SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

Irish Family Planning Association
Solomons House, 42a Pearse Street
Dublin 2, Ireland

T: +353 (1) 607 4456
F: +353 (1) 607 4486
E: post@ifpa.ie
www.ifpa.ie

Dear Committee members,

The Irish Family Planning Association (IFPA) has prepared this report to assist the Committee on Economic, Social and Cultural Rights (hereafter, the Committee) in its preparation of a list of issues in advance of the review of the State Party's compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR).

IFPA Credentials

The IFPA submits these remarks based on its experience in providing reproductive health care services to women and girls. Since 1969, the IFPA has worked to promote and protect basic human rights in relation to reproductive and sexual health, relationships and sexuality. The IFPA provides the highest quality reproductive health care at its two medical clinics in Dublin and twelve counselling centres across Ireland. Our services include non-directive pregnancy counselling, family planning and contraceptive services, medical training for doctors and nurses, free post-abortion medical check-ups and educational services. In 2013, IFPA medical clinics provided sexual and reproductive health services to over 16,200 clients and provided information and support to 3,705 women and girls experiencing pregnancies that were unplanned, unwanted or that had developed into a crisis because of changed circumstances. The IFPA is recognised as a respected source of expertise because of its proven track record in the provision of sexual and reproductive health care services, and is regularly called upon by statutory agencies, parliamentary committees, medical associations and service providers to give its expert opinion on a wide range of issues related to sexual and reproductive health and rights.

These comments address concerns regarding lack of adequate implementation of Covenant ***Article 12*** *(the right of everyone to the enjoyment of the highest attainable standard of physical and mental health)* ***in conjunction with Article 2.2*** *("the Covenant's rights should be exercised "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status").*

The IFPA wishes to draw the Committee's attention to three particular issues where the law prevents the access to and exercise of rights under the Covenant:

1. ***Abortion law***: the ways in which Ireland's restrictive constitutional, legislative and regulatory legal regime in relation to abortion restricts women's access to the right to health;

2. ***Access to contraception/ access to reproductive health care***: specifically the ways that laws relating to consent to sex and consent to medical treatment act as barriers to access to reproductive health; other barriers to access, including cost, stigma and lack of measures to ensure access by marginalised groups;
3. ***Sexuality education***: the inadequacy of provision of sexuality education in the school curriculum; the ways that laws relating to consent to sex in general, and in relation to people with intellectual difficulty in particular, impact on access to sexuality education, and consequently on people's health.

Basis in the Covenant for IFPA comments

General Comment 14 clarifies that states' obligations under the CESCR include the requirement to take measures to fulfil the right to health and the removal of barriers to the exercise of that right. States' obligations include the requirement to take measures to improve child and maternal health, **sexual and reproductive health services, including access to family planning,** pre- and post-natal care, emergency obstetric services and **access to information, as well as to resources necessary to act on that information.**

Further, the Committee has highlighted that realization of women's right to health requires the **removal of barriers that interfere with access to health services, education and information, including in the area of sexual and reproductive health**.

In repeated Concluding Observations, the Committee has urged states parties to adopt and implement national sexual and reproductive health programs, to take measures to ensure access to comprehensive sexuality education and to ensure that pregnant adolescents are able to continue their education.

ISSUE 1. **Abortion law: the ways in which Ireland's restrictive constitutional, legislative and regulatory legal regime in relation to abortion restricts women's access to the right to health.**

Abortion in Ireland is permitted only in cases where there is a "real and substantial" risk to the woman's life, as distinct from a risk to her health.[1] Abortion is not permitted where the health of the woman is at risk. Nor is abortion lawful where the pregnancy is the result of rape or incest, or in cases of fatal foetal anomaly. Impacts on women include increased risks to women's health related to delay in accessing services; the requirement to travel to another country for abortion services and incur significant costs; parenting in situations where this is against a woman's best interests and her own wishes; and recourse to unsafe abortion.

The IFPA wishes to highlight three aspects of the law and their impacts on women's health and well-being:

1.1 The restrictive laws on abortion and the failure of legislation to guarantee even existing limited right to abortion where there is risk to life;

1.2 The need for women to travel outside of Ireland to access safe and legal abortion services (which is both an impact of the law, and, in itself involves harms that are inconsistent with the State's obligations under the Covenant);

1.3 The law in regard to information about abortion services in other countries.

1.1 The restrictive laws on abortion and the failure of legislation to guarantee even existing limited right to abortion where there is risk to life

The *Protection of Life during Pregnancy Act 2013* (hereafter the 2013 Act) was enacted on foot of a 2010 judgment of the European Court of Human Rights[2] which found Ireland in violation of the European Convention on Human Rights for its failure to give effect to the right to abortion in cases of risk to life., The right to abortion in such cases was established in a 1992 Supreme Court ruling.[3] The 2013 Act does not give rise to substantive changes to the law; it aims merely to give procedural clarity to access to the existing right.

