SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

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

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).

This submission provides additional information to supplement the responses in the Reply of Ireland to the List of Issues. We focus primarily on **Question 23** of the List of Issues, which addressed abortion and Ireland's restrictive constitutional, legislative and regulatory legal regime. We also provide some additional information in relation to aspects of the response to **Question 17**.

IFPA Credentials

The Irish Family Planning Association (IFPA) submits these remarks based on its experience in providing reproductive health care services to women and girls. Since 1969, the IFPA has worked to promote and protect basic human rights in relation to reproductive and sexual health, relationships and sexuality. The IFPA provides the highest quality reproductive health care at its two medical clinics in Dublin and eleven 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 2014, the IFPA medical clinics provided sexual and reproductive health services to over 16,000 clients and provided information and support to 3,700 women and girls experiencing pregnancies that were unplanned, unwanted or that had developed into a crisis because of changed circumstances. (Reply of Ireland: paragraph 125-127). In 2014, the IFPA opened the first specialist treatment centre in Ireland for women who have undergone female genital mutilation. On the basis of this track record, the IFPA is recognised as a respected source of expertise in the provision of sexual and reproductive health care services, advocacy and policy development.

Abortion in Ireland

Abortion in Ireland is permitted only in cases where there is a "real and substantial" risk to the woman's life, as distinct from a risk to her health.[1] Abortion is not permitted where the health of the woman is at risk. Nor is abortion lawful where the pregnancy is the result of rape or incest, or in cases of fatal foetal anomaly.

[1] Attorney General v. X [1992] IESC 1; [1992] 1 IR 1.

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

1 The restrictive laws on abortion and the failure of legislation to guarantee even the existing limited right to abortion where there is risk to life. Additional information is provided in relation to the Protection of Life During Pregnancy Act 2013[2] and the 2014 Guidance Document for Medical Practitioners (Reply of Ireland: paragraphs 119-122, 128-9)
2 The need for women to travel outside of Ireland to access safe and legal abortion services (which is both an impact of the law, and, in itself involves harms that are inconsistent with the State's obligations under the Covenant). (Reply of Ireland: paragraph 123)
3 The law in regard to information about abortion services in other countries. (Reply of Ireland: paragraph 124)
4 The impact of the abortion laws on women asylum seekers. (Reply of Ireland: paragraph 123)

In addition, in section 5, in relation to the government's response to LOI Question 17 (Reply of Ireland: paragraph 77 and 78) we address the issue of asylum seekers' limited access to sexual and reproductive health information and services.

The ***health impacts*** of the law on women and girls include: increased risks to women's health related to delay in accessing services; the requirement to travel to another country for abortion services (and incur significant costs and physical and psychological burdens in doing so); parenting in situations where this is against a woman's best interests and her own wishes; recourse to unsafe or risky methods of self-inducing abortion.

1. The restrictive laws on abortion and the failure of legislation to guarantee even existing limited right to abortion where there is risk to life (**Reply of Ireland: paragraphs 119-122, 128-9)**

The right to abortion in such cases was established in a 1992 Supreme Court ruling.[3] The **Irish authorities' response to the List of Issues** makes reference to the *Protection of Life during Pregnancy Act 2013* (hereafter the 2013 Act), which was enacted on foot of a 2010 judgment of the European Court of Human Rights[4] which found Ireland in violation of the European Convention on Human Rights for its failure to give effect to the right to abortion in cases of risk to life. The IFPA contends that the 2013 Act does not ensure practical and effective exercise of the constitutional right to life-saving abortion, and draws the attention of the Committee to the relevant observations on the Act by the national human rights institution, the Irish Human Rights Commission (as it then was).[5]

Additional information: the Protection of Life during Pregnancy Act 2013 (2013 Act)

Certification of eligibility under the Act. *The test to be applied under the Act is onerous and unworkable in clinical practice in many circumstances*. The Act includes separate provisions for the certification of cases of non-emergency physical threat to life (section 7), medical emergencies (section 8), and cases of risk to life from suicide (section 9). Certification involves a two-part test based on the *X* case: first, doctors must make a determination that there is a "real and substantial" risk to the woman's life; and second, they must jointly certify "in good faith" that the relevant "medical procedure" is the only reasonable means of eliminating that risk.

[2] 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.
[3] *Attorney General v. X* [1992] IESC 1; [1992] 1 IR 1.
[4] *A, B and C v Ireland* [2010] ECHR 2032.
[5] Irish Human Rights Commission. Observations on the Protection of Life During Pregnancy Bill 2013. http://www.ihrec.ie/download/pdf/ihrc_observations_protection_of_life_in_pregnancy_bill_2013.pdf. Published July 2013. Accessed April 13, 2015.

