Submission in relation to the review by the Committee on Economic, Social and Cultural Rights

of Ireland's compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR)

55th Session of the Committee, 1-19 June 2015

I. Reporting Organisation

The Women's Human Rights Alliance (WHRA) was established in 2001 as a coalition of human rights and women's organisations promoting a human rights approach to the advancement of women's equality in Ireland and internationally. The purpose of the Alliance is to promote women's human rights, monitor the implementation of international commitments as they relate to women, raise awareness of economic, social and cultural rights and to develop the capacity of women's organisations to engage in women's human rights advocacy.[1]

In 2009 – 2010 the WHRA conducted a country-wide consultation on the right to health which were held as part of the WHRA shadow report of the Government's implementation of the ICSECR. Thirteen workshops were held with women in rural areas, women in disadvantaged communities, women living in poverty, Traveller women, Roma women, refugee and asylum seeking women, women with disabilities, LGBT women, and older women. From these conversations, detailed recommendations on women's right to health in Ireland were derived.

In the course of these consultations, an overwhelming number of women felt that they did not have full access to the right to health. Some regularly recurring issues related to sexual and reproductive health, access to services, and issues relating to care work. The underlying issue relating to all of these specific problems is the urgent need for a much greater degree of gender sensitivity across healthcare provision in Ireland.[2] This submission draws on these

[1] Members of the Women's Human Rights Alliance include: National Women's Council of Ireland (convenor), Akidwa, Cairde, Irish Family Planning Association, Immigrant Council of Ireland, Migrant Rights Centre Ireland, National Collective of Community Women's Networks, Women's Aid, Dublin Rape Crisis Centre, Irish Feminist Network, Justice for Magdalenes, Pavee Point Traveller and Roma Centre and Ruhama. This submission is endorsed by a broad range of non-governmental organisations and civil society groups. All the views expressed in the report do not necessarily reflect the policies and positions of each endorsing organisation.

[2] Dr. Jane Pillinger presentation to the WHRA conference on consultations held on right to health December 2012. Available at http://www.nwci.ie/download/pdf/jane_pillinger_presentation.pdf

consultations and respectfully asks the Committee to recommend policy and legislative changes to the Irish Government to ensure that all women in Ireland can fully realise the right to health.

2. Summary of Issues

National Women's Strategy - Importance of Gender Sensitive Healthcare
In the National Women's Strategy 2007-2016 the Irish government made a firm commitment to gender mainstreaming in health, to integrate a gender dimension into Irish health care policy planning and service delivery. Irish healthcare systems, policies, strategies and services are gender blind and this commitment was made in an effort to address this deficiency. For example the current mental health strategy *A Vision for Change* is gender blind, failing to recognise gender differentials in presentation and treatment for illness.

Gender is a key determinant of health. There is a necessity of taking both biological and socio-cultural aspects of women's experiences into account in devising a gender-sensitive approach to healthcare. This approach should take stock of the services which are most important to women, including services relating to sexual and reproductive health, childcare, and services addressing abuse and domestic violence. These are women's priority areas, yet in the WHRA consultations, they were often listed by women as the areas in which their rights are most undermined.

In 2010 the Health Service Executive (HSE) and the National Women's Council of Ireland (NWCI) initiated a gender mainstreaming project to devise a framework for applying a much needed gender lens to the health system. This work culminated in the launch of Equal but Different: A Framework for Integrating Gender Equality into HSE Policy, Planning and Service Delivery in November 2012.[3] This document sets out the steps needed to ensure a gender sensitive healthcare system. Since that date there has been slow progress towards implementation of the recommendations in the framework in particular the translation of the framework to a specific policy objective and key performance indicator in each service plan of the HSE. Without this step the State will not succeed in creating a gender sensitive health system and not meet the needs of women in the health system.

There has been a failure by the State to integrate gender or human rights principles into the healthcare system, or to meaningfully consider health's social determinants. Restructuring the healthcare system requires a broad analysis of society and economics and this must include contemplation of the various ways in which women experience inequalities in their lives. This should look at gender equality across the diverse areas of family life, in the workplace, in relation to poverty, housing, training, community participation, and participation in public life. It is important to consider social determinants in relation to Traveller and Roma women, asylum seeking women, and women living in poverty, whose access to health is consistently impacted by factors such as discrimination and availability of facilities.[4]

A human rights approach to health has the objective of increasing accountability of governments for health; this also means that governments do not impose retrogressive measures and cut backs and provide minimum standards that are essential to the enjoyment of health.

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[3] HSE / NWCI: Equal but Different: A Framework for Integrating Gender Equality into Health Service Executive Policy Planning and Service Delivery. (2012) available at https://www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

[4] Dr. Jane Pillinger presentation to the WHRA conference on consultations held on right to health December 2012. Available at http://www.nwci.ie/download/pdf/jane_pillinger_presentation.pdf

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Translate the gender mainstreaming framework as developed by the Health Service Executive into a policy objective and key performance indicator in each HSE service area to ensure that health policy practice and service delivery is responsive to the needs of all women in Ireland**
- **All government policies should be assessed for impact on key areas of women's lives – in other words a gender impact assessment – on the multiple and complex inequalities experienced by women.**
- **A gender based approach and gender impact assessment should be integral to all health policy decision making and planning and the outcomes should be acted upon.**
- **All policy actions impacting on the right to health must give voice to women's concerns and priorities; their participation is imperative.**
- **A rights-based approach should underpin all approaches to policy development, service delivery and planning.**

