered on the MyOptions list.

3.3.2.3 Acute care

Implementing a new service is challenging. To establish services, the HSE released €12 million for workforce and infrastructure investment in acute care in 2019. Data provided by the HSE on request indicates the number of posts funded specifically for termination of pregnancy care by the NWIHP since 2019 (Table 3). In an explanation of the conditions of workforce and infrastructure, the NWHIP Director explained:

> *the posts listed below were approved to support the development and rollout of termination of pregnancy services as part of the various hospitals suite of maternity and gynaecology services. Prior to approving these posts, NWIHP engaged at hospital group, maternity network and local levels to identify key opportunities and challenges with regard to TOP service provision and to determine how best to proceed with the advancement of TOP services. These engagements also enabled NWIHP to establish what resource/skill mix was required to facilitate commencement of TOP services.* (Statement from NWHIP Director, September 2022)

Table 3: Number of posts approved to support development/roll-out of ToP services by NWHIP

Posts	Filled	Filled (Temp. Basis)	Vacant	Grand Total
Consultants/Medics	17	4	6	27
Midwives/Nurses	21	1	2	24
Health and Social Care Professionals	11	0	3	14
Administrative Posts	6	1	1	8
Grand Total	55	6	12	73

Termination of pregnancy care over 10-weeks' gestational age is led by hospital-based clinicians in acute, maternity care. In January 2019, seven of Ireland's nineteen maternity hospitals

agreed to provide care across all four pathways[2]. By 2019 Q4, this had increased to ten (Annual Report, NWIHP, 2019). One further hospital commenced provision when this research was being conducted and we were informed that further hospitals had agreed to begin providing a full range of services by the end of 2022.

Tables 4 and 5 outline provision by hospital group in 2019 and 2022 (Q2) respectively. The sections of the Act hospitals provide care under is identified. All hospitals with sonography departments now offer dating scans for termination of pregnancy patients. Under the Health Act 2018, all hospitals should, in theory, provide ToP care accessed under Section 10 (risk to health/life in an emergency) and facilitate access to care through provision of treatment for post-abortion complications and anti-D.

Hospital name	Group	Section 9	Section 11	Section 12	Notes
National Maternity Hospital	Ireland East	x	x	x	
Regional Hospital Mulligar	Ireland East			x	
Rotunda	RCSI	x	x	x	
Our Lady of Lourdes Drogheda	RCSI	x		x	
Coombe	Dublin Midlands	x		x	
Cork University Maternity Hospital	South/Southwest	x	x	x	
University Hospital Waterford	South/Southwest	x		x	Mon-Fri Clinic
Mayo University Hospital	Sáolta	x		x	Ambulatory Gynaecology
University Hospital Galway	Sáolta	x		x	
University Maternity Hospital Limerick	UL Hospitals	x	x	x	

Table 4: Hospital Provision (2019)

[2] Meeting with NWHIP, April 2022

Hospital name	Group	Section 9	Section 11	Section 12	Notes
National Maternity Hospital	Ireland East	x	x	x	
Regional Hospital Mulligar	Ireland East			x	
Rotunda	RCSI	x	x	x	MVA Clinic for ToP
Our Lady of Lourdes Drogheda	RCSI	x		x	
Coombe	Dublin Midlands	x		x	
Cork University Maternity Hospital	South/Southwest	x	x	x	
University Hospital Waterford	South/Southwest	x		x	Mon-Fri Clinic
University Hospital Kerry	*South/Southwest*				*Providing OBGYN appointed to commence in Q4*
Mayo University Hospital	Sáolta	x		x	Ambulatory Gynaecology
University Hospital Galway	Sáolta	x		x	
Sligo University Hospital	Sáolta	x		x	
University Maternity Hospital Limerick	UL Hospitals	x	x	x	

Table 5: Hospital Provision (2022, Q2)

A number of acute settings took the additional step of appointing trained midwife sonographers, or making allocations for this training, as well as establishing ambulatory manual vacuum aspiration (MVA) clinics (Hayes-Ryan et al, 2021). MVA clinics were reported in Mayo and Dublin, with plans to establish further clinics in Cork and Waterford.

3.3.3 Use of services

3.3.3.1 Rate of Access 2019 - present

Under the Health [Regulation of Termination of Pregnancy] Act 2018, healthcare providers must notify the Minister for Health about all terminations performed under the Act. Tables 6 to 8 provide figures by sections of the Act, month, and county (where reported) since 2019. In 2021, the Department of Health released an additional statement regarding the figures, which were lowest than in the preceding two years, noting the impact of Covid-19 and the 2020 cyber-attack on health information systems as impacting data collection.

Section	2019	2020	2021
9 – Risk to life or health	21	20	9
10 – Risk to life or health in an emergency	3	5	2
11 – Condition likely to lead to death of foetus	100	97	53
12 – Early pregnancy	6542	6455	4513
Total	6666	6577	4577

Table 6: Terminations by sections of the Act 2019-2021

Month	2019	2020	2021
January	625	709	628
February	490	552	493
March	508	654	405
April	538	639	289
May	580	520	100
June	533	510	103
July	602	605	157
August	530	516	142
September	506	541	488
October	545	490	521
November	548	456	630
December	592	327	559
No date received	69	58	62
Total	6,666	6577	4577

Table 7: Terminations by month 2019-2021

County	2019	2020	2021
Carlow	74	56	46
Cavan	77	107	70
Clare	73	83	82
Cork	606	645	408
Donegal	127	128	90
Dublin	2493	2414	1618
Galway	280	274	206
Kerry	48	110	103
Kildare	295	264	165
Kilkenny	96	83	64
Laois	79	60	46
Leitrim	27	28	22
Limerick	226	278	186
Longford	47	52	41
Louth	213	220	160
Mayo	111	105	83
Meath	252	240	168
Monaghan	36	54	46
Offaly	67	67	49
Roscommon	43	53	38
Sligo	59	60	54
Tipperary	174	161	128
Waterford	149	158	124
Westmeath	104	108	76
Wexford	165	159	147
Wicklow	138	141	145
Northern Ireland	67	36	5
Other	15	8	2
No address given	525	425	204
Total	6666	6577	4577

Table 8: Terminations by county 2019-2021

The abortion rate – a robust calculation based on the number of terminations per capita for women of gestational age (approximated at 16-49 years old) – in Ireland is much lower than the UK or countries of a similar population size such as New Zealand. It is, based on most recent census data, broadly comparable to Portugal, which has similar legal permissions for access at early gestation (under 10-weeks).

Figure 4 provides a comparative illustration. It is important to exercise caution when interpreting abortion rates as they are based on census data – which carries limitations – and an estimate of 'gestational age' which is robust. Data used, as here, may be outdated due to differences

in when data is collected and reported. That said, as a robust guide, this indicates where Ireland 'sits' in relation to comparator countries.

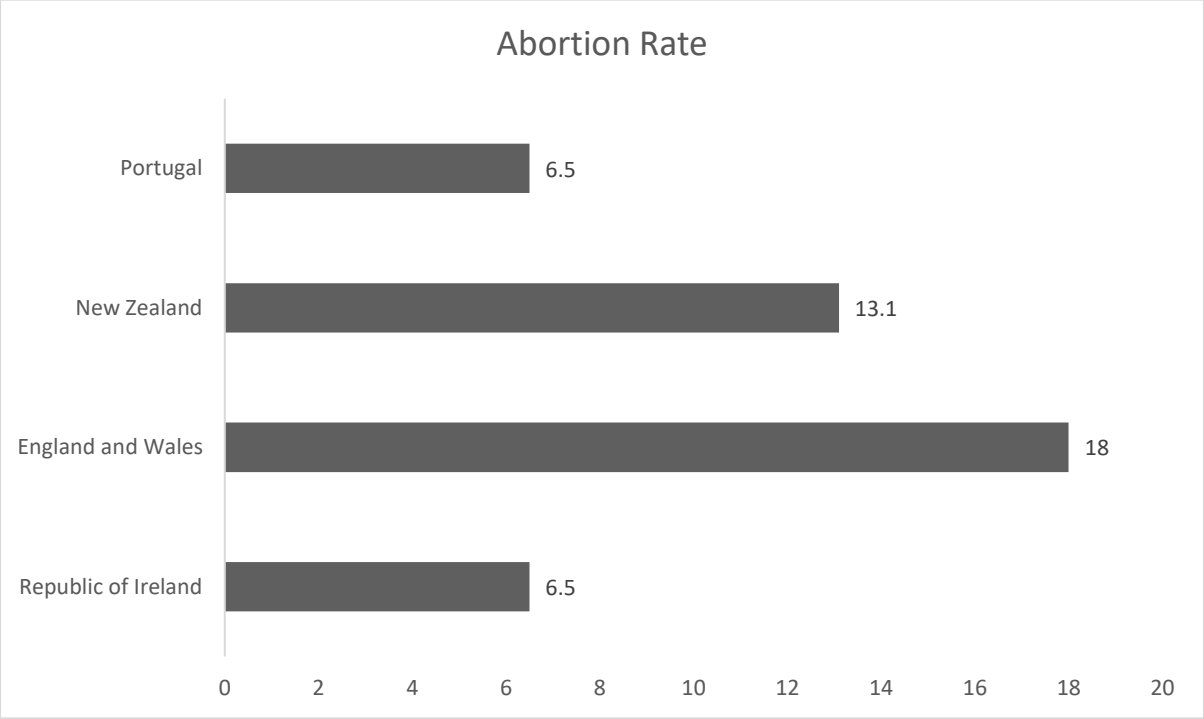

Figure 4: Abortion rate estimate based on 2020 data

3.3.3.2 Comparison with Protection of Life During Pregnancy Act

The numbers reported to the Department of Health show a clear increase in termination of pregnancy access within the state overall between 2018 and 2019. Information released under the Protection of Life During Pregnancy Act (PLDPA) 2015 indicates that fewer than fifty terminations were reported under the PLDPA.

However, a comparison with numbers reported under the PLDPA (Table 9) indicates that the number of terminations recorded under the categories of 'risk to maternal life' has decreased. This may be a result of the ability to provide services at an earlier gestation under Section 12 of the Health Act 2018. It is important to note that 'risk to maternal life' is different in the PLDPA than in the Health Act 2018.

Year	2017	2018	2019	2020	2021
ToP recorded under 'risk'	15	32	24	25	11

Table 9: Count of Terminations recorded under 'risk'

3.3.4 Access to services outside the State

3.3.4.1 Abortion travel

Figures on 'abortion travel' by Irish residents to other jurisdictions have declined overall since 2019.

The number of patients registering addresses in the Republic of Ireland at termination of pregnancy service providers in England and Wales (Figure 5) has declined. Interestingly, the number of Irish addresses registered at clinics in the Netherlands increased significantly in 2021 and is now at its highest rate since the Dutch authorities began recording Irish service users in 2015 (Figure 6).

Spain, another known destination for Irish abortion travel does not disaggregate data to a country level.

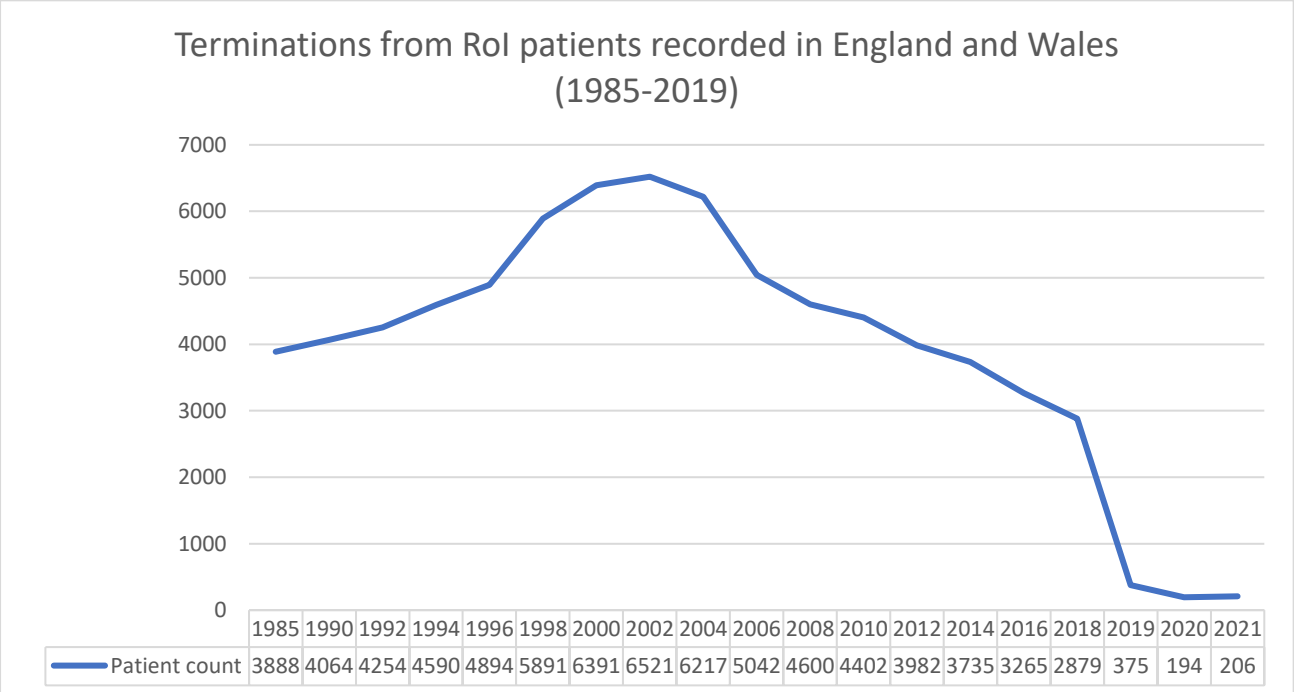

Figure 5: Abortion travel (England and Wales) 1985-2021

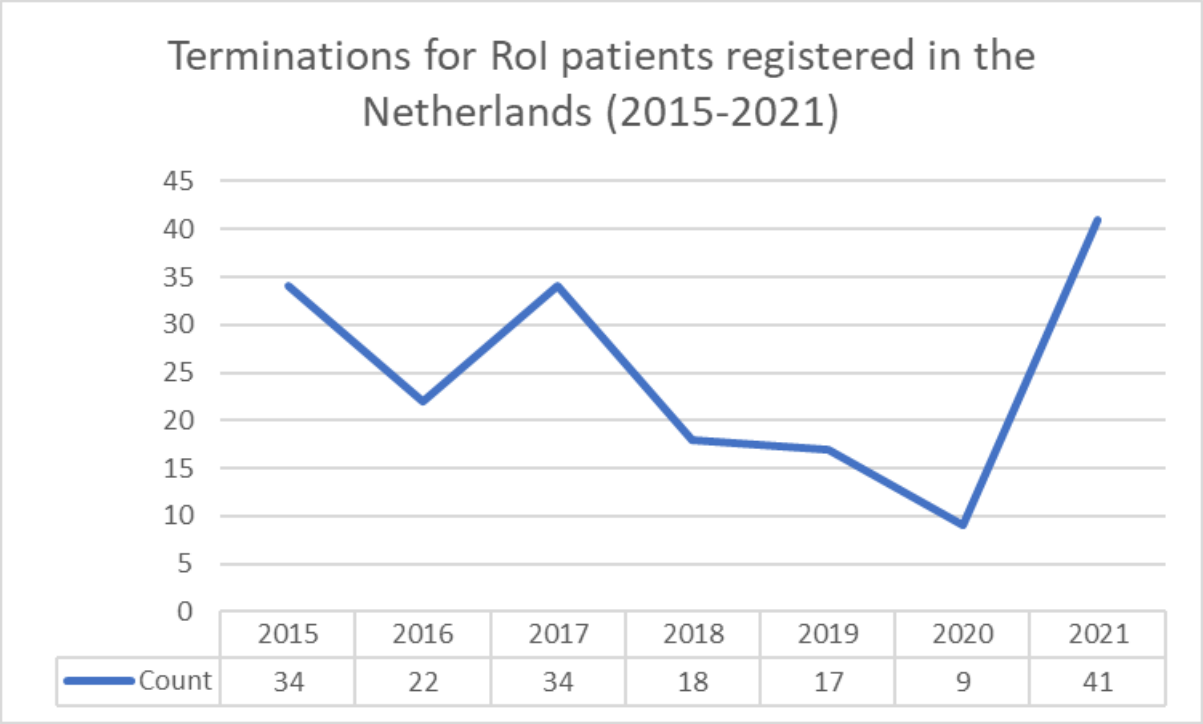

Figure 6: Abortion travel (Netherlands) 2015-2021

3.3.4.2 Abortion Support Network data – number of contacts

The Abortion Support Network (ASN) are the largest organisation providing financial and logistical support for Irish 'abortion travel'. On request, ASN provided a synthesis of data relating to Irish residents following the implementation of services in January 2019. ASN provided data on the number of Irish residents who had contacted the organisation and the number of residents to who ASN had provided financial support.