Guidance Document. (Reply of Ireland: paragraph 122) A Guidance Document for Medical Professionals was published by the Department of Health on the interpretation of the Act in 2014.[6] ***The guidance document makes no reference to international best practice standards. It is restrictively drafted and offers little more than a restatement of the Act and the associated regulations, and provides no assistance to medical professionals as to how they are to determine that a risk to health involves a risk to life.*** The guidance contains no additional provisions for ensuring that particularly vulnerable groups such as migrant women, asylum seekers, young women and women who are living in poverty can access lawful abortion.[7] To date, April 2015, no accessible information on the implementation of the Act has been published for the guidance of the general public.

Review process and certification. (Reply of Ireland: paragraph 122, 128-9) More ***onerous provisions apply to cases where risk is of suicide*** than in circumstances of physical risk to life***: this is discriminatory.*** Decision-making is in the hands of medical specialists and is different under each section. One doctor can make the decision in emergency cases. A pregnant woman who asserts her right to abortion because of physical risk to life under Section 7 must be examined by two medical practitioners (an obstetrician and a specialist in a relevant area). However, the requirements for certification more onerous in cases of suicide risk than when there is physical risk to life. Section 9 provides that three specialists—two psychiatrists and an obstetrician—must jointly certify a woman's legal entitlement to the "medical procedure". If certification is refused under section 7 or section 9, the pregnant woman, or someone acting on her behalf, can seek a second opinion or initiate a formal review procedure. She will then be examined by a review panel of the same number and specialisations as under Sections 7 and 9, depending on the nature of the risk to life. A review procedure was a requirement of the *A, B and C v Ireland* judgment, but these provisions place significant burdens on women, particularly a pregnant woman who asserts suicide risk, and is, by definition, extremely vulnerable: she will, if she is denied certification and seeks a review of the decision, be subjected to examinations by four psychiatrists and two obstetricians. The role of the psychiatrists in the process is only to assess risk of suicide; it is not to provide treatment. The apparent purpose of Section 9 of the Act is to subject women's veracity to scrutiny, rather than to fulfil the intent of *A, B and C v Ireland* to positively ensure pathways for accessing lawful abortion.

Issues not addressed in the Government's reply to Question 23.

Criminal provisions. Ignoring the recommendations of international human rights bodies[8] and of WHO[9], the Irish Government chose to enact legislation that fully secured the most restrictive possible

[6] Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals. Available at http://health.gov.ie/wp-content/uploads/2014/09/Guidance-Document-Final-September-2014.pdf.

[7] Supra, note 5, para 39 which criticises the accessibility of the right to lawful termination for vulnerable groups. See also paras 28; 38; 117; 119.

[8] [19] United Nations Committee against Torture. Concluding Observations: Ireland, UN Doc CAT/C/IRL/CO/1. http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/C/IRL/CO/1&Lang=En. Published June 2011. Accessed April 13, 2015; United Nations Committee on the Elimination of Discrimination against Women. Concluding Comments: Ireland, UN Doc CEDAW/C/IRL/CO/4-5. http://www.un.org/womenwatch/daw/cedaw/cedaw33/conclude/ireland/0545060E.pdf. Published July 2005. Accessed April 13, 2015; United Nations Committee on the Elimination of Discrimination against Women. 21st session, June 1999. Concluding Comments to the State of Ireland, UN Doc A/54/38. New York, NY: United Nations; 1999; United Nations Human Rights Committee. Concluding observations on the fourth periodic report of Ireland, UN Doc CCPR/C/IRL/CO/4. http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FIRL%2FCO%2F4&Lang=en. Published August 2014. Accessed April 13, 2015; United Nations Human Rights Committee. Concluding Observations to Ireland, UN Doc CCPR/C/IRL/CO/3. http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fIRL%2fCO%2f3&Lang=en. Published July 2008. Accessed April 13, 2015; Sekaggya M. Report of the Special Rapporteur on the situation of human rights defenders: mission to Ireland (19–23 November 2012). UN Doc A/HRC/22/47/Add.3

approach to Article 40.3.3.The law retains ***harsh criminal sanctions for women and their doctors of 14 years' imprisonment*** if an abortion is carried out for any reason other than to save a life.[10] The 2013 Act also discriminates against women in cases where risk to life relates to risk of suicide, imposing more onerous requirements to establish eligibility under the Act in such cases.[11]

Conscientious objection. The Act allows for conscientious objection of doctors, and there is cause for concern that this may result in refusal of care, particularly where the risk to life arises because of mental health problems.