The Irish Constitution and the Right to Health

A human rights approach to health has the objective of increasing accountability of Government, and requires that they do not impose retrogressive measures affecting the right to health. The right to health should be enshrined into law, and the Constitutional Convention examined this in great detail.[5] The Constitutional Convention recommended the enhanced constitutional protection of economic, social and cultural rights; to be realised progressively, subject to maximum available resources and to be justiciable. The Convention further recommended that specific additional rights should be enumerated in the Constitution (housing, social security, essential health care, language and cultural rights and the right of people with disabilities).[6]

We respectfully suggest that the Committee make the following recommendations to the State:

- **Ireland should take concrete steps to implement the recommendations issued by the Constitutional Convention to enumerate the right to health and other socio-economic rights in the Irish Constitution.**

Sexual and Reproductive Health (Article 12, in conjunction with Articles 2 and 3)

Restrictive laws on abortion

Ireland has one of the most restrictive and punitive abortion regimes in Europe. Abortion is lawful only to save a woman's life, as distinct from her health, and in making a decision about life-saving and other treatment in pregnancy, doctors must have "due regard" to the right to life of the "unborn", which is guaranteed by Constitution article 40.3.3.

The Protection of Life During Pregnancy Act 2013[7], enacted on foot of the judgment of the European Court of Human Rights (ECtHR) in the case of A, B and C v Ireland[8], does not

[5] The Constitutional Convention was an initiative of the State to consider and make recommendations on certain topics as possible future amendments to the Constitution. It was a forum of 100 people, representative of Irish society and parliamentarians from the island of Ireland. www.constitution.ie

[6] Final report of the Constitutional Convention March 2014 www.constitution.ie

[7] Houses of the Oireachtas. Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. http://www.oireachtas.ie/documents/bills28/acts/2013/a3513.pdf.
Accessed April 13, 2015.

alter this position. The Act addresses only the situation of women in whose case pregnancy poses a serious risk to life: it does not change the absolute prohibition on abortion in all other cases, including where there is risk to a woman's physical or mental, where the pregnancy is the result of a crime or where there is serious foetal anomaly. The retention of harsh criminal sanctions in the new legislation, in combination with a high level of political scrutiny of hospitals in which procedures under the legislation may take place, will reinforce, rather than alleviate the chilling factor which was identified by the European Court of Human Rights in the A, B and C v Ireland case. The 2014 Guidance Document[9] for medical practitioners on the implementation of the Act makes no reference to the woman's rights to health, bodily integrity and autonomy, and includes language that is more restrictive than the Act itself.[10] The legislation and guidelines regulating access to lawful abortion in such limited cases fall far short of international human rights bodies' recommendations: they fail to deliver effective procedural rights to all of the women eligible for lawful abortion within the state and create new legal barriers to women's reproductive rights. [11]

It is noteworthy that a Minister for Justice, Equality and Defence has used the term "great cruelty"[12] in relation to the situation the current abortion regime creates for women in cases of rape and fatal foetal abnormality.

Irish law guarantees women the right to travel to access abortion in another state, however, the exercise of this right places undue financial, physical and psychological hardship on women and girls. WHRA is of the view that in many cases in particular those involving minors, undocumented women, migrant women, women living in poverty and women who choose termination because of medically indicated reasons, the burdens imposed on women by the requirement to travel to terminate a pregnancy reach the threshold of cruel, inhuman and degrading treatment.[13]

WHRA is of the view that in many cases in particular those involving minors, undocumented women, migrant women, women living in poverty and women who choose termination because of medically indicated reasons, the burdens imposed on women by the requirement to travel to terminate a pregnancy impose unacceptable limits on women's access to the highest attainable standard of reproductive health, and discriminate against women in denying health services that only women need and placing the entire burden of accessing abortion services on women.

WHRA respectfully suggests that the Committee urge the government to:

- **Decriminalize abortion and amend its laws to guarantee, at a minimum, women's entitlement to an abortion in Ireland in case of risks to her physical and mental health, where a pregnancy results from sexual assault, or when it is affected by a fatal fetal impairment.**
- **Repeal the Protection of Life During Pregnancy Act 2013.**
- **Revise the Irish Constitution to remove Article 40.3.3.**

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[8] European Court of Human Rights. A, B and C v Ireland (Application no. 25579/05). http://www.bailii.org/eu/cases/ECHR/2010/2032.html. Published December 16, 2010. Accessed April 13, 2015.

[9] Department of Health. Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals. http://health.gov.ie/wpcontent/ uploads/2014/09/Guidance-Document-Final-September-2014.pdf. Published September 2014. Accessed April 13, 2015.

[10] Taylor M, Women's right to health and Ireland's abortion laws, Int J Gynecol Obstet (2015), http://dx.doi.org/10.1016/j.ijgo.2015.04.020

[11] Taylor M, Women's right to health and Ireland's abortion laws, Int J Gynecol Obstet (2015), http://dx.doi.org/10.1016/j.ijgo.2015.04.020

[12] Mac Cormaic R. Shatter describes abortion restrictions as 'a great cruelty'. http://www.irishtimes.com/news/ireland/irish-news/shatter-describes-abortion-restrictions-asa-great-cruelty-1.1473673. Published July 24, 2013. Accessed April 13, 2015

[13] Irish Family Planning Association. IFPA annual report 2013. http://www.ifpa.ie/sites/default/files/documents/annual-reports/ifpa_annual_report_2013.pdf. Accessed April 13, 2015.