Detail	2019	2020	2021	2022 (to June)	Total
Number Contacts	159	158	175	116	609
Number Funded	69	51	59	50	229

Table 10: Abortion Support Network data 2019-2021

ASN reported that a total of 123 clients had disclosed a diagnosis of fetal anomaly. It is important to note that ASN does not insist those requesting support provide comprehensive details regarding their circumstances.

3.3.4.3 Gestation and abortion travel

The UK Department of Health and Social Care annual report provides figures for the gestation at which termination of pregnancy services were provided to patients registering addresses in the Republic of Ireland. The gestation recorded since 2019 are provided in Table 11 below.

Gestation	2019	2020	2021
3 - 9	65	11	7
10 - 12	33	7	2
13 - 19	198	134	137
20 and over	79	42	60

Table 11: Gestational age of Republic of Ireland ToP service users England and Wales (2019-2021)

ASN gave us information regarding gestational age they had recorded for the period 2019 through June 2022. This is detailed in Table 12. However, when offering this data, they emphasised that their clients do not always know or provide this information.

Gestational age	**Count of contacts**
Unknown	3
Under 9 weeks 6 days	21
10 weeks to 11 weeks 6 days	28
12 weeks +	427
Missing data	130
Total number of contacts	609

Table 12: LMP of contacts received by ASN, self-reported (2019-June 2022)

3.3.4.4 Abortion travel (England and Wales) and grounds for application

The Abortion Act 1967 (England and Wales) permits termination of pregnancy under one or more grounds. These are outlined in Table 12 below. The figures for the grounds under which termination of pregnancy care for patients providing addresses in the Republic of Ireland are provided in Table 13.

Grounds for provision of termination [Abortion Act (1967), England, Wales and Scotland]	
A	That the continuance of the pregnancy would involve risk to the life of the pregnant person greater than if the pregnancy were terminated
B	That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant person
C	That the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant person
D	That the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant person
E	That there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped
F	To save the life of the pregnant person
G	To prevent grave permanent injury to the physical or mental health of the pregnant person

Table 13: Abortion Act (England and Wales) 1967, legal grounds

Grounds	2019	2020	2021
A (alone or with B, C or D)	0	0	0
B (alone)	0	0	0
B (with C or D)	0	0	0
C (alone)	311	131	103
D (alone or with C)	0	0	0
E (alone or with A, B, C or D)	64	63	103
F or G	0	0	0

Table 14: Grounds for Termination of Pregnancy Recorded (England and Wales), 2019-2021

4 Primary qualitative research design and collection

4.1 Method

Primary qualitative data was collected through semi-structured interviews. In total, we conducted 41 interviews will 43 participants. All interviews were conducted by phone or secure video communication platform. Interviewers used a topic guide, covering the key requirements of the review and the tender. Topic guides included questions on service arrangements, experiences of implementation, challenges observed in practice, and the extent to which the objectives of the Act have not been met.

Consistent with Realist Evaluation, additional topics were included as new issues emerged during interviews or as requests from stakeholders (in this case the review Chair). These included experiences with protestors and the impact of the legally mandated three-day wait between the first and second consultation.

4.2 Sampling

We used a targeted recruitment approach and focused on addressing population gaps. Sampling focused on three factors:

1. Requirements of the tender
2. Representation of providers and settings
3. Evidentiary and population gaps

A purposive sampling approach designed to address evidentiary and population gaps were both methodologically consistent and would, in combination with secondary, desktop data, provide a robust dataset. As SPIDER synthesis illustrates, recent studies included qualitative data from GPs, consultant obstetricians and gynaecologists, anaesthesiologists, and MyOptions staff. Perinatal psychiatrists and neonatologists are underrepresented in published research. Recruitment, therefore, targeted these groups.

While qualitative research does not view numeric targets as quality criteria, to ensure the results were robust and comparable to existing studies we aimed to recruit a minimum of 40 participants for qualitative interviews. The distribution of interviewees by acute hospital group, setting, and discipline/specialism are tabulated below.

Hospital group	Count
Ireland East	4
RCSI	1
Dublin Midlands	4
Limerick University	1
South/Southwest	8
Sáolta	3

Table 15: Interview sample by hospital group

Setting	Count
Primary (GP)	6
Primary (WHC)	3
Acute	21

Table 16: Interview sample by setting

Disciplines/specialisms	Count
Perinatal psychiatry	4
Fetal medicine	2
Midwifery and nursing	3
Bereavement support MW	1
OBGYN	6
Social Work	1
Counselling	2
NCHD	2
Neonatology	3

Table 17: Interview sample by discipline/specialism

4.3 Coding approach

The researchers followed a coding approach consistent with reflexive thematic analysis (Braun and Clarke, 2019). Reflexive thematic analysis is a form of social science research that involves the presentation of research data under thematic labels selected by the researchers based on the researchers' reading of data collected with reference to wider understanding, including existing research data.

In practice, reflexive thematic analysis involves repeatedly reading and discussing data during and after data collection. Codes are agreed upon interpretations of participant accounts based on inductive and deductive reasoning. Inductive reasoning means that codes are drawn from participant statements; deductive reasoning means that codes are drawn from comparison with existing literature and data.

4.4 In-project research adjustments

Initially, the research design had included a focus group component with specific groups of health professionals. Following conversations with stakeholders, this component was removed. Health managers questioned the feasibility of co-ordinating groups of consultants in a short time frame.

Recognising the need to gather additional data on primary care, a GP survey component was added at the study mid-point. As it was designed after the research had commenced, the survey is not comprehensive, and it is advisable to undertake an additional, dedicated review of primary care with sufficient time and resources.

5 Realist Evaluation (Qualitative component)

5.1 Findings and Analysis

Through an iterative analytic process guided by Realistic Evaluation, we identified and connected a range of contextual factors and mechanisms impacting, from the perspective of healthcare professionals participating in the research, the attainment of the intended outcomes of the expanded programme of abortion services. The following sections provide a more detailed explanation with illustrative quotes.

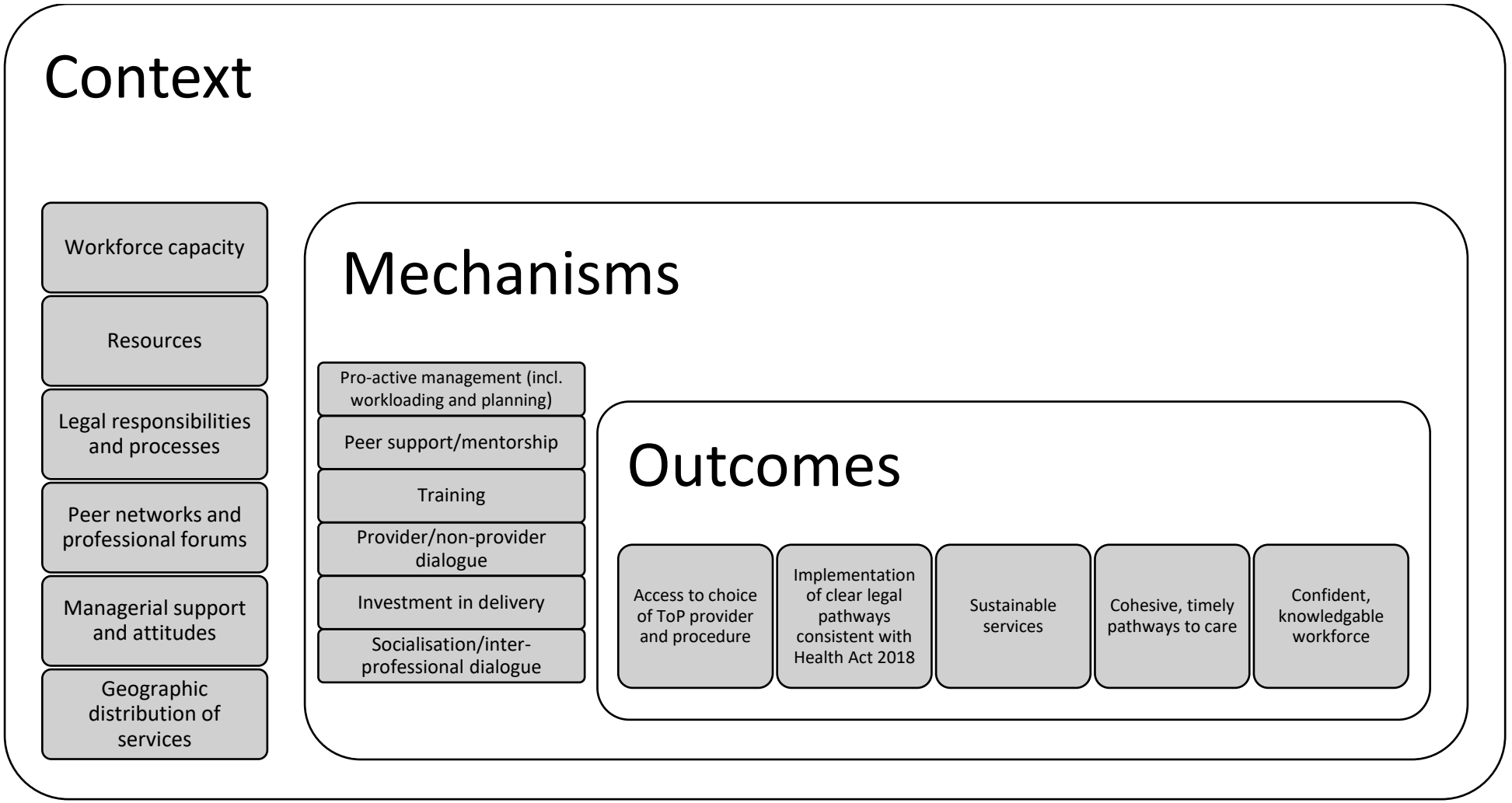

Figure 7: Realistic Evaluation findings (context-mechanism-outcomes)

5.1.1 Development of a confident, knowledgeable termination of pregnancy workforce

Based on our data, there has been incremental growth in a confident, knowledgeable termination of pregnancy workforce. As one consultant obstetrician commented in relation to GPs in the area:

> *…you can feel their confidence even growing in that the discussions and the referrals are very, I don't think it happens so much. I would imagine that three years ago, I would say it was different when it originally started, but no, I feel the GPs locally are quite confident.* (R105)

Respondents identified the following mechanisms as critical to the growth and development of the ToP workforce: provider and peer support, training, and providing opportunities to practice. As the primary data in this section indicates, these mechanisms are contingent on a range of contextual factors.

Some respondents described how their professional network or setting had taken steps to facilitate workforce growth, skills development, and service enhancement. For example, primary care providers outlined the introduction of mentorship programmes and peer-support fora through first the START group and later the ICGP. As the following participant described:

> *I suppose what we've done as well is that anyone who wants a more formal mentor, one-to-one, so when they do the ICGP training, we usually ask that if anyone wants to be allocated a mentor, often someone who's local enough to them so that again, you're using the same referral pathways and things like that, that they contact women's health and the ICGP and that we give them the name of one of the trainers who'd be an experienced, relatively local provider to them to give them some one to one support.* (R201)

> *I have to say, oh yeah, very quick and very, very supportive, and very clear. And very safe, you know, sometimes these things need to be teased out a little bit, and it's good to get*

another person's opinion, so like say, "Oh no, I wouldn't do that," or, "Yes, that's fine to go like that." (R213)

Another respondent, a midwife manager in a large secondary care setting, said she had co-ordinated training sessions with staff within their setting and primary care providers in the community. These sessions had proven valuable, in their experience, as they clarified the responsibilities of staff and improved workforce understanding of ToP care.

So, those meetings were good but it also… I suppose, it gave people a forum to address their fears and felt that they were being listened to as well. And there was a conversation then amongst staff as to, you know, this was coming in. And, you know, I think it made people think rather than putting their heads in the sand. (R204)

Yet this prior training had not been made available to all providers. As the following research participants note, they had learned through practice and informal information sharing from staff in other settings:

The training only has come in this year. There was no training. It was basically we made mistakes along the way. I suppose originally the women weren't cannulated when they came in and then we had women that were fainting and we had no IV access…. I suppose with the pain, we had women falling all over the place. We had one woman that actually fell up against a radiator and had a bruise on her face because of falling, fainting. Now we've learnt. (R217)

Trained? No. On the job learning. I suppose just as part of doing my job and going to communication skills courses, yes, but no, I didn't get any formal training about the provision of termination. Maybe in 2019 when it started they did, I don't know, but no. (R105)

Other healthcare providers, including consultants, stated that peer networks and peer support would be welcomed and improve both the quality of care and the size of the providing workforce.