However, the 2013 Act does not ensure practical and effective exercise of the constitutional right to life-saving abortion.[4] The 2013 Act introduces new legal barriers of complicated certification and review processes that women must undergo to access a lawful abortion.[5] An unprecedented process of parliamentary scrutiny has also been introduced: abortions must be notified to the Minister for Health and a report on all abortions carried out must be laid before parliament each year.[6]

The legislation is constrained by the requirement enshrined in the Eighth Constitutional Amendment, Article 40.3.3° to protect the "right to life of the unborn" with "due regard to the equal right to life of the mother". The Eighth Amendment thus requires that in crisis pregnancies covered by the Act, doctors must always prioritise live birth whatever the impact on a woman's physical or mental health.[7] In the view of the IFPA, this provision and its restatement throughout the guidance document, will act as a deterrent to doctors acting in the best interests of patients.

The law retains harsh criminal sanctions for women and their doctors of 14 years' imprisonment if an abortion is carried out for any reason other than to save a life.[8] The 2013 Act also discriminates against women in cases where risk to life relates to risk of suicide, imposes more onerous requirements to establish eligibility under the Act in such cases.[9] The Act allows for conscientious objection of doctors, and there is cause for concern that this may result in refusal of care, particularly where the risk to life arises because of mental health problems.

The 2013 Act and its accompanying guidance document for medical professionals[10] contain no provisions for ensuring that particularly vulnerable groups such as migrant women, asylum seekers, young women and women who are living in poverty can access lawful abortion.[11]

Impacts on access to the right to health

1.1.1 The constitutional, legislative and regulatory landscape necessitates a medically unsound distinction between risks to the life of a pregnant woman and risk to her health. Such a distinction may put women's lives at risk and prevent medical practitioners from acting in women's best interests.

1.1.2 Even where a woman is lawfully entitled to abortion in Ireland, i.e. when her life is at risk, there is a lack of clarity for women and their doctors about how and when they can access their Constitutional right to life-saving abortions. This impacts most severely in cases where a woman is already disadvantaged.

1.1.3 Due to the restrictive legal framework, the vast majority of women who seek to end a pregnancy must travel to access abortion services, even in cases of serious risks to their health and where their pregnancy is the result of a crime such as rape or incest. This requirement involves significant harms to women's health and well-being, as outlined in the following sections.

1.2 The need for women to travel outside of Ireland to access safe and legal abortion services

The UN Special Rapporteur for Health has stated that the criminalisation of reproductive health services is a violation of the right to health and shifts the burden of accessing the right from the state onto a pregnant women.[12] The Irish State criminalises abortion and justifies its restrictive laws on abortion by providing for the right to travel to other jurisdictions to access services, and to obtain information about abortion services. The Constitutional right to travel to access abortion services is contained in the Thirteenth Amendment of Article 40.3.3°.[13]

In *A, B and C v Ireland,* [14] the European Court of Human Rights recognised that the requirement to travel for abortion involves stigma and amounts to an interference with rights under the Covenant (the dissenting minority of the court argued that the requirement to travel is of itself a violation of the right to privacy).

The World Health Organisation has highlighted that restrictions on and unavailability of induced abortion result in unequal access to safe abortion services, disproportionately forcing poor women to seek abortion services from unsafe providers.[15]

Impacts on access to the right to health

1.2.1 The harms of the criminalisation of abortion are significant in Ireland. At least 4000 women travel from Ireland to the UK to access abortion services each year and at least 150,000 women have travelled since statistics began to be collected.[16] Each woman who must leave Ireland to access services that most states recognise as integral to reproductive health endures costs to her physical and mental health, including stigma.

The World Health Organisation is unambiguous: delays accessing abortion services can result in increased risks to women's health.[17] The need to organise finances, and also the logistics of travel, accommodation, childcare, time off work etc. leads to a delay between women's decision to have an abortion and the time when she can avail of the procedure.