Violence Against Women

During the WHRA consultations violence against women emerged as a significant problem for the health of women from a range of backgrounds. There are multiple stakeholders in responses to violence against women and there has been progress by the HSE in developing policy and planned responses to the issue. Despite this, it remains a grossly under-resourced area. Women in the consultations felt that the State had failed to respond to the problem, and that this constituted a violation of their human rights. The women noticed a lack of preventive measures and provisions for the safety of women in violent situations.[14]

WHRA note that the Committee for the International Covenant on Civil and Political Rights (ICCPR) in 2014 expressed concern that domestic and sexual violence against women remains a serious problem and recommended that Ireland should take further legislative and policy measures to ensure that all women, particularly women from vulnerable and marginalized groups have equal access to protection against perpetrators of violence.[15]

A recent European survey on violence against women had found that in Ireland 14% of women have experienced physical violence by a partner (current or ex), 6% of women have experienced sexual violence by a partner (current or ex) and 31% have experienced psychological violence by a partner (current or ex). The same survey found that in Europe, 73% of women who have experienced physical or sexual violence from a current or a previous partner indicate that their children have become aware of the violence.[16] This violence has a significant and devastating impact on the physical and mental wellbeing of women in Ireland. [17]

NGOs providing services to women experiencing domestic and sexual violence are witnessing an unprecedented growth in demand for their services. Rape Crisis Centres have seen a relentless year on year increase in demand for their services. In 2014 the Dublin Rape Crisis Centre (DRCC)'s National 24 hour helpline took a total of 12,059 counselling contacts. There was a dramatic increase of 30% in first time contacts compared to 2013.There was an increase of 14% in the number of calls specifically relating to adult rape.[18]

In relation to domestic violence in 2013, 46,137 helpline calls were answered and 8,033 individual women and 3,424 individual children received support from domestic violence support services.[19] Demand on services has greatly increased. For example the number of women receiving support from a domestic violence service has increased by over 36% from 2008 to 2012. Over the same time period core HSE funding to services has been cut by 14% in total, with some services being cut as much as 37%.[20]

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[14] Dr. Jane Pillinger presentation to the WHRA conference on consultations held on right to health December 2012. Available at http://www.nwci.ie/download/pdf/jane_pillinger_presentation.pdf

[15] Human Rights Committee: Concluding Observations on the fourth periodic report of Ireland July 2014.

[16] European Union Agency for Fundamental Rights (FRA), 2014: Violence against women: An EU wide survey main results page 134. Data not available by country.

[17] Safe Ireland: Safety in a time of crisis 2014 www.safeireland.ie

[18] Dublin Rape Crisis Centre (DRCC): Annual Statistics for 2014.

[19] Safe Ireland Domestic Violence National Statistics 2013. www.safeireland.ie

[20] Safe Ireland: Safety in a time of Crisis 2014. www.safeireland.ie. Please note that domestic and sexual abuse services were previously funded by HSE but now come under the remit of TUSLA, the Child and Family Support Agency.

Services for violence against women have been chronically underfunded for years. This situation has reached crisis point as there have been additional cuts to funding since the recession began in 2008. More and more women are not being accommodated in refuges or are on waiting lists for support services.[21] Services have been forced to cut positions, programmes or hours of operation. Further cuts to domestic violence services are planned by TUSLA Child and Family Agency for 2015.

Refuge provision remains inadequate and many women and children are unable to access refuge accommodation each year. In 2013, 3,494 requests for refuge could not be met because the refuge was full.[22] The Council of Europe recommends that there should be a target by member states of at least 1 refuge place per 10,000 of population and Ireland seriously lags behind this modest target.[23]

Habitual Residence Condition
WHRA would also like to highlight the particular needs of marginalized women such as migrant women, women seeking asylum, women survivors of trafficking from EEA countries and Traveller and Roma women. The requirement to satisfy the Habitual Residence Condition (HRC) can have particular gender implications.[24] All applicants applying for social protection are required to meet the HRC, including Irish and EU citizens. Application of the HRC has placed migrants, Travellers (who move across jurisdictions, generally from the UK to Ireland) and Roma in Ireland (and indeed returning Irish immigrants) in very vulnerable positions, whereby they cannot access any support services. In relation to victims of human trafficking, due to the HRC, they cannot be housed in appropriate shelters but are housed in asylum reception centres which are inappropriate. In other jurisdictions, for example Northern Ireland, survivors of trafficking are housed in shelters specifically for them.

The HRC has a particular negative impact upon women experiencing violence and their children. For women trying to leave a situation of violence, if they do not have access to financial resources from the State, it can impact on their ability to successfully leave a violent relationship long term and it also impacts on their ability to access a refuge because a woman generally has to be in receipt of social welfare to access a refuge beyond an emergency period. Ireland must ensure that women experiencing violence are not subject to the HRC when trying to access safety in a domestic violence situation.

