Country Profile: Ireland

Region: Northern Europe

Last Updated: 15 December 2023

Identified policies and legal sources related to abortion:

- Reproductive Health Act
- ✓ General Medical Health Act
- Constitution
- Criminal / Penal Code
- Civil Code
- Ministerial Order / Decree
- Case Law
- ✓ Health Regulation / Clinical Guidelines
- ✓ EML / Registered List
- ✓ Medical Ethics Code
- Document Relating to Funding
- ✓ Abortion Specific Law
- Law on Medical Practicioners
- Law on Health Care Services
- ✓ Other

Related Documents

From General Medical Health Act:

- Health Act, 2004

From Health Regulation / Clinical Guidelines:

- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

From EML / Registered List:

- Summary of Product Characteristics of Misoprostol
- Mifegyne Approval, 2018
- Mifegyne Package Leaflet, 2021
- Mifegyne Product Characteristics, 2021
- Mifegyne MisoOne Pharmacy Circular, 2018

From Medical Ethics Code:

- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019

From Abortion Specific Law:

- Health Regulation of Termination of Pregnancy Act, 2018

From Other:

- National Consent Policy Revised, 2019
- Guide to surgical abortion, 2018
- Guide to medical abortion, 2018

List of ratified human rights treaties:

- ✓ CERD
- ✓ CCPR
- ✓ Xst OP
- ✓ 2nd OP
- ✓ CESCR
- CESCR-OP
- ✓ CAT
- CAT-OP
- ✓ CEDAW
- ✓ CEDAW-OP
- ✓ CRC
- CRC:OPSC
- ✓ CRC:OPAC
- ✓ CRC:OPIC
- CMW
- CRPD *
- CRPD-OP
- CED **
- Maputo Protocol

Download data

Concluding Observations:

- CAT
- HRC
- HRC
- CRC
- SR VAW
- CEDAW

Persons who can be sanctioned:

- A woman or girl can be sanctioned
- ✓ Providers can be sanctioned
- ✓ A person who assists can be sanctioned

Abortion at the woman's request

✓ **Gestational limit: 12**

Legal Ground and Gestational Limit

Economic or social reasons	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 18) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 16)
Foetal impairment	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 18) • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is not viable. Grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers and leave women no choice but to continue with pregnancy. Being required to continue with a pregnancy that causes significant distress violates numerous human rights. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64) **Additional notes** Abortion is legally permitted where there is a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 11)
Rape	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 18) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64)
Incest	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 18) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64)
Intellectual or cognitive disability of the woman	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10)

Mental health	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **Gestational limit** **Weeks: viability** There is no gestational limit in cases when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk. • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 16) Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7. **Source document**: WHO Abortion Care Guideline (page 103)
Physical health	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **Gestational limit** **Weeks: viability** There is no gestational limit in cases when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk. • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 16) Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7. **Source document**: WHO Abortion Care Guideline (page 103)
Health	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **Gestational limit** **Weeks: viability** There is no gestational limit in cases when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk. • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 16) Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7. **Source document**: WHO Abortion Care Guideline (page 103)

Life	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **Gestational limit** **Weeks: viability** There is no gestational limit in cases when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk. • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available where the life and health of the woman, girl or other pregnant person is at risk. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64) Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7. **Source document**: WHO Abortion Care Guideline (page 103)
Other	Condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 11)

Additional Requirements to Access Safe Abortion

Authorization of health professional(s)	No **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 10) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 13) • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 10) • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 10) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2. **Source document**: WHO Abortion Care Guideline (page 81) **Additional notes** As per the 2018 Draft Model of Care, a risk to the life or serious harm to the health of a person who is over 12 weeks pregnant must be certified by two clinicians, one of whom is an obstetrician. Where a condition exists which is likely to lead to the death of the fetus either before or within 28 days of birth, certification by two clinicians is required, one of whom must be an obstetrician. Both clinicians must be on the relevant specialist register. The Interim Clinical Guidance related to risk to life or health further states that an appropriate medical practitioner is one who is on the specialist register of the Medical Council of Ireland, who may be an Obstetrician, a psychiatrist (who preferably has expertise in perinatal mental health), or a Physician with expertise in the medical or surgical disorder that is relevant to the risk to maternal health and life. It also recommends that Obstetric Multidisciplinary Team (MDT) discussions take place for individual cases, which would form an important component of the assessment of the risk to life or health. This guidance also provides details of the review process in case a physician does not certify to facilitate an abortion.