New legal barriers. It introduces new legal barriers of complicated certification and review processes that women must undergo to access a lawful abortion. An ***unprecedented process of parliamentary scrutiny*** has also been introduced: abortions must be notified to the Minister for Health and a report on all abortions carried out must be laid before parliament each year.

Impacts on access to the right to health

The Reply of Ireland to Question 23 does not address any of the following issues:

1.1 In crisis pregnancies covered by the Act, doctors must always prioritise live birth whatever the impact on a woman's physical or mental health. The constitutional, legislative and regulatory system necessitates a medically unsound distinction between risk to the life of a pregnant woman and risk to her health. Such a distinction may put women's lives at risk and prevent medical practitioners from acting in women's best interests: ***doctors must wait until a woman's condition has deteriorated from risk to health to risk to life before a lawful termination of pregnancy can be carried out.***

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

Case study

The case of "Ms Y", the first known case of a decision under the 2013 Act, highlights the ways in which the restrictive application of art 40.3.3 impacts on women's right to health. The fullest account of the facts and the ethical and human rights issues involved[12] show that Ms Y was pregnant as a result of rape. She was clearly distressed and made her wish to have an abortion known. She was living within Ireland's direct provision system for asylum seekers and was unable to gather the necessary travel documents and financial means to travel to a state where abortion is legal. At approximately 21 weeks of pregnancy, she attempted to enter the UK to seek an abortion, but was detained by immigration officials and returned to Ireland. Newspaper reports indicate that Ms Y was admitted to hospital and assessed under Section 9 of the Protection of Life During Pregnancy Act some weeks later, and that a panel of two psychiatrists and an obstetrician found that her life was at risk from suicide. However, rather than authorise an abortion, a plan was put in place to deliver a live

2. http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A-HRC-22-47-Add-3_en.pdf. Published February 2013. Accessed April 13, 2015.

[9] World Health Organisation: Safe abortion: technical and policy guidance for health systems. 2nd edition 2012 1,18 (2nd ed., 2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434 _eng.pdf

[10] S.22.(2), Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available at http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf.

[11] S.9.3; S.9(4), Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available at http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf.

[12] Fletcher R. Contesting the cruel treatment of abortion-seeking women. Reprod Health Matters 2014;22(44):10–21.

neonate by caesarean section. Ms Y went on hunger strike in protest. Lawyers acting on behalf of the governmental Health Service Executive obtained a High Court order to forcibly hydrate and sedate her. It is understood that Ms Y was not forcibly hydrated, ultimately ended her hunger strike, and consented to a caesarean delivery, which was carried out in August 2014 at approximately 25 weeks of pregnancy. Had she refused consent, the hospital was preparing to seek further orders to authorise the performance of the caesarean section without her permission.

See also section 4, below.

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

2. The need for women to travel outside of Ireland to access safe and legal abortion services (Reply of Ireland: paragraph 123)

The UN Special Rapporteur for Health has stated that the criminalisation of reproductive health services is a violation of the right to health and shifts the burden of accessing the right from the state onto pregnant women.[13] The Irish State criminalises abortion and justifies its restrictive laws on abortion by providing for the right to travel to other jurisdictions to access services, and to obtain information about abortion services. The constitutional right to travel to access abortion services is contained in the Thirteenth Amendment of Article 40.3.3°.[14]

In *A, B and C v Ireland,*[15] the European Court of Human Rights recognised that the requirement to travel for abortion involves stigma and amounts to an interference with rights under the Covenant (the dissenting minority of six judges argued that the requirement to travel is of itself a violation of the Convention).

The World Health Organisation has highlighted that restrictions on the availability of induced abortion result in unequal access to safe abortion services, disproportionately forcing poor women to seek abortion services from unsafe providers.[16]

In spite of the recommendations of UN treaty monitoring bodies and UN special rapporteurs, the 2013 legislation does not extend the grounds for lawful abortion to include cases of rape, risk to a woman's health, or fatal fetal anomalies—although persuasive arguments had been made that at least fatal anomalies could have been included in the legislation. In *D v Ireland* in 2006, the Irish authorities had argued before the European Court of Human Rights that abortion in such cases could be lawful within Article 40.3.3.[17] The current Attorney General has issued contrary advice.[18]