There also needs to be formal recognition of domestic violence in immigration law by making provisions which enable migrants who experience domestic violence to apply for independent residence permits. While WHRA acknowledge that the Irish Naturalisation and Immigration Service (INIS) has developed useful guidelines in relation to survivors of domestic violence, these need to be placed on a statutory basis. Pending determination of

[21] Safe Ireland: lifelines to Safety: A National Study of Support Needs and Outcomes for Women Accessing Domestic Violence Services in Ireland. July 2011. www.safeireland.ie
[22] Safe Ireland: Safety in a Time of Crisis 2014 www.safeireland.ie
[23] Safe Ireland report that Ireland is ranked 24th in Europe, only meeting one third of the minimum standards for refuge provision, translating to 141 family places for women and children.
[24] Habitual Residence is a condition which applicants must satisfy in order to qualify for certain social welfare assistance payments, including child benefit. Habitual residence essentially means an applicant must be able to prove a close link to Ireland.

applications to remain in Ireland, victims of domestic violence must be able to access safe emergency housing and essential welfare benefits to meet basic needs.[25]

The Human Rights Committee in 2014 as part of Ireland's examination under ICCPR expressed concern at the existence of administrative and financial obstacles for marginalized women to access essential support services especially women whose immigration status is dependent on her spouse / partner or who does not meet the criteria of HRC.

Legislation on Domestic Violence

WHRA acknowledge the positive changes made to the domestic violence legislation in 2011 and the government commitment to continue to review the legislation and to introduce a Domestic Violence Bill by the end of 2015. While this Bill has not as yet been published, the WHRA calls for the Bill to ensure greater accessibility to legal protection and centre-staging of all victim's needs and rights. The law on domestic violence must be updated to deal with the realities of the many different types and forms of relationships in Ireland today. Despite the extension of eligibility for orders in the Civil Law (Miscellaneous Provisions) Act 2011, the law still does not provide for women in dating relationships. WHRA submit that Safety Orders must be available to all parties who are or have been in an intimate relationship.[26]

WHRA has concern with the restricted eligibility for barring orders for unmarried cohabitants. Requirements related to the duration of the relationship and a property test requirement whereby the applicant must show an equal or greater legal or beneficial interest in the property can create huge problems for women seeking to obtain a barring order. As the legislation currently stands, children are not taken into account when making considerations regarding property interests. The Irish government must explore the possibility of removing the property test, in particular in cases where it conflicts with the best interest of the children of the family, or when the safety and welfare of the child should override property rights.

A further gap in the current legislation is the lack of emergency barring orders to provide immediate protection during out-of-hours times. There is a clear need for orders to be available outside of traditional Court hours, so that victims of domestic violence do not find themselves without protection for extended periods of time. Such an emergency order would last until the next sitting day in the nearest Court. [27]

Women experiencing domestic violence are often controlled, followed, harassed and stalked by their abusers both during the relationship and after separation. Stalking often escalates after separation and is linked to the abuser wanting to continue to control the victim. Legislation dealing with harassment and stalking does not explicitly refer to a number of new technologies that are used to stalk and harass women, and the offence is difficult to prove in court.[28] A specific offence of stalking should be introduced in Irish law and stalking should be recognised as a ground to apply for a Safety Order, even in the absence of a criminal conviction. Cyber harassment also needs to be legislated for.

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[25] See Domestic Violence Coalition Submission to the Joint Oireachtas Committee May 2013. Available at www.womensaid.ie

[26] Domestic violence does occur in young/dating relationships. 190 women have been murdered in Republic of Ireland since 1996. 39 (21%) of these women were aged between 18 and 25 years. Of the 39 women aged 18-25, 30 cases have been resolved. Of the resolved cases, 16 women were killed by someone they were or had been in an intimate relationship with. Of these 16 women 10 were not living with their murderers. See Women's Aid Female Homicide Media Watch Statistics 1996-2013.

[27] Please note Article 52 of the Council of Europe Convention on Preventing and Combating Violence Against Women to bar the perpetrator of domestic violence from the home in situations of immediate danger

[28] Currently harassment is dealt with under Section 10 of the Non-Fatal Offences Against the Person Act 1997 but the definition in this Act is complex and hard to prove, according to Women's Aid.

Further legislative gaps exist in Family Law regarding the issue of Custody and Access when parents separate in the context of an abusive relationship. We are concerned that Custody, Access and Guardianship orders are often made that disregard the impact of domestic violence on children and the risk of continuing abuse to both children and their mothers. This is compounded by a lack of expert child welfare and safety assessment to support the Courts when making determinations regarding Custody and Access.

The recent Children and Family Relationships Act 2015 may partly address these concerns. WHRA welcome the inclusion of domestic violence as one of the criteria the Family Law Court is to consider when looking at the best interest of the child in Custody, Access and Guardianship and we will monitor how it works in practice. We also welcome the introduction of expert reports and of appointing experts to determine the child's views. It is imperative that proper training and support is provided to judges and to these experts if these provisions are to make a difference to women and children experiencing domestic violence and that supervised access centres are available throughout the country.

Women often decide to leave an abusive relationship when they realise the impact it has on their children or when they see that the abuser is also directly abusing the children. It is essential that when mothers leave an abusive relationship they are confident that the arrangements made in the Family Court do not jeopardise their own or their children safety and well being either at interim or final stage.