The introduction of these mechanisms remains contingent on contextual factors. The availability of opportunities to engage in training and professional development, according to respondents, are unevenly distributed and influenced by meso- or hospital-level factors. As the two quotes below indicate, not all settings provide opportunities for non-consultant hospital doctors, for example, to train or gain experience in practice:

> *We haven't explored that at all really, yet, we haven't gone there yet* (R113)

> *Regarding NCHDs, like I said, they are not really part of our service at this point. In terms of training, I'm aware there is some training for the nursing staff but I think we've distributed those and there are one or two study days here and there.* (R207)

> *The patients were exclusively seen by consultants, it never really filtered down to the NCHDs and we didn't get a huge exposure to it in that first, probably a year to eighteen months. There was very limited teaching on it, around the legislation and implementation of things.* (R208)

Healthcare providers, including those not involved in ToP care provision at the time of research, drew attention to capacity in particular, as illustrated in the following quotes:

> *I think from a GP perspective and I suppose from an ICGP perspective, what we'd probably say is I think the GP workload crisis and workforce crisis, probably a lot of GPs have said that and capacity within general practice is a massive problem at the moment. We are out the door. I think many of the GP providers, they've created time in their schedule to look after TOP patients, but it just becomes challenging when you might have someone goes on annual leave and even things like if you're locum comes in, maybe not provide training.* (R201)

I think sometimes, if there's only one of us there, sometimes you see the MyOptions call and you say 'oh God', just from a time factor. Because they're so unpredictable, you know, when you can't book in the appointment as such, for people waiting, you don't know how many will ring. And I mean, I would find that even more that we would do more with the follow-on. Very rarely, I think, some visits are done. That's a good 45 minutes usually, I would find, maybe not 45 minutes, actually, for that, it'd be a good 20 to 30 minutes. Which is a fair bit out of your day when you don't have that schedule, and generally when a call comes in, maybe in the morning, or often late afternoon, and it's not scheduled into your day. So that's the biggest difficulty, I think, with us. And especially if we need lots of numbers, it's whoa, it became too much. (R213)

Even where the HSE had taken steps to address capacity issues, through releasing funding for posts, for example, these have not always resulted in an increased workforce for termination of pregnancy as investment in ToP providers was not meaningfully supported by senior management at a hospital level. Interviewees at two separate secondary care sites included in our study reported the appointment of staff who later did not provide a full range of termination of pregnancy care. In one instance, outlined in the quote below, the consultant appointed using funding provided by NWHIP[3] declared a conscientious objection once in post.

Our fourth post had a long-term locum in it and that was advertised and interviewed back in January and we interviewed for the fifth post at the same time. Dr X who has now taken over the fourth post, arrived and started work last month. But Dr X has said he is not interested in providing a ToP service. (R220)

[3] As the NWHIP Director stated in a query by the PI regarding the 'ring fencing' of funding and conditions of this funding: "Posts were not 'ring fenced' for TOP services however, funding approval was conditional on the basis that the recruited personnel would provide or participate in the provision of termination of pregnancy services within the hospital/unit." (NWHIP Director statement, September 2022)

At this specific setting, which had applied for further funding to support development of a full range of services from NWHIP, the interviewee stated that the ultimate provision of services may depend on future managerial support as well as capacity:

> *So that's why we're aiming to get the fifth and sixth posts in and on-site and commence the service. Then when myself and my colleague retire, we'll see whether or not our successors are willing to be part of the service at that stage.* (R220)

According to a consultant obstetrician in another setting, this example was not necessarily unusual. At the same time, in the interview quoted below, they argued that the overall workforce and resource limitations in the health service, the macro-level context, meant that hospitals would not always use funding provided by the HSE as intended by national managers:

> *There certainly have been people recruited to posts for termination where when they went into the job they ended up not doing that at all. That's kind of because of the way the system works to a certain extent. If a hospital gets funding and approval for a job, they're going to grab that with both hands and they're going to put the person they want into that job and they'll work around it afterwards. They won't necessarily prioritise what the job was supposed to be if that makes sense.* (R125)

Primary care providers suggested that the presence of a local providing hospital and other primary care providers impacted the development of a confident, knowledgeable workforce:

> *I think there is a bit of a snowball effect then hopefully once you see someone up and running, that it will encourage more people to do the same.* (R201)

> *When there is no providing hospital in the locality, that does stifle discussions and it does have an indirect effect on the discussion, on education and very much so on provision.* (R121)

That said, primary care providers noted that it was challenging to improve workforce knowledge as they received limited information or feedback from secondary care, as the following provider in a WHC explained:

> *We never find out what's happened to them. So it's important from a learning for us point of view to know which ones are the relevant ones that we should send to hospitals and which ones maybe we could wait and see on. We just don't know what's happening to them.* (R123)

This data indicates that there has been some incremental workforce development, both in terms of knowledge and confidence. This development has been facilitated through peer support, training, and having opportunities to practice. However, these mechanisms are all dependent on workforce capacity, the existence of professional forums or peer networks, and managerial support.

5.1.2 Implementing clear legal pathways to care consistent with the aims of the Health [Regulation of Termination of Pregnancy] Act 2018

The data indicates variation in the outcomes of the new legal frameworks and interim guidance. Providers felt that the legislative change and model of care for applications under 12-weeks had expanded access for most women. Section 12 was identified as having had a significant effect. Both the community and remote models of care have expanded provision and access to termination of pregnancy. Other providers felt the legal changes allowed them to discuss termination more openly and to support women and families who experienced fetal anomaly, maternal risk to health, and bereavement more effectively. As these providers said:

> *As a maternal medicine practitioner, I had very limited circumstances in which I could offer someone a termination of pregnancy and in those circumstances, the legislation change made it slightly easier.* (R112)

I suppose it's good we have a system, it's not perfect, it's better than it was for sure. At least the majority of women are able to access termination now in their own community as opposed to having to travel. So that's good. There is definitely room for improvement. (R108)

That said, the effect of legal frameworks and guidance in terms of broadening access remains uneven. Aspects of both the legislation and the guidelines, according to primary and secondary data, can act as barriers to care. The mandatory three-day wait between the first and second consultations for termination was reported as problematic for marginalised and vulnerable service users by GPs working in HSE Inclusion Services. Organising and attending multiple appointments could be challenging for members of the homeless community who, as one GP working with addiction and inclusion services explained, "*would not have GPs and would not have access to GPs*" (R102). Attending multiple appointments with a mandatory three-day wait between consultations could, as this respondent explained, present a substantial barrier as it required travel:

it's to do with logistics. And even though CITY is very small, it is a big deal if you have an active addiction to get on a bus and go out to AREA A, or go down to AREA B, to see your GP, or something like that, you know. (R102)

A GP working in inclusion services in a different city made similar criticisms, emblematised in the quote below:

The other thing is people often come to these inclusion health settings because they don't trust or want to have had bad experiences in normal GP practices, in hospitals, in other settings [….] you will see the minute I start saying, "Okay, you need to go across the city, round the corner at 3 o'clock tomorrow afternoon." The amount of people you lose to follow-up even if it's me, even if it's literally me. (R218)

GPs in rural areas also highlighted the challenges created by the legislative requirement for multiple appointments with a mandatory three-day wait. These included a cost burden. As the GP in

the following quote, based in the north-west stated, *"I think the cost of fuel is a big one to be honest. It's not a free service if you have to spend 100 Euro on petrol to get there and back"* (R215).

Primary and secondary care providers involved in early abortion care stated that the combination of the three-day wait and the gestational limit for Section 12 created challenges when coordinating services for service users over 9-weeks gestational age. The coordination of care for this group depended on the availability of hospital staff to complete scans and either discharge to the community or treat in secondary care. As the provider in a WHC notes in the following quote, such availability cannot be guaranteed leading to service users 'timing out' of care:

> *Every year at Christmas we've had people who are ringing around desperately trying to get appointments before because there's going to be no clinics the next week because there's going to be so many bank holidays. So if they're in that 10-12 weeks, we literally can't get them an appointment. It has definitely happened, that I've spoken to someone on Christmas Eve saying, "I'm sorry, by the time the next clinic is available, you're going to be over twelve, there's nothing I can do," and that was having rung all the hospitals on Christmas Eve which is just a horrible thing to have to tell somebody that, "Yes, you're actually legally eligible but you're not going to get there." That's purely down to the three days. I mean if that lady, because I had seen her maybe a day before that, she had had her scan, she was further on than she thought so she wasn't eligible for me to look after the next week. There was bank holidays on successive Mondays and there was no other clinic that week so that was it. She just wasn't going to make it.* (R101)

The issue of staff and service availability was also raised by GPs who explained that, when there is only one provider at a clinic, or clinics have limited opening hours, the three-day wait may be more than three days. Again, the waiting period created pronounced challenges for those close to the gestational limit or close to 9-weeks gestation:

You might have a woman who is eight weeks and five days or getting close to that kind of cut-off period where she would be suitable for a medical termination and then to say, "You have to wait three days," maybe that puts you over that time period. I just think that's a little bit silly. Then also we're a GP office so we're not open seven days a week. So even though it's a three- day waiting period, if we're not open on a Sunday, that ends up being four days or five days if you're waiting to get into us on Monday. Plus, if you find out you're pregnant maybe six or seven weeks, that gives you a very little window to come into us. (R215)

On the other hand, co-ordinating midwives in secondary care reported that the three-day wait provided them sufficient time to organise the delivery of care. This is illustrated in the accounts below from midwife coordinators in different maternity hospitals:

The three-day reflection period, I don't know if I find that a bit patronising, but if somebody somewhere thinks that's the best thing for people then that's that, and it certainly gives me the window of getting the scan done. I can't always do it on the day that the woman is referred, it could be the following day, so I don't have a huge problem with that. (R212)

It gives me that time to try and sort everything for her, to find a consultant who will meet her, to book a bed on the ward and make sure there's a bed available. You know? Free up my diary that I have a few hours when she comes in there. Where I think if a GP got onto me today, saying this woman is whatever, she needs to come in today, because she might need medications, do you know? It wouldn't give me enough time to organise and free up a space for her. So, I think that time is really important to us as well, because our Health Service isn't available for everyone, just right now, you know? (R117)

The critical legislative challenge highlighted in these accounts is not the three-day wait but the need to complete terminations before 12-weeks gestation. According to respondents, this requirement meant that, even where service users had initially accessed care within the parameters of Section 12, they may 'time-out' of this pathway due to the availability of resources or the ability of

staff to coordinate care. This could create a particular problem where the termination was incomplete, as one GP outlined:

> *We'd love some clarity around the fact that if we have commenced or if treatment has been commenced, and this would be pertinent to hospital care as well, if treatment has commenced, can we complete the treatment if she's gone over eleven weeks plus six days. So the instances where those, maybe examples I could give would be say a woman has come to me at nine plus six weeks and I've treated her because that's the medical model at the moment, I can still treat her and for some reason, she doesn't get back to me or I haven't been able to make contact and I realise maybe at twelve weeks plus zero days that it hasn't worked but we've given her extremely potent medication, can we complete that treatment... If there's still a heartbeat... so it's incomplete but there could still be a heartbeat, but you've exposed the foetus to teratogenic medication* (R121)

To minimise the potential for 'timing out', healthcare providers who participated in the study reported adopting agile and flexible working patterns as well as undertaking and leading training in their settings. Agile working patterns included working out of clinic hours and responding to short-notice requests for scans as the following midwife co-ordinator explained:

> *If a referral came in on the Friday and the GP said to me, "She might be close to twelve weeks and needs to start on Monday", like I said, I'll come in on the Saturday and see if the woman can come in, and we'll do the scan then, so we're ready to go.* (R212)

Health professionals involved in care under Sections 9 and 11 participating in the research found the 2018 legislation problematic. Three key issues were highlighted: (i) the location of care within criminal law; (ii) the responsibilities and role of health professionals within the legislation; and (iii) the training and socialisation of healthcare professionals.

Consultants in neonatology, maternal and fetal medicine, and perinatal psychiatry who participated in the research all identified the potential criminalisation as a problem. Some, such as the following consultant neonatologist at a major maternity hospital, felt that the location of termination of pregnancy in criminal law deterred healthcare professionals from engaging in provision:

> *I would like the criminality aspect of the Act removed or dealt with really significantly to allow people to practice in a professional way and would make people feel more protected but also more inclined to get involved. It's a real barrier to many clinicians now wanting to get involved in these cases because they're afraid of what it will mean for them professionally and personally if even one case goes wrong, which means that you'll be left with very few, there's only 20 or 30 neonatologists in the country. You could find yourself with very few people that are willing to engage in the process purely because it doesn't protect them, not because they don't want to.* (R216)

Another consultant, specialised in maternal and fetal medicine, working at a different maternity hospital, stated that the continued criminalisation of termination of pregnancy impacted the conduct and tone of decision-making processes, specifically multidisciplinary teams. While, under Sections 9 and 11, the legislation only required two medical professionals to agree that a termination was necessary, this provider argued that criminalisation meant MDTs orientated towards a consensus. As the following participants argue, consensus decision-making gives reassurance to healthcare professionals that they are not breaching the law:

> *What I feel and from, you know, my interactions with clinicians sometimes there are situations where people feel that there has to be almost unanimity or consensus in the MDT sort of forgetting that the legislation doesn't require that. So, it's almost being too onerous. So now, obviously, if nobody in an MDT agrees, that's a bit of a red flag. But you could have a situation where a large proportion of the MDT agrees and another smaller proportion,*

doesn't agree. It's, you know, quite reasonable to sign off on that. But, again, there is a reluctance to be… and I think it's… if that's true, I don't think it's anything to do with conscientious objection or anything, it's the fear of getting something wrong and subsequently being be challenged on that or there being a case. So again, criminalisation, I think, feeds into that. Okay, so there's a lot more discussion, a lot more worry about it than there would be in other types of MDTs. You know. (R204)

As a group, you know, I think having the group MDT meetings means that we feel protected as a group, so we'll all sign in together, so there will be ten people in the room, or twelve people in the room, and we'll all feel that we've been able to voice our opinions in a confidential, safe space, but that at the end of it, that the consensus is reached and everyone is in on it. So yes, it's in the back of your mind. You don't want to do something that's illegal, you know. (R120)

Connected to the problem of criminalisation, some perinatal psychiatrists connected with care under Section 9 who participated in the study, argued that the responsibility to identify termination as a definitive solution to risk to mental health was extremely challenging. These providers underlined the complexity of perinatal mental health concerns and, as the quote below describes, how the experience of accessing termination of pregnancy under Section 9 could be in itself a traumatic event:

It's weighing up is the continued pregnancy more traumatic than the termination itself, which we know is traumatic. So, you're weighing things up but it's not going to completely the avert the risk of anything because it's another traumatic thing. The whole process has been traumatic for them. So, the wording feels very strict which you wonder whether that might mean people that, I think in the spirit of the legislation that if you think that continued pregnancy is really going to have a detrimental impact on their mental health in a serious

way; but someone may not say the termination doesn't avert that. Do you know what I mean? (R203)

The central issue raised by this group of health professionals, whose accounts resonated with those of MFM specialists and neonatologists, was the responsibility to present termination as a resolution to a concern. In reality, as the consultant neonatologist at one major specialist centre explained in relation to Section 11,

I suppose in Section 11, number one, 'likely' is the word I suppose there to lead to death of the foetus either before or within 28 days. That's a very hard thing to predict even if the condition is universally fatal, that they'll die within 28 days. It's a hard thing for a doctor to predict the timing of a death. (R124)

A perinatal psychiatrist in another setting described a similar challenge in relation to Section 9 for a patient with a history of mental ill-health.