The IFPA is aware of situations where the time involved in organising the journey to have an abortion has resulted in a delay of many weeks in exercising the right to travel. The requirement to travel can result in more women opting for the surgical

procedure rather than the medical abortion, which can only be performed up to 9 weeks gestation.

Stigma around accessing abortion services and the chilling effect of the criminal sanctions contained in the law can cause delays seeking aftercare, resulting in further risks to women's health.

1.2.2 Because of abortion stigma within health services in Ireland, most women, even women who have underlying medical conditions that can make abortion more complicated, must travel for abortions abroad without a referral letter from their doctor outlining their medical history. This would not happen in accessing any other medical treatment, in particular in the case of a patient with a life-threatening illness.[18]

1.2.3 Restricted access to abortion services and information, and the financial burden of travel can lead women to seek illegal and unsafe abortion-inducing drugs. These medications may be ineffective or harmful, and are administered without proper medical advice or supervision. According to the Irish Medicines Board, 487 tablets were seized by the Customs Authority in 2012 and 635 in 2011. It is likely that many more are not intercepted, either because those selling them change the packaging regularly to avoid detection or because some women have them sent to addresses in Northern Ireland.[19]

1.2.4 The costs involved in accessing safe abortion services are high.[20] There is no state support for women to access abortion, even when they have inadequate financial resources .

1.2.5 The requirement to travel for abortion has discriminatory impacts on women living in poverty or on low incomes, migrant women, women asylum seekers, minors and undocumented women. Lack of access to safe abortion services therefore particularly affects women who are already burdened by inequality.

Not all women can afford the costs of paying for abortion care and the travel costs involved. Not all women can travel freely between states, and in many cases the most disadvantaged women are those who experience greatest delay in travelling to access abortion and, consequently additional stress, stigma and worse health outcomes because of delay.

In addition, the cost of travelling to another country for abortion represents a significantly higher proportion of the disposable income of the most disadvantaged, compared to women who are, for example, in well-paid employment, have access to credit or have savings.

1.3 The health impacts of the law in regard to information about abortion services in other countries

The Fourteenth Constitutional Amendment[21] protects the right to obtain information about abortion services in other countries, subject to certain conditions. The *Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act 1995* stipulates that women who seek information on abortion can only obtain it if they are also given information and counselling on "all the options available to the woman in her particular

circumstances". The law does not regulate the existence of rogue counselling agencies established to manipulate women's choices and withhold information about abortion.

Impacts on access to the right to health

1.3.1 The regulation of women's right to information on abortion is an unwarranted interference with women's right to make autonomous decisions about their own health care. It also impacts on doctors' ability to act in their patients' best interests. In her 2013 report on the situation of human rights defenders in Ireland, the UN Special Rapporteur Margaret Sekaggya highlighted that the provisions of the Information Act can pose significant barriers for counsellors and potentially restrict women's access to information on sexual and reproductive rights: *"Moreover, the provision can restrict the ability of defenders to make contact with some women who may not be able to attend a face-to-face counselling session, including women who live in isolated or rural areas, young women, women in State care and/or migrant women. The inability of counsellors to make appointments on behalf of their clients further restricts the support they can offer to women seeking this type of service abroad."*[22]

1.3.2 In the context of strict regulation of information, the emergence of 'rogue agencies'—unregulated agencies that actively provide misleading or inaccurate information about abortion and abortion services in order to prevent women from accessing abortion is of concern. These 'rogue agencies' present themselves as legitimate crisis pregnancy centres that provide impartial information on options for women who have an unplanned pregnancy.[23] However, women who have unwittingly used these services have reported that they were shown videos of ultrasounds and a late-term abortion procedure. The women were also provided with unfounded information about the negative repercussions of terminating a pregnancy and harassed by follow-up phone calls.[24] Despite calls by advocacy groups and politicians, no regulation of these agencies has taken place.[25]

The CESCR and restrictive abortion laws

The **CESCR** has consistently called on States to make therapeutic abortion available, and to decriminalise abortion in cases of rape and incest.[26] Most recently, in its review of El Salvador, the Committee expressed concern about the ban on abortion, "which affects poor and less educated women in particular" and has given rise to "grave situations of distress and injustice."[27] The Committee acknowledged that blanket bans on access to abortion interfere with women's basic dignity, the right to health, and the right to life.