Adequate Data

WHRA notes that the baseline prevalence study on sexual violence, the Sexual Abuse and Violence in Ireland (SAVI) report was published in 2002 and, though it has since acted as a key informant of Irish policy in relation to sexual violence, it is considerably out of date. In order to develop clear comparative analysis, a SAVI II report is required to evaluate changes over the past decade and provide an evidence base to inform contemporary responses to the issue of sexual violence. There is also a clear need for more data on the nature and extent of domestic violence in Ireland in order to develop evidence based policy, plan service provision and identify gaps in services or discrimination. Notwithstanding the work of COSC and its data committee, there is still no data publicly available regarding domestic violence offences and prosecutions. Data should be disaggregated by gender and ethnicity. The Human Rights Committee in 2014 at the examination of Ireland's report under ICCPR expressed concern at the lack of a comprehensive data collection system on violence against women and asked that in the next periodic report Ireland provide statistics on the situation.

We respectfully suggest that the Committee make the following recommendations to the State:

- **Sign the Council of Europe Convention on preventing and combating violence against women and domestic violence as a matter of urgency and then work towards its expeditious ratification.**
- **Protect domestic and sexual violence support services from further cuts Increase funding to front-line services by 10% to offset budget cuts in recent years**

- **Ensure access to safe, emergency accommodation for women experiencing male violence, a target of at least 1 refuge place per 10,000 of population should be agreed and resources ring fenced to make progress towards that target.**

- **Amend the Habitual Residence Condition to make an exception in cases of domestic violence and survivors of human trafficking so that women can have ease of access to welfare and social housing supports including refuge support**

- **Allocate resources to fund a SAVI 2 report in relation to establishing the nature and extent of sexual abuse and violence in Ireland and prioritize the work of COSC in relation to improving much needed domestic violence data.**

- **Amend the Domestic Violence Act 1996 to extend eligibility for Safety Orders to all parties who are or have been in an intimate relationship, regardless of cohabitation; investigate the possibility of removing, or amending, the determination of property interests in issuing barring orders in particular in cases where it conflicts with the best interests of the child/ren; include a provision in the Domestic Violence Act to allow Garda to apply for emergency orders to an on-call judge; introduce a specific offence of stalking that allows the Court to make a Non-Harassment/Restraining Order to protect the victim; include stalking in the guidelines as a ground for applying for a Safety Order.**

Female Genital Mutilation (FGM) and the Right to Health

Prevention and protection
An estimated 3,780 women and girls living in Ireland have experienced FGM,[29] and are therefore likely to have specific related healthcare needs: FGM health sequelae can include serious obstetric complications, sexual dysfunction and psychological trauma.[30]

Effective measures to combat FGM include prohibition, child protection, prevention and treatment. Since the production of Ireland's First National Action Plan to Address FGM by a coalition of NGOs in 2008, progress has been made in the *prohibition* and *treatment* of FGM. This progress includes the enactment of the Criminal Justice (Female Genital Mutilation) Act 2012,[31] and the funding by the Health Service Executive (HSE) of a specialist treatment service for women and girls who have undergone FGM. This service provides free comprehensive physical and psychological care to women affected, as well as referral for the de-infibulation procedure where required.[32]

[29] Akidwa & RCSI (2013). Female genital mutilation: Information for health-care professionals working in Ireland, 2ND Edition.
[30] IFPA (2014). Female genital mutilation: http://www.ifpa.ie/Hot-Topics/Female-Genital-Mutilation
[31] Criminal Justice (Female Genital Mutilation) Act 2012, available at http://www.irishstatutebook.ie/pdf/2012/en.act.2012.0011.pdf
[32] The cost of accessing this procedure privately is prohibitive, estimated to amount to approximately €5000. For more see Irish Family Planning Association, Free FGM Treatment Service: http://www.ifpa.ie/Sexual-Health-Services/FGM-Treatment-Service

Although there is currently reference to FGM in some guidelines for relevant professionals,[33] these do not provide adequate guidance on the identification of risk and appropriate referral pathways. This means that women are presenting to maternity hospitals, GPs and sexual health services nationwide where professionals are not aware of FGM or its health implications, particularly as they relate to childbirth or referral pathways including child protection pathways.[34]

Progress on child protection and prevention has been slow and hampered by the absence of a clear government strategy or action plan that would assign responsibility and resources and include processes of monitoring and accountability. An NGO-led steering group is in the process of developing recommendations towards a second National Action Plan. Government agencies, including the HSE and Tusla (the Child and Family Agency) are involved in the steering group. Government involvement in this process is positive, but insufficient to provide comprehensive cross-departmental coordination and implement the actions necessary to prevent FGM and protect girls who may be at risk.

Access and acceptability
FGM is part of a set of wider issues in healthcare provision for women from minority ethnic backgrounds in Ireland, particularly refugees and asylum seekers. A combination of factors, including lengthy stays in direct provision reception centres while asylum claims are processed, makes accessing services and information particularly difficult for these groups.[35]

Poor communication and language barriers are often reported by women seeking asylum and service providers as an obstacle to care. Lack of knowledge about FGM further exacerbates this problem for women affected. Such women may feel stigmatised in the healthcare system, and have significant difficulty accessing appropriate care for FGM sequelae, including timely access to the de-infibulation procedure. It is the view of the WHRA that this situation is not compatible with women's right to accessible and acceptable healthcare as outlined by the Committee in General Comment 14.

