Termination of Pregnancy for Fetal Anomaly

Pregnancy Loss Research Group

HSE

National Women & Infants Health Programme

Contents **Page**

Introduction

While most pregnancies develop without major concerns, approximately 1 in 50 (2%) are found to have a major fetal anomaly, which is a condition that develops during pregnancy and is present in the baby or fetus before birth, seriously affecting the baby's health, development or long-term wellbeing.

For many people, this diagnosis is deeply distressing, and the decision to end a pregnancy can be a uniquely complicated and painful experience. This booklet aims to provide information about the diagnosis, your options, and the steps involved, as well as supports available for people from all backgrounds and circumstances.

Specifically, this booklet offers support, information and guidance if you are considering or will undergo a termination of pregnancy for fetal anomaly (TOPFA). It covers the legal and clinical aspects of navigating a diagnosis of fetal anomaly in the Republic of Ireland, according to the Health (Termination of Pregnancy) Act 2018.

The information here is for pregnant women and people, partners, and anyone affected by a diagnosis of fetal anomaly. It covers medical, emotional, and practical aspects of care in the Republic of Ireland; where relevant, it also provides information for those who need to travel outside the Republic of Ireland to access services.

This booklet was developed by the Pregnancy Loss Research Group in Ireland, in collaboration with the Health Service Executive (HSE)'s National Women and Infants Health Programme (NWIHP), with the input of people with lived experience, advocacy groups like LMC Bereavement Support, and healthcare professionals. Throughout the booklet, you will find direct quotes from people with lived experience from previously conducted research.

We hope this booklet can offer practical, compassionate support during a challenging time. At the time of printing, there is little guidance in one place about this form of pregnancy loss.

As the content can be heavy at times, and may be distressing for some in places, the booklet is meant as a reliable reference for information that may not exist elsewhere. You might read certain sections of this booklet, based on the information you need, rather than reading it cover to cover.

This booklet is not a substitute for personalised medical advice, which should always be addressed with your fetal medicine team. Finally, care pathways can change; we encourage you to consult with your healthcare professionals for any concerns or questions.

Language used

People who receive a diagnosis of a fetal anomaly, and who are considering or undergoing a termination of pregnancy, use many different words to describe their pregnancy, the diagnosis, what happens to the baby or fetus, and the process itself.

People also differ in how they describe the ending of the pregnancy. Some people prefer using the word abortion to termination of pregnancy, while others use words like loss, induction of labour, or delivery. The later the pregnancy, the more common it is that parents or people/couples speak about their baby, although this can also happen earlier in pregnancy.

Health services and legal documents may use words or phrases such as ‘malformation’, ‘anomaly’, ‘products of conception’, ‘pregnancy tissue’, or ‘remains’ to refer to the baby or fetus and the surrounding tissues after the pregnancy has ended. While many people think of and talk about their baby, others may feel more comfortable with terms such as fetus, fetal anomaly, or pregnancy tissue, and may choose not to use the word baby at all.

Throughout this booklet, terms such as pregnancy, fetus, baby, fetal anomaly, pregnancy tissue, fetal remains, and baby’s body are used in an effort to be inclusive and clinically accurate, while recognising that no single term reflects everyone’s experience. Clinical and legal terms are defined in the Glossary on pages 84-87.

This booklet mainly describes the experiences of cisgender women, but it also discusses laws and clinical care that affect anyone who can become pregnant, including transgender and non-binary people.

Healthcare professionals should be guided by you, using the language you prefer.

Understanding fetal anomaly

Termination of pregnancy for fetal anomaly (TOPFA) means ending a pregnancy because a serious condition has been diagnosed in the developing baby (fetus).

The term termination for medical reasons (TFMR) is regularly used by support communities. This term may also be talking more broadly about ending a pregnancy for serious maternal or fetal health reasons.

This booklet uses the abbreviation TOPFA when referring to decisions made after a diagnosis of fetal anomaly, but, in most cases, termination of pregnancy for fetal anomaly is written without abbreviation.

Fetal anomalies can vary widely and include congenital anomalies. A congenital anomaly is a condition that develops during pregnancy and is present from birth.

Major fetal anomaly

A serious condition that develops during pregnancy and is present in the baby or fetus before birth that is likely to have a significant impact on a baby's health, development, or survival. Also referred to in clinical settings as a major congenital anomaly.

Major fetal anomalies involve changes in the baby's body structure, chromosomes, or genes that are likely to have significant effects on health or daily life, and usually mean the baby will need medical or surgical care. These conditions can affect many different parts of the body and are often the ones with the biggest impact on a baby's chances of survival or long-term health.

This booklet focuses primarily on major fetal anomalies — the most serious of these conditions, where the baby would not be expected to survive. These may also be referred to as major congenital anomalies by healthcare professionals.

Many people, including clinicians and the media, use the phrase ‘fatal fetal anomaly’, but it is not an agreed medical diagnosis and does not have an agreed international definition or list of conditions attached to it. This phrase came into wide use in Ireland leading up to the 2018 referendum.

However, the law in the Republic of Ireland since 2019 describes a situation where a fetal condition is likely to lead to the baby’s death during the pregnancy (in utero) or within 28 days after birth, without specifying an exact list of qualifying diagnoses or clarifying how possible medical or surgical treatments are taken into account.

Findings from Ireland show that only some fetal anomalies clearly fit this legal definition. Some chromosomal or structural conditions that will be explained below are often described as 'fatal', but there are rare cases of babies who survive with these diagnoses, and what happens can depend on other serious, associated health issues. Each pregnancy needs careful, individual consideration by the fetal medicine team rather than relying on the label 'fatal fetal anomaly' on its own.

> “She said there is a problem with your baby’s heart.
>
> I burst into tears.
>
> I felt then that he was going to die.”

The finding of a fetal anomaly

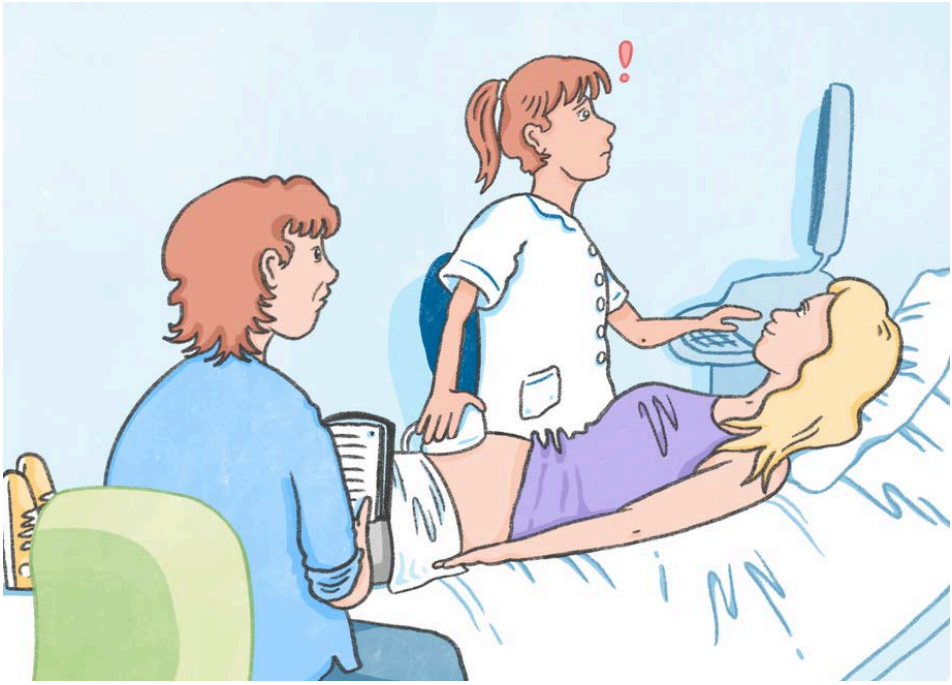
This finding of a fetal anomaly most commonly happens at the second trimester anatomy ultrasound scan, but can happen earlier. This is a deeply personal and complex situation. Often, people have planned their future around this pregnancy, and this diagnosis can come as a profound shock.

> I was given 2 impossible choices. I was lying in bed, waiting for it to blow over. But then I realised this would not blow over. We had to choose.

> No idea the rug was going to be pulled from under us. Days were really long, and really torturous.

> We went for the scan. It took about 20 minutes. I was shaking and sweating, trying not to cry.

> I sat there in disbelief as my life burned down around me... I can still hear that ringing in my ears, the tears waiting to come as I'm moved to the 'Private Waiting Room' and given a box of tissues. Alone.



Some people choose to continue their pregnancy, while others choose to end it. Both choices are deeply personal and deserving of compassionate care. Decisions may not be easy, and each person's feelings, beliefs, and circumstances are unique.

The legal framework in Ireland can also determine what choices are available to you, depending on the particular diagnosis. This will be discussed in greater detail throughout the booklet.

Table: Examples of major fetal anomalies include

Condition	Plain-language description
Anencephaly	The baby's brain or skull does not develop fully, resulting in no possibility of survival after birth.
Bilateral renal agenesis	Neither kidney develops, resulting in no possibility of survival after birth in almost all cases.
Severe heart or organ defects	Some cardiac or organ abnormalities may be so serious that they lead to death in the newborn period.
Hydrops fetalis	A serious condition involving abnormal fluid accumulations in the baby's body, which can have many different underlying causes.
Severe chromosomal anomaly	This may include trisomy 13 (Patau syndrome) or trisomy 18 (Edwards syndrome), both associated with a very limited life expectancy and significant health complications.

This is not an exhaustive list, and each case is considered individually, based on detailed assessments by the fetal medicine team, the specific diagnosis, and the likely outcome for the baby.

Some physical anomalies or developmental differences are very serious but are not immediately life-threatening. This distinction matters because termination of pregnancy is not allowed in Ireland for conditions where the baby could potentially survive longer than 28 days after birth, even if there are significant health needs or disabilities anticipated.

The legal framework for termination of pregnancy in the Republic of Ireland is discussed in detail in the section on 'Understanding the Legislation' on pages 32-37, as well as in our other booklet *Termination of Pregnancy: Guide to the 2018 Legislation.*

In brief, the law allows termination of pregnancy in specific circumstances, including where a fetal anomaly is diagnosed that is likely to lead to the death of the baby before birth or within 28 days of birth.

The decision-making process always needs to consider the specific clinical details of the pregnancy and a compassionate approach to each unique situation.

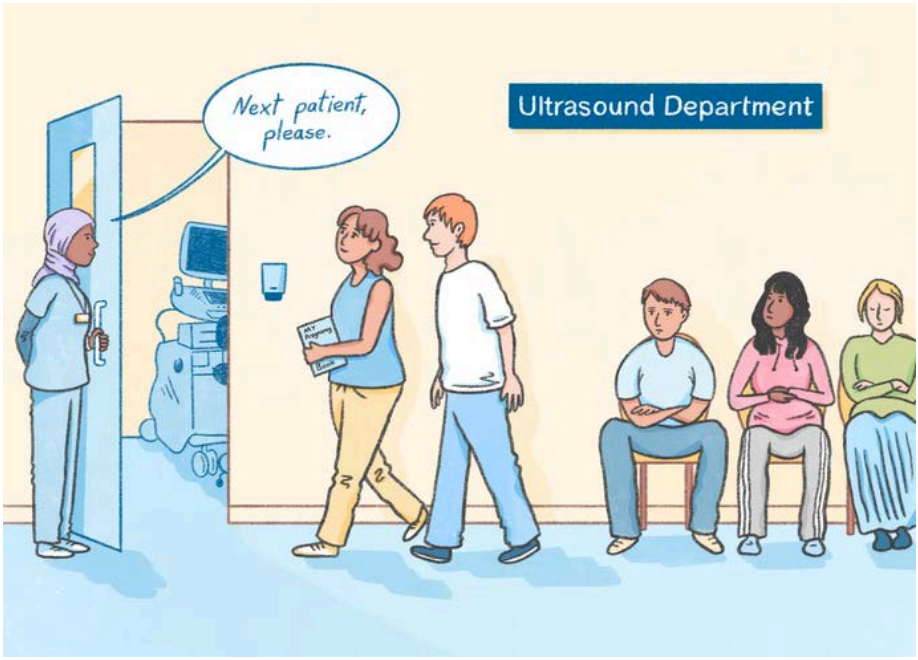
> "I felt like saying, I haven't had a miscarriage. I've had something a million times worse than a miscarriage you know, you can't compare the experiences. I was hoping for miscarriage*."

> "I really appreciated that because it was very upsetting, like, kind of going in knowing everyone was getting good news and I don't know if everybody was getting good news, but it seems like everybody was."

*While every ending of a pregnancy can come with its own emotional difficulties, the aspect of having to take the decision whether to end the pregnancy can bring further complexity to any existing distress.

Diagnosis of fetal anomaly in pregnancy

Most people find out about a fetal anomaly at a routine pregnancy scan, or after a scan or screening test they have chosen or been advised to have. Others may be advised to have a more detailed ultrasound scan because of their medical or family history. In a small number of pregnancies, a concern is picked up when an ultrasound is done for reasons other than those already described.



However it happens, hearing that there may be a problem can be shocking and overwhelming. People generally need clear information, time, and support to begin to process what this might mean.

Routine prenatal screening

In Ireland, routine prenatal screening is by ultrasound scans.

This means a first trimester dating ultrasound (done between 11 to 13 weeks), which confirms pregnancy location, estimates the due date, and determines the number of fetuses, and a second trimester anatomy ultrasound, which is a detailed and systematic examination of the baby's size, organs, and structures, and which is done between 20 to 22 weeks.

Scan type	When it is usually done	Why it is done
First trimester dating ultrasound	Around 11 to 13 weeks of pregnancy	Confirms the pregnancy location, estimates due date, checks number of fetuses
Second trimester anatomy ultrasound*	Around 20 to 22 weeks of pregnancy	Provides detailed, systematic examination of the baby's size, organs, and structures

*The anatomy scan is sometimes called an anomaly scan. In national guidance in the Republic of Ireland, the term anatomy scan is preferred; in the UK, anomaly scan is more commonly used.