[The pregnancy] might have exacerbated it but in good faith, I can't say that if you terminated, that you would feel better and in someone like her, she has a personality disorder as well, so very poor distress tolerance, she could very well get worse. (R115)

These findings indicate that the criminalisation of abortion and allocation of responsibility to sanction an abortion as necessary limited the effectiveness of the legal change in terms of liberalising access to abortion. As one senior consultant neonatologist commented, there were *"concerns about personal safety or exposure or criminal culpability"* (R118).

A further contextual problem raised by research participants was the limited training and socialisation in termination of pregnancy care received by some health professionals. Training here refers to training in legislation as well as values clarification. While some training was offered in advance of implementation and has continued irregularly in the intervening three years, not all health professionals have engaged with this training. The effect of this limited training, according to

some participants in the research, has been, in certain circumstances, a misinterpretation of legal responsibilities. As one consultant obstetrician commented based on her experience of MDT meetings for Section 11 applications:

> *what I've seen at the MDTs around Section 11 is that people's feelings very much spill into that decision-making. People are not very good at separating their feelings from those of the patient in front of them and from the legal right of the woman to access care.* (R125)

Socialisation is a critical learning process through which health professionals develop a sense of professional identity and belonging. Following the implementation of termination of pregnancy services in January 2019, based on reflections from health providers in our study, it quickly became clear that encouraging some health professionals to see themselves as belonging to a health service that provided women-centred termination of pregnancy was going to be challenging. This challenge is not limited to staff with conscientious objection or non-providers. There are still health professionals working in specialisms identified in the interim guidelines as part of the termination of pregnancy care process, who participate in MDTs, who do not view themselves as connected to termination of pregnancy care. The importance of and need for socialisation was outlined by multiple respondents as illustrated in the following quotes:

> *This is a group of people, fetal medicine specialists in general and paediatricians are a group of people whose job it is to save babies' lives, to get these pregnancies as far along as possible and to ensure a good outcome for parents who want to continue with the pregnancy. So it takes a huge shift in thinking really for them to do it and that's their own responsibility is to actually change the way they think with the woman at the centre of it. But some of them aren't very good at that.* (R125)

> *The problem is historically everyone would go over to the UK but even now, even now in your Section 9 assessments, that's part of your assessment is what would you do if you don't give a termination? They're going to say they'll be straight on a ferry over to the UK. So you're*

doing all the assessment, the whole thing is existing within the knowledge that people can just go over to the UK for it. I think some of the hospitals in Ireland are just like, "Well if they want it that much, they can go over to the UK." I feel that that's a real abdication of responsibility, especially in COVID times when people were forced, in COVID times, to go over and have a termination in Liverpool or wherever. That wasn't fair basically. (R203)

From this data, the key mechanisms for maximising the positive outcomes of legislative changes and applying guidelines effectively are training, peer-to-peer dialogue, pro-active management, and provider communication and coordination. Within the category of training, socialisation, values clarification, and legal education as to health professionals' roles and responsibilities could be, based on primary and secondary data, important mechanisms for ensuring the appropriate application of legislation. Based on our data, the operation of these mechanisms is affected by the legal framework (particularly the criminalisation of termination of pregnancy and the three-day wait), workforce capacity, resources, and managerial support for training opportunities.

5.1.3 Equal access to a choice of ToP services

Desktop statistical data indicates that access to ToP care has increased overall. However qualitative secondary and primary data from providers strongly suggests that there is limited choice. This includes choice of provider and choice of procedure.

In relation to access to a choice of ToP services, providers in the study focused on contextual factors. They drew attention to macro- (national) and meso- (institutional) level issues. The primary macro-level issue highlighted as impacting choice was the geographic spread of services. While the number of providers per county was increasing incrementally, these providers do not always offer a full range of services. As the GP below stated:

So, whilst there is a geographic spread to a degree and the numbers have increased somewhat, there is still a lack of services, particularly in some counties where you may only

have one or two GPs providing so that's certainly an issue in terms of giving somebody choice I suppose and lots of choice around providing GPs (R215)

Secondary care providers reported similar limitations, but in relation to the geographic spread of the full range of ToP services. As a consultant obstetrician at a major maternity hospital stated:

It's a postcode lottery. It depends on where you go. Some units have very good access to surgical termination. They tend to be maternity hospitals and that's just because the focus in maternity hospitals is women's health, that's all they do. If you go to a general hospital that has a maternity unit on site, their operating theatres are part of the general operating theatres, so they have broken bones, appendixes, burns, whatever going through them as well. Their focus is not on looking after women's health. (R125)

For example, the following clinical leads, who identified their tertiary hospitals as a non-providing, reported that they offer some components of ToP care but not all and not to all patients:

I'm a clinical lead in the hospital which has got four consultants and we deliver a thousand patients in the unit, on the downside of it, I work with three colleagues who have religious objection to termination of pregnancy hence this hospital hasn't taken or it's basically not providing TOP services but we do look after people if they need scanning services for medical management or when they're making up their mind and for TOP complications we do manage. (R113)

The four consultants on site here don't do termination of pregnancy apart from one of them who has done a couple for fatal fetal anomalies on her own patients. (R220)

Providers in secondary care, even in major sites, reported that there is effectively no access to surgical termination of pregnancy. This is exemplified in the following quotes:

So women who are in second trimester and undergoing a termination for whatever reason, aren't offered a surgical option. It's medical, or nothing in Ireland. (R108)

there aren't other centres, like, I can't say, "We can't do that here in HOSPITAL, but I can arrange for you to go to HOSPITAL", we haven't got that option either, so it's like, no surgical pathway (R212)

Providers attributed the lack of choice of provider and procedure to meso-level context. This included conscientious objection within hospitals and surgeries, resources, and managerial support. As a co-ordinating midwife in one hospital outlined, in primary care the objections of GPs in surgeries can limit the ability of GPs willing to provide to offer care:

but even the GPs who have performed it or who have been performing it and have to negotiate alternative areas for them to see these patients and because not all of their partners or the other people practising in that surgery are agreeable to the service being supported. (R207)

Providers in secondary care reported experiencing resistance from theatre staff, including anaesthesiologists, to supporting the provision of surgical termination of pregnancy. While participants stated that conscientious objection and staff opposition to termination of pregnancy was a factor, the obstruction to surgical provision was also connected with resources and staff positions on what the appropriate use of theatre space in maternity hospitals. As the consultant obstetrician and co-ordinating midwife at one setting recounted:

Originally, before I even realised that theatre access was very difficult, I suppose, broadly, in the whole obstetrics and gynaecological service here, it did feel like there was a lot of resistance from the theatre staff. We have a labour ward theatre and a general theatre, and there was a lot of, "I do not feel it is appropriate to perform terminations in a labour ward

theatre," and it was very strong about that. The general theatre [staff] were very resistant originally to have these cases in theatre. (R105)

Our labour ward is our maternity admissions, and it's also where our miscarriage ladies have their… if they're having surgery, they have it on the labour ward, that's the theatre that's used. From the beginning, we did feel that's an inappropriate place for a lady terminating her pregnancy to have a surgical pathway, and there was resistance all around to that. (R212)

In this setting, both participants outlined how they had made efforts to engage in a professional dialogue with non-providing staff and staff who did not support provision to expand choice:

I do a lot to try and make it more acceptable, but despite all that, our surgical pathway is very limited. I then went on the attack saying, "Maybe in at least three circumstances if we could secure a surgical pathway, and those instances would be if we had a medical indication, and it would have to be a failed medical termination?" We're trying. (R212)

So, I do think there's been a lot of work done where we've now identified, I have found a number of key staff who are very comfortable and willing to be involved, both from a theatre nursing point of view and anaesthetics. Now actually, the main barrier is physical theatre access and time, you know. But I think those barriers have been overcome with training and education. (R105)

That said, as the second quote highlights, the availability of resources acts as a barrier, as a perinatal psychiatrist at another setting underlined:

So, there's other things like infrastructural and staffing issues in some units across the country. So, you know, adding a service may not be the easiest thing to do. (R204)

A similar combination of barriers – staff attitudes to termination of pregnancy, conscientious objection, and resources – limit the choice of procedure:

But it's a kind of an uphill battle at the minute because obviously introducing a full service involves not just me being on board, it involves other colleagues, as well as anaesthetics, as well as theatre staff. And then because you're introducing a new surgical service, you're taking away from the hours in theatre from other gynae procedures for example and bed days and beds. (R108)

Willing providers in primary care encountered similar problems. As the GPs quoted below explained, the additional resources required to deliver ToP services was, in their experience, a deterrent to involvement in the service. Again, this limits choice of where to access services:

I think it's just the thought of trying to add in another service to what you're already doing when you're barely keeping your head above water with the amount of work that's coming in. I think that's probably a big thing. (R201)

So, I had a colleague who isn't involved in the service, not because [they were not] interested. Just like, [they] don't want to do all that extra work, [they] have enough work to be doing. (R108)

Respondents identified managerial support and the existence of opportunities for training as key to expanding choice of care location and procedure. Training opportunities were again connected with the availability of resources to cover staff undertaking training. As one interviewee from a WHC stated:

We haven't looked at surgical options because I suppose the training that would be involved, we just don't have the personnel available to take time off to go on a training course. We don't have a lot of experience as a whole in Ireland on surgical terminations. (R123)

As one consultant perinatal psychiatrist, explained in relation to later-term care, resistance from hospital-level senior management was a key barrier:

> *[The hospital] don't like doing terminations. They don't feel trained and set up for it. There's a lot of moral objection to it, certainly at quite senior level is the feeling I get. So that's a definite barrier to people getting late-stage terminations. They want to just be able to refer it up because they refer their high-risk stuff to Dublin anyway. They want to refer it up. They see Dublin, it's more acceptable to staff so they just don't bother to get themselves trained up because they don't want to anyway because they don't want to deliver these terminations.* (R203)

This comment points to numerous interconnected issues including managerial support[4], conscientious objection, and resources. It also underlines the role of training and the impact of lack of managerial support and resource restrictions on providing staff. As previously noted, training sessions can encourage further staff engagement with provision. However, as a consultant obstetrician at a major hospital noted:

> *But again, [training sessions] were run by a very small number of… I would say, committed doctors on sites who, you know, drove this rather than necessarily the management or anything within the sites, yeah, so.* (R204)

Where the managerial support was not present, the data consistently pointed to a close connection between access to a choice of care with the existence of proactive providers negotiating

[4] Managerial support includes recognition of the importance of services, investment in staff, adequate work loading, and engagement in coordinating workforce and resources to ensure the provision of services.

and developing services. These 'committed providers' absorb significant responsibilities as outlined by a consultant obstetrician in the following illustrative quote:

> *But again, it takes a lot of coordination for me at the minute, if I have somebody who needs surgical, I need to try to see the patient, then I have to find a day in theatre that I am free. As I like to do it, that there's an anaesthetic person, find out who's available that day. Are they comfortable with termination? Find out from the Theatre Sister, what theatre nurses are on that day? Are they comfortable with it and all that, so there's a lot of co-ordination. It takes me two or three hours work just to book someone in for a surgical termination* (R108)

For some providers, these resource limitations had resulted in restriction of their service, as the bereavement counsellor quoted below explained:

> *I'm a limited resource, so I have to be very pragmatic about what I can offer, because the need for service is really high and I just have a one day a week contract. So, what I've opt... My model of care is that I see people not very frequently but I offer that extended care so that they feel like they're held across that stretch of time.* (R214)

Taken as a whole, data analysis indicates that access to a choice of ToP services has not been established. There is limited access to medical termination of pregnancy and uneven geographic coverage. To address this staff have engaged in dialogue with non-providers, introduced training, and engaged in 'managing up' and negotiating access. Both the outcomes and mechanisms are impacted by the macro-context of the workforce and geographic coverage and the meso-context of managerial support and resources.

5.1.4 Establishing cohesive, timely pathways to care

The expanded termination of pregnancy service initially included four pathways to care: a community model through GPs and WHCs; a hospital-based early pregnancy medical model; a

hospital-based surgical model; and a hospital-based model for pregnancies over 12-weeks gestation. A fifth, remote model of care was introduced in response to Covid-19 restrictions in 2020.

Research participants in the study expressed differing views on how well the pathways to care had been established. The implementation of community pathway for early medical abortion and remote model of care for pregnancies under 9-weeks and six days gestation, where service users were confident in the date of the first day of their last menstrual period, was described positively by primary and secondary care providers. Opportunities to practice and workforce engagement were identified as key factors assisting the implementation of the community pathway. As the respondents quoted below, a WHC provider and a GP, stated:

> *But I mean it feels now, in a lot of ways, like we're doing it forever. It's very embedded into the service and it's very much part of just daily work and everybody is very familiar with it.* (R101)

> *I do think the fact that abortion care is embedded into normal general practice is massive… I think more and more people are interested in providing and I think they get confident when they see colleagues providing and that it is such a safe service when it's done correctly.* (R121)

The introduction of the remote model of care, which allows for one of the two legally required consultations to take place by phone or through an online video chat, has further reinforced the community pathway. As the following GP stated:

> *I think the fact that we can do visit one remotely has been a huge game changer for my cohort of women and girls coming because they often have to travel quite a distance, not as much now that there's a few more providers but there could be an hour or more coming to see me. These, very often, were women of very meagre means, no access to transport, students in the same situation or if they were concealing it from an abusive partner. It really*

threw up huge problems for them. So being able to do a remote consultation was massive. (R121)

A representative from the ICGP said they would like to see an extension of remote provision post-Covid.

We're hoping that that [remote provision] will be retained in some capacity or at least flexibility. I think most people would prefer still, GP providers would prefer, if they can, to see somebody for one of the visits, visit one or two, and do one remotely. (R201)

At the same time, GPs noted that the community pathway presents challenges for the homeless population or women living in direct provision.

There's certainly added challenges I mean for those women, even in trying to work out when and where and how they take the medication if they're in shared accommodation or a hostel situation or homeless. I mean you need to think of creative ways of coming at this by way of supporting those women as best we can. (R123)

Telemedicine also presents challenges for this group as they may not have access to a smartphone or other electronic device and the internet.