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Ensure that child protection, prevention and treatment of FGM are fully integrated into health policy, strategy and training, consistent with best international practice, including by developing a National Action Plan on FGM with extensive civil society consultation, that contains measurable time-bound targets and key performance-related indicators.**

[33] Tusla Child Protection and Welfare Practice handbook, p. 90-1, available at http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf; Practice standards for midwives, p. 14, available at http://www.nursingboard.ie/en/publications_current.aspx; Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland, p.84, available at http://www.icgp.ie/go/courses/women_s_health/programme_news/17E8DE25-A6A3-02CA-3DCDBB88C6767C80.html
[34] National Action Plan to Address FGM 2008-2012. Available at https://www.ifpa.ie/sites/default/files/documents/media/fgm_plan_of_action_report.pdf
[35] UNHCR (2014). Towards a new beginning: Refugee integration in Ireland. Available at: http://www.refworld.org/docid/52ca8a6d4.html

Symphysiotomy

Symphysiotomy is a childbirth operation that unhinges the pelvis, severing the symphysis joint or sundering the pubic bones. Ireland was the only developed country in the world to practice these childbirth procedures in the mid to late 20th century.

At least 1,500 of these 18th century operations were performed here from 1942 onwards, mostly in Catholic private hospitals. Around 200 women survive today, many of them permanently disabled, incontinent and in pain. Some babies died or were brain damaged, or otherwise injured during the process. These operations were illegal: doctors ignored their legal obligations to seek patient consent. Some women were operated upon without their knowledge or consent under general anaesthetic during pregnancy or even after the birth of a baby by Caesarean section.

The Human Rights Committee when looking at Ireland's compliance under International Covenant on Civil and Political Rights (ICCPR) in July 2014 expressed concern that Symphysiotomy was practiced in public and private hospitals between 1944 and 1987 without the free and informed consent of the women.

While noting the planned establishment of an ex-gratia scheme for the survivors of symphysiotomy, the Committee expressed concern at Ireland's failure to initiate a prompt and comprehensive independent investigation into the practice of symphysiotomy and identify, prosecute and punish, where still possible, the perpetrators for performing symphysiotomy without the woman's consent and to provide effective remedies to survivors of symphysiotomy for the damage sustained as a result of these operations.[36]

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Initiate a prompt, independent and thorough investigation into cases of symphysiotomy, prosecute and punish the perpetrators, including medical personnel and provide an effective remedy to the survivors of symphysiotomy for the damage sustained, including fair and adequate compensation and rehabilitation, on an individual basis.**
- **Facilitate access to judicial remedies by victims opting for the ex-gratia scheme, including allowing a challenge to the sums offered to them under the scheme.**

Impact of Cuts and Universal Social Insurance

During the WHRA consultations many women stated that the right to health was denied them because of the costs of healthcare. In particular women living in poverty spoke about their neglect of their own health care as they give priority to their children first and foremost. Many women recommended that improved access to health care can only be achieved by removing the two-tier health care system that exists at present and implementing a universal health care service. More services should be provided in the community, including maternity and mental health services.[37]

User fees are a major deterrent to the take up of community health services. A more equitable and effective system for funding should be based on direct taxation. Women attending the WHRA consultations favoured social insurance. This position is supported by

[36] Human Rights Committee: Concluding Observations on the fourth periodic report of Ireland July 2014.

[37] Dr. Jane Pillinger presentation to the WHRA conference on consultations held on right to health December 2012. Available at http://www.nwci.ie/download/pdf/jane_pillinger_presentation.pdf

international best practice research into the financing of health systems in OECD countries which demonstrates that taxes and social insurance schemes provide the most sustainable and equitable basis for health financing.[38] WHRA believe that universal access to primary care services is the best means to provide an accessible quality health care system, capable of meeting the needs of all citizens.

Since the consultations took place, the situation for women's health has worsened as a result of austerity, with more reports of ill health and greater inequality. The impact of cuts to frontline health services is particularly significant, as are cuts to family carers, and to Ireland's equality infrastructure. It is predicted that these cuts will lead to future exacerbation of the already-evident problems with women's access to the right to health.

In discussing the concepts of availability, accessibility, acceptability, and quality in healthcare during the consultations Ireland's two-tier health system was widely regarded as unfair, and as the cause of poor health outcomes. Longer waiting times for public patients and the poorer quality of the service particularly affects women because women are more likely to be poor, to parent alone and to be at a disadvantage. Waiting times for public patients remain excessive, despite some improvements in recent times. Additionally, the lengthy waiting times in community based services are significant, and these are not subject to the same controls as public hospital care under the new Special Delivery Unit in the Department of Health.[39]

User fees are a major deterrent to the uptake of community-based services; people who are just above the threshold for a medical card must pay between €60 and €80 to see a GP, or €100 to attend A&E. Women in the consultations said that this level of inaccessibility seriously compromised their right to health. Many cases of violations of women's right to healthcare have been reported by former Ombudsman Emily O'Reilly in recent years, showing the Department of Health and the HSE to be responsible for cases of neglect and inequality in the healthcare system, poor quality services, and deficits in accountability. Arbitrary and discriminatory decision making not only denies rights to women, but also serves to perpetuate a system that is ultimately more costly.