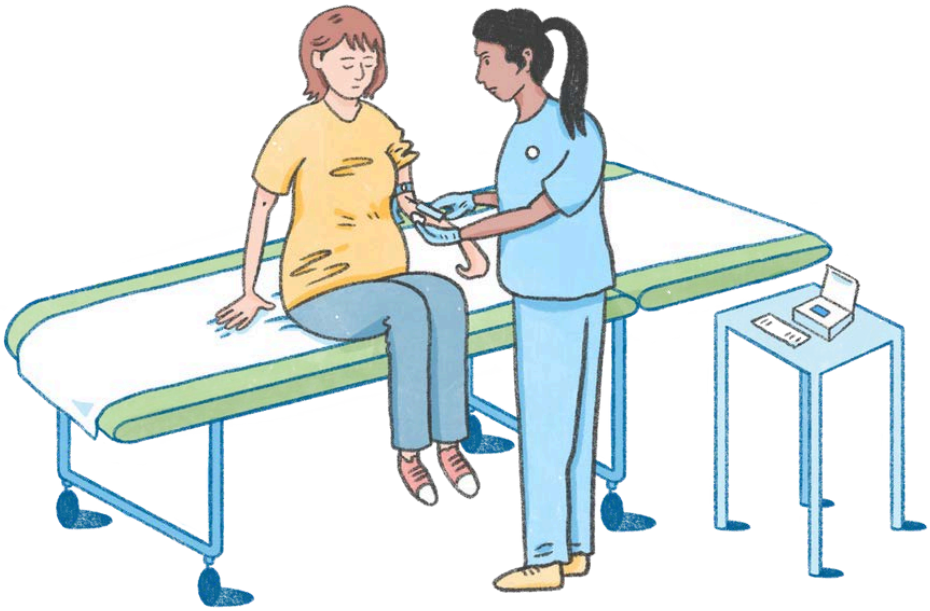
The anatomy scan aims to identify major structural anomalies so that care can be planned and further tests offered where appropriate. It cannot detect all chromosomal or functional problems. No ultrasound scan can see everything or rule out every possible condition.

Additional screening tests

Screening tests estimate the chance that a baby has a particular condition — they cannot give a definite yes or no answer. They can also give false positive or false negative results. A false positive is a test result that says a condition is present when it isn't; while a false negative is a test result that says a condition is absent when it actually is present.

Non-invasive prenatal testing or non-invasive prenatal screening (NIPT/NIPS) is now the most commonly used first trimester screening test for common chromosomal conditions such as:

- Trisomy 21 (Down syndrome)
- Trisomy 18 (Edwards syndrome)
- Trisomy 13 (Patau syndrome)



People usually have 46 chromosomes in the body's cells, arranged in 23 pairs. Half of these – 23 chromosomes – come from each parent. Chromosome conditions happen when there are extra or missing chromosomes, or extra or missing parts of a chromosome. NIPT/NIPS screens for the three most common chromosomal conditions.

Table: Common types of chromosome conditions

Name of condition	Description of condition
Trisomy 21*	Down syndrome: an extra chromosome 21 is present
Trisomy 18	Edwards syndrome: an extra chromosome 18 is present
Trisomy 13	Patau syndrome: an extra chromosome 13 is present

*Trisomy 21, on its own, is not considered a condition that meets the legal grounds for termination of pregnancy in Ireland (more on the legislation on pages 32-37).

NIPT/NIPS is not currently offered as part of a national public screening programme in Ireland. It is usually arranged and paid for privately.

Because screening cannot confirm a diagnosis, any result that suggests a condition is followed by diagnostic tests such as chorionic villus sampling (CVS) or amniocentesis, which examine fetal or placental cells directly. In some cases, an amniocentesis may also be required after CVS to confirm the diagnosis. There is more information about CVS and amniocentesis on page 17.

Timing

Most major fetal anomalies are diagnosed at the anatomy scan at 20 to 22 weeks. Some concerns may be seen earlier, e.g. at the dating scan (at 11 to 13 weeks), though detection rates at this stage are lower, and in most maternity hospitals/units in Ireland this scan is currently not a detailed anatomy scan.

Even with optimal scanning, some anomalies will only become apparent later in pregnancy or after birth. The extent and seriousness of some conditions can sometimes not be fully assessed until the third trimester (after 28 weeks), as the baby develops and further tests such as MRI (Magnetic Resonance Imaging) become more useful (see page 19).

In addition, a small number of fetal anomalies may be first noticed when an ultrasound scan is done for another reason—for example, if a baby seems smaller than expected, or if there are concerns about reduced fetal movements. So, a diagnosis can sometimes come at an unexpected time in the pregnancy.

If you have had a previous pregnancy affected by a fetal or genetic condition, or you have a history of genetic conditions in the close family, your healthcare team may suggest a different screening plan in a future pregnancy, with earlier or more detailed scans, and the option of additional screening tests.

There is a national clinical practice guideline for the fetal anatomy ultrasound (listed in the section 'More information and support' on pages 88-91), which recommends that all pregnant women in Ireland should be offered a detailed anatomy scan between 20 and 22 weeks, with informed written consent and clear information about the purpose and limitations of the examination.

> "It was a way of, a very sort of project mode. Okay, I need to know what's happening when, how many weeks in advance, what we're going to be doing."

Decision-making after a diagnosis of fetal anomaly

After a diagnosis of a fetal anomaly, many people describe feeling as though their whole future has changed very quickly, while at the same time, waiting for information and next steps can feel painfully slow. This section of the booklet looks at what typically happens after a diagnosis, including how it is confirmed, who is involved in your care (see page 24), and how decisions are made over time.

What happens after a diagnosis of fetal anomaly

When a fetal anomaly is first suspected on an ultrasound scan, the finding is usually reviewed by the local obstetrician in the local maternity hospital/unit, who may repeat or extend the scan to clarify what has been seen. If concern remains, you will be referred to a specialist in one of the six Fetal Medicine Centres in Ireland (located in maternity hospitals/units in Cork, Limerick and Galway, and three in Dublin, as well as in some other units staffed by those centres) for confirmation of the diagnosis and more detailed assessment, which may include further imaging and, where appropriate, genetic testing.

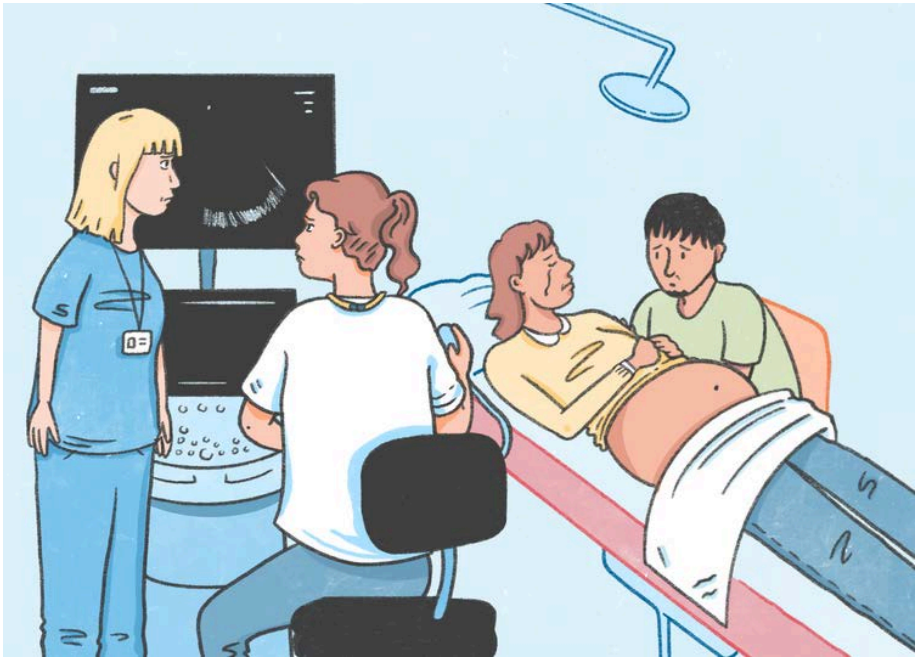
Current guidance in the Republic of Ireland recommends that this referral should happen promptly — ideally within five working days for a suspected anomaly, and within 24 to 72 hours where a major fetal anomaly is suspected — in one of the six specialist Fetal Medicine Centres.

Although the aim is for people to be seen as quickly as possible, actual appointment times can vary between hospitals. This waiting period can be extremely stressful, and it can be useful to seek emotional support during this time. Healthcare staff will signpost these and more information on where to access support can be found on pages 88-91.

Confirming the fetal anomaly diagnosis

The diagnosis is usually confirmed by a fetal medicine specialist, who is a hospital-based clinician with particular expertise in diagnosing and managing problems in the baby during pregnancy.

This confirmation happens after a detailed ultrasound scan and, where needed, diagnostic tests such as chorionic villus sampling (CVS), amniocentesis, or fetal MRI. Clinical geneticists may also become involved, particularly where findings are complex or uncertain. Information below is in highly clinical language. Medical terms can be found in a glossary at the end of this document (pages 84-87).

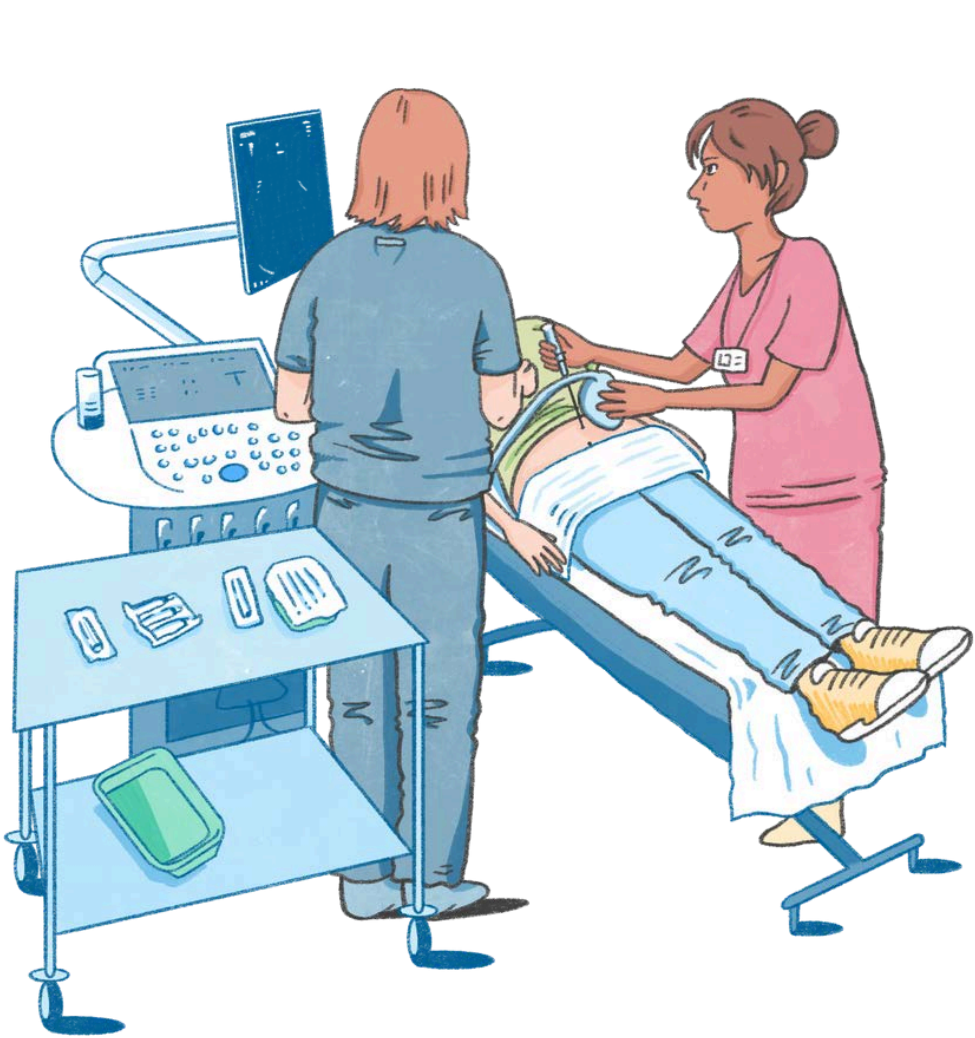


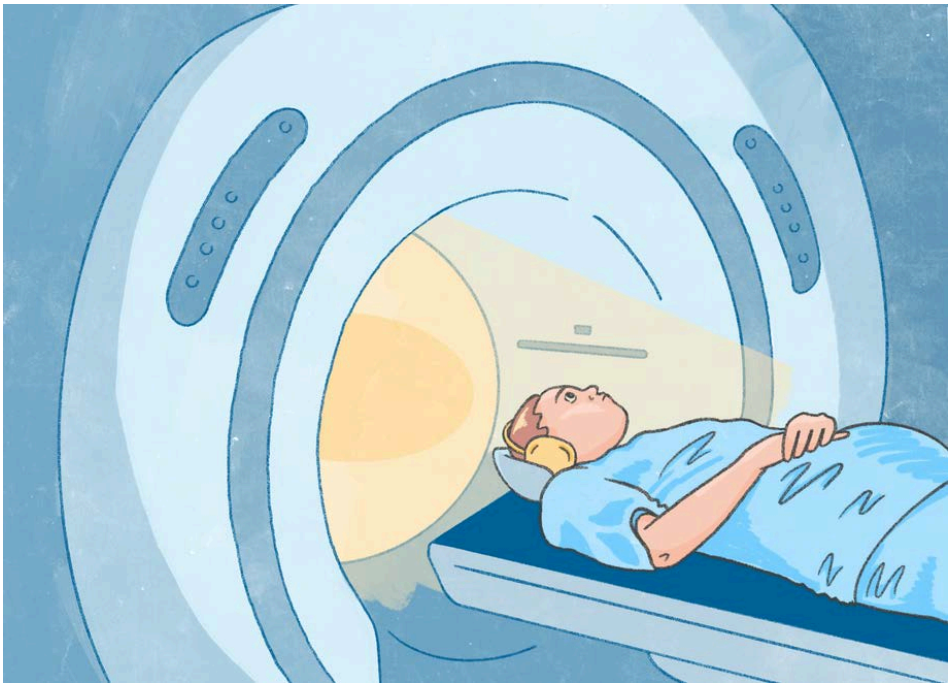
Chorionic villus sampling (CVS)

- A small sample of placental tissue is taken using a thin tube or needle, usually through the abdomen, guided by ultrasound.
- Used when there is a high chance of a chromosomal or genetic condition (e.g. from screening, clinical or family history).
- Usually performed after 11 weeks of pregnancy.
- Confirms or excludes whole chromosomal differences (aneuploidy) and can be used for other genetic and chromosomal diagnoses.
- Carries a small risk of pregnancy loss (less than 1 in 200).
- In some cases, a subsequent amniocentesis test may also be required to confirm the diagnosis.

Amniocentesis

- A fine needle is inserted through the abdomen into the uterus under ultrasound guidance to withdraw a small amount of amniotic fluid (fluid around the baby).
- Used when there is a high chance of a chromosomal or genetic condition (e.g. from screening, clinical or family history).
- Performed after 15 weeks of pregnancy.
- Confirms or excludes aneuploidy and can be used for other genetic and chromosomal diagnoses.
- Carries a small risk of pregnancy loss (less than 1 in 200).