Authorization in specially licensed facilities only	No **Related documents:** • Guide to medical abortion, 2018 (page 4) • Guide to surgical abortion, 2018 (page 4) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1. **Source document**: WHO Abortion Care Guideline (page 52) **Additional notes** Medical abortions up to 9 weeks of pregnancy take place with a doctor in the community. Medical abortions between 9 and 12 weeks take place in a hospital. Surgical abortions take place in a hospital.
Judicial authorization for minors	**Not specified** When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 • Draft Model of Care for the Termination of Pregnancy Service, 2018 • National Consent Policy Revised, 2019 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2. **Source document**: WHO Abortion Care Guideline (page 81) **Additional notes** If there is no contactable parent or guardian, a social worker may be authorised by the District Court to give consent. This also applies to children in foster care for less than five years. If the child is the subject of a voluntary care order, consent is required from the parents unless a Court order is given dispensing with such consent. In respect of children under interim or emergency care orders, an application should be made to the District Court. Again, every effort would be made to contact and seek consent from the parents. In relation to children under a full care order, it is best practice to seek consent from parents but the HSE is authorised to give consent under the Child Care Act to medical or psychiatric treatment. It is possible that the Irish courts may interpret the provisions of the Constitution in such as way as to require parental consent to be obtained before providing a health or social care service to any minor under the age of 16 years. **Related documents:** • National Consent Policy Revised, 2019 (page 58)
Judicial authorization in cases of rape	Not Applicable **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion. The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64)
Police report required in case of rape	Not Applicable **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion. The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2. **Source document**: WHO Abortion Care Guideline (page 64)

Parental consent required for minors	Yes **Related documents:** • Guide to medical abortion, 2018 (page 4) • Guide to surgical abortion, 2018 (page 4) • National Consent Policy Revised, 2019 (page 52) **Can another adult consent in place of a parent?** Yes If there is no contactable parent or guardian, a social worker may be authorised by the District Court to give consent. This also applies to children in foster care for less than five years. If the child is the subject of a voluntary care order, consent is required from the parents unless a Court order is given dispensing with such consent. In respect of children under interim or emergency care orders, an application should be made to the District Court. Again, every effort would be made to contact and seek consent from the parents. In relation to children under a full care order, it is best practice to seek consent from parents but the HSE is authorised to give consent under the Child Care Act to medical or psychiatric treatment. In emergency circumstances where neither parent/legal guardian is contactable, the general doctrine of necessity applies16 and the service provider is obliged to act in the best interests of the child. • National Consent Policy Revised, 2019 (page 58) • National Consent Policy Revised, 2019 (page 52) **Age where consent not needed** 16 • National Consent Policy Revised, 2019 (page 58) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2. **Source document**: WHO Abortion Care Guideline (page 81)
Spousal consent	**Not specified** When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 • Draft Model of Care for the Termination of Pregnancy Service, 2018 • National Consent Policy Revised, 2019 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2. **Source document**: WHO Abortion Care Guideline (page 81)
Ultrasound images or listen to foetal heartbeat required	No **Related documents:** • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 14) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 1) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5. **Source document**: WHO Abortion Care Guideline (page 85)

Compulsory counselling	No **Related documents:** • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 24) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 5) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality. Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements. The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual's situation and needs. Abortion Care Guideline § 3.2.2. **Source document**: WHO Abortion Care Guideline (page 77)
Compulsory waiting period	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 12) • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 8) • Guide to medical abortion, 2018 (page 5) • Guide to surgical abortion, 2018 (page 5) **Waiting period** **Date of certification by medical practitioner that the pregnancy has not exceeded 12 weeks** **3** **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Mandatory waiting periods delay access to abortion, sometimes to the extent that women's access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1. **Source document**: WHO Abortion Care Guideline (page 79) **Additional notes** Under 12 weeks of pregnancy, the person is eligible to have the termination of pregnancy on the third day following certification. For terminations of pregnancy carried out under section 9 (risk to life or health), section 10 (risk to life or health in an emergency) or section 11 (condition likely to lead to death of fetus) of the legislation, the 3 day requirement does not apply **Related documents:** • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 2)
Mandatory HIV screening test	**Not specified** When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 • Guide to medical abortion, 2018 • Guide to surgical abortion, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Draft Model of Care for the Termination of Pregnancy Service, 2018 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1. **Source document**: WHO Abortion Care Guideline (page 59) **Additional notes** Patients are to be offered an STI risk assessment as part of your abortion care. **Related documents:** • Guide to medical abortion, 2018 (page 11) • Guide to surgical abortion, 2018 (page 11)

