

**Comments of the Irish Family Planning Association
(IFPA) in respect of the Fourth Periodic Review of
Ireland under the International Covenant on C**

ivil and Political Rights (ICCPR)



SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

The Irish Family Planning Association (IFPA) has prepared this report to assist the Human Rights Committee (HRC) in its review of the State Party's compliance with the International Covenant on Civil and Political Rights (ICCPR).

IFPA Credentials

The IFPA submits these remarks based on its reproductive rights advocacy experience within Ireland and 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 2012, 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, advocacy and policy development. In accordance with the law, the IFPA has never provided any abortion services. The IFPA 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.

1. Introduction

This report focuses on issues related to the status of women's reproductive rights in Ireland and the failure of the State adequately to respond to the Committee's urging to bring Ireland's laws into compliance with the Covenant.

In its Concluding Observations to Ireland at the ninety-third session of the HRC in July 2008, the Committee highlighted its concern about the restrictive nature of the law in Ireland in relation to abortion in the following terms:

“The Committee reiterates its concern regarding the highly restrictive circumstances under which women can lawfully have an abortion in the State party. While noting the establishment of the Crisis Pregnancy Agency, the Committee regrets that the progress in this regard is slow. (arts. 2, 3, 6, 26)

The State party should bring its abortion laws into line with the Covenant. It should take measures to help women avoid unwanted pregnancies so that they do not have to resort to illegal or unsafe abortions that could put their lives at risk (article 6) or to abortions abroad (articles 26 and 6).¹

The inclusion of “abortions abroad” with illegal and unsafe abortions that put women's lives at risk locates the situation of women who have to terminate a pregnancy in another state as a fundamentally harmful experience that is incompatible with international human rights law. Ireland's prohibitive regulation of abortion and the discriminatory nature of its application have also been criticised by other UN treaty bodies and international human rights monitoring bodies, including the Committee Against Torture (CAT), the Committee on the Elimination of

Discrimination Against Women (CEDAW) and during the Universal Periodic Review of Ireland in 2011.²

Some progress has been made in relation to reproductive rights, notably the wider availability of emergency contraception, the enactment of the Criminal Justice (Female Genital Mutilation) Act 2012, and the enactment in 2013 of The Protection of Life During Pregnancy Act³ (hereafter the 2013 Act) which governs the limited grounds on which abortion is available. The ongoing work of the Crisis Pregnancy Programme (formerly the Crisis Pregnancy Agency) in raising awareness in relation to contraception and providing supports to women and girls who experience pregnancies that are unwanted, unplanned or that become a crisis is highlighted in the Irish Government's response to the list of issues⁴ and is significant.

However, such supports do not ameliorate the failure of the State to fully implement the Covenant or to adequately address the harms to women as a result of the denial to exercise their reproductive choices within the State.

The introduction of the 2013 Act is a significant step. However, the IFPA is of the view that questions arise as to the compatibility of the new legislation with human rights standards and has made a communication⁵ to this effect to the Committee of Ministers of the Council of Europe, which supervises the execution of judgments of the European Court of Human Rights. Moreover, the new Act does not change the substantive issue of the restrictiveness of the law in Ireland and its failure to vindicate the rights to health, bodily integrity and equality.

Furthermore, the IFPA is of the view that denial of abortion to women who are pregnant as a result of a crime, women in whose case pregnancy presents a risk to health, women whose pregnancies involve foetal anomalies of such severity that there is no realistic prospect of life outside the womb, women who experience serious obstacles or delays in exercising their right to travel, or who cannot travel for abortion, is a violation of their right to freedom from cruel, inhuman and degrading treatment under Article 7 of the ICCPR.

This report describes the legal framework in relation to abortion in Ireland and discusses the ways in which absolute prohibition on and the criminalisation of abortion (in cases other than where there is a risk to a woman's life), the consequent financial burden and legal barriers to the exercise of the constitutional right to travel, and the restrictions on provision of information, stigmatise women in ways that cause harm and impact on their enjoyment of rights under the Covenant. The report also considers the 2013 Act and issues arising in relation to its conformity with the Covenant. Finally the report invites the Committee to make recommendations to the State.

2. Legal Framework (Articles 2, 3, 6, 7)

Irish law continues to place an absolute prohibition on abortion in cases where pregnancy presents a risk to health, where pregnancy is the result of a crime, in cases of fatal foetal anomaly and where women choose abortion for reasons related to their own or their families' well-being.