Fetal MRI (Magnetic Resonance Imaging)

- Safe non-invasive imaging that does not involve radiation.
- Uses magnetic fields rather than X-rays to produce detailed pictures of the fetus, focussed on the brain, chest, spine, limbs, placenta or other specific organs.
- Fetal MRI is considered when ultrasound images are limited or more detail is needed, particularly for conditions affecting the brain or chest, or when there is concern for an underlying genetic or syndromic cause.
- Typically performed in the second or third trimester, and in a specialist centre, where MRI is interpreted by radiology specialist doctors.
- Fetal MRI does not replace ultrasound but is complementary with ultrasound to help refine the diagnosis, guide counselling about prognosis and support decision-making.

Emotions surrounding the diagnosis

Most people go to a scan assuming everything will be well, so hearing that there may be a concern can feel like the ground has shifted suddenly. People in this situation have described intense shock, sadness, confusion, or grief. It can take time for your mind to catch up with what you have been told, and you may find that information is hard to absorb or that your feelings change from hour to hour.

One of the aspects that people with lived experience describe as being very difficult is the shock of new, devastating information, combined with uncertainty and the need to wait for various referrals, and tests with different timelines for results.

> "You're on a different world, there's no place for you in the pregnancy world."

> "People don't get bad news like this, people go to their 20-week scan to find out the gender, this doesn't happen to people. I didn't know anybody who had gotten bad news at their 20-week scan. So this... was just awful. Both of us were just in disbelief."

> "I suppose from a male perspective... You still don't have or I didn't have, maybe it was just more me, but like I suppose, you know, I hadn't had a child before. So, I hadn't you know, that connection to the baby just yet."

A timeline for diagnosis leading to decision-making could look like the following:

- After the initial scan: a specialist review by a fetal medicine team should be organised as promptly as possible, ideally within five working days (or 1 to 3 days if a major anomaly is suspected).
- At the fetal medicine visit: you will usually meet a fetal medicine consultant and a midwife sonographer or co-ordinator. They repeat or extend the ultrasound, confirm or revise the diagnosis, and arrange any further tests such as amniocentesis, CVS, fetal MRI or specialist fetal heart scan. These moments can be some of the hardest, i.e., learning that something is very wrong, but not yet knowing exactly what this is or what will happen.
- Tests and timing: scan results are available the same day, while other test results take days to weeks, and this can affect how quickly you get clear answers and can make decisions about the pregnancy.


20 MAY
19 MAY
13 MAY
9 MAY
7 MAY
6 MAY

How long tests usually take

- Ultrasound findings: available straight away — the doctor or sonographer can see and explain structural problems in real time.
- MRI – may take 1 to 4 weeks to be scheduled and reported, depending on the reason for doing the scan.
- Rapid targeted genetic tests (e.g. for trisomies 13, 18 and 21): usually done on CVS or amniocentesis samples and results are back within a week.
- Chromosome microarray (CMA): looks more closely at the chromosomes using the same samples and is now the first-line genetics laboratory test when a significant fetal anomaly is seen. Results typically take longer, from 10 days to 3 weeks.
- More complex tests (such as gene panels or trio exome sequencing): examine many genes, need specialist interpretation, and usually have the longest turnaround — often several weeks.

All of these steps and their waiting times can feel disorienting. Emotions such as denial, guilt, anger, numbness, or feeling detached from the pregnancy are common responses and also ways that people try to cope.

Talking with your healthcare team, including the fetal medicine midwife, a peer support organisation, or professional specialist pregnancy counsellor (see pages 88-91) can be a vital part of navigating this experience.

If you need guidance on what might be important to discuss, the Appendix on pages 92-94 lists examples of questions you may wish to ask your healthcare team.

Who is involved in your care

During and after the diagnosis, you will meet a number of people. Wherever possible, your care should be co-ordinated so that you know who your main contact is between appointments.

Most people will meet:

- Fetal medicine specialist (consultant obstetricians).
- Fetal medicine midwife.
- Midwife sonographers, advanced ultrasound practitioners, and/or a fetal medicine coordinator who help organise scans, tests and appointments.

Depending on the diagnosis and your needs, you may also meet or be referred to:

- Clinical geneticists and/or genetic counsellors to discuss genetic results and future pregnancy risks.
- Neonatologists and/or paediatricians to talk about care for the baby after birth. This may include paediatric palliative care consultants, who can support antenatal parallel planning and help with decision-making.
- Bereavement midwife specialists who provide support around pregnancy loss and decisions about care.
- Doctors in training who may be present as part of the healthcare team.
- Medical social workers who can help with practical and emotional support, including financial concerns, travel arrangements, and community services.
- External specialist pregnancy counselling organisations, other counsellors or therapists, if needed/referred.

You or your healthcare team may request a second opinion from another fetal medicine specialist or centre at any stage.

Multidisciplinary team (MDT)

Fetal anomaly cases in Ireland are usually discussed by a multidisciplinary team (MDT) — a group of specialists who review your scans and test results together, agree on the most likely diagnosis, and discuss what care to suggest next.

MDT meetings are typically held once a week in each Fetal Medicine Centre and include fetal medicine specialists, neonatologists or paediatricians, clinical geneticists (where relevant), fetal medicine midwives and other relevant clinicians. Once key results are available, your case is reviewed by the MDT.

After the meeting, the fetal medicine specialist (sometimes with other members of the team) meets you to go through the confirmed diagnosis, expected outcomes, and the care options available, including continuing the pregnancy, specialist neonatal care, or, termination of pregnancy.

Decision-making stage

After a diagnosis is confirmed, you may need time and help to make decisions about what happens next. Support pathways should be offered to you, and you may wish to reach out to your own supports.

Take the time you need to consider a pathway that is right for you, whether it includes:

- Termination of pregnancy (where the law allows it in Ireland, or in another country)
- Continuing the pregnancy with routine or specialist care (during the pregnancy and following the birth of the baby)
- Planning for palliative care.

Perinatal palliative care

Perinatal palliative care is holistic care for a baby and family where there is a serious condition (diagnosed before or around birth) that is expected to shorten the baby's life. It focuses on comfort, dignity and quality of life, alongside bereavement support.

> "You need to get that story in your head of how you're gonna tell people and you either just hide away and this is some sort of secret or you do the opposite you can say look, this is what we're doing."

> "I suppose I also wanted to let her know, that she wasn't the only person that made that decision..."

Partners of people who go through this experience share that they also experience their own grief and can benefit from support (see details of supports on page 76).

> I guess it was just something, you went into a bit of a Google frenzy of trying to find out what this meant. And not having that sort of upfront information with you to deal, to help you deal.

Feelings of shock, worry, guilt, anger, or relief are all normal. There may be grief not just about the diagnosis, but also the loss of plans you had for your pregnancy.

In Ireland there is no legal limit on when you are allowed to have a termination of pregnancy if you meet criteria under section 11 of the Health (Regulation of Termination of Pregnancy) Act 2018 (see page 32 for more information). Therefore, you should not feel rushed. It is always okay to ask questions or request a second opinion. Your fetal medicine doctor can arrange a second opinion for you, which could be with another fetal medicine specialist in the same fetal medicine centre, or in another fetal medicine centre.

The decision-making process often involves mixed feelings that change over time; if you feel pressured at any stage, speak with your healthcare professionals so they can help. Your healthcare team should provide you with compassionate care and clear, honest information.

> "As soon as we went in for scans, I saw the heartbeat, I saw the movement, we have to see this through."

> "Nobody could empathise; nobody could help. I was no longer in their world. I felt completely isolated from everything I ever knew."

> "Everyone had time to listen to you, because that means so much...for people like to understand what you were going through and to take the time to listen."

The team's role is to offer support and answer questions, including possible pregnancy risks, what may happen next, and all options available to you. They are there to help, guide, explain, and recommend helpful supports as you make your decision.

Supports you should have during decision-making

- The fetal medicine midwife provides emotional support, information and co-ordination of care. Where needed, external specialist counselling can also be arranged (see page 88 for details), whether you decide to continue or end the pregnancy.
- Practical support from the healthcare team includes information on procedures, logistics, and, if required, travel arrangements (particularly if care involves referral to another maternity unit/hospital).
- Bereavement specialist midwives may also be involved at this stage.
- Peer support and direction to voluntary support groups should be offered — these groups can provide valuable insight from others with lived experience (see pages 88-91 for more detail).
- Clear written information about the planned care pathway and options should be provided at the point of diagnosis.
- If a termination of pregnancy is not approved by the healthcare team, you have a legal right to request a formal review under the Act. This is discussed in the 'Understanding the legislation' section on pages 32-37.

> "Being frightened, and so sad, just feeling so alone and nobody—my general practitioner wasn't aware of what was going on and nobody from the hospital contacted me."

> "I kind of knew I was in this club that nobody wants to be in but okay, so there was really good support."

Where to go for more information (also see pages 88-91)

- Your fetal medicine team can direct you to recommended online resources relevant to your diagnosis.
- All Fetal Medicine Centres can give contact details for hospital support staff, including fetal medicine midwives, bereavement specialist midwives, and national advocacy groups such as LMC Bereavement Support and the My Options helpline, which offer non-judgmental pregnancy-related counselling and support. It can help to talk to a professional specialist pregnancy counsellor (see pages 88), who can also provide information and support around care pathways inside and outside Ireland
- You can request a second clinical opinion from another Consultant in the hospital/maternity unit, or in another Fetal Medicine Centre if you need another opinion on the diagnosis, prognosis, or care plan (this is separate from the formal legal review process – see pages 35-37).
- More information about the legislation can be found in the *Termination of Pregnancy: Guide to the 2018 Legislation* booklet.

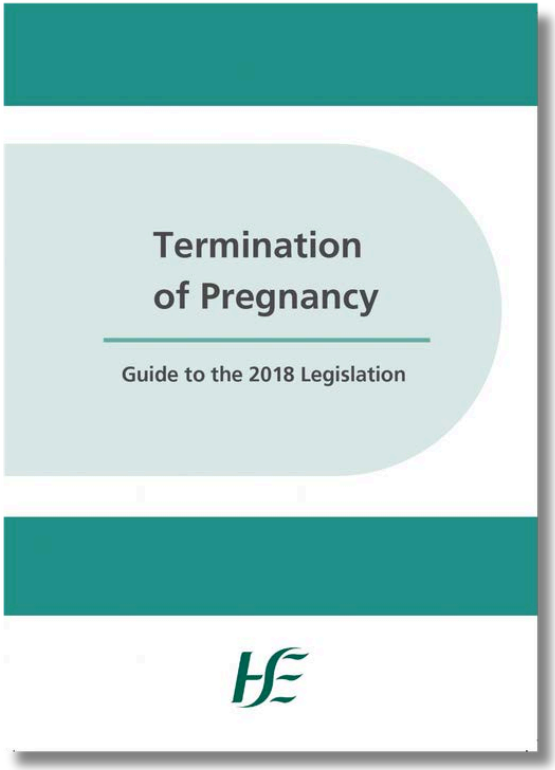
> "I feel like I was cocooned by this, these really sympathetic, lovely people."

> "We met a fabulous nurse and she was like, we're waiting for you. It was so lovely because they were able to say, like, you know, like you're safe now, you know, you don't have to worry about anything else – we're gonna mind you."

Understanding the legislation

Part of your decision-making may involve navigating the law around termination of pregnancy in Ireland. This can feel confusing and overwhelming, especially during an already distressing time.

The Health (Regulation of Termination of Pregnancy) Act 2018 (the Act) sets out when and how termination of pregnancy can legally take place. Your healthcare team can help explain what options apply in your situation, and you can obtain further information from your healthcare provider at any stage. You can also refer to the *Termination of Pregnancy: Guide to the 2018 Legislation* booklet for more detailed information.



When termination of pregnancy is allowed in Ireland

The Act allows termination of pregnancy only under certain circumstances:

Table: Summary of when termination of pregnancy is allowed in Ireland

Legal ground	Section	Description
Early pregnancy (up to 12 weeks)	Section 12	For any reason, you can access a termination of pregnancy if a doctor confirms that the pregnancy is less than 12 weeks along.
Risk to life or health (including mental health)	Section 9	If continuing the pregnancy could seriously harm your life or health (including your mental health).
Risk to life or health in emergency	Section 10	If a situation develops that threatens your life or risks seriously harming your health.
Condition likely to lead to death of fetus	Section 11	If your baby has been diagnosed with a condition likely to cause death before birth or within 28 days after birth.

Certification paperwork around Section 11 and who is involved in the decision

Certification refers to the process of documenting that a termination of pregnancy is being provided according to the law in the Republic of Ireland. If a fetal anomaly is diagnosed and a decision is made to terminate the pregnancy, the process involves specific requirements:

- Two doctors must examine you and agree, in good faith, that your baby has a condition likely to cause death before birth or shortly after (within 28 days); in legal terms, a key factor in ensuring that an opinion was formed in good faith is whether the doctor acted within clinical/medical guidelines.

- Both doctors must be on the Specialist Division of the Register of Medical Practitioners. One must be an obstetrician (usually a consultant), and the other must be an "appropriate medical practitioner" (doctor) with expertise in the specific condition affecting the fetus.

- Both doctors must document and certify their opinions by completing the official certification paperwork confirming that the legal criteria are met, before the pregnancy can be ended.

- The medical procedure is done by the obstetrician. If both doctors are obstetricians, either may provide this care.

- All decisions and paperwork—including results of assessments, completed certification forms, and planned procedures—are recorded in your medical records, as set out in the legislation.

What happens if a request for a termination of pregnancy is denied?

If you believe you meet the legal criteria and are told you cannot have a termination of pregnancy in Ireland, the Act provides for a formal review process. Under the Act, you can submit an request for a formal clinical review of your case. This is your legal right, and there are strict timelines.

Information for requesting a review under the Act

To request a review after termination of pregnancy provision has been refused, you (or someone you have chosen to support you in this process) must submit a request to the Health Service Executive (HSE). The doctor who refused your request for a termination of pregnancy will inform you in writing that you have the right to review and should provide information on how to make this request.

You or your representative should follow these steps:

- Obtain the paperwork from the HSE or your healthcare provider.

Contact:
National Programme Director
Tel: 01 778 8970 / 087 7853069
Email: TOP.Reviews@hse.ie

- Submit the request with all the details about your case. If you need help with this, a healthcare professional or someone acting on your behalf can help.
- Send this to the HSE contact (your healthcare provider will inform you how to do this).
- Wait for the review committee to be established. The HSE must establish the review committee as soon as possible, but no later than 3 days from receipt of the request for review. You will be notified in writing once the committee has been established.

- You and/or someone you have chosen to support you in the process will meet the review committee, which consists of two doctors not previously involved in your case, including an obstetrician and another relevant medical specialist.

- The review meeting will happen no later than 7 days from the establishment of the review committee (10 days from receiving your request for a review).

- In the review meeting, you will be informed of the committee's decision. You will also receive this information in writing.

- If the review says you qualify, arrangements are made for you to have a termination of pregnancy; your local fetal medicine team is informed, and you return to them for care.

- If the review says you do not meet the criteria, you and your fetal medicine team will be informed, and further supportive care will continue.