One of my patients last week, she's literally had four phone numbers I would say in the last month…part of it I think is relating to some of the addiction issues and also a part of it is living in hostels and stuff, getting nicked. (R218)

The availability of a GP or primary care provider who understood the legislation was highlighted as a key contextual issue impacting the effective implementation of the pathways. For example, the following midwife coordinators at different sites connected inappropriate or unnecessary referrals of patients to emergency departments, which could delay care, with a lack of understanding by non-providers:

Where people are actively involved in the provision of termination services, the understanding is very good. We have educated ourselves and we know what we're doing. However, where women are presenting to EDs or on-call maternity services, or mental health services in crisis, I feel there's a very poor understanding of the Act and people's responsibility within the Act. (R109)

Some GPs are sending the women into early pregnancy units or telling them to go to A&E. I mean that's not the referral pathway, that's terrible for the woman. I mean they shouldn't be sent into Casualty, there is a pathway there, a national pathway. (R206)

Similar comments were made by GP providers who participated in the research as in the following quote, who argued that some non-providing GPs had not engaged with education and training, and this impacted the implementation of the care pathway:

So, I would have had patients…say "Oh no, my GP told me I'm fine up to twelve weeks."… It's further education like that that needs to be addressed. (R213)

The successful implementation of a timely, cohesive care pathway for service users who require gestational dating scans or hospital-based care is impacted by macro- and meso-level factors. The availability of staff, specifically pathway coordinators, and providing sonographers were underlined as influencing the implementation of care pathways. This is outlined in the following

Oh no, we're very lucky here, we are very lucky. We have our midwife, who it's solely her main, she has a couple of roles but basically her primary role is to the termination services. She is a very experienced midwife who's a sonographer, who's had many years in early pregnancy and gynae, so she scans them all. And if she's away then early pregnancy are very happy to have the termination services under their wing as well. But we have a primary midwife who does the dating herself, and coordinates all of it. And then I will come and do

concerns and any complication stuff, and any queries. But no, we're very lucky, we have really good access for scanning. We think so. (R105)

Certainly in the bigger units it works extremely well. Because you have quite a senior admin person, you have someone who is the initial point of contact for GPs. (R125)

I think that the GP pathway does work kind of well and I suppose because of the delicacies around the service, we focus all of our calls and enquiries through one person (R207)

When you connect with the lead person there, the Clinical Nurse Specialist. Everything works really smoothly. Fantastic. If they're on holiday or they're not there that afternoon and then I'm off the next day, and it gets lost. Not lost but just, that streamlining isn't there, you know. So, for me, that's probably the biggest issue with the hospitals. (R213)

At the same time, while the appointment of the co-ordinator has been very positive in implementing care pathways, some co-ordinators are left with a huge workload and burden of responsibility:

I do feel we're quite stretched, trying to look after and facilitate these women, with only, like it's only a 39-hour post.... It's a shared post... I think it should be like probably two by 39-hour posts, you know, it's not enough, because it's got much busier in the last year or two. (R117)

Some hospitals might have one ToP coordinator who works part-time meaning the ToP service is only available two days a week which may be a problem for those close to the 12-week gestational limit.

There is invariably only one of them. [ToP co-ordinator] Now there's patchy cover in some hospitals so the coverage does exist but it's not brilliant. So, there isn't a second person who can just step seamlessly into that role or there aren't people say job sharing or working part-time who are each doing half a job. It tends to be one person doing half a job, so half their hours that week are dedicated to that role. (R125)

Some respondents connected the implementation of pathways with workforce training regarding health professionals' roles and responsibilities within hospitals. Yet, as one midwife coordinator illustrates, this training is often initiated by individual staff without managerial support:

> *I think a lot of the wider team aren't aware... It was kind of rolled out in 2019, with no huge education, so I think now, I think it's only now that we're educating more staff. But I've given education sessions on some of the wards, just like that providing education to them, about what happens...if the midwifery team in the emergency room, they kind of know what to do if someone comes in and has heavy bleeding, you know?... So, I think everyone knows their little bit in their area that they need to know, but they don't know the other bits, you know, they don't know the wider bits that I suppose, that's what I'm trying to do, is educate staff now on that... And the education session I'm completely stretched doing that. It's basically trying to fit them in myself, on a lunch break, or something.* (R117)

This account highlights once again how mechanisms for enhancing pathway implementation are led by committed providers in excess of their allocated workload. As one midwife co-ordinator, within a context of inadequate geographic coverage, working overtime was unavoidable:

> *If someone's coming from north COUNTY NAME on a bus, there's no point in me saying, "Can you come in at nine o clock in the morning?" If they've kids, or maybe no partner, I'll stay late, or I'll come in on a Saturday morning in a time-sensitive situation. It means I have to be flexible because the access in the surrounding areas is limited* (R212)

The care pathways for service users seeking termination under Section 9 and Section 11 were highlighted by research participants as more challenging. A particular concern for providers was the absence of guidance on the pathway for Section 9 applications on mental health grounds. As one perinatal psychiatrist stated:

There's no standardised formal way... It's slightly disturbing. There's no formal clear pathway and sometimes it's GPs ringing us, sometimes there are people in the clinic will contact us. Occasionally it's women themselves contacting us. There isn't a clear pathway for how somebody should come for a termination on mental health grounds…We're aware that this needs to be standardised but we're not sure how to standardise it. We're probably a little afraid to drive that too hard in case that actually creates a barrier. Look, I appreciate that as it currently exists may be a barrier in and of itself (R107)

Another respondent, a GP, also raised concerns about the absence of a care pathway for mental health applications under Section 9:

There's no clarity around it. I mean we really want proper, as I said earlier on, standardised pathways that we know exactly… each hospital has their own way of doing things which is okay but I really think there should be standardised protocols. (R121)

The absence of guidelines for Section mental health applications was discussed as problematic within the context where workforce training and knowledge regarding perinatal mental health as well as understanding of the legislation vary. As the following quote illustrates:

There is an element of luck. The luck goes all the way up. We've talked to obstetricians who are like, "But the person is not suicidal," and we're like, "That's not part of the Act." There's a lack of knowledge amongst obstetricians about the Act. So your obstetrician can be poorly informed. Your GP can be ideologically opposed to termination. Your psychiatrist can just be not sure what to do and not sure who to contact. There's just so many different areas where it can go a bit wrong that it is a bit worrying. (R107)

For service users accessing care under Section 11, respondents stated that these pathways were complex and often protracted. Part of the complexity is expected as these applications require input from a limited number of specialists. However, again respondents argued that a lack of

geographic coverage and the level of understanding of the pathway influenced the timeliness and cohesiveness of care. This is illustrated in the quotes below:

> *the fact there are some geographical areas not well served, for sure is a barrier. You know, and we've seen that where… and, you know, particularly if anybody gets it wrong or doesn't sign at the first contact and then there's a second contact. And so, there's another delay, you know, potentially when they come into hospital.* (R204)

> *So, in fairness, those women in those centres will have gone to that hospital for their care, have had maybe a twenty-week scan, all their whatever, go to HOSPITAL or wherever and have another scan, and be told. And then be sent down to HOSPITAL. So they'll have actually potentially seen three hospitals, and be sent to us, rather than be taken care of by their original hospital. And even the tertiary hospital who saw them. So sometimes there can be three hospitals in the cases of fatal fetal abnormalities which, you know, these are very small numbers, but I think it's dreadful.* (R105)

The review process for patients refused terminations under Section 11 by MDTs was also identified as challenging by health providers. At time of research, interim guidance for healthcare professionals on the review process is available. However, health professionals who spoke about the reviews in research interviews expressed concerns about the process. One neonatologist, who had participated in a review, stated that:

> *I felt we were all somewhat ill-prepared for this. This was clearly a new process that hadn't really been thought out very well. There were some very good people involved but, down to basic stuff. There wasn't really a formalised structure for the meeting* (R118)

Another neonatologist, who is involved in national strategic planning, also pointed to the limited formalisation. Although clarifying the review process has been discussed by NWHIP and the CAF

since 2019, progress in relation to establishing clear guidance and training on reviews of MDT decisions is, to their knowledge, limited:

> *There was talk about trying to get some training for the review, that review panel but that's not really happened as far as I know.* (R124)

This respondent also expressed concerns about the responsibilities of review committees to assume caregiving for the patient. As they reflected in the following quote:

> *I don't think anybody… if I was on the review committee, I wouldn't want to get involved with a patient like that. I might look at the merits and demerits of the case and look at it dispassionately in a balanced way, whether who was in agreement with the original decision or we overturned the original decision. I would regard my duty had begun and end that. But I don't think I have a role in the clinical care of the case.* (R124)

Given the effect of the review process on the timeliness of care, these reflections suggest that there is a need for further work to clarify and formalise MDT reviews.

5.1.5 Establishing Sustainable Services

Data indicates that the implementation of a sustainable termination of pregnancy service and workforce remains a work in progress. From primary data, there are pockets of strong support and this is sustaining provision, even where the number of providers is small. Some providers, like the midwife below, said they felt very well supported in their role, even though the service was delivered by a small team:

> *Yeah, I feel supported. Yes, I work mostly with the consultants. It's a very sensitive time for the couple and we keep it very tight-knit. We try and keep it the minimum of professionals, so it would be the consultant and myself and the mobile phone and the couple supporting them around the decision and the days following that and waiting for results and then getting them into the hospital. We would support each other, and I have a colleague that I*

work with that we would support and on a day-to-day basis I suppose I do feel supported. Yeah. (R114)

Others, like the following GP, felt that, through peer support and training, termination of pregnancy had become 'normalised':

In general, there is good collegial support but with regard to termination of pregnancy, certainly at the beginning, we wouldn't have… things have changed...My colleagues in Start who we have a very good network within Start, that has normalised it very much and has normalised the conversation. So now I'm much more comfortable talking about it just like any other type of healthcare with my colleagues. (R121)

On the other hand, as in the following accounts from consultant obstetricians, some providers feel distanced from colleagues:

They're not exactly grateful that you're doing it instead of them. I think it's probably seen as being quite niche and maybe a little bit indulgent. Yes. Maybe a little bit of a luxury and we can probably do without it. If it disappeared tomorrow, nothing bad would happen. Whereas they wouldn't say the same for a labour ward or operating theatre or fetal medicine scanning. It's not that integrated or that normalised to the extent that people would realise that we couldn't do without it (R125)

And within the system, in some cases, you know, they're seen as less than because they provide that service. I certainly know of a colleague who, you know, doesn't get saluted in the corridor now that she's the main provider of the service, you know, by some people. She doesn't care. But you would need to be that thick-skinned is what I'm saying. (R204)

One co-ordinating midwife reported feeling isolated from colleagues who did not appreciate the complexity of her role:

We mightn't see loads and loads of patients, but I don't think they realise how much time one patient could take...They are very time-consuming. I don't think people realise that. (R117)

Whereas others, like the midwife co-ordinator and consultant obstetrician below, described regularly having to work around or motivate other staff to support provision.

You have to look at the opportunity, to make sure who was on, and to make sure who was conscientious objector or not, are the women actually going to be taken care of, able to be taken care of that day. I had two doctors yesterday that couldn't give the medication because of their religion. I had to go to a consultant to get a lady sorted yesterday. So yes, there's barriers on all sides. (R209)

I think, only because I'm new in the role and motivated and have time at the minute, able to commit. All the extra work it takes to develop these protocols and SOPs and to have the meetings with the different people involved from management and pharmacy to everything and trying to push this. I have been trying to get this clinic up and running for well over a year now and it feels like it's going at a snail's pace. It's just very, very slow […] It definitely is challenging trying to…and a lot of resistance, and I think only for me pushing it and pushing it constantly. There's no one else seems to be pushing it, it seems a bit of a single struggle at times. Yeah. (R108)

The core contextual factors impacting the implementation of sustainable services are workforce and management support. Where there is managerial support, and workforce engagement, staff have been able to ensure that services are not being developed or negotiated by individuals or small teams. This managerial support, according to research participants, is critical in establishing, at a hospital level, the parameters of conscientious objection and non-provision. This ensures that all staff clearly understand their responsibilities. As one midwife described this co-ordination work with providers and non-providers took pro-active management engagement:

Anyone who would be coming in there and then theatre, and we had to do a big piece on conscientious objection, because especially the on-call staff in theatre, we would have a huge cohort of Filipino and Indian girls, and a lot of Filipinos in particular, are quite religious and they're all part of the one church. And they needed to know where they're bound so like, if you're on call and someone comes in and the consultant says they need to go theatre, you can't be opting out. So, what you can opt into and what you can opt-out of. So that the lines were really, really clear. (R120)

Pro-active management is equally critical, a midwife manager explained, for ensuring that staff were not obstructing care:

Well, it would happen proactively if the manager notes that there's a problem. Sometimes the way most managers find out is when there's a complaint or when she observes what may be abnormal behaviour by the midwife, be it the way she speaks to someone or be it the woman maybe passes a comment to the manager that she was spoken to or something happened. That's the same for all members of staff, including catering. It's amazing the attitude that some of the caterers didn't want to even serve the woman but it's only when you challenge and say, "Well first of all you should know her diagnosis or why she's here is none of your concern. Your job is basically to provide the food to the patient." So a good manager on a unit will deal with any of those issues. (R122)

However, health professionals in the study argued that this pro-activity was neither always present nor always practical. All interviewees referenced the workforce problems facing health services. As one consultant obstetrician outlined, these workforce limitations made it difficult to challenge inappropriate conscientious objection or obstructive behaviour:

We're all working in really stressful environments. We have no staff. We actually can't afford to discipline the obstructors because then who is going to look after all the other women. At the moment on a ward you might have one midwife who's happy to look after the woman

having the termination. You might have four who aren't but they're looking after all the other people so what are you going to do if you fire the obstructors. You've got nobody to look after the women who have had a hysterectomy or with early pregnancy bleeding or who have lost their babies. (R125)

Limited managerial support and workforce result in providing staff absorbing the responsibility to deliver the service. As health providers in primary and secondary care who participated in the study noted, this is not sustainable and puts the service, and providing staff, at risk of burnout:

I'm on my own. I should have a nurse with me. I did have a nurse with me. She's gone now. She's on maternity leave and she's not coming back to the service... Another nurse came into the service...but she really doesn't want a huge amount to do with the TOP service... So I'm at a disadvantage with that... Even writing in diaries. I can't even get the time to do that. (R201)

GPs who participated in the research argued that the bureaucratic requirements of the legislation threatened the sustainability of the service. According to these providers, the combination of the limited geographic spread of providers and the additional reporting obligations, taken over time, presented a substantial burden for providing GPs:

It's quite complex administratively and this might be a small practice with one GP, one nurse, one secretary, it's not a thing in terms of financial, there might be a huge volume that you wouldn't be doing. So even if you're looking at it purely from that point of view, of course, that can affect the number of providers that would sign up. (R121)

Workload. I mean, my worry is that we won't be able to continue as providers, not that we don't want to, but that it would become just too time-consuming, you know. (R213)

Here the primary data provides a clear connection between the context and outcomes. Managerial support and workforce are critical contextual factors impacting the implementation of a sustainable service. Managerial support needs to be proactive to ensure that all staff, including non-providers, are aware of and meet their responsibilities. In the absence of this support, staff are left to organise care themselves, risking burnout. Yet, some staff feel isolated from peers and, in a context of workforce shortage, find it difficult to challenge inappropriate behaviour.

6 GP survey

6.1 Overview of the survey

The survey component was designed to provide a robust picture of termination of pregnancy service provision in general practice. It aimed to explore further the reasons for provision and non-provision, the scale of non-provision, and the impact of provision in secondary care on provision in primary care.

The survey was developed through the Qualtrics platform and distributed using an anonymous link. The link was embedded in a public-facing summary of the research.

The survey included a combination of closed- and open-response questions. Closed questions included yes/no and multi-choice questions and a series of Likert scale questions. Open-response questions provided a space for additional comments.

The survey included basic geographic data including the county location of the respondents' practice, the community health organisation they practised within, and the maternity hospital they referred patients to.

Except for consent questions and the beginning and end of the survey, there were no forced response questions. Participants could also review and change responses before submitting although the survey had to be completed in one sitting.

A consent question asking participants to confirm their responses could be analysed as part of the review was included. This allowed potential respondents to review all questions without agreeing to participate.