The law on abortion in Ireland derives from the Constitution, case law and legislation. Article 40.3.3 of the Constitution of Ireland states that:

"The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

"This subsection shall not limit freedom to travel between the State and another state."

"This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another State."

In 1992, the Irish Supreme Court determined that an abortion in Ireland is lawful when it is established that there is a real and substantial risk to the life (as distinct from the health) of the pregnant woman, this includes the risk of suicide.⁶

In December 2010, the Grand Chamber of the European Court of Human Rights ruled in *A, B and C v Ireland*⁷ that the Irish State violated Applicant C's right to privacy by failing to provide for an accessible and effective procedure by which the Applicant could have established whether she qualified for a lawful abortion.

In July 2013, the Protection of Life During Pregnancy Act (hereafter the 2013 Act) was signed into law. The 2013 Act goes some way to providing clarity for women and for doctors in determining the circumstances in which abortion may lawfully be carried out within the State to save a woman's life. The legislation includes provisions governing the procedure (including a review procedure) to be followed in determining whether or not a woman's life is at risk, the circumstances in which a medical practitioner may exercise a conscientious objection to carrying out an abortion and the procedure to be followed in the event of such an objection occurring.

The Act includes wide ministerial powers to suspend abortion services and rigorous reporting requirements, including identification of doctors who carry out terminations under the legislation. The Act includes an offence of "destruction of unborn human life". The maximum penalty for this offence, which applies equally to pregnant women and abortion providers, is 14 years imprisonment.⁸

3. Criminalisation of Abortion (Articles 2, 3, 6, 7)

Despite numerous recommendations to States from human rights monitoring bodies, including the HRC, to decriminalise abortion, the 2013 Protection of Life During Pregnancy Act maintains the legal position whereby abortion is criminalised in all circumstances that fall outside the Act, including where there is a risk to a woman's health and well-being.

The new offence of "intentional destruction of unborn life" in section 22 of the 2013 Act carries a maximum penalty of 14 years imprisonment, which is applicable to a pregnant woman or another person who carries out an abortion in any circumstances except where a woman's life is at risk. Prosecutions under this section require the consent of the Director of Public Prosecutions. The effect of section 22 is that it remains a crime to provide an abortion in the interests of a woman's health, where the pregnancy is the result of a crime and in cases of fatal foetal anomaly.

The offence of intentional destruction of unborn life appears to be sufficiently widely drafted to criminalise women and girls who obtain medication from an online or other provider and self-induce abortion. The extension of criminal liability to bodies corporate raises the concern that hospitals may be inclined to err on the side of caution and implement restrictive internal governance procedures which reinforce the chilling effect and act as a barrier to effective access to lawful reproductive health services.⁹

In 2011, the Committee Against Torture highlighted the risk of criminal prosecution and imprisonment facing both women and their doctors, and expressed concern that this may raise issues that constitute a breach by Ireland of the Convention.¹⁰ The European Court of Human Rights considered that the existence of criminal penalties for having or assisting in an unlawful

abortion constitutes a significant “chilling factor” for both women and their doctors.¹¹ The IFPA is concerned that the 2013 Act does not adequately address the chilling effect highlighted by the European Court of Human Rights, and may in fact substantially reinforce it.

Furthermore, the criminalisation of a medical procedure needed by women and the potential prosecution of women and girls who require access to safe abortion services contribute to the stigmatisation of abortion in Ireland. The Irish State has actively engaged in litigation to prevent access to abortion by putting the full resources of the Attorney General’s Office behind seven court actions against women and girls seeking judicial remedies to access safe abortion services and information, even when it has been established that it is lawful to do so.

In its reply to the list of issues, the Irish Government states that while it recognises that the potential criminalisation of a pregnant woman is a very difficult and sensitive matter, this provision reflects the State’s constitutional obligation arising from Article 40.3.3.¹² The IFPA is of the view that the State’s obligation under the Constitution to vindicate the life of the unborn does not require that women and health services providers be subject to harsh criminal sanctions. The 2013 Act defines “unborn” as “human life [following implantation until such time as it has completely proceeded in a living state from the body of the woman”, i.e. it treats the life of the unborn as if it were the same as the life of a woman and affords equal protection to a non-viable foetus as to a living woman. In doing so, the law exposes women to the harms of criminalisation, including stigma.