Other mandatory STI screening tests

No

Related documents:

- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 21)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.

Source document: WHO Abortion Care Guideline (page 59)

Additional notes

Patients are to be offered an STI risk assessment as part of your abortion care.

Related documents:

- Guide to medical abortion, 2018 (page 11)
- Guide to surgical abortion, 2018 (page 11)

Prohibition of sex-selective abortion

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

In situations where abortion is restricted for sex selection purposes, terminating a pregnancy for this reason is likely to involve an unsafe procedure carrying high risks. Any policies or guidelines on the use of technology in obstetric and fetal medicine should take into account the need to ensure women’s access to safe abortion and other services - efforts to manage or limit sex selection should also not hamper or limit access to safe abortion services. Preventing gender-biased sex selection: an interagency statement.

Source document: Preventing Gender-Biased Sex Selection (page 17)

Restrictions on information provided to the public

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Dissemination of misinformation, withholding of information and censorship should be prohibited.

Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers. Abortion Care Guideline § 3.2.1.

Source document: WHO Abortion Care Guideline (page 74)

Restrictions on methods to detect sex of the foetus

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. Safe Abortion Guidelines § 4.2.1.4.

Source document: WHO Abortion Care Guideline (page 103)

Other	

Clinical and Service-delivery Aspects of Abortion Care

National guidelines for induced abortion	Yes, guidelines issued by the government **Related documents:** • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 1) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 1) • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 1) • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 1) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3. **Source document**: WHO Abortion Care Guideline (page 50)

Methods allowed

Vacuum aspiration

Yes

- Guide to surgical abortion, 2018 (page 9)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 15)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 29)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 19)

Dilatation and evacuation

Yes

The Interim Clinical Guidance Riskt to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy of 2019 states that it is unlikely that surgical termination of pregnancy after 12 weeks will be widely available nor that D&E after 14 weeks will be offered in Ireland in 2019, but this may change over time. Additionally, as per the Interim Clinical Guidance related to Fatal Fetal Anomalies, feticide refers to induced fetal demise performed as part of termination of pregnancy procedure. Feticide should only be performed in tertiary referral centres where there are fetal medicine specialists with the appropriate level of training. Feticide is most commonly performed before medical termination for FFA/LLC after 21 weeks and 6 days of gestation to ensure that there is no chance of a live birth.

- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 31)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 19)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 20)

Combination mifepristone-misoprostol

Yes (63 DAYS)

As per the Interim Clinical Guidance related to Fatal Fetal Anomalies, feticide refers to induced fetal demise performed as part of termination of pregnancy procedure. Feticide should only be performed in tertiary referral centres where there are fetal medicine specialists with the appropriate level of training. Feticide is most commonly performed before medical termination for FFA/LLC after 21 weeks and 6 days of gestation to ensure that there is no chance of a live birth.

- Guide to medical abortion, 2018 (page 7)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 25)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 21)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 15)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 20)

Misoprostol only

Not specified

As per the Interim Clinical Guidance related to Fatal Fetal Anomalies, feticide refers to induced fetal demise performed as part of termination of pregnancy procedure. Feticide should only be performed in tertiary referral centres where there are fetal medicine specialists with the appropriate level of training. Feticide is most commonly performed before medical termination for FFA/LLC after 21 weeks and 6 days of gestation to ensure that there is no chance of a live birth.