If the review finds that the termination of pregnancy cannot be provided legally in Ireland, your healthcare team will provide continued care and discuss any further pregnancy options with you.

This includes providing information on care pathways and organisations outside Ireland, should you wish to seek termination of pregnancy care in another country. Please see pages 52-62 for care pathways outside Ireland.

See our booklet *Termination of Pregnancy: Guide to the 2018 Legislation*.

Additional important details within the legislation

If a healthcare professional has a conscientious objection to participating in a termination of pregnancy, they are not required to do so except in emergencies. However, they must by law ensure your care is transferred without delay.

All terminations of pregnancy are reported annually to the Minister for Health. The report includes the doctor's registration number, the county where you live, and the date — but not your name or identifying information. The Department of Health publishes yearly reports on all terminations provided under the Act.

Understanding your rights and options can be empowering, but legislative language and processes can still feel daunting. If anything is unclear, ask your healthcare team as many questions as you need.

You may also seek support from the organisations listed on page 88-91 of this booklet, and you may wish to consult the *Termination of Pregnancy: Guide to the 2018 Legislation* booklet for detailed information on the legislation and clinical practices around termination of pregnancy in the Republic of Ireland.

Undergoing a termination of pregnancy for fetal anomaly

If a diagnosis of a fetal anomaly is made and termination of pregnancy is allowed under the law in the Republic of Ireland, a multidisciplinary team will support you throughout. This typically includes the fetal medicine team responsible for clinical care and the bereavement team, who provide emotional and practical support tailored to your needs.

The fetal medicine team oversees your care, arranges further investigations, and provides information about the diagnosis, prognosis, and available options.

While different people will have different needs, the bereavement team offers counselling and practical advice. If you would like guidance around memory making and care of your baby's remains, the bereavement team can also support you with thinking through this before, during, and after the pregnancy is ended.

When considering termination of pregnancy for fetal anomaly, the available treatments, timing, and place of care depend on the gestational age of the pregnancy and individual clinical circumstances. The process is coordinated by your healthcare team to ensure safety, support, and dignity. This section of the booklet considers care in the Republic of Ireland; care outside of the Republic of Ireland is covered in the next section.

Termination of pregnancy for fetal anomaly under 12 weeks

In rare instances, a fetal anomaly may be detected before 12 weeks, or a genetic condition might be diagnosed early because of previous history or suspected because of an early screening test such as NIPT/NIPS. Where confirmed, both medical and surgical termination may be considered.

- Medical termination: medications (mifepristone followed by misoprostol) are given to end the pregnancy, with monitoring and pain relief in hospital.

- Surgical termination (where available): the pregnancy is removed through the vagina in an operation under sedation or anaesthetic.

All 19 maternity hospitals/units provide medical termination of pregnancy care. Not every maternity unit offers surgical termination before 12 weeks.

Medical termination of pregnancy beyond 12 weeks

Medical termination of pregnancy beyond 12 weeks for fetal anomaly in Ireland falls under Section 11 of the Health (Regulation of Termination of Pregnancy) Act 2018, and care is provided in hospital by specialist obstetric and midwifery teams. The process involves medical induction of labour, meaning you will be given medication to prepare your body and then to bring on labour. The exact medication, process, and dosage is described below.

Some people and hospitals use the term 'compassionate induction of labour' for this process. However, the use of this phrase isn't recommended; it can be misleading because it may not clearly convey that the clinical intention is to end the pregnancy and that the fetus is not expected to survive. The clinical focus is on safe, technically appropriate care and sensitive support during a planned ending of the pregnancy.

Talk to your healthcare team about induced labour, especially if this is your first pregnancy. Even though your baby will likely be significantly smaller than one born at term, you may still experience physical or emotional distress. It can also be difficult not knowing how long the labour may take.

A note about surgical termination of pregnancy for fetal anomaly beyond 12 weeks in Ireland

Surgical termination of pregnancy for fetal anomaly is not routinely available in Ireland beyond 12 weeks, though the National Women and Infants Health Programme plans to expand this service. If your preferred or clinically recommended method is not available in Ireland, you may seek a provider in the UK or EU. Surgical termination does not allow for seeing the baby or conducting a full post-mortem examination. See pages 52-62 for more information on care pathways outside Ireland.

Up to 22 weeks

Before the medication is given, there is a discussion around process and timing and written consent for the procedure. You will be given the first medication (mifepristone) and then released to go home. You are admitted to the ward 24–48 hours later for the second medication (misoprostol), and you will usually stay in hospital from that point until after the birth.

The induction process can sometimes take longer than expected — up to 24 to 72 hours in some cases. Throughout, there is monitoring, access to pain relief (including stronger medicines or an epidural where available), and emotional support from the healthcare team.

If possible, it is helpful to have someone with you to support you during your time in the hospital.

Beyond 22 weeks

For pregnancies beyond 22 weeks, a procedure called feticide may be offered before induction. This word may be difficult to read, hear or see. Feticide is performed by a fetal medicine specialist using ultrasound guidance to inject medication into the fetus that stops the fetal heartbeat. This procedure is carried out to ensure that the baby is not born alive.

> “The medical term is feticide, but I can't really bring myself to say it very often. I didn't want to end my baby's life; what we did was choose to alleviate her suffering and stop her from suffering out here in the world.”


Admissions

Before and during admission, whatever the stage of pregnancy, the fetal medicine team will discuss several things with you in separate, clear steps.

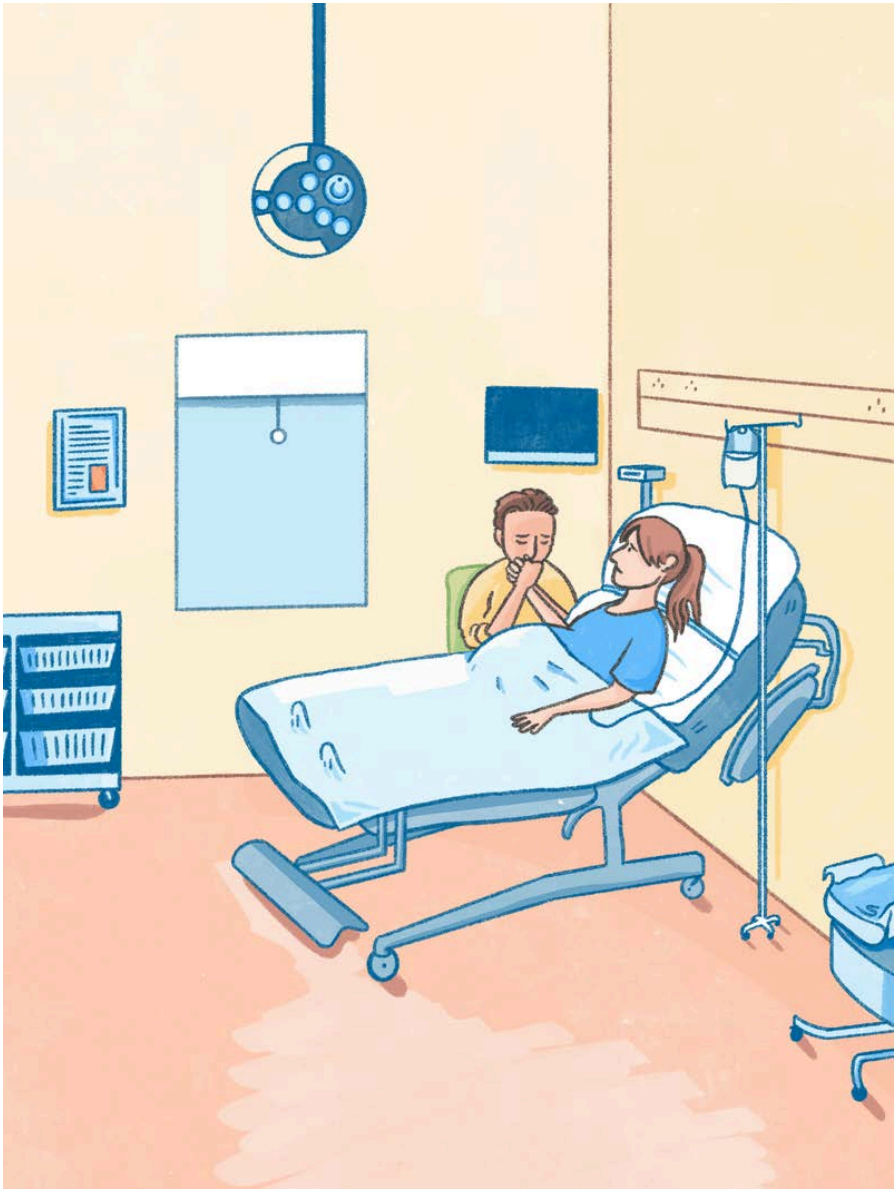
- They will talk to you about who, if anyone, you would like to be present during labour and at the delivery.
- They will also explain whether feticide will be performed. If there is no feticide procedure, they will talk about the chance that the baby might be born with brief signs of life, such as breathing or small movements, and this will be described at the time so you will know what to expect.
- If there is no feticide procedure and any possibility that the baby could be born alive for minutes or hours, the healthcare team will outline how comfort care will be provided for the baby during that short time.
- This can include comfort-focused care for the baby, the opportunity for you/parents to hold the baby, and support from the bereavement team. In some maternity hospitals/units, the paediatric palliative care team may be involved in supporting/directing the approach to comfort care.

Practical advice when preparing for hospital admission

Coming into hospital can feel overwhelming. Be prepared that you will be in hospital overnight, sometimes longer, and that you may need to arrange care if you have children or other dependents. It may help to know in advance what to bring:

- Comfortable clothing, toiletries, slippers, nightdress or dressing gown
- Several changes of comfortable underwear and sanitary towels
- Any prescribed medication, inhalers, or medical devices
- Earplugs or headphones, phone chargers, personal comfort items
- If staying overnight, a complete overnight bag
- A wrap or small keepsake for your baby, if you wish.

If possible, it is helpful also to have someone to support you.



What happens in the procedure and possible complications

Medical termination may take place in a gynaecology or maternity ward in the maternity hospital/unit. There can be emotional difficulty with either setting — being near other pregnant women, or feeling isolated on a general gynaecology ward. Whichever ward you are on, you should be given your own room.

The medical induction process in Ireland usually involves taking the medication mifepristone followed by repeated doses of misoprostol to start labour, with access to pain relief and ongoing midwifery and medical support on the ward.

It can take time, and sometimes several doses, before contractions begin; if labour does not start after the first dose of medication, there may be a delay of up to 24 hours before further medication will be given. Certain stronger options, such as epidurals and entonox (gas and air), will only be available on a labour ward and after 20 weeks. Ask staff which pain relief you can have.

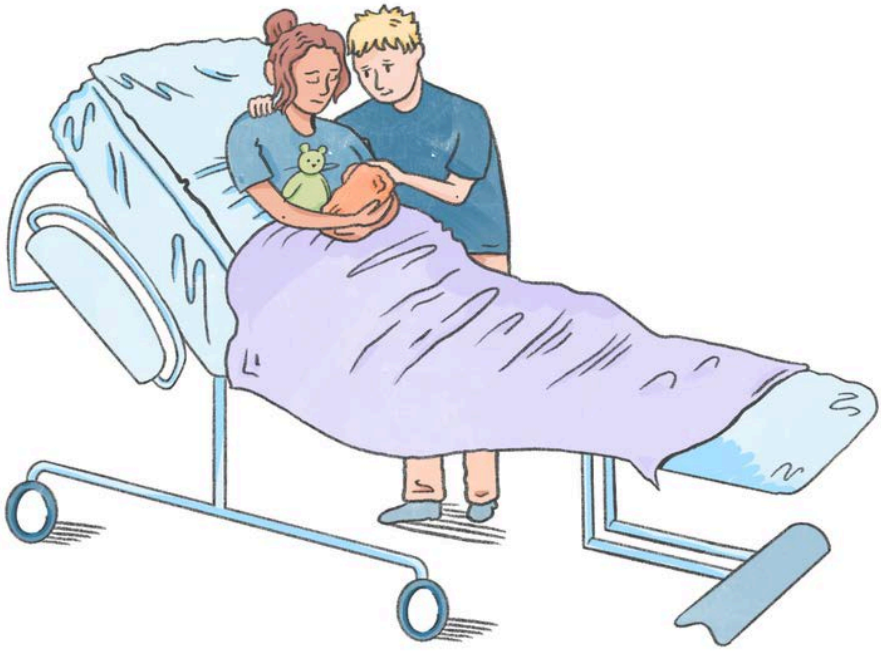
With a medical induction process, your baby will be born fully formed. It's impossible to predict exactly when during the process the baby will die, as this can depend on the baby's diagnosis as well as how far along in the pregnancy you are. Your baby's heart rate will not be monitored during labour.

Even before 23 weeks, if a baby is born showing clear signs of life and then dies, this must be officially registered as a live birth and then a death — your healthcare team will explain what this means and what steps are involved.

Please also see the feticide procedure described in the 'Beyond 22 weeks' section above on pages 40-42.

> "She kept talking about the baby, and when you deliver, and to be honest, it all seems so foreign to me because I didn't even really feel like I was that pregnant."

During induction and labour, the same range of events that can occur in any labour can happen, including variation in how long labour lasts, pain and cramping, nausea, vomiting, diarrhoea, fever or chills, infection, problems delivering the placenta (which may require a surgical procedure under anaesthesia, called manual removal of placenta), and, more rarely, heavy bleeding that may require medication, transfusion, or further surgery. These risks relate to labour and birth itself, not the termination procedure. Ask the staff about what to look out for, what will be available to you, and how any complications are managed.



After the pregnancy has ended, people may experience complex grief, with intense sadness, shock, guilt, anger, and relief sometimes occurring together. It is common to feel emotionally and physically exhausted. Partners can feel under pressure to be the ‘strong' one while managing their own grief. Healthcare teams should offer follow-up, counselling, and bereavement support — you can ask at any stage if you feel you need more help.

Care after medical termination of pregnancy in hospital

You will usually stay on the ward for several hours and often overnight, and, in some situations, a longer hospital stay of several days may be needed. The healthcare team will monitor your bleeding, temperature, pulse, and blood pressure, and offer regular pain relief, as well as checking that your uterus (womb) is contracting as it should. You will be encouraged to rest, eat, and drink as you feel able.

Before you leave, a doctor or midwife will talk through any tests that have been done or are planned (for example, blood tests or post-mortem examination – for more detailed information, see page 63), explain what they showed so far if results are available, and outline how and when follow-up appointments will happen. They will also give you information about pain relief, expected bleeding, signs of infection or heavy bleeding to watch for, and contraception if you wish to discuss it. Some people will be advised to take medication to prevent blood clots for several weeks, as this is a higher risk for some women after the ending of pregnancy at any stage.