The current criminal law does not deter the more than 4,000 women who travel to the UK for abortions each year. Nor does the criminal law deter many other women from resorting to the importation of medication which may be used incorrectly and without medical supervision and which may not be genuine or safe. 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.¹³ The law does, however, deter some women in such circumstances from seeking medical advice in cases of any post-abortion complications that arise. Delay in seeking medical advice may result in risk to a woman’s health.¹⁴

4. Denial of Abortion (Articles 3, 7, 17 and 19)

4.1 Overview

Denial of services that only women need was recognised as a violation of women’s human rights by then Minister for Justice, Equality and Defence, Minister Alan Shatter during the parliamentary discussions on the implementation of the *A, B and C v Ireland* judgment:

“The reality of course is that there is no impediment to men seeking and obtaining any required medical intervention to protect not only their life but also their health and quality of life. I am, of course, not only Minister for Justice and Defence but also Minister for Equality and it can truly be said that the right of pregnant women to have their health protected is, under our constitutional framework, a qualified right as is their right to bodily integrity. This will remain the position. This is a republic in which we proclaim the equality of all citizens but it is a reality that some citizens are more equal than others. We should not pretend that the limited measures that must now be put in place to satisfy the judgment of the European Court ensure true equality for all citizens of this republic, both men and women.”¹⁵

Article 7 of the ICCPR guarantees the right to freedom from cruel, inhuman and degrading treatment, a right that carries with it nonderogable state obligations to prevent, punish, and redress violations of this right. The Committee has emphasised that the prohibition contained in this article extends to acts that cause mental as well as physical pain and suffering.¹⁶ The Committee has found that Article 7 may be relevant where women have become pregnant as a result of rape¹⁷ or have received a diagnosis of foetal impairment.¹⁸ In *L.M.R. v. Argentina*, the Committee found a violation of Article 7 for the refusal to terminate a young girl's pregnancy resulting from rape, noting that it resulted in severe mental suffering.¹⁹

The CAT has criticised abortion bans that do not have exceptions for rape and incest²⁰; noting that without a rape exception, a woman is constantly exposed to “the violation committed against [her] and [experiences] serious traumatic stress...”²¹ The CAT has also stated that women are especially at risk in contexts of “deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes.”²² Two recent cases of the ECtHR (*RR v Poland*²³ and *P and S v Poland*²⁴) indicate that states are obliged to ensure that women seeking lawful abortions should not be exposed to inhuman and degrading treatment.

The former Minister for Justice, Equality and Defence characterised the failure to permit abortion in cases of fatal foetal anomaly or rape as a “great cruelty” and an “unacceptable cruelty”.²⁵ The Minister has acknowledged that “as a State we have responsibilities we should live up to in this area.”²⁶ In its reply to the Committee's list of issues in relation to the fourth periodic report of Ireland, the Government stated that there are currently no proposals to amend Article 40.3.3 of the Constitution.²⁷

4.2 Risk to a Pregnant Woman's Health

Doctors are required under Irish law to make a distinction between risk to a pregnant woman's life, in which case abortion is lawful, and risk to her health or her quality of life, in which case abortion is criminalised. As a medical services provider, the IFPA is of the view that a distinction between life and health is medically unsound and prevents medical practitioners from acting in the best interests of their patients. The serious risk posed to pregnant women's health—for example by heart and vascular diseases, pulmonary diseases, kidney diseases, oncological, neurological, gynaecological, obstetric and genetic conditions—may become a risk to life in particular circumstances. Pregnancy may also exacerbate the risk to women of pre-existing conditions. Ireland is the only member state of the Council of Europe that permits abortion to protect the life but not the health of a pregnant woman. To refuse a pregnant woman an abortion until her health has deteriorated to such an extent that her life constitutes an unjustified interference with and violation of women's rights, including the right to life.

The Supreme Court in its consideration of the constitutionality of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act of 1995 (“Information Act”) t²⁸ held that nothing in the Act precludes a doctor from communicating with another doctor who is to perform a termination with regard to the woman's state of health, the effect of the pregnancy on her health and the consequences if the pregnancy continues.²⁹

Yet, in the IFPA's experience, in cases where a woman's medical history gives rise to concerns, it is not the norm for a doctor or health institution to proactively communicate with the doctor who is to carry out the termination (although this does occur in some cases). Unlike any other medical treatment situation, the continuum of care is broken: the onus shifts to the woman to seek care outside Ireland; her doctor is then deprived of the option of discussing her case with the treating doctor involved in her antenatal care prior to the abortion.