Other human rights treaty bodies and mandates

With respect to Ireland, the **UN Committee against Torture** was critical of uncertainty for women and their doctors and recommended putting in place an "effective and accessible procedure" to determine when a lawful termination could take place.[28] Most recently, Irish laws on abortion have been examined and criticised by the **UN Human Rights Committee**.[29] In its concluding observations, the Committee expressed concern about the "highly restrictive circumstances under which women can lawfully have an abortion in the

State party," as well as restrictions on provision of information, the lack of procedural clarity under the current law, and its discriminatory impact. The HRC called on the state to revise its laws. The CEDAW Committee has also criticised the restrictiveness of the law.[30]

We respectfully suggest that the CESCR ask the following questions of the state:

- What measures is the state taking to revise the law in order to bring Ireland's abortion laws into line with the Covenant and ensure that women have access to abortion at a minimum where there is risk to health, where there is a diagnosis of foetal anomaly or in cases of rape or incest, so that women's rights under Article 12 are fully realised?

- What measures does the state plan to take to ensure that women are not prevented by considerations of cost, difficulties in travelling between states and other social and legal barriers from accessing abortion services outside of Ireland?

- What measures does the state plan to take to ensure that the current legislative framework is compliant with the requirements of the Covenant and guarantees access without legal barriers to abortion in cases where it is lawful?

***ISSUE 2*. Access to Contraception / access to reproductive health care**

Contraceptives can be sold to anyone who is named in a prescription from a doctor, regardless of age, and condoms can be sold in any outlet, including from vending machines. There are no age restrictions on buying condoms. There is no law in place to prohibit or regulate the giving away of free condoms.[31] The government runs frequent awareness raising campaigns about contraception under the auspices of the Crisis Pregnancy Programme. Women who have a medical card are entitled to free GP care and contraceptives (excluding condoms).

However, there are a number of significant barriers to access by particular groups, notably young people, to a choice of acceptable, affordable, quality contraceptives, and to other sexual and reproductive health services and treatment. Barriers to access to sexual health services are dangerous to health and welfare: they increase their risk of unplanned pregnancies and sexually transmitted infections (STIs).

The IFPA wishes to highlight the following issues and their impacts on access to the right to health:

2.1 Inappropriate laws and lack of policies and guidelines for medical professionals

2.2 Refusal of reproductive health care, cost and other barriers to access

2.3 Lack of measures to ensure the most disadvantaged groups have access to reproductive health care

2.4 Lack of protection of health rights of people with intellectual disability

2.1. Inappropriate laws and lack of policies and guidelines for medical professionals

The age of consent to medical treatment is 16. In the case of children under 16, parents or legal guardians can consent to medical treatment for them. But the legal status of prescribing contraception to young people under the age of 16 without parental consent is very unclear.[32] This poses a major dilemma for doctors who are ethically required to provide a confidential service which is in the best interest of their client.

The situation is further complicated by the fact that the age of sexual consent in Ireland is 17.[33] Lack of clarity results in unnecessary barriers to young people accessing sexual health services and more than half of GPs feeling legally exposed when dealing with requests for contraception from young people.

And, although over 80% of GPs have prescribed contraception to girls aged under 16,[34] a health care provider can refuse to treat a young person under 18 without incurring any civil liability for so doing and without a duty to refer appropriately. Those young people who do avail of sexual health services do so under threat of being reported to their parents or the Gardaí. Doctors who provide sexual health services do so in a legal vacuum risking legal action by parents or guardians.

Ireland's sexual health services lag well behind many of our European neighbours when it comes to education, prevention, accessible and prompt treatment and aftercare in the area of sexual health. Sexual health is currently delivered by a number of different agencies and services, with many aspects being ad hoc and inequitable, as well as the general public having little awareness of STI risks and subsequently the availability of STI services.

Ireland does not have a national health sexual health strategy. While a working group was convened by the Department of Health in 2012 to develop such a strategy, and this was described by the Minister for Health in February 2013 as being "due in a number of months", no strategy has been published

Impacts on access to the right to health

2.1.1 The ambiguity in the current law can give rise to the following scenarios:

- medical professionals refusing to provide sexual health services including emergency contraception to young people;
- doctors violating principles of confidentiality by contacting the parents of the young person against their express wishes;
- and doctors reporting consensual sexual relationships between young people under 17 to the Gardaí as a potential criminal act. [35]

2.1.2 The IFPA is aware of cases where young people are refused sexual health treatment by medical professionals. We are also aware that other young people choose to avoid sexual health services altogether, and risk unplanned pregnancies and STIs, rather than consult with their parents on contraception and sexual health services.