You will also be given information about who to contact urgently in the maternity hospital/unit if you have any concerns once you are at home.

> “The care I received there was extraordinary. They were like angels, guiding me gently through one of the hardest moments of my life.”

Care of the baby's body

There is no right/single way to think of any form of pregnancy loss; that said, many people at this stage feel they have lost a baby, and care of the baby's body is a deeply personal aspect of this experience. You will be given time to think about what you would like to happen, and to consider options for burial or cremation.

Most maternity hospitals/units have established pathways for shared or individual burial or cremation services for babies and pregnancy remains, often in a local cemetery or crematorium. Staff will explain what is done as standard in that hospital, whether there is a specific plot or memorial area, and whether you can visit in future.

If you prefer to organise a service and arrangements of your own, you can discuss practicalities with hospital staff; such as timing, transport, and whether you wish to have a ceremony at home, in a funeral home, church, or cemetery. Funeral directors are familiar with pregnancy and baby loss and can advise on burial or cremation options for different gestations, costs, and any local requirements.

Additional investigations, including a post-mortem examination, may be offered and are discussed further in the 'Tests After Pregnancy Ends' section on page 63. If planned, a post-mortem examination will interact with the timing of burial or cremation. Healthcare staff will explain if there is likely to be any delay before a funeral, ceremony, and/or burial can take place.

In some cases, you may wish to bring your baby home for a short period before burial or cremation. Healthcare staff will explain how this can be arranged.

If you are undecided about any of these arrangements, you can ask how long decisions can be delayed and whether there is a hospital remembrance garden, shared plot, or memorial service you could attend later.

Whatever you choose, your decision should be respected. You should be able to ask as many questions as you need about practicalities and timing.

Paperwork and legal requirements

There may be legal requirements for registration of birth or death depending on gestation (how far along the pregnancy is). Staff will advise you about registration, burial or cremation certificates, and documentation supporting leave from work or benefits (e.g. maternity or paternity benefit) where applicable. For full details see pages 69-70 on Registration.

- Under the Civil Registration Act 2024, the Civil Registration Office confirms that parents can register a stillborn baby who meets the criteria of being over 23 weeks' gestation or weighing more than 400 grams. A link for this registration is provided below
- citizensinformation.ie/en/birth-family-relationships/miscarriage-and-stillbirth

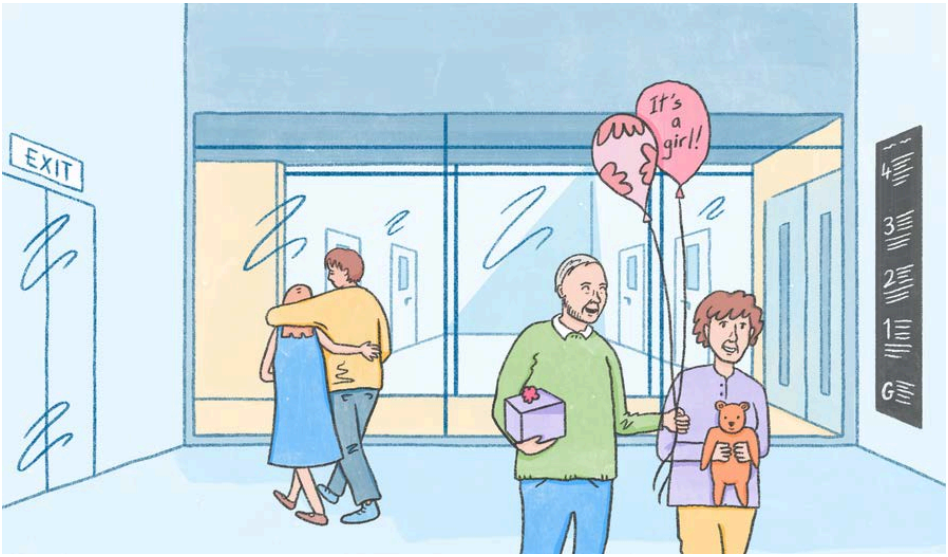
- For pregnancies that do not meet the legal definition of a stillbirth, there is currently no option to register the baby's birth or death. The legal definition and thresholds for stillbirth registration may be updated; your healthcare team can explain what applies in your situation.

- If your baby is born at or beyond the legal stillbirth threshold, staff will explain how to register a stillbirth, what information is needed (for example parents' details and place of birth), and how this links to any maternity or paternity leave and benefit entitlements.

- If your baby is born alive, there will be a formal registration of birth, followed by a death certification when the baby dies. Staff will explain what this means, and how it links to social welfare entitlements.

- If post mortem examination or other tests are planned, you will be asked to sign a separate consent form specifying what is being done; staff will explain the timing involved so that you can plan for burial or cremation arrangements. Post mortem examination and other tests are explained more on pages 63 and 64.

Discharge from hospital and follow-up care



Your healthcare team will outline a follow-up plan before you leave hospital, including guidance for the first few days at home about rest, pain relief, showering, and when to contact the hospital, your GP or emergency services if you are worried. Staff may also advise that you might be tired for the first couple of weeks, with gradual improvement over several more weeks, especially after later-gestation procedures.

In the first 1 to 2 weeks, light to moderate bleeding and cramping are common. Seek urgent review if you soak pads, pass large clots, develop a fever, or notice increasing pain or foul-smelling discharge from your vagina.

You should have a follow up appointment with your fetal medicine specialist or obstetrician around 6 to 8 weeks after the pregnancy has ended.

This is to see how your recovery is going, discuss test or post-mortem results (these can take longer; up to 3 to 4 months in some cases), and plan for future pregnancies and contraception. It is important to attend this appointment regardless of where you received care. If specialist analysis of the post-mortem findings is needed, results can take longer still. Where possible, your follow-up appointment should not take place in a general clinic waiting area alongside pregnant women, but in some hospitals/units, this cannot be avoided.

Some units may also offer earlier follow-up, as this may support some people's grieving process, helping to prevent more complicated grief responses.

Counselling and emotional supports

Psychological, spiritual, or emotional supports after a termination of pregnancy for fetal anomaly are available, but there is no expectation that everyone will need or choose to access this type of support. If you would like to talk to someone, options include your GP, bereavement specialist midwives, other hospital-based clinicians or counsellors, or independent counsellors in the community.

National and community organisations, as well as My Options (HSE) and Pregnancy and Infant Loss Ireland, can signpost free or low-cost counselling, telephone helplines, support groups, and online resources. You can use these supports at any stage — for example, in the first few weeks, or months later if difficulties appear. For example, there can sometimes be challenges for some people when they return to work or if they start to consider another pregnancy.

Your maternity hospital/unit may also have its own information leaflets or booklets on pregnancy loss and supports.

More details on counselling, emotional support and links for national support and information services can be found on pages 88-91 at the end of this booklet.

Whether you have your procedure in Ireland or outside of Ireland, you should have a follow up appointment with your fetal medicine specialist or obstetrician around 6 to 8 weeks after the pregnancy has ended.

Care pathways outside Ireland

This section of the booklet provides guidance if you need to travel outside of the Republic of Ireland for termination of pregnancy — for example, because you do not meet the legal criteria for care under Section 11 in the Republic of Ireland, or because you are seeking surgical options beyond 12 weeks. It covers care provider options in the EU and UK, what to expect, associated costs, and practical information on preparing for travel.

This information is for guidance only, and may change over time - it is as accurate as we can make it at this moment – please check for updated information with the organisations and the sites listed on pages 88-91.

The IFPA (Irish Family Planning Association) offers wraparound support for anyone going through a termination of pregnancy for fetal anomaly. This includes grief counselling, emotional support during and after your termination, and practical information and support with logistics — for example, if you need to travel for your care.

The Abortion Support Network (ASN) can help with all practical and financial challenges of travelling for care. In 2025, ASN supported 245 people from Ireland — around 15% of whom were seeking a termination of pregnancy for fetal anomaly — with information, logistics, and funding towards travel and accommodation costs where needed.

> “The flight over was rowdy. Last place we wanted to be. People were going for stags/hens and weekends.”

> “I was in the streets, inconsolably crying, here to terminate my much-wanted pregnancy, not knowing what was happening.”

Care in the European Union

Travelling to another EU country for termination of pregnancy is usually arranged and paid for privately. The European Health Insurance Card (EHIC) does not cover planned travel for termination of pregnancy.

Some people travel to the Netherlands, Belgium, France, or Spain where local law allows procedures that are not available in Ireland, for surgical procedures after 12 weeks or termination for conditions that do not meet the criteria under Section 11.

People may choose one EU country over another for several reasons:

- Law and gestational limits: countries differ in how far into pregnancy termination is allowed. For example, the Netherlands (Amsterdam; Bloemenhove) generally permits abortion up to 21 weeks + 6 days within a regulated clinic or hospital system, while Spain (Barcelona, CMA) permits up to 22 weeks + 6 days.

- Type of procedure: some centres offer surgical procedures, while others mainly provide medical induction — this can matter if you have preferences about seeing your baby or having access to a post-mortem examination.

- Links: your fetal medicine and healthcare team in the Republic of Ireland may have established pathways with specific hospitals or clinics outside Ireland, making access and follow-up more straightforward.

- Practical factors: language, travel connections, cost, and whether you have family or support networks nearby.

Care in the United Kingdom

In England, Scotland, and Wales, termination of pregnancy is regulated by the Abortion Act 1967. The Act sets out specific legal grounds (called grounds A–F), including Ground C (risk to the physical or mental health of the pregnant woman) which is generally used up to 24 weeks, and Ground E (substantial risk that the child would be born seriously disabled), which has no upper gestational limit, meaning that termination of pregnancy for fetal anomaly can be provided after 24 weeks.

UK-based organisations such as ARC (Antenatal Results and Choices) can provide useful information and will support you before and after termination of pregnancy. See pages 89-90 for more detailed information.

Independent clinics (up to 24 weeks)

Independent providers such as the British Pregnancy Advisory Service (BPAS), NUPAS (National Unplanned Pregnancy Advisory Service) and MSI Reproductive Choices (formerly Marie Stopes International) offer surgical termination of pregnancy within this legal framework. MSI's and NUPAS's UK clinics are in England only. While there are BPAS clinics in Wales, BPAS directs people travelling from the Republic of Ireland primarily to English clinics, usually close to transport links.

These clinics accept self-referrals and provide information, care, and support, although access may be more limited for people with complex medical problems or who are at later gestations. Depending on the medical issues involved, your care may need to be redirected to a particular clinic. Some pre-existing conditions, such as significant maternal cardiac disease, may mean that a pregnancy is not suitable for treatment in these clinics and needs hospital-based care instead.

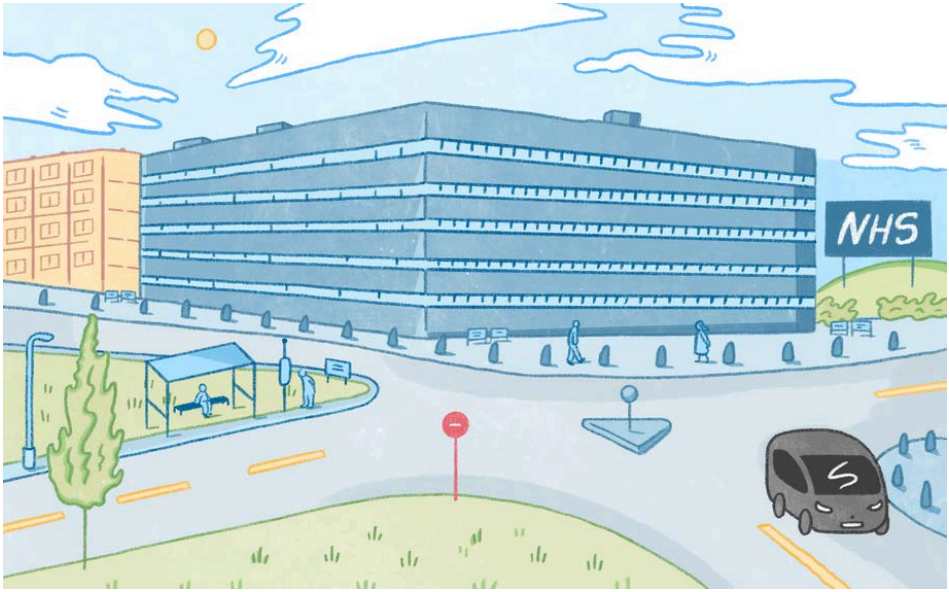
For people travelling from the Republic of Ireland to the UK, there's a dedicated section at www.bpas.ie, primarily focused on unplanned pregnancies, but with a relevant subsection for pregnancies affected by fetal anomaly (see 'Ending a pregnancy because of fetal abnormality' via www.bpas.ie).

It's important to note that, if you are having a termination of pregnancy at an independent clinic you will need to tell them if you wish to have your baby's remains returned to you for burial or cremation. There are no legal requirements to bury or cremate a baby born dead before 24 weeks in the UK.

> "I don't know how you could expect a woman in my situation to do that, to just hop on a plane with everybody else going on their weekend away and come back knowing that I have just stopped my baby's heart. It's insanity."

National Health Service (NHS) hospitals and fetal medicine units

Some English NHS hospitals (e.g. Homerton University Hospital, Liverpool Women's Hospital, University College Hospital London) can accept patients from the Republic of Ireland for termination of pregnancy for fetal anomaly when the baby's condition meets UK legal criteria under Ground C or Ground E. This varies according to the fetal anomaly and the stage of the pregnancy, and will sometimes involve meeting the fetal medicine team in that hospital, before proceeding.



In practice:

- Under 24 weeks, people may attend an independent clinic or an NHS Hospital.
- After 24 weeks, all care (this is under Ground E) is provided in specific NHS Fetal Medicine units.

Arrangements and any links with UK services vary by hospital and fetal medicine centre in the Republic of Ireland. In some cases, the fetal medicine team in the Republic of Ireland may help and direct you; in others, patients are given their medical notes, results, and contact details to arrange care themselves. Each UK service has its own criteria, processes, and waiting times. Your healthcare team in the Republic of Ireland should continue providing support and any needed clinical care while arrangements are underway.

Termination of pregnancy procedures in the UK and EU

Surgical termination

Independent specialist clinics in England, such as BPAS and MSI Reproductive Choices, and some other European providers, offer day case surgical procedures under sedation or anaesthesia within their local legal frameworks. These procedures include vacuum aspiration (usually up to around 12 to 15 weeks) and dilatation and evacuation (D&E) up to 24 weeks. These surgical services focus on ending the pregnancy safely and quickly. Surgical procedures do not allow for opportunities to see and hold a baby, or to have a post mortem examination or additional tests undertaken.

Medical termination

The medical induction process outside the Republic of Ireland is essentially the same as in Ireland (see the pages 38-46) — mifepristone followed by misoprostol to start labour, with access to pain relief and midwifery and medical support. After 24 weeks, this is always provided in NHS fetal medicine units. If the pregnancy is over 22 weeks, a feticide procedure will be performed before the medical induction begins. In most situations, you leave the hospital after this procedure and are admitted for the medical induction 1 to 2 days later, during which time people may need to find accommodation and stay locally.