In these circumstances, the burden of accessing abortion services to preserve her health is placed on the woman rather than the health care system. Women who end a pregnancy for medical reasons must leave the mainstream health care service. They must make their own way to a private medical facility in another country without the protection of the protocols that apply in other situations where people travel for health care. While some doctors make *ad hoc* arrangements, the IFPA is aware of women who have travelled without medical files detailing their medical history or without proper referral by their doctor.

4.5 Barriers to the Exercise of the Right to Travel (Articles 6, 7)

As stated above, women in Ireland rely on the provision of abortion services in other states, in particular the UK, for the ability to exercise their constitutionally guaranteed right to travel to access such services. In *A, B and C v Ireland*, although the ECtHR applied a wide margin of appreciation and did not find a violation of the rights under the European Convention on Human Rights of Applicants A and B, who travelled for abortion in circumstances where abortion is criminalised in Ireland, the Court found that the need to travel involved an interference with their right to privacy.³⁰

In 1999, the CEDAW stated that the need for pregnant women to travel abroad for abortion “creates hardship for vulnerable groups, such as female asylum seekers who cannot leave the territory of the State”.³¹ The CEDAW has also held, in *Alyne da Silva v Brazil*³², that governments have a human rights obligation to guarantee that all women in their countries—regardless of income or racial background—have access to timely, non-discriminatory, and appropriate maternal health services. In its 2011 Concluding Observations on Ireland’s Initial Report, the Committee Against Torture highlighted that Irish law results in “serious consequences in individual cases, especially affecting minors, migrant women, and women living in poverty”.³³

The costs of travelling for abortion are significant. The minimum direct cost of travelling to the UK for a first trimester abortion is €1000. This includes clinic fees of €500-€600, flights and accommodation. This does not include indirect costs such as child care and loss of income. Clinics fees rise significantly when procedures are carried out at later gestational periods.

The costs of travelling are higher for women who are subject to travel restrictions and visa requirements, including women asylum seekers and other migrant women. Fees for visas to the country where the abortion provider is located, re-entry visa to Ireland, and temporary travel documents where required can add between €120 and €240 to the cost of accessing abortion.³⁴ Women who require visas and travel documents must also gather extensive supporting documentation and attend the relevant embassies and the Department of Justice and Equality in person.³⁵ These requirements can take a considerable amount of time to fulfil and, for women living outside the capital, can involve significant additional expense and time.

The women most likely to be delayed in exercising the right to travel and consequently those who incur the greatest expense are women asylum seekers.³⁶ The weekly allowance paid to asylum seekers is €19.10.³⁷ Furthermore, for women living in reception centres—the State’s institutional living arrangement for asylum seekers—the process of organising to travel for abortion may involve multiple disclosures of their private situation in order to obtain information and financial support and to acquire documents allowing them to travel. Women may not be aware of the fact that they can obtain temporary travel documents to allow them to leave and re-enter Ireland. Language barriers and other cultural factors may prevent women from accessing supports and information.

For many women, the need to raise funds to cover fees for a health service denied within the state and to travel to avail of such a service elsewhere means that they experience significant delay in accessing services. The IFPA is aware of situations where the time involved in organising the journey to have an abortion has resulted in a delay of 8 to 12 weeks in exercising the right to travel.

Research shows that restrictive abortion provisions cause significant hardship, they do not deter women from seeking abortion.³⁸ However, restrictions that increase the financial burden on women take a significant emotional and financial toll, delay access to the procedure, or, in the most difficult cases, leave them with no option but to parent in spite of their wish to end a pregnancy.³⁹ Such restrictions inevitably have discriminatory impacts on women on low incomes or women living in poverty who have most difficulty in accessing the financial means to avail of services in another state.

The exercise of the right to travel to avail of services in another country is a real option, therefore, only for women who have or can access the financial means to do so and who are able to exercise their right to travel. Some women decide that they have no real option but to continue with the pregnancy. The IFPA knows from our services that some women, for financial reasons or for reasons related to their residency status and/or the practicalities of organising a journey outside Ireland, find these obstacles insurmountable and are forced to continue with an unwanted pregnancy or resort to illegal and unsafe methods of abortion, creating a risk to their health and wellbeing.