2.1.3 There is no clear, rights based policy in place in relation to sexual health.

2.2 Refusal of reproductive health care, cost and other barriers to access

Young people in Ireland encounter additional barriers in accessing appropriate contraceptive information, services and supplies. There are significant regional inequalities in quality and availability of services. The high cost of condoms, which are not available under the medical card scheme, and the high cost of GP visits to renew a prescription for the contraceptive pill or other method are real barriers to young people, not all of whom have medical cards.

Pharmacists are not obliged to supply contraceptives: the Family Planning Act 1993 allows them to exercise conscientious objection and refuse to supply contraceptives. Most young people cannot choose their own doctor: young people who are covered by the medical card scheme of state subsidised medical care are assigned a general practitioner, generally their parents' family doctor. Families will also tend to use the same pharmacist for administrative purposes.

Embarrassment, stigma, lack of knowledge of where and how to access alternative services are major barriers to young people's access. Real or perceived lack of confidentiality, particularly in rural areas and in urban working class settings, are significant causes for concern for young people, especially those from a lower socio-economic background.[36]

The IFPA provides youth friendly confidential services and treats clients who hold medical cards. However, cuts from the Health Service Executive (HSE) means that the IFPA, which provides services to low income and marginalised clients, has been unable to meet increased demand for services from medical card clients.[37]

Impacts on access to the right to health

2.2.1 Young people and others who lack resources to pay for contraception may engage in unprotected sex rather than avoid sex. They may have genuine and well-founded fears of lack of confidentiality and be deterred from attending their regular doctor.

2.2.2 In the absence of youth friendly services, young people may be exposed to unplanned pregnancy and/or STIs.

2.2.3 Cost also impacts on women's contraceptive choices. Most women have different needs and choices regarding contraception throughout their life cycle. The IFPA regularly sees women who are using less reliable and more expensive forms of contraception such as the oral contraceptive pill, because they cannot afford the initial outlay for more effective long-term contraception such as the implant or coil. Many women are using methods of contraception that are not the most suitable in their particular circumstances or for their particular health profile. Women using less effective forms of contraception because of lack of resources are at a greater risk of unplanned pregnancy.

2.3. Lack of measures to ensure the most disadvantaged groups have access to reproductive health care

The IFPA provides services and supports that are aimed specifically at migrant and asylum seeking women because we are aware that these women face particular barriers to access to health care. The situation of people living in direct provision centres (the state's accommodation for asylum seekers) is well documented. Sexually active adults in these

circumstances face particular difficulties and face all the barriers of cost, lack of choice, lack of information, etc. outlined above.

In addition, the law relating to sexual offences and people with intellectual disability (see section 2.4 below) has implications for access to reproductive health care for sexually active people with intellectual disability, especially those living in care.

Impacts on access to the right to health

2.3.1 Those living in direct provision frequently use their scant financial resources for their children's welfare, in particular school-related expenses and may be unable to afford prescription costs for contraception or to purchase condoms. The barriers to access result in increased risk of unplanned pregnancy or STIs.

2.3.2 The IFPA is aware from our outreach services of women being unable to afford condoms and being charged €50 (equivalent to two and a half weeks' allowance) for a fitting of a long-acting contraceptive.

2.3.3 The IFPA is also aware that may women asylum seekers are not be reached by government awareness raising campaigns about avoiding unprotected sex, or about free breast and cervical cancer screening services.

2.4 Lack of protection of sexual and reproductive health rights of people with intellectual disability

Section 5 of the Criminal Law (Sexual Offences) Act 1993 provides that a person who (a) has or attempts to have sexual intercourse or (b) commits or attempts to commit an act of buggery with a person who is 'mentally impaired' shall be guilty of an offence. 'Mentally impaired' is defined as 'suffering from a disease of the mind, whether through mental handicap or mental illness, which is of such a nature or degree as to render a person incapable of living an independent life or of guarding against serious exploitation'. Section 5 does not apply where the complainant is married to the defendant (or where the defendant has reasonable cause to believe that he is married to the complainant).[38]

Section 5 fails to recognise and protect the sexual autonomy of people with intellectual disability or mental illness who have the capacity to consent. Yet it also assumes that no person who is incapable of living an independent life is capable of consenting to a sexual act, a presumption rejected by the Law Reform Commission (LRC) in its 2013 report, Sexual Offences and Capacity to Consent (hereafter LRC 109-2013).

The criminalisation of some forms of sexual activity under section 5 leads to fear that providing information on relationships and sexuality might be portrayed as facilitating a criminal offence.