There have been significant problems with implementation of plans and strategies in healthcare in Ireland. For example Vision for Change mental health strategy of 2006 is an example of excessive delay. Careful to emphasise that the fault for these problems does not lie with healthcare staff, women in the consultations praised the kindness and understanding of staff, who worked to the best of their ability with limited time and resources. Many of these public healthcare workers receive low wages, with a significant proportion of care workers earning only minimum wage.[40]

Women in the WHRA consultations felt that their needs were not prioritised, their symptoms were often over-medicalised, and they were not always treated holistically. Over-prescription of medications particularly impacted poor and marginalised women, to whom alternative treatments such as counselling were not made available. Attitudinal barriers and health professionals' lack of understanding of women's health issues sometimes resulted in embedded assumptions determining diagnoses, including a variety of symptoms being attributed to the menopause, for example, even where this was not the case. Absence of

[38] P. Ostlin, WHO Regional Office for Europe's Health Evidence Network (2005): What evidence is there about the effects of health care reforms on gender equity, particularly in health?

[39] Dr. Jane Pillinger presentation to the WHRA conference on consultations held on right to health December 2012. Available at http://www.nwci.ie/download/pdf/jane_pillinger_presentation.pdf

[40] Ibid

community services, lack of information about available services, and biomedical determinism all caused significant problems for women in the consultations.

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Implement the commitment in the new Programme for Government 2011 to the creation of a universal single tier healthcare system from taxes and social insurance schemes as the best means to provide an accessible quality primary health care system, capable of meeting the needs of all women in Ireland.**

Traveller and Roma and the Right to Health

The All Ireland Traveller Health Study reported the following findings:

- Life expectancy at birth for male Travellers has remained at the 1987 level of 61.7 which is 15.1 years less than men in the general population, representing a widening of the gap by 5.2 years.
- Life expectancy at birth for female Travellers is 70.1 which is 11.5 years less than women in the general population.
- Traveller infant mortality is estimated at 14.1 per 1,000 live births. This is a small decrease from an estimated rate of 18.1 per 1,000 live births in 1987. Over the same time period the general population infant mortality rate has reduced from 7.4 to 3.9 per 1,000 live births.
- Travellers, in particular males, continue to have higher rates of mortality for all causes of death.
- Traveller suicide rates are seven times higher than in the general population.[41]

Despite this evidence, the government has failed to take concerted action to address the health inequalities that Travellers face and adopts a "mainstreaming approach", which ignores disparities in health outcomes. The Department of Health National Traveller Health Advisory Committee (which had Traveller organisation representatives), has been convened since October 2012, at a time when major reform is taking place within health services in Ireland with the establishment of new Health Directorates. Despite the evidence that Travellers experience the worst health status in Ireland, Traveller health is not a priority among health planners and the budget for Traveller health developments has been used for mainstream health services.

Many Roma children in Ireland do not have access to medical cards. This is related to a lack of access to social protection and an inability to prove their means when applying for a medical card. The result is lack of access to basic GP care, as without a medical card this is very costly. Roma women report inability to access GPs and being afraid to use accident and emergency or maternal health services in case they receive bills for treatment. Women report receiving conflicting reports in relation to payment for maternal services and a lack of knowledge of the Maternity and Infant Care Scheme.

[41] Kelleher et al (2010) *Our Geels, All Ireland Traveller Health Study,* University College Dublin & Department of Health & Children.

Lack of financial resources or state support, combined with a lack of clear accessible information, and a lack of trust in maternal and broader health services all impact on engagement with pre and post-natal services. Many women delay accessing care to a late stage of pregnancy. The first point of contact for Roma women with a health service can be in the A&E ward of a maternity hospital when already in labour.

Women also report fears of children being taken away from them if they engage with health practitioners, particularly if they are living in poverty and overcrowded accommodation. The removal of two blonde Roma children from their families in October 2013 has further exacerbated fears within the community. As a result, public health nurses often experience difficulties tracking mothers of new born babies when mothers make themselves inaccessible upon visits. This can mean children do not get vaccinations. This affects women's health, children's health and public health more widely. Also, accessing nutritious food and buying clothes and nappies for a new baby can be extremely challenging.[42]

Another key issue is the need to build up trust and engagement between Roma and health service providers. Following on from the successful Primary Healthcare for Travellers Projects in Ireland, a similar pilot project could be developed with Roma. This would build up a network of engagement between Roma communities and service providers.

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Develop a new National Traveller Health Implementation Plan to address the findings of the All Ireland Traveller Health Study**
- **Ensure access to basic healthcare for Roma in Ireland.**
- **Develop a primary healthcare project with Roma so as to increase access to information on healthcare.**
- **Develop an Ethnic Identifier throughout the HSE as a matter of urgency. This would ensure that data could be collected on the access, uptake and referral rates of services.**

Direct Provision and the Health Rights of Women Seeking Asylum

Women seeking asylum and protection are maintained at subsistence levels in the Direct Provision dispersal and accommodation system for unduly long periods of time, impacting on various human rights including the right to health. Accommodation centres, the majority of which are managed by for profit private businesses on behalf of the state are particularly unsuitable for women and children. There is a lack of independent inspection of these facilities. In July 2014 the Human Rights Committee recommended that the duration of stay in Direct Provision centres is as short as possible and introduce an accessible and independent complaints procedure in Direct Provision Centres.[43]

The particular health care and health information needs of asylum seekers have been recognised in policy documents such as the HSE National Intercultural Health Strategy as

[42] Pavee Point (2014) Challenging Barriers and Misconceptions: Roma Maternal Health in Ireland, p 4-7. http://www.paveepoint.ie/tempsite3/wp-content/uploads/2013/11/Roma-Maternal-Health-in-Ireland.pdf
[43] Human Rights Committee: Concluding Observations on the fourth periodic report of Ireland July 2014.

well as reports such as the recent United National Refugee Agency (UNHCR) report Towards a New Beginning: Refugee Integration in Ireland, which highlight that isolation, difficulties in accessing information, lack of choice of healthcare provider, cost, language barriers and communication barriers which all act to seriously limit asylum seekers access to health services.