In *Alyne da Silva v Brazil*, the CEDAW found a violation of human rights in circumstances where multiple and intersecting aspects of disadvantage and discrimination were at issue. The CEDAW held that discrimination based on sex and gender is inextricably linked to other factors, including pregnancy, general health status, ethnic minority status and socio-economic status.⁴⁰ This focus on vulnerable populations within a state is of particular relevance to the situation of women asylum seekers in Ireland, who experience the barriers outlined above in exercising their right to travel to avail of services that only women require.

4.4 Restrictions on the Right to Information (Articles 7, 17, 19)

According to the World Health Organisation, every pregnant woman considering a termination should receive adequate information in order to make a choice about abortion and its risks.⁴¹ In Ireland the right to receive information about abortion is enshrined in the Constitution. However, the Information Act restricts the content and form of information that may be given to pregnant women about abortion.⁴² Any such information must be given in the context of a face-to-face counselling session or in person by a medical provider and may not be “accompanied by any advocacy or promotion of, the termination of pregnancy.”⁴³ Agencies, doctors and counsellors are also prohibited from making arrangements on behalf of their clients for an abortion abroad.⁴⁴

In *L.M.R. v. Argentina*, the Committee recognised that the right to privacy includes the right to make decisions about one’s life without interference from the state.⁴⁵ The restrictive provisions of the Information Act undermine a woman’s right to make personal, autonomous decisions about her reproductive health. 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.⁴⁶

4.3 Fatal Foetal Anomalies

The IFPA knows from our services that as foetal anomalies are not usually detected until the later stages of a pregnancy, they involve particularly severe emotional and physical hardship. The hardship is exacerbated by the abrupt cessation of care by the health service of women who chose to end a pregnancy and find that they cannot by law do so within the State. Some clients of the IFPA who have received a diagnosis of serious foetal anomaly during a pregnancy have reported subsequent refusal by the health service to provide them with genetic testing. Abortion in such cases involves longer and more complex medical treatment than in cases of earlier abortion. Treatment which can last 4-5 days involves higher costs; these costs are not reimbursed by the State.

It is not clear whether abortion in cases of fatal foetal anomaly may be permitted under the Constitution; the question has never been tested by the courts. However, the Irish State argued before the ECtHR in 2006 in *D v Ireland*⁴⁷ that there was “at least a tenable argument” that the right to life is not actually engaged in the case of a foetus that has no prospect of life outside the womb and that such a foetus may not be considered “unborn” for the purposes of Article 40.3.3. The ECtHR accepted that there was a possibility that the Irish Supreme Court could rule that termination of pregnancy could take place lawfully in the State in these circumstances.

A number of senior government ministers have indicated support for measures to broaden access to abortion in certain circumstances. In July 2013 the Minister for Justice, Equality and Defence stated:

“I personally believe it is a great cruelty that our law creates a barrier to a woman in circumstances where she has a fatal foetal abnormality being able to have a pregnancy terminated, and that according to Irish law any woman in those circumstances is required to carry a child to full term knowing it has no real prospect of any nature of survival following birth”.⁴⁸

The Minister further stated that it was also an “unacceptable cruelty” that abortion was not available to rape victims unless there was a risk to their life.⁴⁹

4.6 The harm of Abortion Stigma

Stigma, understood as a mark of disgrace or discredit, has permeated attitudes towards recipients of sexual and reproductive health services; the clearest instance being in the case of abortion, which is highly stigmatised even in countries where it is legal. Stigma is linked to stereotyping and is invariably negative.⁵⁰ Speaking at a seminar organised by the IFPA in December 2013, Professor Rebecca Cook has described the stigma of criminalisation of abortion as a wrong in and of itself because “it destroys women and affects the hearts and minds in ways unlikely ever to be undone”.⁵¹ The European Court of Human Rights recognised in the case of *A, B and C v Ireland* that all women who travel for abortion experience stigma and endure physical, financial and psychological hardship:

“The Court considers it reasonable to find that each applicant felt the weight of a considerable stigma prior to, during and after their abortions....Moreover, obtaining an abortion abroad, rather than in the security of their own country and medical system,

undoubtedly constituted a significant source of added anxiety. The Court considers it evident that travelling abroad for an abortion constituted a significant psychological burden on each applicant.”⁵²