Impacts on access to the right to health

2.4.1 The IFPA knows from its work with frontline staff in disability services that the criminalisation of some forms of sexual activity under section 5 creates and reinforces stigma around sexuality and can have a chilling effect whereby people working in services for people with disabilities may believe it is their role to discourage or prevent the consensual sexual behaviour of service users.

2.4.2 People with intellectual disability are frequently denied access to contraception information, advice and services, STI screening and cervical cancer screening.

2.4.3 Frontline staff are unclear as to their protection at law if they facilitate access to such services, and are thereby unable to act in the best interests of people in their care.

2.4.4 People with intellectual disabilities are denied knowledge and understanding of sexuality and relationships as positive aspects of life, and about how to protect themselves from inappropriate sexual behaviour, sexually transmitted infections and unplanned pregnancy.

The CESCR and access to reproductive health care

In its General Comment 14 on the right to the highest attainable standard of health, the Committee of Economic, Social and Cultural Rights, states that: *"the realisation of the right to health of adolescents is dependent on the development of youth-friendly health care which respects confidentiality and privacy and includes appropriate sexual and reproductive health services". (Para. 23).* Young people in Ireland encounter legal, financial and social barriers to access to such services.

We respectfully suggest that the list of issues requests provide information on:

- Measures to ensure that medical professionals have the protection of the law when they supply services in the best interests of the young person.
- Plans to implement the recommendations of the Law Reform Commission's 2011 report *Children and the Law: Medical Treatment* ensure that young people have access to reproductive health care in a way that reflects their evolving capacities to make informed decisions about their own health and wellbeing.
- The date of publication for the National Sexual Health Strategy and the provisions included therein to ensure access to the highest attainable standard of sexual and reproductive health.

  Measures to ensure that those living in direct provision and other vulnerable and marginalised groups, including people with intellectual disability, have access to appropriate quality sexual and reproductive health information, services and care free of charge.

***ISSUE 3*. Comprehensive sexuality education**

Sexuality education is mandatory in Irish schools, and in theory there is a strong relationships and sexuality education (RSE) curriculum in place. However, there is a lack of clarity in relation to the content of sexuality education as well as the resources that need to be dedicated to it to ensure equal implementation of sexuality education across the country.[39]A Department of Education and Skills inspectorate report[40] from November 2013 found that 39 of the 63 schools inspected displayed "evident weaknesses" in the quality of planning RSE at senior cycle. A 2014 survey which interviewed 252 young people found that

66% of respondents reported that they had received sex education in school, but only 23% of these felt that they had received enough sex education.[41] In the IFPA's extensive experience of working in schools and with teachers and parents, the quality of RSE is not consistent across schools. Many schools lack the resources and support to include RSE in a consistent or meaningful way. The provision of RSE is largely dependent on the ethos of the teacher, principal or board of management.

Impacts on access to the right to health

3.1 Many young people do not receive adequate or comprehensive sexuality education, and such sexuality education as they do receive may be confined to biological information and with a focus on delaying sex. The delivery is uneven and inconsistent.[42]

3.2 As it is unclear to what extent education about sexual relationships, contraception and STIs can be provided before young people reach the legal age of consent, information is delivered too late and is therefore not effective.

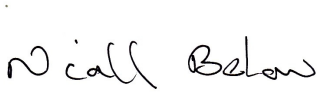
3.3 Children and adolescents receiving education outside the formal school system may be particularly disadvantaged and may receive no sexuality education.

3.4 Many adolescents and children are not informed about sexually transmitted infections and contraception, and are therefore effectively denied adequate, age-appropriate knowledge and understanding of sexuality and relationships as positive aspects of life, and about how to protect themselves from inappropriate sexual behaviour, sexually transmitted infections and unplanned pregnancy, and are therefore more at risk to sexual exploitation and abuse, STIs and unplanned pregnancy.

The IFPA respectfully suggests that the following questions be asked of the State in the list of issues:

What measures, including legislative reform, are planned by the State to ensure that all children and young people, including those with intellectual disability, receive adequate, quality, evidence based sexuality education that will enable them better to exercise the right to health?