6.1.1 Recruitment

To reach the greatest number of GPs, we adopted an active recruitment strategy. This included the following components:

1. Drafting and finalising the survey with GP providers to ensure the relevance of the questions
2. Following up direct email distribution with phone calls to confirm receipt of the survey
3. Following up phone calls to confirm receipt with reminder phone calls to encourage completion
4. Getting agreement from the HSE PCRS service to distribute and promote the survey through official platforms (the GP Suite)
5. Distributing through established networks with GPs and GP networks
6. Extending the completion period.

Initially, we distributed the link to a sample of GPs. We adopted purposive sampling, targeting counties with both a limited and high number of contracts for provision of termination of pregnancy services. In total, we distributed the survey to 1,000 registered email addresses and followed up with confirmation phone calls.

Following a one-month review, we recognised that the number of completions was very low and changed to a 'whole cohort' distribution. This increased the number of completions. In total, once we excluded returned surveys with a completion rate of under 50% and surveys where respondents had given consent to use their data in the report, we were able to analyse 188 surveys. Based on figures provided by the HSE on the total number of registered GPs, this amounts to a completion rate of 6%.

6.2 Contribution and limitations of the survey data

A completion rate of this size means that the survey should not be analysed in isolation as representative of GP views. It also precludes correlation analysis due to insufficient sample size and potential response bias (i.e. GPs aware of and interested in the topic are more likely to complete the survey). The data collected cannot address the initial aims stated above.

However, quality standards in health service research state the data can be legitimately used in combination with other data as part of an *exploratory sequential mixed method* analysis. The purpose of this analysis is to explore issues raised by GPs in qualitative research further.

Specifically, the quantitative data can be used to establish whether there is evidence of:

1. A lack of engagement in professional development and training by non-providers;
2. A connection between individual GPs providing and colleagues in surgeries providing;
3. A connection between local hospital provision and GP provision; and
4. A relationship between non-provision and workload.

Using the survey data in this way is consistent with realist evaluation which advocates revisiting data continually to establish if programme theories identified in one area of data collection can be confirmed by findings in another area.

That said, the quantitative data collected cannot be tested to explore the strength of these relationships or their generalisability to all GPs. This level of analysis would require a more extensive research programme.

In addition, due to time constraints, we were not able to apply for ethical approval for demographic questions relating to respondents' personal characteristics (e.g. age or gender). Nor were we able to apply for ethical approval for an assisted completion phone survey which potentially could have improved the response rate. A future survey, within a more extensive review, should address these limitations.

6.3 Results: Geographic characteristics, provider status, and local referral hospital.

Tables 18 and 19 below present the geographic locations of survey respondents. Most participants work in Cork and Dublin and are located in Community Health Organisation Area's 4, 7, and 9. The data is skewed towards urban areas.

		Frequency
	Carlow	2
	Cavan	3
	Clare	4
	Cork	40
	Donegal	4
	Dublin	47
	Galway	8
	Kerry	11
	Kildare	4
	Kilkenny	1
	Laois	2
	Leitrim	1
	Limerick	6
	Longford	3
	Louth	4
	Mayo	6
	Meath	3
	Monaghan	2
	Offaly	4
	Roscommon	1
	Sligo	4
	Tipperary	10
	Waterford	7
	Wexford	1
	Wicklow	10
	Total	188

Table 18: Location of respondent practice (county)

Community Health Organisation Area		Frequency
	Area 1: Donegal, Sligo/Leitrim/West Cavan and Cavan/Monaghan	14
	Area 2: Galway, Roscommon and Mayo	15
	Area 3: Clare, Limerick, and North Tipperary/East Limerick	14
	Area 4: Kerry, North Cork, North Lee, South Lee, and West Cork	51
	Area 5: South Tipperary, Carlow/Kilkenny, Waterford and Wexford	16
	Area 6: Wicklow, Dun Laoghaire and Dublin South East	18
	Area 7: Kildare/West Wicklow, Dublin West, Dublin South City, and Dublin South West	20
	Area 8: Laois/Offaly, Longford/Westmeath, Louth and Meath	14
	Area 9: Dublin North, Dublin North Central and Dublin North West	26
	Total	188

Table 19: Location of respondent practice (Community Health Organisation)

More than half of respondents stated that they do not currently provide early medical abortion (Table 20).

		Frequency	Percent	Valid Percent
Valid	Yes	89	47.3	47.3
	No	99	52.7	52.7
	Total	188	100.0	100.0

Table 20: Provision of early medical abortion by respondent (count)

Responses to the question “what maternity unit do you refer patients to?” are detailed in Table 21.

Most respondents identified larger maternity hospitals.

Hospital	Count
Coombe Women's Hospital	12
National Maternity Hospital	24
Rotunda Hospital	25
Cork University Maternity Hospital	40
Kerry General Hospital, Tralee	11
South Tipperary General Hospital	7
St Luke's General Hospital Kilkenny	3
Waterford Regional Hospital	7
Wexford General Hospital	1
Galway University Hospitals	9
Letterkenny General Hospital	3
Mayo General Hospital, Castlebar	6
Portiuncula Hospital, Ballinasloe	1
Sligo General Hospital	7
University Maternity Hospital Limerick	13
Cavan / Monaghan Hospital Group	3
Our Lady of Lourdes Hospital, Drogheda	7
Midlands Regional Hospital Mullingar	6
Midland Regional Hospital Portlaoise	3
Total	188

Table 21: Local referral hospital (count)

6.4 Analysis

Data was analysed statistically using SPSS software. We conducted descriptive analysis of frequencies. The sample size precluded correlational analysis using statistical tests. We were able to compare frequencies for two different categories of respondents – GPs who provide EMA and non-providers – through cross-tabulating valid responses. These comparisons are presented in tables and as bar charts below.

6.4.1 Non-provision and Conscientious Objection

123 respondents answered a specific question on conscientious objection. Of these, 26% (n=32) put themselves into the category of conscientious objector, 64.2% (n=79) did not and 9.8% (n=12) said that they would prefer not to say.

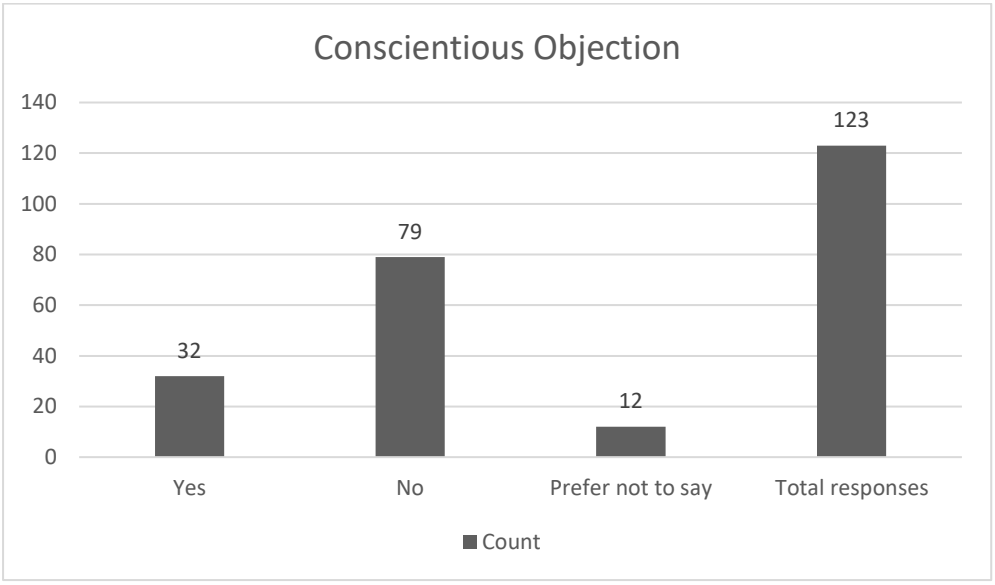

Figure 8: Conscientious objection by respondent (count and percentage)

In terms of the extent of this objection, only 28 respondents stated that they "would not provide termination of pregnancy under any circumstances". In free-text comments, a number of these respondents stated that they did not feel termination of pregnancy should be part of medical practice.

6.4.2 Engagement of non-providers in professional development and training

Qualitative data collected in the study indicates that non-providers are not engaging with training and professional development on early medical abortion. As this training includes training on the limits of conscientious objection, the legal framework, values clarification, and training on responsibilities in terms of referral and patient handover the participation of all health professionals is essential.

Quantitative survey data confirmed these qualitative findings. As Table 22 indicates, non-participation in training applies to non-providers who are not exercising a conscientious objection.

		Doctors, nurses and midwives may exercise conscientious objection in relation to the delivery of termination of pregnancy services. Do you fall into this category?			
		Yes	Prefer not to say	No	Total
Have you participated in any training programmes?	Yes	5	2	39	46
	Prefer not to say	2	1	0	3
	No	25	9	40	74
Total		32	12	79	123

Table 22: Participation in training - Conscientious Objection

Non-engagement in training is also indicated by comparison of responses to the questions “have you sought out training programmes?” and “Have you participated in training programmes?”. This is illustrated in Figures 9 and 10.

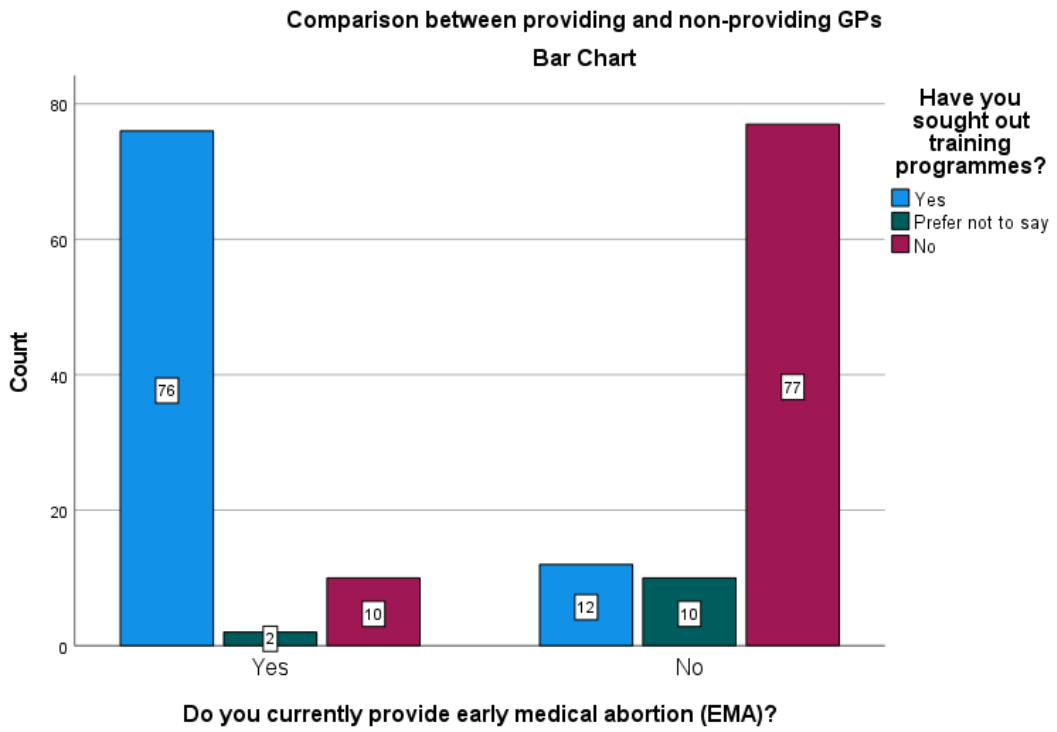

Figure 9: Seeking training programmes by provision status (comparison)

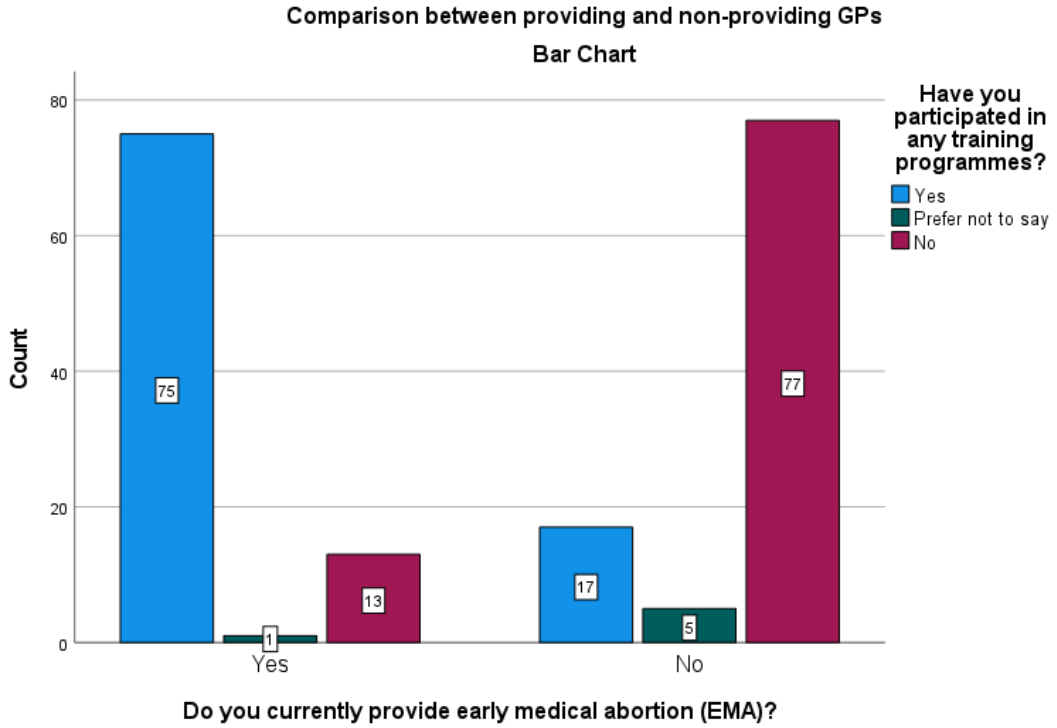

Figure 10: Participation in training by provision status (comparison)

The survey asks respondents to state whether they felt they had the requisite skills, knowledge, and competence to provide EMA. The responses to this are provided in Table 23 and Figure 11. Again, we have compared the responses for providers and non-providers.