State disapproval of abortion pervades the law and is reflected in policies regarding tax, social welfare and private health insurance. The entire burden including the financial burden, of accessing abortion in another state falls on women. The law therefore, and much of the public discourse in relation to abortion in Ireland, constructs abortion as criminal, undesirable and contrary to the public good. The ban on abortion, in conjunction with the equal constitutional right to life of the unborn with a woman, impedes understanding of abortion as a regular medical procedure while, at the same time, fosters stereotypical notions of motherhood as the natural and only role of women and as the only option that pregnant women may want to follow.

Access to information about abortion services is framed in law as a conditional right and the information itself treated as odious and hazardous. The right to information is not treated as a positive right the realisation of which is in the public good and requires action by the state to remove barriers to its exercise. Rather, the Information Act is the statutory framework for a system of strict state control governing the manner in which information must be given. The specific provisions of the Information Act combine with the stigma surrounding abortion in Ireland have a significant chilling effect on the provision of information by health care professionals.

The IFPA knows from our clients that the criminalisation of abortion in virtually all circumstances, the restrictions on the provision of information in relation to abortion and the need to travel to avail of services increases this stigma significantly. Criminal laws do not deter women from seeking abortion, but they do contribute to the stigma against these women and constitute a significant harm. The IFPA knows from our services that the psychological hardship associated with denial of abortion services is considerable. For some women, the most difficult aspect can be the abdication of responsibility by the health service and the way this makes women and their partners feel stigmatised, “like criminals” or “like a displaced person”.

For many women, the financial, physical and emotional burdens of travelling for a termination are exacerbated by the often clandestine and secretive nature of the journey. Where women do not disclose their situation to friends and family, the sense of isolation and secrecy adds to the burden and deprives them of the support networks that they would otherwise have.

Many women who attend the IFPA for post-abortion services express outrage and disbelief that a modern health care system, whose medical personnel are highly regarded as experts at the cutting edge of their practice and which makes repeated claims about the excellence of maternity care, cannot act in their patients’ best interests and provide medical treatment that is available in other highly developed countries.

Many women feel anger at the experience of being expelled and exiled from a health service they trust—and pay for through taxes—yet which obliges them to organise and pay for health care in another country.

5. The Protection of Life During Pregnancy Act 2013 (Articles 2, 3, 6, 7)

The Human Rights Committee’s General Comment 6 interprets Article 6 of the ICCPR, which guarantees the right to life, as requiring measures to protect women from unnecessary losses of life related to pregnancy and childbirth.⁵³ However, as a provider of medical services, the IFPA

is of the view that the legislation does not place sufficient emphasis on the State's duty of care and requirement of due diligence to ensure practical and effective exercise of a constitutional right.

5.1. Access to an Effective Remedy / Lack of Clinical Guidelines

The IFPA knows from our services that pregnant women who are concerned about a possible risk to life tend to present at a primary care setting before the risk becomes imminent. The 2013 Act omits a clear referral and treatment pathway for a woman or girl seeking access to the procedure through which a certification that her case falls under the Act is made or refused. The legislation further omits safeguards to ensure that a woman will not experience undue delays in referral for examination by a medical practitioner at an appropriate location in circumstances where she is unclear whether a risk to her life exists and/or where she is not under the care of a doctor.

In its response to the list of issues, the Government stated that a guidance document to assist health professionals in the implementation of the Act and to identify referral pathways was in preparation and would be finalised in early 2014.⁵⁴ Although an Implementation Committee was appointed in August 2013 to draw up clinical guidelines on how the legislation would work in practice,⁵⁵ no clinical guidelines have yet been published. Medical professional bodies, including the Irish College of General Practitioners and the Irish College of Psychiatrists, have expressed concern at the commencement of the Act in the absence of clinical guidelines.⁵⁶

Questions also arise regarding access to an effective remedy in cases of women and girls in whose cases access to medical practitioners may be in doubt and/or the making of an application in writing may pose difficulties, e.g. women or girls from lower socio-economic backgrounds or geographic areas with limited access to or lack of choice regarding health care, women or girls of ethnic minority backgrounds, including asylum seekers and refugees, or women or girls who are functionally illiterate or who have intellectual disabilities.⁵⁷

5.2. Onerous Requirements

Where a woman seeks treatment under the Act on the grounds of a risk to her life arising from her physical health, she must be examined by two medical professionals. Where a woman seeks treatment under section 9 of the legislation on the grounds that the risk to her life arises from a risk of suicide, the requirements of the Act for certification are *more onerous* than in the case of physical risk to life. The pregnant woman must be examined by three rather than two specialists (two psychiatrists and an obstetrician).