Yours sincerely,



Niall Behan,
Chief Executive Officer

References

[1] Attorney General v. X [1992] IESC 1; [1992] 1 IR 1.
[2] A, B and C v Ireland [2010] ECHR 2032.
[3] Attorney General v. X [1992] IESC 1; [1992] 1 IR 1.
[4] IFPA Submissions to the COE and UN Human Rights Committee, available at http://www.ifpa.ie/Media-Info/Publications/Submissions; Irish Human Rights Commission Observations on Protection of Life During Pregnancy Bill 2013, particularly Para 39 which criticises the accessibility of the right to lawful termination for vulnerable groups. See also paras 28; 38; 117; 119.
[5] Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals. Available at http://health.gov.ie/wp-content/uploads/2014/09/Guidance-Document-Final-September-2014.pdf.
[6] S.15.(4), Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available at http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf.
[7] http://www.thejournal.ie/readme/ms-y-suicidal-abortion-maternity-care-1685650-Sep2014/.
[8] S.22.(2), Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available at http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf.
[9] S.9.3; S.9(4), Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available at http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf.
[10] Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals. Available at http://health.gov.ie/wp-content/uploads/2014/09/Guidance-Document-Final-September-2014.pdf.
[11] See Irish Human Rights Commission Observations on Protection of Life During Pregnancy Bill 2013, particularly Para 39 which criticises the accessibility of the right to lawful termination for vulnerable groups. See also paras 28; 38; 117; 119.
[12] Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. August 2011. UN Doc A/66/254.
[13] Text of Amendment available at: http://www.irishstatutebook.ie/1992/en/act/cam/0013/index.html.
[14] A, B and C v Ireland [2010] ECHR 2032.
[15] World Health Organisation: Safe abortion: technical and policy guidance for health systems. 2nd edition 2012 1,18 (2nd ed., 2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434 _eng.pdf; see also Center For Reproductive Rights et al., *Fulfilling Unmet Promises: Security And Protecting Reproductive Rights And Equality in the United States,* 21 (2013), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_ICCPR%20Shadow%20Report%202013_Final.pdf (discussing that bans on abortion disproportionally affect vulnerable groups such as poor women).
[16] Average figure from the last five years. See http://www.ifpa.ie/Hot-Topics/Abortion/Statistics for full list of UK figures. Note: this figure is an underestimate: it only captures the number of women who provide Irish addresses in UK clinics, and excludes women who provide other addresses, or who travel to other countries to access services.
[17] World Health Organisation: *Safe abortion: technical and policy guidance for health systems*. 2nd edition 2012. At page 106. Available at http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.
[18] The Irish Times. 17 January 2012. "*New Expert Group Must Vindicate Right to Abortion*" Op. ed. by Niall Behan, CEO of the IFPA. Available at http://www.ifpa.ie/Hot-Topics/Abortion/Resources.
[19] The Irish Times: July 27, 2013. *Abortion law: what comes next?* Available at http://www.irishtimes.com/news/health/abortion-law-what-comes-next-1.1476187.
[20] Travelling to the UK for a surgical abortion below 14 weeks of gestation costs at least €1000. Abortion in cases of foetal anomaly costs more due to the duration of the treatment, which can last 4-5 days. This is due to the fact that foetal anomalies are not usually detected until the later stages of a pregnancy, resulting in longer and more complex medical treatment. Women who need visas to travel abroad and to re-enter Ireland may have to wait 6 to 8 weeks for the necessary documents, or in some cases, may not be able to travel. Asylum seekers must apply and pay for an emergency re-entry visa from the Department of Justice and a visa to enter the UK or the Netherlands. Most asylum

seekers in Ireland are housed in reception centres until their refugee application is decided. They are not entitled to work and currently receive a weekly allowance of €19.10 from the State. The cost of a UK visa is £78 (€99 at August 2012) while a visa to enter the Netherlands is €60 (at August 2012). Figure includes travel and clinic fees but excluding indirect costs such as child care and loss of income. See 'Psychological, Physical and Financial Costs of Abortion' available at http://www.ifpa.ie/node/506 .

[21] Text of Amendment available at: http://www.irishstatutebook.ie/1992/en/act/cam/0014/index.html.

[22] Report of the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya. Addendum Mission to Ireland (19–23 November 2012) A/HRC/22/47/Add.3; 26 February 2013.

[23] Irish Family Planning Agency (2006) *Briefing Document on Rogue Crisis Pregnancy Agencies*, Dublin: IFPA, p.3.

[24] Human Rights Watch (2010) *A State of Isolation: Access to Abortion for Women in Ireland*, USA: HRW, p.26.

[25] Irish Family Planning Agency (2006) *Briefing Document on Rogue Crisis Pregnancy Agencies*, Dublin: IFPA, pp.6-7.