Other considerations / what to look out for

Your stay in hospital or a clinic may be shorter with a surgical procedure under general anaesthetic, but the effects of the anaesthetic can persist for several days afterwards.

It is usual to have cramping and vaginal bleeding for 1-2 weeks after any termination procedure, depending on the stage of the pregnancy. You should be given clear instructions on pain relief, how to monitor your bleeding, and when to seek help for possible infection (for example, fever, worsening abdominal pain, or foul-smelling discharge from your vagina). You should contact the clinic/hospital or your healthcare team in the Republic of Ireland promptly if you are worried.

Travel adds extra physical, as well as practical strain (as explained below). You may be traveling while still bleeding or in pain. Regular movement, drinking plenty of fluids/water, and compression stockings (where advised) can help reduce the risk of blood clots in the legs or lungs (this risk is increased after any pregnancy ending). Your healthcare team should explain warning signs to watch for.

Costs and other considerations in care pathways outside of Ireland

Costs for ending a pregnancy outside Ireland are self-funded and change over time. Ask for exact figures.

- Specialist EU clinics (e.g. Amsterdam): self-funded; many centres charge around €1,500 up to about 22 weeks, with higher fees at later gestations.
- Independent clinics in England (BPAS, MSI): approximately €1,000 to €1,800 depending on gestation.
- NHS fetal medicine units in England: patients from the Republic of Ireland are usually treated as private, self-funding patients. Costs for feticide and induction are often in the region of €1,800 to €2,250 under 24 weeks. After 24 weeks, full costs (including feticide, delivery, scans, and inpatient care) can range from €4,000 to €10,000, depending on the stage of pregnancy and procedures required. Payment is typically required in advance via the hospital's overseas or finance office.

- Additional expenses: travel, accommodation, local transport, meals, childcare (where applicable), and lost income can add substantially.

- Organisations such as the Abortion Support Network (ASN) will be able to help with information and logistics as well as travel and accommodation costs. For more detailed information, see page 90.

These costs reflect what is available at the time of publication and are for guidance only. For the most current guidance, consult your healthcare team or support.

What will I need to bring with me?

As with doing this procedure in Ireland, you must be prepared that you will be in hospital overnight, sometimes longer, and that you may need to arrange care if you have children or other dependents. It is advisable to bring:

- Comfortable clothing for recovery
- Several changes of comfortable underwear and sanitary towels
- Any prescribed medication, inhalers, or medical devices
- Earplugs or headphones to listen to music or podcasts
- Phone chargers/adapters
- Personal comfort items
- If staying overnight, a complete overnight bag with toiletries and essentials
- Medical notes, records, or documents requested by your care provider

You may also wish to bring a blanket or small keepsake for your baby and/or something familiar or comforting such as a teddy bear. If possible and costs allow, it may also be helpful to have someone with you for support.

Particular challenges of travelling outside of Ireland

Travelling for care can be logistically and emotionally challenging. You may be managing luggage, navigating airports, and crossing borders while still bleeding or in pain. Depending on residency and citizen status, there may be challenges with visas and passports; depending on other care responsibilities, it may be difficult to leave or to ask someone to accompany you. There are also logistics to consider about bringing your baby or ashes back home, and different circumstances will have different processes. Your healthcare team in the Republic of Ireland should be available to help with guidance, and support before and after your procedure, and you should have a continuing point of contact.

Accessing follow up care, counselling or bereavement support can be harder to access when care was provided in another country, and some people describe a sense of stigma or secrecy linked to having travelled for a termination of pregnancy for fetal anomaly.

Each experience is unique, and your choices should be respected throughout the process. Make use of the supports and information provided to ensure you feel as prepared and supported as possible during this difficult time.

Coming back to Ireland

Investigations

Plans for tests and any post-mortem examination need to be discussed before you travel, ideally discussed with your healthcare team in the Republic of Ireland and the hospital outside Ireland. Full post-mortem is generally only possible when care is provided in a hospital-based fetal medicine unit, after a medical termination. After a surgical termination in an independent clinic, there is no opportunity for further testing on the baby. If you are having a surgical termination at an independent clinic and you wish to have your baby's remains for burial or cremation, it is important to make this clear to the clinic in advance, so that appropriate arrangements can be made.

Travelling back

Bringing your baby's body home is possible after a hospital-based induction and usually requires specific paperwork from the crematorium, or coordination with a funeral director outside Ireland. Many NHS healthcare teams encourage cremation locally with return of ashes, as this is usually simpler and less costly. If you need information about whether ashes or your baby's body can be brought back to Ireland, and it is not offered, it is important to ask. Some hospitals in the Republic of Ireland can provide blankets, garments, and coffins to help parents bringing remains home, and can assist with burial or cremation on return — ask your healthcare team about this.

Your main point of contact for practical arrangements is usually the healthcare team in the Ireland (for example, a termination-of-pregnancy coordinator or a bereavement specialist midwife) sometimes together with the hospital team outside Ireland if you are in an NHS unit.

If you are cared for in an independent clinic, staff can explain what they can organise locally, but clinical care as well as emotional and bereavement support when you return to Ireland should come from your hospital in the Republic of Ireland, GP and community services rather than from the clinic outside Ireland.

After termination of pregnancy outside of Ireland

If your procedure involves labour and delivery in hospital, the midwives, doctors, and bereavement staff should discuss pain relief and ensure your comfort, wellbeing, and privacy. You can ask in advance about seeing and holding your baby, photographs, hand- and footprints, or other keepsakes, if these are what you want.

Whether you are looked after in a clinic or hospital, you should be given a record of your medical treatment for yourself and to bring back to your healthcare and/or fetal medicine team in the Republic of Ireland.

Returning home after ending a pregnancy outside Ireland can carry a significant emotional toll. Many people report feeling isolated or 'in between' services. Accessing follow-up care and bereavement support can be harder when the termination of pregnancy procedure was provided in another country.

Postnatal care should include:

- Monitoring for infection, excessive bleeding, and healing process, as well as information around timelines for physical recovery
- Clear information on who to contact if you have concerns about bleeding, pain, mood, or breast symptoms.
- Access to bereavement support, counselling, and peer groups.

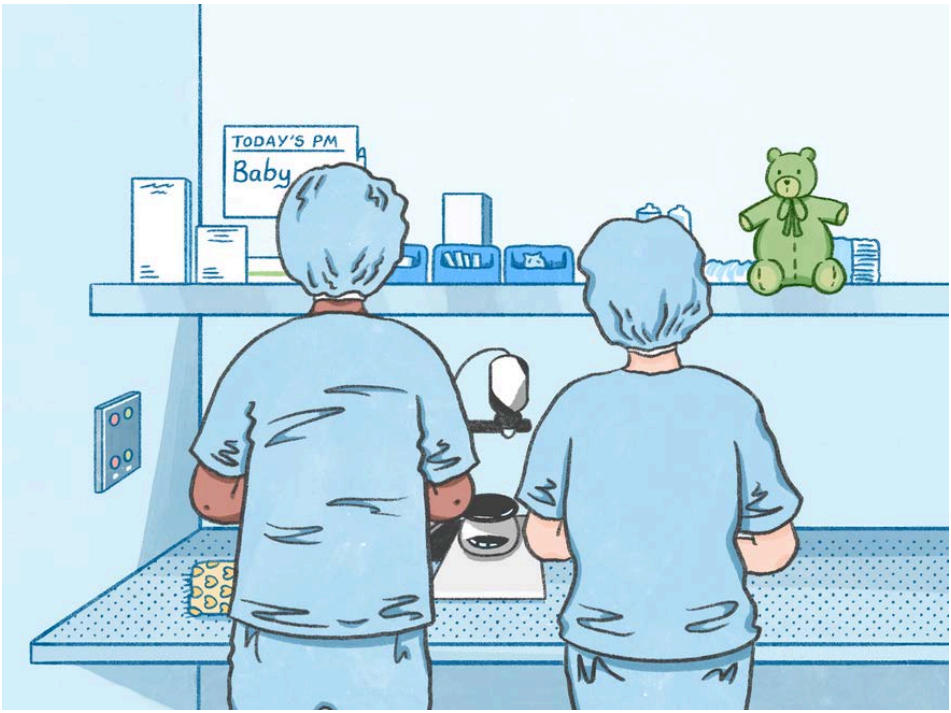
A follow-up appointment with your healthcare team in Ireland should be available to you, usually 6 to 8 weeks after the procedure. This is to review your recovery, discuss any test results, make plans for future pregnancies if relevant, and address any questions you might have. If this appointment is missed for any reason, contact the fetal medicine team who looked after you in Ireland.

> “Nine weeks later, we had a review meeting with me, the consultant and the bereavement midwife, maybe 3 hours of an appointment – this is really amazing, you know. like that’s like a real intense connection with them.”

Once back in Ireland, your healthcare team and GP can link you to specific counselling, peer support, and other services. National and community organisations such as My Options (HSE unplanned pregnancy and post-abortion support) and LMC Bereavement Support, and others can also signpost free or low-cost counselling, telephone helplines, support groups and online resources. You can use these supports at any stage—for example, in the first few weeks if you are struggling day-to-day, or months later if difficulties only become apparent, for example, when you return to work or if you consider another pregnancy. More details are listed at the end of this booklet on pages 88-91.

Tests after pregnancy ends

Your fetal medicine team may discuss additional investigations after the pregnancy has ended, such as genetic testing or a post-mortem examination (a detailed medical examination of the baby's body performed by a specialist pathology doctor). A surface (external) examination, which does not involve an internal examination, may also be offered as an alternative.



Genetic testing and post mortem examinations are intended to offer more information about the underlying anomaly, help clarify the chance of recurrence in a future pregnancy, and sometimes explain why the anomaly occurred, rather than to confirm the original diagnosis.

> They asked us if we wanted to have a post-mortem done... We already knew enough about her condition to know that it wasn't genetic, and it was 'just one of those things.'

> I chose to have a post-mortem afterwards… as none of the tests were able to definitively tell me what the problem was, I felt a post-mortem was important.

Your healthcare team will seek your consent for any tests and will explain the options, benefits, and limitations of each. The fetal medicine and pathology teams may also recommend a review by a clinical geneticist — a doctor who specialises in genetic conditions — and, depending on your circumstances, more detailed genetic analysis of your baby's DNA. The geneticist can link scan or post-mortem findings with possible genetic causes, helping you understand the chances of the same problem happening again. In this situation, you may also meet a genetic counsellor who helps explains genetic test results, what they mean for you, and the options available now and in future pregnancy.

These tests are usually discussed at the time of diagnosis or after the pregnancy has ended. If you are considering travelling outside Ireland for care, your fetal medicine team in the Republic of Ireland can advise on which tests are best done before you travel and what may be possible in the centre outside Ireland. In some settings, detailed post-mortem examination or certain types of memory-making may be more limited, so it is important to discuss what matters most to you before finalising travel plans.

Memory-making

Memory-making and care of your baby's body can take many different forms, and there is no single "right" way to acknowledge your loss. Some people find comfort in photographs, rituals, or keepsakes, while others prefer quiet or private forms of remembrance, or simply wish to know that their baby will be treated with dignity and respect. Some may not wish to take part in memory-making at all. All of these responses are valid, and your wishes will be respected.

Memory-making can begin before the pregnancy ends as well as afterwards. You could take photographs with yourselves and other children as a family picture, while still pregnant. Before a planned induction or procedure, you may be offered the chance to have another scan, have a 3D scan, record your baby's heartbeat, or involve family members. These can become important keepsakes or memories.

After a medical induction in an Irish maternity hospital/unit, you will be offered time with your baby, as well as options such as photographs, handprints or footprints, naming or blessing rituals, and keepsakes like blankets or memory boxes. For bigger babies, parents sometimes wish to dress their baby or bring their own garments or blankets. Your baby can stay with you in a cool cot, or go to a quiet room or mortuary — your healthcare and bereavement team should support whatever you prefer.

> "My first instinct was to say no. Why would I want to have a reminder of this? But then, on second thought, I accepted it, and I am very glad I did."

If there are other children in the family, parents may wish to include them in an age-appropriate way. Your bereavement team can advise on this.

Midwifery, bereavement, and chaplaincy teams usually coordinate memory-making and should always be guided by your preferences and beliefs. All maternity hospitals/units in Ireland use a dedicated symbol at ward doors to quietly indicate that a family has experienced a loss, helping staff and visitors to be sensitive and to protect your privacy.

Acknowledging your loss in ways that are meaningful to you

- Rituals and services: you may wish to hold a remembrance service, light a candle, name your baby, plant a tree, or create keepsakes. Hospital chaplaincy teams can help arrange a service — religious or secular — tailored to what feels right for you.

- Involving family and friends: sharing your story, involving loved ones in memory creation, or finding safe spaces to talk about your baby can help validate your loss.

- Online remembrance: some organisations offer virtual spaces for remembrance and connecting with others on significant dates.

- Pregnancy loss remembrance services: hospitals often facilitate annual services with readings, music, and candle lighting. There is no expectation that you attend.

Some people may not wish to do any of the above. Everyone responds to these situations differently, and you should be guided by what feels right for you.

Memory-making when the pregnancy ends outside Ireland

If your pregnancy ends in another country, ask in advance what memory-making options are available. If spending time with your baby after birth is important to you, discuss whether a hospital-based medical induction may better support this.

You can also discuss arrangements for burial or cremation with the clinic or hospital. Remains can often be taken home in a sealed container with an accompanying letter, or cremated locally with ashes later returned to Ireland. Hospital, clinic, and bereavement teams in and outside Ireland can help coordinate memory-making, care of remains, and practical documentation around this.

> “I was like, there's no way, I don't want someone coming in the worst moment in my life and taking… I don't want someone coming in taking pictures of a dead baby… but once again, so glad we did.”

Registration and certification

After a termination of pregnancy for fetal anomaly, you may need documents for work, social welfare, health/travel insurers, and other organisations. The exact paperwork depends on how far along the pregnancy was, where the pregnancy ended, and whether there were signs of life at birth. The healthcare and/or bereavement team can advise you and help complete the forms you need.

In Ireland, entitlements to maternity benefit, illness benefit, and leave are linked to the gestation at which the pregnancy ended, whether the loss meets the legal definition of a stillbirth in the Republic of Ireland, and whether the loss was recorded as a neonatal death or late pregnancy loss. Your social welfare office, employer, or HR department can guide you on specific forms and timelines to apply. More information can be found at the Citizens Information website under 'Miscarriage and Stillbirth' (you can find the link on page 88).

Some key things to know are:

- If the baby is born at or after 23 completed weeks, or weighs 400g or more, with no signs of life, this meets the legal definition of stillbirth. A stillbirth can be registered with the Civil Registration Service, and parents are usually entitled to 26 weeks' maternity leave (with potential maternity benefit) and paternity leave where PRSI conditions are met.