If a woman is refused certification and subsequently appeals, she will be subjected to examination by a further *two* medical professionals in the case of physical health risk and by *three* medical professionals in the case of suicide risk: two psychiatrists and an obstetrician. Such a requirement will inevitably increase the mental anguish and suffering of a vulnerable person.

5.3. Review Procedures

Where a woman is refused certification that she is entitled to an abortion under the Act, she is entitled to apply for the decision to be reviewed. Under the Act, it is the responsibility of the Health Service Executive to establish and maintain the panels, and to request nominations for candidates from medical bodies.⁵⁸ However, the College of Psychiatrists has declined to participate in the nomination procedure until the clinical guidelines regarding the operation of the Act have been published, citing concerns as to how a pregnant woman with suicidal thoughts, and the doctors caring for her, will access psychiatric first and second opinions and, where necessary, a review panel. The College also expressed concerns about situations where concerns

might arise regarding the ideological stance on abortion of particular psychiatrist and its impact on a woman's access to lawful treatment.⁵⁹

5.4. Conscientious Objection

The legislation provides for the exercise of conscientious objection by a medical practitioner. The Act places an obligation on such a practitioner to ensure the transfer of the pregnant woman's care. However, the Act does not place an explicit obligation on hospitals to ensure that women can receive life-saving treatment under the Act. In this context, the insufficiently robust provisions of the Act, and the omission of sanctions in the case of refusal of care, may act as a barrier to access to lawful care in cases where a woman's life is at risk.

5.5. Reporting Requirements and the Chilling effect

The 2013 Act requires that an annual report be submitted by the Health Services Executive on the operation of the review process⁶⁰ and be laid before each House of the Oireachtas (parliament).⁶¹ All abortions carried out under the Act must be notified to the Minister for Health⁶² and such notification must include the Medical Council Registration number of a doctor⁶³ who carries a termination under the legislation and the name of the institution where it was carried out.⁶⁴ The Act includes ministerial powers to suspend abortion services, other than in emergency cases, if she or he believes that there is a serious risk of failure to comply with the 2013 Act.⁶⁵

Taken together, these provisions represent an unprecedented and unwarranted degree of ministerial and parliamentary scrutiny of an aspect of health care. No other medical procedure is the subject of a report which is laid before parliament. While the chilling effect is usually used to describe the impact of criminal laws on the provision of lawful services, it is the view of the IFPA that these provisions will similarly act to prevent the provision of lawful abortion services.

Recommendations

The IFPA respectfully invites the Committee to make the following recommendations to the State:

- **Urge Ireland in the strongest possible terms to bring its laws into conformity with the ICCPR.**
- **Amend the Protection of Life During Pregnancy Act in order to decriminalise abortion for both women and health care providers and to remove excessive legal barriers to access to abortion where it is lawful.**
- **Repeal the Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act, 1995.**
- **Revise the law by providing for lawful abortion, at a minimum, in cases of rape, incest or fatal foetal anomaly.**
- **Initiate a referendum to remove from the Constitution the clause that equates the right to life of the foetus with that of a pregnant woman, in order to bring Ireland's laws into conformity with the Covenant.**

References

- ¹ Concluding Observations of the Human Rights Committee (HRC), 93rd session, 30 July 2008, CCPR/C/IRL/CO/3 at para 13.
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- ¹⁷ In its General Comment 28, the Committee states that information on the availability of safe abortion to women who have become pregnant as a result of rape is required for assessment of compliance with Article 7. HRC Gen Comment No 28: Equality of rights between men and women (article 3), UN Doc CCPR/C/21/Rev.1/Add.10 (2000).
- ¹⁸ In the 2005 *K.L. v Peru* case, the Committee held that the physical and psychological harm arising from forcing a pregnant girl to carry a pregnancy to term despite a diagnosis of anencephaly (a foetal complication incompatible with life) amounted to a violation of Article 7.
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