		Do you currently provide early medical abortion (EMA)?		
		Yes	No	Total
Do you feel that you have the requisite knowledge, competence, and skills to provide EMA?	Yes	85	22	107
	Prefer not to say	2	10	12
	No	2	67	69
Total		89	99	188

Table 23: Knowledge and competence by provision status (count)

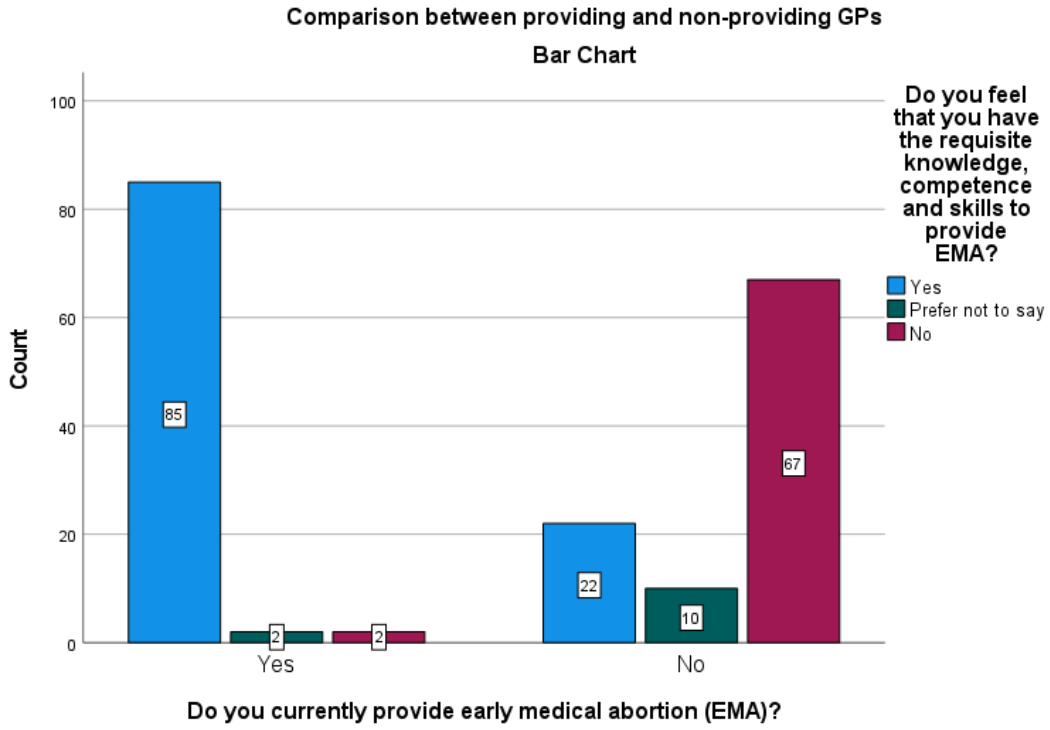

Figure 11: Knowledge and skills by provision status (comparison)

Table 24 provides figures for responses regarding the perceived benefit of training programmes. This question used a Likert scale from 'strongly agree' to 'strongly disagree'. 92 survey participants responded to this question. Most respondents to this question (n=85) stated that they found training programmes beneficial.

Did you find this training programme beneficial?	Count
Strongly agree	64
Agree	21
Neither Agree nor Disagree	6
Strongly Disagree	1
Total	92

Table 24: Training participant feedback (count)

6.4.3 Connection between individual provision and provision by colleagues in surgeries and clinics

Most survey respondents working in surgeries or clinics with three or more colleagues.

		Frequency	Percent
Valid	1-2	76	40.4
	3-4	68	36.2
	4 or more	44	23.4
	Total	188	100.0

Table 25: Number of GPs per clinic by respondent

We also asked GPs who worked in multi-GP settings whether their colleagues currently provide EMA services. The results for providers and non-providers are presented in Figure 12. A larger number of respondents who provide work with other providers. By comparison, a larger number of non-providers work with non-providers.

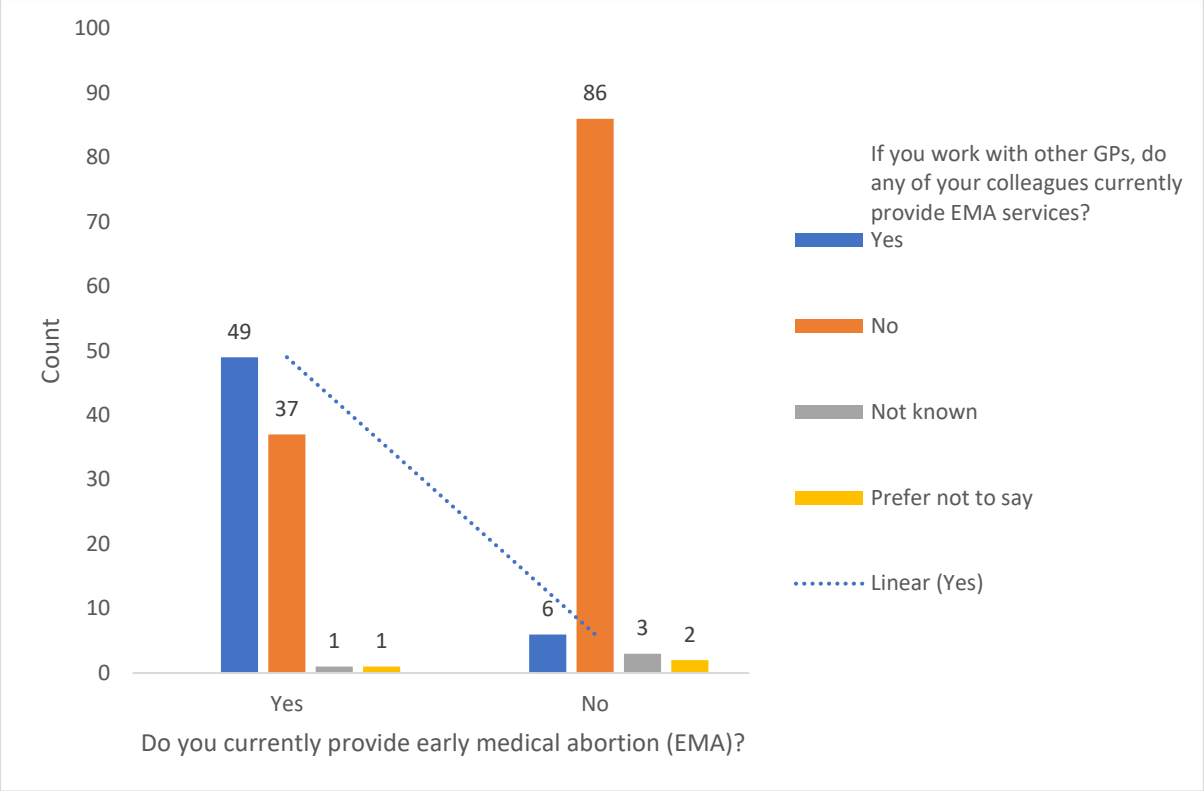

Figure 12: Descriptive analysis of individual provision and colleague provision

When asked to rank factors relevant to the decision to provide EMA along a five-point Likert scale, 36.3% of respondents to the question (n=33; total respondent n=91) said the attitudes of colleagues were “very relevant” or “quite relevant”. 51.6% (n=47) of respondents to this question said colleagues’ attitudes were “not that relevant” and 4.4 % (n=4) said they were “not relevant at all”.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	17	9.0	18.7	18.7
	Quite Relevant	16	8.5	17.6	36.3
	Somewhat Relevant	7	3.7	7.7	44.0
	Not that Relevant	47	25.0	51.6	95.6
	Not Relevant at all	4	2.1	4.4	100.0
	Total	91	48.4	100.0	
Missing	System	97	51.6		
Total		188	100.0		

Table 26: Relevance of attitudes of colleagues in practice to provision (Likert)

Responses to the relevance of not having access to experienced colleagues to approach for support to the decision not to provide early medical abortion were also mixed. 45.2% (n=42, total question respondent n = 93) respondents to the question said this was relevant; 49.5% (n=46) said it was “not that relevant” and 5.4% (n=5) said it was “not relevant at all”.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	13	6.9	14.0	14.0
	Quite Relevant	15	8.0	16.1	30.1
	Somewhat Relevant	14	7.4	15.1	45.2
	Not that Relevant	46	24.5	49.5	94.6
	Not Relevant at all	5	2.7	5.4	100.0
	Total	93	49.5	100.0	
Missing	System	95	50.5		
Total		188	100.0		

Table 27: Relevance of lack of access to experienced colleagues to support (Likert)

6.4.4 Connection between local hospital provision and GP provision

Published research on the implementation of services since 2019 based on qualitative data connected local hospital provision with provision in primary care. The survey included questions on local hospital provision. Responses were compared with provision by survey participants. The results are presented on Table 28 and Figure 13.

		Responses	
		N	Percent
ToP services at closest hospital	Yes	110	58.5%
	Yes but not across all pathways	18	9.6%
	Yes but not regularly	2	1.1%
	No	12	6.4%
	No but offers gestational scans through Early Medical Unit	10	5.3%
	No but offers gestational scans through private provider	1	0.5%
	Not known	35	18.6%
Total		188	100.0%

Table 28: Provision in local hospital by respondent (count)

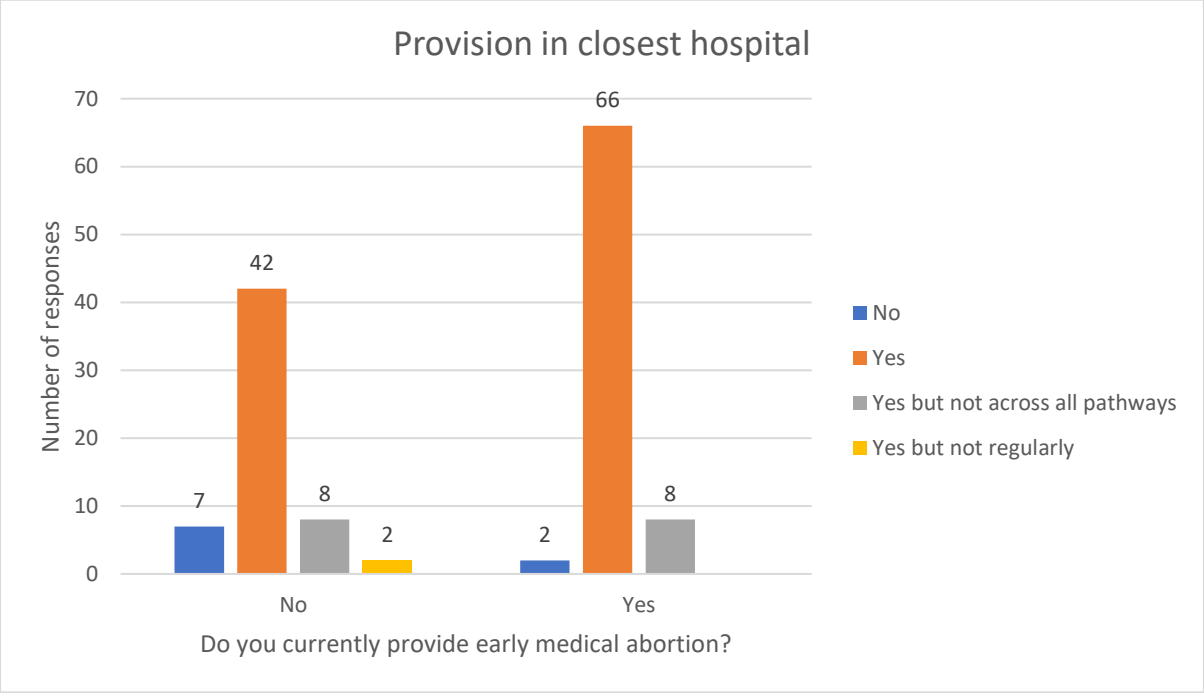

Figure 13: Provision in local hospital and GP provision (comparison)

We also asked respondents to rank the relevance of three hospital-related issues to their decision regarding care provision on a Likert scale. The issues were:

- Availability of a local providing maternity hospital
- Capacity of local hospital

- Proximity/travel time to nearest maternity unit

As Tables 29 through 31 indicate, survey respondents did not identify these issues as relevant to their decision-making.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	9	4.8	9.7	9.7
	Quite Relevant	12	6.4	12.9	22.6
	Somewhat Relevant	5	2.7	5.4	28.0
	Not that Relevant	62	33.0	66.7	94.6
	Not Relevant at all	5	2.7	5.4	100.0
	Total	93	49.5	100.0	
Missing	System	95	50.5		
Total		188	100.0		

Table 29: Relevance of providing local maternity hospital to provision (Likert)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	14	7.4	15.2	15.2
	Quite Relevant	13	6.9	14.1	29.3
	Somewhat Relevant	8	4.3	8.7	38.0
	Not that Relevant	50	26.6	54.3	92.4
	Not Relevant at all	7	3.7	7.6	100.0
	Total	92	48.9	100.0	
Missing	System	96	51.1		
Total		188	100.0		

Table 30: Relevance of local maternity unit capacity to provision (Likert)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	7	3.7	7.5	7.5
	Quite Relevant	11	5.9	11.8	19.4
	Somewhat Relevant	12	6.4	12.9	32.3
	Not that Relevant	54	28.7	58.1	90.3
	Not Relevant at all	9	4.8	9.7	100.0
	Total	93	49.5	100.0	
Missing	System	95	50.5		
Total		188	100.0		

Table 31: Relevance of proximity/travel time to nearest providing maternity unit to provision (Likert)

6.4.5 Relationship between non-provision and workload

Qualitative data gathered in this research and in other studies indicates that the decision to provide services is influenced by workload capacity. The survey data supports this qualitative finding. As Table 32 shows, the demands on services were identified as very relevant by 41.3% of respondents to this question (total number of question respondents = 92).

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	38	20.2	41.3	41.3
	Quite Relevant	6	3.2	6.5	47.8
	Somewhat Relevant	7	3.7	7.6	55.4
	Not that Relevant	25	13.3	27.2	82.6
	Not Relevant at all	16	8.5	17.4	100.0
	Total	92	48.9	100.0	
Missing	System	96	51.1		
Total		188	100.0		

Table 32: Relevance of other service demands on decision to provide

By comparison, 67.8% of respondents to the prompt regarding criminal sanctions said these were "not that relevant" or "not relevant at all" (Table 33).

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	8	4.3	8.9	8.9
	Quite Relevant	12	6.4	13.3	22.2
	Somewhat Relevant	9	4.8	10.0	32.2
	Not that Relevant	53	28.2	58.9	91.1
	Not Relevant at all	8	4.3	8.9	100.0
	Total	90	47.9	100.0	
Missing	System	98	52.1		
Total		188	100.0		

Table 33: Relevance of criminal sanction to decision to provide

6.5 Key messages

Despite the survey's limitations, exploratory sequential analysis involving comparison with qualitative data from providers (primary and secondary) and descriptive analysis of survey responses highlights key messages for policy and practice.

The survey data indicates a potential interprofessional gap between providers and non-providers. While some providers and non-providers are working together as colleagues in GP practices, there are clearly surgeries where all GPs are non-providers.

Engagement in training and professional development is potentially connected to whether a GP is a provider or non-provider. Non-providers who participated in this study have not engaged with training or sought it out. At the same time, more non-providers than providers who submitted completed surveys felt that they lack the requisite skills, knowledge, and/or competence to provide early medical abortion.

The relationship between whether a GP provides and whether their local hospital provides termination of pregnancy care is complex. Most survey respondents who provide work near a providing maternity hospital. However, many survey respondents who do not provide also work near providing maternity hospitals. Furthermore, most respondents to questions regarding the factors influencing their decision to provide termination of pregnancy reported that the proximity of a providing maternity unit was not relevant to their decision.