- Guide to medical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 20)

Other (where provided)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilatation and sharp curettage (D&C), including for sharp curette checks (i.e. to “complete” the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

Source document: WHO Abortion Care Guideline (page 101)

Dilation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

Source document: WHO Abortion Care Guideline (page 103)

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

Source document: WHO Abortion Care Guideline (page 106)

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

Source document: WHO Abortion Care Guideline (page 106)

Country recognized approval (mifepristone / mife-misoprostol)

Yes

Related documents:

- Mifegyne Approval, 2018 (page 1)
- Mifegyne Package Leaflet, 2021 (page 1)
- Mifegyne Product Characteristics, 2021 (page 1)
- Mifegyne MisoOne Pharmacy Circular, 2018 (page 1)

Pharmacy selling or distribution

Yes, without prescription

- Mifegyne Approval, 2018 (page 1)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 µg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 µg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)

Country recognized approval (misoprostol)

Yes, for gynaecological indications

Related documents:

- Summary of Product Characteristics of Misoprostol (page 1)
- Mifegyne MisoOne Pharmacy Circular, 2018 (page 1)

Misoprostol allowed to be sold or distributed by pharmacies or drug stores

No

Administered by a trained physician in hospital only.

Allowed to be sold or distributed by pharmacies or drug stores, no information on prescription requirements.

- Summary of Product Characteristics of Misoprostol (page 1 see note)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 µg) are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)

Where can abortion services be provided

Related documents:

- Guide to medical abortion, 2018 (page 4)
- Guide to surgical abortion, 2018 (page 4)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 9)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 17)

Primary health-care centres

Yes

Medical abortions between 9 and 12 weeks and surgical abortions take place in a hospital. A Person can be referred to hospital under 9 weeks if the patient prefers it.

- Guide to medical abortion, 2018 (page 4)
- Guide to surgical abortion, 2018 (page 4)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 14)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 25)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 5)

Secondary (district-level) health-care facilities

Yes

Medical abortions between 9 and 12 weeks and surgical abortions take place in a hospital. A Person can be referred to hospital under 9 weeks if the patient prefers it.

- Guide to medical abortion, 2018 (page 4)
- Guide to surgical abortion, 2018 (page 4)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 14)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 25)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 5)

Specialized abortion care public facilities

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Private health-care centres or clinics

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

NGO health-care centres or clinics

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Other (if applicable)

Tertiary Centre

- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 17)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

National guidelines for post-abortion care

Yes, guidelines issued by the government

Related documents:

- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 1)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 1)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 1)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

Source document: WHO Abortion Care Guideline (page 50)

Where can post abortion care services be provided	**Primary health-care centres** Yes • Guide to medical abortion, 2018 (page 11) • Guide to surgical abortion, 2018 (page 11) **Secondary (district-level) health-care facilities** Not specified • Health Regulation of Termination of Pregnancy Act, 2018 • Guide to medical abortion, 2018 • Guide to surgical abortion, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **Specialized abortion care public facilities** Not specified • Health Regulation of Termination of Pregnancy Act, 2018 • Guide to medical abortion, 2018 • Guide to surgical abortion, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **Private health-care centres or clinics** Not specified • Health Regulation of Termination of Pregnancy Act, 2018 • Guide to medical abortion, 2018 • Guide to surgical abortion, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **NGO health-care centres or clinics** Not specified • Health Regulation of Termination of Pregnancy Act, 2018 • Guide to medical abortion, 2018 • Guide to surgical abortion, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman's location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1. **Source document**: WHO Abortion Care Guideline (page 133)
Contraception included in post-abortion care	Yes **Related documents:** • Guide to medical abortion, 2018 (page 11) • Guide to surgical abortion, 2018 (page 11) • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 26) **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4. **Source document**: WHO Abortion Care Guideline (page 126)