- If medical staff record that the baby is born alive at any gestation, the birth and (if relevant) death are registered as for any liveborn infant, and maternity and paternity leave follow the usual rules.

- For pregnancy loss before the stillbirth threshold, there is currently no specific civil registration and no automatic statutory entitlement to maternity or paternity leave. Time off is usually through sick leave, pregnancy-related sick leave (for many public sector workers), compassionate or bereavement leave (where available, varies by employer), or annual leave. Some employers have introduced pregnancy loss leave policies, but there is no standard provision in terms of number of days / what type of loss is covered.
- Where same-sex parents are involved, there may be additional complexity due to legal requirements for designation as 'parent'. More details can be found on page 82.

- Pregnancy loss leave is being planned by the government at the time of the writing of this resource.

- For earlier gestations or where the pregnancy ended outside Ireland, a hospital doctor or GP can document a pregnancy loss, supporting decisions about leave and benefits.

- A certificate may also be available from the hospital/unit where you were looked after, if you would like something to formally acknowledge your loss or baby but do not meet the criteria for registration.

In all scenarios, a hospital doctor or GP can issue medical certificates confirming the pregnancy loss has happened and the need for time off, and can help access or complete Department of Social Protection forms.

If your pregnancy ended in another country

In England and Wales, pregnancies ending before 24 weeks are usually not registered as stillbirths — hospitals or clinics issue their own documentation instead. They can provide a letter confirming when the pregnancy ended; this does not have to mention that a termination took place or give details of the diagnosis.

In Ireland, accessing social welfare entitlements requires specific medical certification. A UK clinic letter may not automatically meet the criteria in the Republic of Ireland, so you will typically need an additional letter from your GP or healthcare team in Ireland to support any claims. This can confirm the date and gestation of the pregnancy loss without giving details about the diagnosis or procedure.

If your baby was born in the UK at 24 weeks or more, the birth will meet the criteria for registration there and the relevant hospital team will provide information about how this is done; this may require a longer stay. Your healthcare team in the Republic of Ireland can also provide a separate letter confirming the birth and its timing if this is needed to support applications.

Other official documentation

You may also need letters for travel insurers, mortgage or loan protection policies, colleges, or immigration authorities, if your plans have been disrupted. Your healthcare team (or GP) can usually provide a concise summary confirming that you had a pregnancy complication requiring hospital care, tailored to the level of detail you are comfortable sharing.

Physical recovery

Most pregnancy symptoms — such as nausea, breast tenderness, and fatigue — usually ease within days to weeks after the pregnancy ends, depending on how far along you were and the method used. Pain is usually managed with paracetamol and ibuprofen, and if nausea, breast symptoms, or a general feeling of being unwell persist for several weeks, you should contact your GP or another healthcare provider.

Bleeding can continue for up to four weeks, with cramping, tiredness, and discomfort common in the early days and weeks. Breast tenderness or milk production can occur after later pregnancies, and your healthcare team can advise on medicines to prevent or relieve this, including cabergoline to suppress milk production when appropriate.

When should my period return / when can I have sex again?

Your menstrual period usually returns within four to six weeks, though it can take longer and varies with gestation and individual hormonal response. Bleeding straight after the pregnancy ends is not a period. If your period has not returned after three months, or if you are worried, contact your healthcare provider.

Avoid sex for at least one week or until bleeding has stopped, to reduce infection risk. Fertility often returns quickly, sometimes before your first period, so discuss contraception with your healthcare provider if you wish to avoid another pregnancy and/or you are waiting for test results (see page 79). Only resume sex when you feel physically and emotionally ready.

Rest and returning to work

Fatigue and emotional exhaustion are common after a termination of pregnancy for fetal anomaly, and resting afterwards is strongly advised. Any pre-existing anxiety or mental health challenges may become more pronounced during this time. Seeking support — from family, friends, healthcare professionals, or the resources listed in this booklet — can be beneficial.

There is no set timeframe for returning to work. Some people feel ready for light duties after 2 to 3 weeks, while others need 4 to 6 weeks or longer, particularly after later gestations or where there have been complications.

Depending on what stage you were in your pregnancy, full maternity leave (26 weeks) and associated benefits may be available to you.

Many people benefit from a phased or flexible return. If you feel comfortable doing so, discuss a realistic plan with your GP and your manager or HR, so that adjustments such as shorter days or temporary changes in duties can be arranged.

It is important to acknowledge that not everyone is in a position to take as much time off as they might need, whether for financial reasons, workplace expectations, or other pressures.

If tiredness or emotional distress persists, it is important to consult your GP, who can offer advice and, if needed, provide documentation for work or additional support. Discuss any ongoing concerns with your healthcare provider or employer to ensure you receive the help and flexibility you need during your recovery.

Emotional and psychological impact

Receiving a diagnosis of a fetal anomaly and thinking about ending a pregnancy can affect every part of your wellbeing — emotional, psychological, spiritual, and physical. Feelings may be shaped by the loss of a hoped-for future, the pressures of decision-making, spiritual or religious beliefs, and the legal and social context, including the need to travel.

Grief after this kind of loss is not linear. Emotions can come in waves, may feel very intense at times, and can continue for a long period. There is no 'right" way to feel. People often report a wide range of emotions — guilt, anger, anxiety, yearning, confusion, and relief. It is common for partners to have different emotional responses, and these may change over time. Some people may feel isolated or experience stigma, especially where family, friends, or society do not fully understand their experience. And for other people, pregnancy announcements and seeing babies can be very triggering.

Support from healthcare staff, specialist pregnancy loss counsellors, bereavement and pastoral care teams, and peer support organisations can be a vital part of navigating this time.

This support should be available to everyone after a termination of pregnancy for fetal anomaly, regardless of where the procedure takes place.

Seeking support

Support is available through hospital bereavement specialist midwives and healthcare teams, who can offer specialist care before, during, and after termination, including memory-making, practical advice, and signposting to counselling or peer groups. You may need to ask about these services, as they are not always offered automatically.

A termination of pregnancy coordinator at your maternity hospital/unit and/or fetal medicine midwife in the fetal medicine centre you attended should be a point of contact. If you travel to the UK, your healthcare team in the Republic of Ireland should offer you a follow up appointment on your return (see pages 54-56 for more detailed information).

Termination of pregnancy for fetal anomaly can present challenges for everyone, but may be more difficult in some situations such as for single parents, people experiencing housing instability or economic hardship, domestic violence, visa challenges, or for someone who may be in the role of a primary carer.

Access to care outside Ireland may not be an option for everyone. These challenges highlight the need for inclusive, sensitive support for all.

Many people find it helpful to link with specialist pregnancy loss and counselling services, either alongside or after hospital-based care. Examples include (see pages 88-91 for a more comprehensive list and links, including LGBTQI+ specific supports):

- Hospital-based bereavement and social work teams – all maternity hospitals/units have Clinical Midwife Specialists in Bereavement and Loss, social workers, chaplaincy and, in some centres, pregnancy loss psychologists offering one-to-one support, and peer support groups that provide memory making and follow-up care.

- Pregnancy and Infant Loss Ireland (national website) – directory of local bereavement supports and groups after pregnancy and baby loss, including termination for fetal anomaly, with some partner-specific services.

- LMC Bereavement Support – non-directive information, peer support and groups for those who have received a difficult fetal diagnosis, are considering or have had a termination of pregnancy, or have decided to continue the pregnancy.

- My Options (HSE) – freephone non-directive counselling and local referrals, including after termination for medical reasons.

- ARC (Antenatal Results and Choices) – UK charity offering non-directive information and telephone/online support around fetal anomaly diagnosis and termination of pregnancy.

Taking care of yourself

Self-care is important during recovery, and people have different ways and possibilities to care for themselves. If you can:

- Allow time for physical rest; prioritise sleep and nutrition.

- Gentle activity such as walking or swimming can help manage stress.

- It is common to need time away from work after a termination of pregnancy for fetal anomaly, both to recover physically and to process what has happened.

- Journalling, meditation, and talking with trusted people can help process grief. It is normal to set boundaries and withdraw from overwhelming social commitments.

As after any birth, postnatal depression can happen after termination of pregnancy for fetal anomaly.

If you experience persistent sadness, sleep disturbances, anxiety, or difficulty coping, reach out to your GP or another healthcare professional for support and further advice.

> “Therapy really helped me to work through my feelings, as well as being open about them with my friends and family.”

Support for partners

Partners often experience intense and complicated grief. Research shows partners may feel excluded by healthcare teams or struggle with supporting their loved one while grieving themselves. Partner supports include:

- Being included in discussions, memory making, and aftercare planning.
- Organisations and online communities with targeted peer support for male partners, including groups such as Dads Don't Cry, Féileacáin Fathers and Dad Still Standing, a UK-based podcast.
- Counselling: Partners may benefit from individual or joint counselling.
- Acknowledge their grief: Partners' feelings are valid and deserve recognition; encourage open communication and access to support services for both.

When you are on your own

If you have carried the pregnancy without a partner, you may feel particularly isolated, but support remains available. Reach out to hospital bereavement teams, peer organisations, or mental health professionals for tailored assistance. Some people find comfort in connecting with others via online groups or support networks designed for solo parents. While friends and family can be a comfort, you may wish to share your experience and feelings only with those whose support feels safe and validating.

> “I was just I just felt very much on my own, very isolated.”

Advice for family and friends supporting someone who has undergone a termination of pregnancy for fetal anomaly

Family and friends can play an important role in supporting someone through this experience. Not everyone will feel comfortable turning to them due to fear of judgement, or for other reasons. If you are supporting someone:

- Listen without judgement or pressuring them to ‘move on'.
- Acknowledge the baby and the significance of the loss, guided by how they refer to this.
- Encourage professional support, if appropriate.
- Offer practical help — meals, childcare, transport.
- Respect their wishes around social contact and do not share their information unless they ask you to.
- Learn about the experience of termination for fetal anomaly, and the ways this may differ from other forms of pregnancy loss.
- Avoid making assumptions about what they may feel and what they need.

Thinking about another pregnancy

After a termination of pregnancy for fetal anomaly, it is natural to have mixed feelings about becoming pregnant again. Some people will not want to become pregnant again, and for some there may be difficulties getting pregnant again. Many people find hope in the idea of a future pregnancy but may also feel apprehensive about recurrence or possible loss. It is important to allow time for emotional and physical recovery, and to seek support from your healthcare team, family, or peer support groups as needed.

Before planning another pregnancy, you will usually be offered a follow-up consultation with your obstetric or fetal medicine team. This gives you a chance to review your personal and family history, understand previous test results, and ask questions about recurrence risks. Your fetal medicine team may also arrange an appointment with a clinical genetics specialist or genetic counsellor to talk through any genetic contribution to the fetal diagnosis, the likelihood of recurrence, and recommended investigations in a future pregnancy.

How will this affect future pregnancies?

A previous termination of pregnancy for fetal anomaly does not usually cause physical harm that would affect your chances of becoming pregnant again or carrying a pregnancy to term, but the emotional impact and fear of recurrence can be significant and often require extra reassurance and support.

Whether a fetal anomaly is likely to recur depends on the specific diagnosis — some conditions arise sporadically, while others have a genetic basis, and have a definite recurrence risk. Your healthcare team will review your case and, where appropriate, arrange genetic counselling to assess risk and plan tailored screening or diagnostic options. In many cases, people go on to have healthy pregnancies in future, but the pathway of care may be different, with earlier appointments, more frequent scans, and options for additional tests.

> I want to get pregnant again, but I am obviously worried about what will happen.

When to try again

You may be advised to wait until all test results are back, in case a condition has a risk of recurring. Otherwise, there is no set timeline — your own readiness is most important.

Fertility can return soon after a pregnancy loss, but most guidelines recommend waiting until you feel physically and emotionally prepared. One or more normal menstrual cycles may be suggested to allow the uterus to recover and make dating of a future pregnancy easier. If you had surgical treatment or complications, discuss timing of a future pregnancy with your clinician.

What happens in another pregnancy?

If you have had a previous fetal anomaly, extra support, monitoring, and a different pathway of care are usually offered in future pregnancies.

You may be seen early by a fetal medicine specialist, have more frequent and detailed scans, or be offered targeted screening (e.g. NIPT/NIPS, see pages 12-13) and diagnostic tests based on your history.

Returning to the fetal medicine specialist/team can help with planning, emotional support, and navigation of your options. If the risk of recurrence is higher, the team will discuss specific monitoring or treatments that can reduce risk or provide reassurance.

Further considerations

Do I have confidentiality regarding my termination of pregnancy?

All information about your care, including decisions about termination of pregnancy and results of investigations, is confidential and protected by medical and data protection laws. Healthcare professionals will not disclose information about your termination to anyone outside your healthcare team without your explicit consent. You may choose to share information with your GP or a specialist to support continuity of care; this is usually discussed with you ahead of time.

What if I'm under 18 years of age?

If you are under 18, you have the right to respectful and appropriate care, and as much as is possible, doctors will respect your privacy. However, doctors must follow child protection law, and if they are concerned about abuse or unlawful sexual activity, they may need to share information with Tusla, the Child and Family Agency. In some limited circumstances your parents may also have a right under Freedom of Information Law to access your medical records.

If you are 16 or 17, the law allows you to consent to medical treatment, including termination of pregnancy, in your own right. Doctors will usually encourage you to involve a parent or trusted adult.

If you are under 16, doctors generally need consent to medical treatment from a parent or legal guardian. In very limited circumstances, where a parent refuses consent and it is considered to be in your best interests, and you want the termination, care may still be provided — your healthcare team can explain how the National Consent Policy applies in your situation. However, such cases may require a court order authorising the termination of pregnancy.

Whatever your age, you can contact the HSE My Options service for confidential information and counselling.

Can a medical professional refuse to participate in a termination of pregnancy?

Under the law in the Republic of Ireland, medical professionals may refuse to participate in a termination of pregnancy on the basis of a 'conscientious objection'. However, they are required by law to arrange for your care to be transferred without delay. Refusal must never compromise your right to timely and appropriate medical services.

What if I have limited transport or financial resources and live somewhere where termination of pregnancy services are not easily accessible?

If you live somewhere where services are difficult to access due to distance, transport, or financial constraints, many hospitals can provide information about financial assistance, transport options, and local referral pathways. Social work teams and advocacy organisations may help with appointments closer to home, grants for travel, or reimbursement paperwork. Organisations such as LMC Bereavement Support, ARC, and the Abortion Support Network can help you navigate available resources.

Where can I go for help if I am an asylum seeker / live in Direct Provision / am an undocumented migrant?

Everyone in Ireland, regardless of migration or legal status, has a right to access healthcare and to seek help from a GP or hospital. Staff should arrange translation, advocacy, and culturally sensitive care.