Not all non-providers have a conscientious objection to termination of pregnancy. Survey respondents identified other workload responsibilities as the most relevant factor influencing their decision to provide termination of pregnancy care. Of those who self-identified as exercising a conscientious objection, only a minority stated that they would not provide termination of pregnancy under any circumstances.

7 Discussion

The research findings illustrate significant areas of achievement since the implementation of the expanded programme of termination of pregnancy services since January 2019. The number of women travelling to other jurisdictions to access abortion has reduced dramatically. Provision for early medical abortion, under 9-weeks gestation, in the community is a very positive step forwards and is working well. The remote model of care has benefitted the delivery of care. The establishment of MVA clinics in ambulatory settings, investment in midwife coordinators and administrators, and training of midwives in sonography create further opportunities for women presenting at hospitals, under 12-weeks' gestation, to receive timely care.

At the same time, there is cause for significant concern regarding the impact of the Act and its operation. The primary and secondary data on inequity of access, workforce constraints, and the sustainability of provision foreground problems that require urgent attention. Our findings from primary research regarding each of these issues are consistent with both secondary literature and grey publications from both the HSE and Health Information and Quality Authority (HIQA).

7.1 Inequity of access

In relation to access, we use equity as opposed to equality intentionally. The uneven distribution of services across the country and pronounced barriers faced by marginalised groups such as the homeless community are the result of policy decisions. The design and implementation of termination of pregnancy as a consultant-led service, and through GPs, mean that people living in areas where there are no providing consultants or who access primary care predominantly through inclusion services are at an automatic disadvantage. As our data conclusively shows, no local consultant, or no local GP, equals no local service.

It is important to note that these policy decisions are organisational as well as sectoral. The failure of hospital management to push for termination of pregnancy provision in their settings has

limited access. The limited choice of method of termination, and restrictions on surgical procedures specifically, are connected with inadequate investment in and management of infrastructural and service arrangements. Both primary and secondary research demonstrates that termination of pregnancy care and other forms of obstetric and gynaecological care frequently have to compete for theatre access. The availability of MVA clinics is a positive step however again the existence of MVA depends on hospital management support and this, from our data, is not consistent.

There is also evidence, from this and other studies, of inequity of access depending on the section of the Act termination is sought under. Access to care under Section 9, on grounds of mental ill-health, was reported as more challenging by all specialists participating in this study. This aligns with previous research studies, such as the WHO study, in which GPs highlighted the absence of clear guidelines on a Section 9 pathway for mental ill-health.

Similarly, access to care under Section 11, for fetal health reasons, over 12-weeks gestation is more challenging. The limited availability of specialist centres for diagnostic scans, the concentration of specialists in certain centres, and inconsistent management of multidisciplinary teams are now well-documented barriers to care. The terms of reference of multidisciplinary teams are not clear and, based on primary and secondary data, out of step with the requirements of the Act. This, according to the data presented here and in secondary literature, creates a clear operational barrier to termination of pregnancy care.

7.2 Workforce constraints

This is not the first study to highlight workforce issues within primary and acute care, specifically obstetrics and gynaecological care. The Health Information Quality Authority's 2020 review of obstetric emergencies and *Safer Better Maternity Services* underlined the limitations facing the maternity workforce. (HIQA Report, 2020) This included the ability to engage with continuing professional development and ensuring appropriate work loading. The HIQA report is significant in that it highlighted a shortfall in recruitment for consultant neonatologist posts and raised concerns

about the adequacy of provision (IHCA, 2020). Our primary data illustrates that the limitations and concerns identified by HIQA are also found in termination of pregnancy services.

The implementation and operation of the Act are, based on the experience of providers in this study, limited by the current workforce realities. NWHIP has invested in workforce training annually and the CAF is currently in the process of implementing a training platform for ToP services. (NWIHP Reports, 2020 & 2021) However, our data indicates, there is insufficient staff to enable meaningful engagement with CPD and staff are both developing and delivering training sessions independently of NWHIP informally, during lunch breaks and peer-support sessions. Obstructive behaviour and inappropriate refusal to facilitate care are restricted by the 2019 Code of Professional Ethics, yet actively addressing breaches when they occur would potentially create a patient safety risk if a member of staff had to be removed from the ward.

The availability of required staff for surgical termination of pregnancy is inconsistent across settings. In primary care, GP surgeries that hold a contract for ToP provision may only have one actively providing GP. These issues are highly problematic and undermine the practicability of ToP care, even where a setting is willing to provide.

From primary data, there remains a portion of the health services workforce who are unclear of or uncomfortable with their responsibilities under the Act. Primary data points to a range of reasons for this including, for example, a dissociation from ToP care or an acute concern regarding potential future criminal liability. From the account of providers in this study, particularly those providers involved in multidisciplinary team meetings for Section 9 and Section 11 applications, members of the health service workforce who are reticent to engage with ToP care can interpret the legislation too conservatively.

7.3 Sustainability of provision

There is evidence, in primary and secondary published data, of strong professional networks supporting ToP providers in acute settings and in the community. (Mishtal et al, 2021; Hogan et al,

2021; Dempsey et al, 2021) There is also a clear indication, in the continuing work of the CAF to establish and quality assurance and evaluation group, that there are health professionals committed to embedding a sustainable ToP service. (NWIHP Report, 2021) The data collected in this report and referenced secondary literature illustrates the achievements to date and suggests that the community and remote models of care are sustainable mechanisms for ensuring access to those who present at an early gestation (Mishtal et al, 2022; Spillane et al, 2021).

That said, the data raises a question mark over the sustainability of ToP care where providers do not have sufficient peer or professional support, for terminations at a later gestation, and for more complex applications. Again, workforce plays a significant role. While qualitative studies undertaken in 2019 and 2020 centred the positive influence of 'committed providers' (Mishtal et al, 2022), this review, based on data collected in 2022, suggests that these providers are now at risk of burnout. Other researchers have also noted burnout in relation to ToP in Ireland (Dempsey et al, 2021). The warning signs, based on this evidence, are clear. Without intervention in the form of investment and support for staff, the service may simply become unsustainable.

8 Conclusions/Recommendations

This report was commissioned to address and make recommendations in relation to six research objectives identified by the Department of Health. Here we will conclude by addressing each, in turn, referencing the data presented in this report with evidence-based recommendations requested by the Department of Health.

8.1 Examine the arrangements put in place to implement the Act

The Department of Health invested €12 million in the development of an integrated model of care spanning four pathways in late 2018. A further remote MOC was added in 2020 as part of the Covid-19 response. A dedicated information service – for provider contact details, non-directive counselling, and nursing advice – was established (MyOptions) with a hotline and webchat facility.

A Clinical Lead and Clinical Advisory Forum were established through the National Women's Health and Infants Programme. Care is currently delivered by registered GPs under the GMS contract, two Women's Health Centres, and acute maternity services. Individual hospitals have developed MVA and ambulatory gynaecological clinics as part of early abortion services. Some, but not all, hospitals have dedicated midwife coordinators and collaborate with Medical Social Work colleagues.

NWHIP and CAF, with support from tSTART, the IOG, the ICGP, and the Office of Nursing and Midwifery Services Directory (ONMSD), have continued to develop and roll-out training since 2018.

Despite this, primary data indicates that arrangements put in place were, and remain, inadequate. The burden of delivering care is unevenly distributed with no staff cover in settings included in this study. Support at a local level from hospital management has been inconsistent since the commencement of services. We found no substantive evidence that the arrangements for surgical termination of pregnancy were ever adequately established. The is a clear ‘postcode lottery’ in termination of pregnancy care.

8.2 Provide a comprehensive description of providing services/service provision under the Act

Section 12 applications for termination of pregnancy, under 9-weeks' and 6 days' gestation are provided care through a community pathway delivered by GPs or WHCs. Over 10 weeks' gestation care is provided in acute settings. Applications under Section 11 are provided under the supervision of a consultant obstetrician, following consultation with a multidisciplinary team. Depending on gestation Section 9 and Section 11 terminations may involve medication or surgical termination of pregnancy, or compassionate induction of labour.

Across data on the operation of the care pathways, the provision of medication termination of pregnancy at an early gestation, under Section 12 of the Act, in the community, is the most clearly and comprehensively described by healthcare providers. Service provision under the other pathways or at a later gestation is vague and from primary and secondary data, varies on a case-by-case basis as well as across settings. Nationally, there is no consistency in how care is provided under the hospital-based pathways for Sections 9, 11 or 12. Access to surgical termination of pregnancy depends on theatre access and staffing, both of which are severely limited.

There is no clear, comprehensive description, either in the form of guidance for practitioners or in primary data from our research participants, of how care is provided under Section 9. The situation is similar for Section 11, although there is guidance in the form of interim IOG guidelines. From our data, health providers involved in these areas, including experienced consultants and specialists, are themselves unclear as to how services are provided under these sections of the Act. Descriptions are based on individual cases and are therefore only partial and personal.

8.3 Assess the impact of the Act's operation on access to termination of pregnancy services in this country

Access to termination of pregnancy services has increased. Based on primary and secondary data, access has generally improved. This is particularly true for those seeking termination at an early gestation, through the community MOC. The rate of abortion travel has declined substantially.

That said, the operation of the Act has resulted in inequities of access. The requirement for a supporting consultant obstetrician limits access in secondary care as NCHDs, who may be willing to provide, are unable to do so if the consultant obstetrician is a non-provider. The operation of the Act in primary care is problematic for those who have no GP or cannot travel easily. The remote MOC has addressed some access issues but the restricted implementation of MVA clinics or surgical termination of pregnancy makes accessing care more challenging for those in unstable, chaotic, or shared accommodation.

The use of MDTs in the Section 11 care pathway is challenging in terms of access. They are, from our data, currently operationalised as mechanisms for permitting termination of pregnancy by consensus-based decision-making. This is not required by the Act. Health providers in our study reported variation in MDT organisation and coordination. Again, there is inconsistency in operation. The MDT process itself creates delays and can lead to service users 'timing out' of legislation.

8.4 Identify any difficulties in providing services expressed by stakeholders which are associated with provisions in the Act, and highlight possible solutions to address any such difficulties

Health providers confident in their professional practice and interpretation of the legislation experienced few difficulties in providing services to service users at an early gestation, who clearly fell within Section 12 of the Act and did not require a dating scan to confirm gestational age. Outside of these circumstances, health professionals in this study, including non-providers, identified difficulties in providing services directly connected with provisions in the Act.

The reference to time limits, both gestational and in terms of post-partum survival whether there was a diagnosis of fetal anomaly/life-limiting condition, were identified as difficulties. Providers stated that, regarding gestational limits, service users who presented after 9-weeks gestation or who required dating scans 'timed-out' of care. This risk of 'timing out' was, providers in primary care reported, worsened by the legal requirement to wait three days between the first and

second consultation. It was also unclear how to provide care when the first course of early medication abortion failed.

Providers stated that, regarding the reference to survival past 28 days post-partum in Section 11, this presented difficulties for complex conditions where there was limited evidence of post-partum survival or where survival required extensive intervention. Provider data suggests that some health professionals are concerned they are being forced, because of the provisions of the Act, to make definitive predictions where such predictions are impossible to make. Similar concerns were expressed by providers with experience working with patients in relation to Section 9 of the Act.

The fundamental problem, as articulated by health providers in this study, is the position of termination of pregnancy within criminal law. Providers spoke of the fear of future criminal prosecution for acting in accordance with their best professional judgement, based on patient circumstances and available evidence.

Providers also drew attention to administration created by the legislative requirements. Termination of pregnancy care came with a lot of additional bureaucracy, providers in this study explained, and this increased responsibility could be overwhelming.

Health providers highlighted the following possible solutions to these difficulties:

- Decriminalisation of termination of pregnancy;
- Removal of gestational limits;
- Removal of mandatory three-day wait;
- Increase training on legal provisions; and
- Strengthen peer support and mentorship to improve provider confidence in interpreting the Act.

8.5 Assess from the service provision perspective the extent to which the Act's objectives have not been achieved and make recommendations to address barriers

Healthcare providers, in this study and secondary published data, while praising the achievements in relation to Section 12 and early medication abortion, expressed dissatisfaction with the Act's progress in implementing an accessible, supportive, and sustainable termination of pregnancy service. Patients encounter barriers to care due to the combination of workforce, management, resource, and legislative issues. Travel for abortion care has decreased, but health providers in this study were not satisfied that the Act was being followed appropriately in all circumstances.

The provision for termination of pregnancy for risk to maternal health remains challenging. There are a limited number of specialists available and, as HIQA's 2020 review noted, there are workforce shortages across the sector.

The regulation of conscientious objection in practice is a challenge within the context of an under-resourced sector. Providers in this study reported instances where conscientious objection had been misinterpreted. However, challenging misinterpretation of the right to exercise a conscientious objection may result in reducing an already limited staff pool.

The creation of opportunities to engage in termination of pregnancy care provision is not consistent. Time is not always allocated for professional development and training, and the expansion of the workforce has been incremental.

In addition to the already mentioned recommendations for legislative change identified by health professionals in the study, providers advised the following steps to address barriers to care and ensure the objectives of the Act are met:

- Invest in the termination of pregnancy workforce;

- Review and engage with non-providers for reasons of conscientious objection, ensure that this right is being exercised appropriately, in accordance with the legislation; and
- Enable non-consultant staff to engage with termination of pregnancy services.

8.6 Explore and weigh the evidence for and against any proposed changes to the Health (Regulation of Termination of Pregnancy) Act 2018 from the service provider perspective

Based on primary and secondary data included in this study, there is a strong service provider-led argument for making changes to the Health (Regulation of Termination of Pregnancy) Act 2018.

The location of the Act within criminal law, from a provider perspective, is problematic. Our data indicates that the potential of criminal repercussions for 'good faith', evidence-based clinical decisions impacts practice by creating professional anxiety, even for highly experienced health professionals.

Health providers are already bound by other legislative and regulatory instruments to direct their practice. There is an established Code of Professional Ethics. These instruments would continue to regulate clinical practice if termination of pregnancy care was decriminalised. Decriminalising termination of pregnancy would not remove clinical regulations.

The 12-week gestational limit should, based on our data, be adjusted to:

- allow for the completion of ‘incomplete’ termination of pregnancy where medicines have already been taken. Providers note that these medicines potentially have teratogenic effects (or harmful fetal effects); and
- Permit women who have had an initial consultation before 12-weeks to access termination of pregnancy under Section 12.

The Act does not recognise these scenarios. From our service provider data, this is impacting access to and provision of termination of pregnancy care, even where legally permissible. There is

strong evidence, from healthcare providers, that service users are 'timing out' of care due to delays in scans or resource limitations.

The statements about likely death 28-days post-partum in relation to Section 11 are, based on provider data, problematic and there is strong evidence to change this feature of the Act. From a provider perspective, this wording is directly in conflict with the realities of clinical practice or the simple fact that a precise date of infant loss is frequently impossible to predict. Again, the service provider perspective, based on this study, is that 'good faith' and evidence-based clinical practice should be emphasised.

The mandatory three-day waiting period between first and second consultations should be changed. From a service provider perspective, the waiting period has resulted in applications for termination of pregnancy falling within the legally permitted pathways 'timing-out' of care.

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