Insurance to offset end user costs	Yes **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 (page 20) • Guide to medical abortion, 2018 (page 4) • Guide to surgical abortion, 2018 (page 4) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 2) **Induced abortion for all women** Yes Termination of pregnancy is free for persons who normally live in the Republic of Ireland. The cost of contraception, pain relief or antibiotics will not be covered unless the person has a medical card. Patients with a medical card will be subject to prescription charges. • Health Regulation of Termination of Pregnancy Act, 2018 (page 20) • Guide to medical abortion, 2018 (page 4) • Guide to surgical abortion, 2018 (page 4) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 2) **Induced abortion for poor women only** No Termination of pregnancy is free for persons who normally live in the Republic of Ireland. The cost of contraception, pain relief or antibiotics will not be covered unless the person has a medical card. Patients with a medical card will be subject to prescription charges. • Health Regulation of Termination of Pregnancy Act, 2018 (page 20) • Guide to medical abortion, 2018 (page 4) • Guide to surgical abortion, 2018 (page 4) • Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 2) **Other (if applicable)** **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2. **Source document**: WHO Abortion Care Guideline (page 53) **Additional notes** Termination of pregnancy is free for persons who normally live in the Republic of Ireland. The cost of contraception, pain relief or antibiotics will not be covered unless the person has a medical card. Patients with a medical card will be subject to prescription charges.

Who can provide abortion services

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018 (page 11)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 17)

Nurse

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Midwife/nurse-midwife

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Doctor (specialty not specified)

Yes

- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 4)

Specialist doctor, including OB/GYN

Yes

- Health Regulation of Termination of Pregnancy Act, 2018 (page 11)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 10)

Other (if applicable)

Medical practitioner, which means a medical practitioner who is for the time being registered in the register. As per the Interim Clinical Guidance Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy of 2019, all surgical terminations must be performed by or under the supervision of a trained and experienced operator.”

- Health Regulation of Termination of Pregnancy Act, 2018 (page 11)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 29)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

Source document: WHO Abortion Care Guideline (page 97)

Extra facility/provider requirements for delivery of abortion services

Referral linkages to a higher-level facility

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Availability of a specialist doctor, including OB/GYN

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Minimum number of beds

Not specified

- Health Regulation of Termination of Pregnancy Act, 2018
- Guide to medical abortion, 2018
- Guide to surgical abortion, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

Other (if applicable)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide access to scientifically accurate, understandable information at all stages; access to quality-assured medicines (including those for pain management); back-up referral support if desired or needed; linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception. Best Practice Statement 49 on service delivery. Abortion Care Guideline § 3.6.1.

Source document: WHO Abortion Care Guideline (page 132)

Conscientious Objection

Public sector providers

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

Individual health-care providers who have objected are required to refer the woman to another provider

Yes

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

Source document: WHO Abortion Care Guideline (page 98)

Additional notes

Medical practitioners, nurses and midwives have a duty to participate in a termination of pregnancy when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

Furthermore, the 2019 Guide to Professional Conduct and Ethics provides more detail of what needs to be done when a provider has objects to providing an abortion.

Private sector providers

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

Individual health-care providers who have objected are required to refer the woman to another provider

Yes

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

Source document: WHO Abortion Care Guideline (page 98)

Additional notes

Medical practitioners, nurses and midwives have a duty to participate in a termination of pregnancy when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

Furthermore, the 2019 Guide to Professional Conduct and Ethics provides more detail of what needs to be done when a provider has objects to providing an abortion.

Provider type not specified

Yes

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

Individual health-care providers who have objected are required to refer the woman to another provider

Yes

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

Source document: WHO Abortion Care Guideline (page 98)

Additional notes

Medical practitioners, nurses and midwives have a duty to participate in a termination of pregnancy when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

Furthermore, the 2019 Guide to Professional Conduct and Ethics provides more detail of what needs to be done when a provider has objects to providing an abortion.

Neither Type of Provider Permitted

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

Individual health-care providers who have objected are required to refer the woman to another provider

Yes

- Health Regulation of Termination of Pregnancy Act, 2018 (page 18)
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018 (page 27)
- Draft Model of Care for the Termination of Pregnancy Service, 2018 (page 17)
- Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2019 (page 35)
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 (page 21)
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 (page 30)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

Source document: WHO Abortion Care Guideline (page 98)

Additional notes

Medical practitioners, nurses and midwives have a duty to participate in a termination of pregnancy when there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and it is immediately necessary to carry out the termination of pregnancy in order to avert that risk.

Furthermore, the 2019 Guide to Professional Conduct and Ethics provides more detail of what needs to be done when a provider has objects to providing an abortion.