The Irish Refugee Council and Migrant Rights Centre Ireland can help with practical issues affecting access to care, such as documentation, transport, and understanding your entitlements. Organisations such as AkiDwA (Akina Dada wa Africa, Swahili for "sisterhood"), Nasc Migrant and Refugee Rights Centre, and the IFPA (Irish Family Planning Association) also provide information and advocacy. More information can be found on page 91.

What targeted information or care should I seek if I am transgender or non-binary (TGNB)?

If you are transgender or non-binary, you should receive sensitive, respectful, and affirming care. If you feel safe to do so, let your GP or healthcare team know your gender identity and any specific needs, so they can use correct language and pronouns throughout your care.

You may request a provider familiar with transgender and non-binary healthcare, or ask for recommendations for affirming support groups. TENI (Transgender Equality Network Ireland) can offer further guidance. If you encounter barriers to your care, do not hesitate to seek a second opinion from another doctor or healthcare team or speak to the hospital's patient advocacy services. More information can be found on page 90.

What if I am in a same-sex couple and there has been a termination of pregnancy for fetal anomaly?

Same-sex couples may face specific challenges around termination for fetal anomaly. Only the person who is pregnant is automatically recognised as a legal parent at the time of the loss. The other partner may not yet be legally recognised, depending on how the pregnancy was conceived and whether steps such as a declaration of parentage have been completed. This can affect registration, official paperwork, and formal decision-making about the baby's care.

For medical care, the pregnant person gives consent for their own treatment. For decisions about the baby (such as post-mortem), staff rely on legally recognised parents, though in practice, most healthcare teams will make a point of including both partners. The pregnant person can take maternity leave after a stillbirth regardless of the type of relationship. The other partner may be able to take paternity or partner's leave, though this can be less straightforward if their legal status is unclear. More information can be found on page 90.

What if my culture or religious beliefs forbid termination of pregnancy after a certain point or under any circumstances?

Many people hold strong cultural or religious beliefs about termination of pregnancy, and these values deserve respect and sensitive discussion. If your faith or culture forbids termination of pregnancy at all or at a particular gestation, your healthcare team can support you in making informed decisions aligned with your values. You may find it helpful to speak to a hospital chaplain, spiritual adviser, or community faith leader. Culturally appropriate counselling is available through many hospitals, social work departments, and voluntary organisations.

What if I feel unsafe or under pressure about decisions relating to my pregnancy?

Domestic violence and coercive control can occur during pregnancy, including pressure around decisions about continuing or ending a pregnancy. It is your right to make your own decisions. If you feel unsafe or under pressure from anyone, please talk to your healthcare professional, midwife, or medical social worker in confidence.

You can also contact Women's Aid on their 24-hour National Freephone Helpline: 1800 341 900.

Glossary

Term	Definition
Amniocentesis	A prenatal test where a thin needle is used to take a small sample of the amniotic fluid around the baby to check for genetic or chromosomal conditions.
Anomaly (fetal anomaly)	A health problem or difference in how a baby's body or organs have developed in the womb.
Anomaly (targeted or detailed) scan	A specialised ultrasound scan, usually around the middle of pregnancy, that looks carefully at the baby's anatomy for signs of anomaly.
Antenatal	The period during pregnancy before birth.
Antenatal screening	Tests offered during pregnancy to assess the chance that a fetus has certain conditions, such as chromosomal or structural anomalies.
Antenatal ultrasound	An imaging test in pregnancy that uses sound waves to create pictures of the fetus, placenta and uterus.
Chorionic Villus Sampling (CVS)	A prenatal test that removes a tiny sample of placental tissue (chorionic villi) to look for genetic or chromosomal conditions in the baby.

Term	Definition
Chromosomes	Structures inside cells that carry genetic information (genes), which provide instructions for growth and development.
Congenital condition	A condition that is present from birth and may be caused by genetic, chromosomal or developmental factors.
Diagnostic test (prenatal diagnosis)	A test in pregnancy that can confirm whether a fetus has a particular condition, for example by testing amniotic fluid or placental tissue.
Fetal anomaly	A structural or functional problem with the fetus that develops during pregnancy and may affect survival or long-term health.
Fetal medicine team / fetal medicine specialist	Hospital-based clinicians with particular expertise in diagnosing and managing problems in the baby during pregnancy.
Feticide	A medical procedure used in later pregnancy to stop the baby's heartbeat before a termination.
Fetus	The term used for a developing baby in the womb from about 8 weeks of pregnancy until birth.

Term	Definition
Genetic counselling	A service that helps people understand information about genetic conditions, inheritance, testing options and what results may mean for them and their family.
Gestation / gestational age	How far along the pregnancy is, usually measured in weeks from the first day of the last menstrual period.
Induction of labour	A process where medicines and/or procedures are used to start labour artificially, rather than waiting for labour to begin on its own.
Major congenital anomaly	A serious structural or functional difference present from birth that is likely to have a significant impact on a baby's health, development or long-term wellbeing, and may sometimes be life-limiting.
MRI (Magnetic Resonance Imaging)	A scan that uses strong magnets and radio waves to produce detailed images of the inside of the body.
Multidisciplinary Team (MDT)	A group of different healthcare professionals (for example obstetricians, neonatologists, midwives, geneticists and counsellors) who work together to plan and provide care for a patient or family.

Term	Definition
Non-invasive prenatal testing (NIPT) or Non-invastive prenatal screening (NIPS)	A blood test taken from the pregnant woman that looks at small fragments of fetal DNA circulating in the blood to estimate the chance of certain chromosomal conditions.
Palliative care (perinatal palliative care)	Supportive care that focuses on comfort and quality of life for babies with life-limiting conditions, and support for their families before and after birth.
Post-mortem examination	A medical examination of a baby's body after death to look for causes of death or contributing conditions, usually with parental consent.
Stillbirth	In Ireland, a stillbirth is defined as a baby born with no signs of life at 23 weeks gestation or later, or with a birthweight of 400g or more.
Termination of pregnancy for fetal anomaly (TOPFA)	Ending a pregnancy because a serious fetal anomaly has been diagnosed, usually following detailed assessment and counselling from specialist teams.
Viability	The stage of pregnancy when a baby may survive outside the womb with medical support; this depends on gestation, birthweight, condition at birth and available care.

More information and support

Health Service Executive (HSE) and My Options – All 19 maternity units now provide care relating to termination of pregnancy within the HSE, Ireland's public health service, under NWIHP, which oversees maternity, gynaecology, neonatal, and sexual and reproductive health services, including both hospital-based and community-based termination of pregnancy care.

The HSE's national support framework, My Options, is a freephone information and counselling service on pregnancy options, including non-directive counselling before and after termination of pregnancy.

This service also provides information on where to get abortion care locally, i.e. they can tell you about GPs and hospitals that provide termination of pregnancy and can link you to counselling services.

- myoptions.ie

Citizens Information - A free public service that provides clear, impartial information and advice on your rights, entitlements, and public services like social welfare, housing, work, health, and education. Specific information about registering a stillbirth can be found at the link:

- citizensinformation.ie/en/birth-family-relationships/miscarriage-and-stillbirth/

Irish Family Planning Association (IFPA) - Irish organisation offering free nondirective decisional counselling, termination of pregnancy / abortion care and contraception. Accredited professional counsellors provide emotional as well as practical and logistical support if you need to travel abroad for care.

- ifpa.ie

LMC Bereavement Support (formerly Leanbh mo Chroí) - Irish organisation offering nondirective information, peer support after a diagnosis of fetal anomaly and supporting people whether they continue the pregnancy or have a termination of pregnancy. LMC offer support and guidance at any stage of the journey, including immediately after a diagnosis.

Some quotes in this booklet are from LMC's 2026 LMC publication, *The Impossible Choice: Stories of families following terminations of pregnancy for medical reasons in Ireland and abroad,* which features stories of people's lived experiences.

- lmcsupport.ie

Pregnancy and Infant Loss Ireland - National directory signposting to local and online supports after pregnancy and baby loss, including termination of pregnancy for fetal anomaly.

- pregnancyandinfantloss.ie

There is a page on the Pregnancy and Infant Loss website where you can find all national clinical practice guidelines, including the *National Clinical Practice Guideline: The Fetal Anatomy Ultrasound*.

- pregnancyandinfantloss.ie/guidelines

Pregnancy Loss Research Group (PLRG) - Academic and clinical group focused on improving care after pregnancy loss and termination of pregnancy for fetal anomaly (developed this booklet in collaboration with the HSE National Women and Infants Health Programme).

- ucc.ie/en/pregnancyloss

The PLRG have also developed *Pregnancy Loss & the Workplace: A Toolkit for Employers & Employees* and *Words at Work: Experiences of pregnancy loss in the workplace {up to 23 weeks}*, where you may find emotional support and helpful information related to returning to work after a termination of pregnancy.

- https://www.ucc.ie/en/pregnancyloss/policyandadvocacy/workplaceresources/

Support in the UK

ARC (Antenatal Results and Choices) - UK charity offering information, telephone and online support around antenatal screening, fetal anomaly diagnosis and decisions about continuing or ending the pregnancy.

- arc-uk.org

Dads Still Standing - award-winning podcast and online resources offering bereavement support for dads and partners following the loss of a child, including baby loss and termination for fetal anomaly.

- dadstillstanding.com

Sands National Bereavement Care Pathway - UK baby-loss charity offering helplines, groups and online resources after stillbirth and neonatal death, some of which are relevant after termination of pregnancy for fetal anomaly.

- sands.org.uk/professionals/national-bereavement-care-pathway

Practical and travel-related supports

British Pregnancy Advisory Service (BPAS) - Independent UK provider offering medical and surgical termination of pregnancy, including for fetal anomaly, and detailed information for people travelling from Ireland.

- bpas.org/abortion-care/considering-abortion/travelling-from-the-republic-of-ireland or www.bpas.ie/foetal-abnormality/

MSI Reproductive Choices (formerly Marie Stopes International) - Independent UK provider offering abortion care, including surgical procedures for pregnancies affected by fetal anomaly.

- msichoices.org.uk/

Abortion Support Network - Organisation offering practical information and, in some cases, financial help with travel and accommodation for those who must travel for abortion care.

- asn.org.uk

LGBTQI+ inclusive resources

LGBT Ireland - National LGBTQI+ organisation offering confidential listening, online chat and signposting to inclusive mental health and counselling supports, including after pregnancy loss or termination of pregnancy.

- lgbt.ie

Trans Equality Network Ireland (TENI) - Advocacy and support organisation for trans and non-binary people, including information on peer groups and trans-affirming mental health supports that may be helpful after pregnancy loss or termination of pregnancy.

- teni.ie

Belong To - Youth service for LGBTQ+ young people providing support around mental health, identity and relationships, including in the context of unintended pregnancy, or pregnancy loss.

- belongto.org

National migrant organisations

AkiDwA (Akina Dada wa Africa) – Network of migrant women that focuses on migrant women's rights, including sexual and reproductive health, pregnancy care and access to services, especially for women in Direct Provision or other vulnerable situations.

- akidwa.ie

Irish Family Planning Association (IFPA) – Sexual and reproductive health organisation providing contraception, pregnancy counselling, abortion care and wider sexual and reproductive healthcare; offers tailored support, including for people living in Direct Provision.

- ifpa.ie (look for information related to Direct Provision / Majira Project).

Irish Refugee Council (IRC) – Non-governmental organisation working with refugees and people seeking international protection, offering information, legal advice and advocacy on the asylum process, Direct Provision, housing and access to services.

- irishrefugeecouncil.ie

Migrant Rights Centre Ireland (MRCI) – Organisation working to advance the rights of migrant workers and their families, particularly those in low-paid, precarious or undocumented situations.

- mrci.ie

Nasc: Migrant & Refugee Rights Centre – National NGO linking migrants and refugees to their rights, including people in the protection process and other vulnerable migrants.

- nascireland.org

Appendix: Questions you might find helpful to ask

About the diagnosis

- Can you explain my baby's diagnosis in plain language, and what it is likely to mean for my baby's life, health, and comfort if the pregnancy continues?
- How certain is this diagnosis, and what further tests are needed to confirm it? Can you signpost to helpful and reliable sites?

About options, including continuing or ending the pregnancy

- What are all my options now (continuing the pregnancy, planning palliative care after birth, or ending the pregnancy), and what would each pathway involve in practice?
- If I am not ready to decide today, how much time do I have to think about this and who can I speak to for support while I am deciding?

About what is legally possible in Ireland

- Given this specific diagnosis, am I likely to meet the criteria for a termination of pregnancy for fetal anomaly under Section 11 of the Irish Act, and why or why not?
- If you feel I do not meet the criteria and I disagree or am unsure, can you explain my right to a formal review, and help me understand how to request one and what the timelines are?

About the type of procedure and practicalities and emotional, spiritual, and family support

- If a termination of pregnancy goes ahead in Ireland, what method would be recommended in my situation, at what gestation, and why?
- What will happen to me physically during the procedure (pain relief options, how long it usually takes, whether I can see and hold my baby, memory-making options, and what will happen with my baby's remains)?

- What bereavement, counselling, social work, or chaplaincy supports are available to me and my partner/family now and after the pregnancy ends, and how do I access them?

- If I already have children or other family members, is there someone who can help me think about how to talk with them about what is happening?

About future pregnancies and tests on the baby

- Will you recommend genetic testing or a post-mortem examination, and what might those results mean for future pregnancies and my family?

- When and with whom will I have a follow-up appointment to review results and discuss chances and care options in a future pregnancy?

About physical recovery and warning signs

- What should I expect physically afterwards in terms of bleeding, pain, milk coming in, and fatigue, and what symptoms mean I need urgent medical help?

- Who should I contact (and how) if I am worried about infection, ongoing pregnancy symptoms, or feel that something is not right once I am home?

About work, benefits and practical issues

- How much time off work or caring duties do you usually recommend in situations like mine, and can you provide medical certificates or letters if needed?

- If I was later in pregnancy, will I be entitled to maternity leave or other supports, and who can advise me on this?

About second opinions and continuity of care

- Who is my main contact person (for example, fetal medicine midwife or coordinator) if I have questions or my feelings change over time?
- If I would like another specialist to look at my scans or test results, how can I request a second opinion or referral to another fetal medicine specialist or another fetal medicine centre?

About care if I need or choose to travel

- If the law in the Republic of Ireland says I cannot have a termination here, where can I find information about services abroad and what I require in terms of aftercare when I return to Ireland?
- Will you and your healthcare team continue to see me for follow-up and support if I end the pregnancy outside Ireland, and how is that arranged?

This guide was created by the Health Service Executive's (HSE's) National Women & Infants Health Programme (NWIHP) and the Pregnancy Loss Research Group (PLRG), with valuable input from legal, medical and mental health practitioners, researchers, and people with lived experience, including LMC Bereavement Support. It also draws on legal resources, national guidelines, research and reviews.

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