During the WHRA consultations the most important issue raised was the need for women and children seeking asylum to have suitable accommodation, and for the Irish government to be aware of the impact of Direct Provision on mental health and well-being, child development and general health. Accommodation centres needs to take better account of the health needs of residents, with attention to the way in which special medical needs, such as special diets of diabetics, can be catered for. It was also highlighted the importance of providing accessible information, that also takes account of language and literacy issues. Medical staff, the Gardai and other service providers should be provided with training on anti-racism and cultural awareness.

WHRA respectfully suggest that the Committee make the following recommendations to the State:

- **Undertake an audit of government policy of direct provision and dispersal to ensure it meets international human rights standards**
- **Require that companies tendering for accommodation centre contracts to provide a code of conduct, an independent complaints procedure for residents and gendered, cultural training for staff running the centres.**
- **Introduce domestic gender guidelines within the asylum and reception system;**
- **Establish a separate women's only accommodation centre for women seeking asylum who have experienced gender based violence.**
- **Implement in full the recommendations of the HSE's *National Intercultural Strategy in Health* for the provision of intercultural health services.**

Funding for women's support organisations

The community and voluntary sector plays a key role in the protection and promotion of women's human rights as well as provision of services to women who are most marginalised, living in poverty, experience domestic violence and sexual violence, and whose voices are furthest away from the decision making strictures of Irish society. Budgetary cuts over the past few years have disproportionately impacted on the capacity of women's organisations to protect the rights of all women in particular vulnerable women through frontline services and advocacy work.

Over the past two years government funding to the National Women's Council of Ireland (NWCI), the leading women's organisation in Ireland, has been cut by 50%.[44] Funding for locally based women's projects has been cut by 41% since 2011[45] and this has significantly reduced the level of services / support that organisations can provide and the level of advocacy they can engage in. Some of the Women's Networks have closed while others have been forced to cut back on staff and on services. The Human Rights Committee governing ICCPR recommended in its Concluding Observations on Ireland's compliance with ICCPR to encourage greater participation of women in both public and private sectors,

[44] Department of Finance / Department of Public Expenditure and Reform: Budget 2012 and 2013
[45] Ibid

including by providing stable and sufficient funding for institutions established to promote and protect gender equality.[46]

Locally based women's organisations provide a wide range of services including information and support around access to health services. They enable women to organise together, speak out on the issues affecting their lives and assist women marginalised by violence to gain confidence to leave dangerous situations. Funding for these organisations has continuously decreased over the past three years and is under constant threat. The newly established Local Social Inclusion and Community Activation Programme (SICAP) which was introduced in April 2015 operating under the auspices of the Department of Environment, community and Local Government is now the primary source of funding to support community development work at local level in Ireland.

WHRA notes with great concern that there is no ring fenced funding within the SICAP programme to provide supports and services to socio economically disadvantaged women. The National Collective of Community Based Women's Networks (NCCWN) local 17 women's networks working with the most disadvantaged women in the communities they work in have now been transferred to the Department of Justice and Equality under a new scheme based on the work which had been funded under the Local and Community Development Programme (which has been replaced by SICAP).

We respectfully suggest that the Committee make the following recommendations to the State:

1. **Conduct a gender audit of the operation of the Irish parliament within the lifetime of the current government**
2. **Ring fence funding to restore an adequate level of service provision and support effective advocacy to women's groups at local, regional and national level.**

We respectfully suggest that the Committee ask the State:

- **What measures it will put in place to protect the work of the 17 women's networks currently excluded from local infrastructures?**

[46] Human Rights Committee: Concluding Observations on the fourth periodic report of Ireland July 2014.

National Women's Strategy and Ireland's Report under CEDAW

A new National Women's Strategy for Ireland

Ireland's current National Women's Strategy was published in April 2007 and covers the period 2007-2016. It is timely now that negotiations between the State and Civil Society Organisations commence to map out a way forward for a new Strategy. The current Minister of State for Equality recently flagged his intention to initiate this process[47], but first a comprehensive and thorough evaluation of the current Strategy and its implementation is needed in order to plan effectively for a new Strategy and an accompanying action plan. This evaluation would allow for the identification of particular policy areas where implementation has been slow or non-existent, which will in turn inform a new Strategy.

Ireland and CEDAW

Ireland was last examined by the Committee monitoring State compliance under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 2005. 10 years later we are still awaiting a fresh report covering the period from 2003/2004 to date from the State and details of when Ireland's next examination will take place. This new report will update the Combined Fourth and Fifth Reports, presented in 2003, and will also take cognisance of the recommendations made by the CEDAW Committee at the oral examination in 2005.

We respectfully suggest that the Committee make the following recommendations to the State:

- **Initiate a full and comprehensive independent evaluation of the implementation of the National Women's Strategy 2007-2016.**
- **Following this evaluation process, commence negotiations on the development of a new National Women's Strategy.**
- **Issue, without further delay, Ireland's next periodic report to CEDAW and ensure that Ireland is scheduled to be examined by the Committee by 2016 at the latest.**

[47] Talks on new national strategy for women's rights to start next week, Kitty Holland, Irish Times, 21st February 2015