[26] Concluding Observations of the Committee on Economic, Social and Cultural Rights, 48th session, 30 May 2012, E/C.12/PER/CO/2-4, at para 21; Concluding Observations of the Committee on Economic, Social and Cultural Rights, 51st session, 4 January 2008, E/C.12/CRI/CO/4, at para 46; Concluding Observations of the Committee on Economic, Social and Cultural Rights, 53rd session, 19 June 2014, E/C.12/SLV/CO/3-5 , at para 22; Concluding Observations of the Committee on Economic, Social and Cultural Rights, 41st session, 1 December 2008, E/C.12/KEN/CO/1, at para 33; Concluding Observations of the Committee on Economic, Social and Cultural Rights, 41st session, 28 November 2008, E/C.12/NIC/CO/4, at para 26. Concluding Observations of the Committee on Economic, Social and Cultural Rights, 41st session, 1 December 2008, E/C.12/KEN/CO/1, at para 33; Concluding Observations of the Committee on Economic, Social and Cultural Rights, 36th session, 13 June 2006, E/C.12/MCO/CO/1, at para 23.

[27] Concluding Observations of the Committee on Economic, Social and Cultural Rights, 53rd session, 19 June 2014, E/C.12/SLV/CO/3-5, at para 22.

[28] Concluding Observations of the Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 46th session, 17 June 2011, CAT/C/IRL/CO/1, at para 26.

[29] Concluding Observations of the Human Rights Committee, 111th session, 23 July 2014, CCPR/C/IRL/CO/4, at para 9.

[30] Concluding Observations of the Committee on the Elimination of Discrimination against Women (CEDAW), 33rd session, 22 July 2005 CEDAW/C/IRL/CO/4-5 at paras 38-39.

[31] Family Planning Act 1993.

[32] Law Reform Commission Report "Children, the Law and Medical Treatment". LRC 1-3-2011

[33] Criminal Law (Sexual Offences) Act 2006.

[34] McMahon et al (2010) *The Prescribing of Contraception and Emergency Contraception to Girls Aged less that 16 – What are the Views and Beliefs of GPs and of Parents?* 16, 2 MLJI 91.

[35] IFPA Annual Report 2010.

[36] Mc Gee et el. (2008) *The Irish study of sexual health and relationships. Sub report 2: Sexual health challenges and related service provision.* McBride et al (2012) *Contraception and Crisis Pregnancy Study 2010* CPP Report Number 24; Murphy-Lawless et al. (2004) *Understanding how sexually active women think about fertility, sex, and motherhood;* CPP Report No. 6; *A follow-up project on perceptions of women about fertility, sex, and motherhood: probing the data further;* CPP Report Number 17. Hyde and Hewlitt (2004) *Understanding Teenage Sexuality in Ireland;* CPP Report Number 9. Chlamydia Screening Steering Group (2012). *Chlamydia Screening in Ireland Pilot Study of Opportunistic Screening for Genital Chlamydia Trachomatis infection in Ireland 2007 to 2009.*

[37] IFPA, Annual Reports 2011 and 2012; Centre for Economic and Social Rights "*Mauled by the Celtic Tiger: Human rights in Ireland's economic meltdown"*. Rights in Crisis Briefing Paper, February 2012. Available at: http://cesr.org/article.php?list=type&type=139. Accessed 22 September 2014.

[38] Leahy, S. *LRC Report on Sexual Offences and Capacity to Consent: A Timely Assessment of a Complex Area*. Human Rights in Ireland Blog. URL http://humanrights.ie/criminal-justice/lrc-report-on-sexual-offences-and-capacity-to-consent-a-timely-assessment-of-a-complex-area/.

[39] Dr Paula Mayock, Senior Researcher at the Children's Research Centre, Trinity College Dublin, quoted in the forthcoming IPPF Eurobarometer Report.

[40] Looking at Social, Personal and Health Education Teaching and Learning in Post-primary Schools Evaluation Support and Research Unit, Department of Education and Skills. Dublin 2013.
[41] Fullerton, D. (2014) *"'It's not all about cute little dresses' Evaluation Of Phase 6 of the REAL DEAL Programme*. Dublin. Insights Health and Social Research.
[42] Mayock, P et al. (2007) *Relationships and Sexuality Education in Post-Primary Schools: Challenges to Full Implementatio*n. Dublin: Crisis Pregnancy Agency/ Dept of Education; De Vries et al (2009) *A Review of the International Literature on the Role of Outside Facilitators in the delivery of School-based Sex Education*. Crisis Pregnancy Agency Report No 22.