Public facilities

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

Private facilities

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- Health Regulation of Termination of Pregnancy Act, 2018
- Interim clinical guidance on termination of pregnancy under 12 weeks 2018
- Draft Model of Care for the Termination of Pregnancy Service, 2018
- Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019
- Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

Facility type not specified	**Not specified** When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Draft Model of Care for the Termination of Pregnancy Service, 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1. **Source document**: WHO Abortion Care Guideline (page 48)
Neither Type of Facility Permitted	**Not specified** When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made. **Related documents:** • Health Regulation of Termination of Pregnancy Act, 2018 • Interim clinical guidance on termination of pregnancy under 12 weeks 2018 • Draft Model of Care for the Termination of Pregnancy Service, 2018 • Interim Clinical Guidance - Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019 • Interim Clinical Guidance – Pathway for Management of Fatal Fetal Anomalies and / or Life Limiting Conditions Diagnosed During Pregnancy, 2019 **WHO Guidance** The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1. **Source document**: WHO Abortion Care Guideline (page 48)

Indicators

Country specific information related to sexual and reproductive health indications. As data for the Sustainable Development Goal (SDG) indicators related to sexual and reproductive health become available, these will be provided, through periodic updates.

Goal 1. End poverty in all its forms everywhere

1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	No data
1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable	No data
1.a.2 Proportion of total government spending on essential services (education, health and social protection)	No data

Goal 3. Ensure healthy lives and promote well-being for all at all ages

3.1.1 Maternal mortality ratio	**5** (2017)
3.1.2 Proportion of births attended by skilled health personnel	No data
3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	No data
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	**9.7** (2015-2020)
3.8.2 Number of people covered by health insurance or a public health system per 1,000 population	No data
3.c.1 Health worker density and distribution	No data

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	No data

Goal 5. Achieve gender equality and empower all women and girls

5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex	No data
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	No data
5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	No data
5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	No data
5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	No data
5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	No data
5.6.2 Number of countries with laws and regulations that guarantee women aged 15- 49 years access to sexual and reproductive health care, information and education	No data
5.a.1 (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure	No data
5.b.1 Proportion of individuals who own a mobile telephone, by sex	No data

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

8.5.2 Unemployment rate, by sex, age and persons with disabilities	No data

Goal 10. Reduce inequality within and among countries

10.2.1 Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities	No data
10.3.1 Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	No data

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months	No data
16.2.2 Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation	No data
16.2.3 Proportion of young women and men aged 1829 years who experienced sexual violence by age 18	No data
16.3.1 Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms	No data
16.5.1 Proportion of persons who had at least one contact with a public official and who paid a bribe to a public official, or were asked for a bribe by those public officials, during the previous 12 months	No data
16.6.1 Primary government expenditures as a proportion of original approved budget, by sector (or by budget codes or similar)	No data

16.6.2 Proportion of the population satisfied with their last experience of public services	No data
16.7.1 Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions	No data
16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age	No data
16.10.1 Number of verified cases of killing, kidnapping, enforced disappearance, arbitrary detention and torture of journalists, associated media personnel, trade unionists and human rights advocates in the previous 12 months	No data
16.b.1 Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	No data

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

17.8.1 Proportion of individuals using the Internet	No data

Additional Reproductive Health Indicators

Percentage of married women with unmet need for family planning	No data
Percentage of births attended by trained health professional	**99.7** (2015)
Percentage of women aged 20-24 who gave birth before age 18	No data
Total fertility rate	**1.75** (2018)
Legal marital age for women, with parental consent	No data
Legal marital age for women, without parental consent	**18** (2009-2017)
Gender Inequalities Index (Value)	**0.11** (2017)
Gender Inequalities Index (Rank)	**23** (2017)
Mandatory paid maternity leave	**yes** (2020)
Median age	**38.2** (2020)
Population, urban (%)	**63.17** (2018)
Percentage of secondary school completion rate for girls	**1.03** (2013)
Gender parity in secondary education	**1.025** (2016)
Percentage of women in non-agricultural employment	**51.5** (2013)
Proportion of seats in parliament held by women	**24.3** (2017)
Sex ratio at birth (male to female births)	**1.06** (2018)