[13] Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. August 2011. UN Doc A/66/254.
[14] Text of Amendment available at: http://www.irishstatutebook.ie/1992/en/act/cam/0013/index.html.
[15] Supra, note 4.
[16] World Health Organisation: Safe abortion: technical and policy guidance for health systems. 2nd edition 2012 1,18 (2nd ed., 2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434 _eng.pdf; see also Center For Reproductive Rights et al., *Fulfilling Unmet Promises: Security And Protecting Reproductive Rights And Equality in the United States,* 21 (2013), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_ICCPR%20Shadow%20Report%202013_Final.pdf (discussing that bans on abortion disproportionally affect vulnerable groups such as poor women).
[17] *D v Ireland* (Application No 26499/02). Decision 27 June 2006.
[18] O'Reagan M, O'Halloran M. Dáil defeats Clare Daly's abortion Bill 104 to 20. http://www.irishtimes.com/news/politics/d%C3%A1il-defeats-clare-daly-s-abortion-bill-104-to-20-1.2098098. Published February 10, 2015. Accessed April 13, 2015.

Impacts on access to the right to health

The Reply of Ireland to Question 23 does not address any of the following issues:

2.1 The harms of the criminalisation of abortion are significant in Ireland. At least 4,000 women travel from Ireland to the UK to access abortion services each year and at least 160,000 women have travelled since statistics began to be collected.[19]

The World Health Organisation is unambiguous: delays in accessing abortion services can result in increased risks to women's health.[20] The need to organise finances, and also the logistics of travel, accommodation, childcare, time off work etc. leads to a delay between women's decision to have an abortion and the time when she can avail of the procedure.

The IFPA is aware of situations where the time involved in organising the journey to have an abortion has resulted in a delay of many weeks in exercising the right to travel. The requirement to travel can result in more women opting for the surgical procedure rather than the medical abortion, which can only be performed up to 9 weeks gestation.

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

Women who receive a diagnosis of fatal foetal anomaly experience particular harms: women who have been receiving care within the mainstream maternity care system experience an abrupt cessation of care should they wish to consider opting for termination of the pregnancy. Denied access to abortion because of the law, they are obliged to undertake all the responsibility and cost of accessing therapeutic abortion outside the state (albeit with the support of agencies, such as the IFPA, that are funded under the HSE Crisis Pregnancy Programme. The denial of abortion to women in these circumstances was described as "a great cruelty" by then Minister for Justice, Mr Alan Shatter, TD in 2013.[21]

2.2 Because of abortion stigma and the chilling effect of criminalisation within health services in Ireland, most women, even women who have underlying medical conditions that can make abortion more complicated, must travel for abortions abroad without a referral letter from their doctor outlining their medical history. This would not happen in accessing any other medical treatment, in particular in the case of a patient with a life-threatening illness.[22]

2.3 The costs involved in accessing safe abortion services are high. Travelling to the UK for a surgical abortion below 14 weeks of gestation costs at least €1000. Abortion in cases of foetal anomaly costs more due to the duration of the treatment, which can last 4-5 days. This is due to the fact that foetal anomalies are not usually detected until the later stages of a pregnancy, resulting in longer and more complex medical treatment. Women who need visas to travel abroad and to re-enter Ireland may have to wait 6 to 8 weeks for the necessary documents, or in some cases, may not be able to travel. Asylum seekers must apply and pay for an emergency re-entry visa from the Department of Justice and a visa to enter the UK or the Netherlands. Most asylum seekers in Ireland are housed in reception centres until their refugee application is decided. They are not entitled to work

[19] Average figure from the last five years. See http://www.ifpa.ie/Hot-Topics/Abortion/Statistics for full list of UK figures. Note: this figure is an underestimate: it only captures the number of women who provide Irish addresses in UK clinics, and excludes women who provide other addresses, or who travel to other countries to access services.
[20] Supra, note 16, at page 106.
[21] Mac Cormaic R. *Shatter describes abortion restrictions as 'a great cruelty'*. http://www.irishtimes.com/news/ireland/irish-news/shatter-describes-abortion-restrictions-as-a-great-cruelty-1.1473673. Published July 24, 2013. Accessed April 13, 2015.
[22] The Irish Times. 17 January 2012. "*New Expert Group Must Vindicate Right to Abortion*" Op. ed. by Niall Behan, CEO of the IFPA. Available at http://www.ifpa.ie/Hot-Topics/Abortion/Resources.

and currently receive a weekly allowance of €19.10 from the State, and €9.60 per child.[23] The cost of a UK visa is £85 [24] while a visa to enter the Netherlands is €60).[25] There is no state support for women to access abortion, even when they have inadequate financial resources.

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

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

2.5 Restricted access to abortion services and information, and the financial burden of travel can lead women to seek illegal and unsafe abortion-inducing drugs. These medications may be ineffective or harmful, and are administered without proper medical advice or supervision. According to the Irish Medicines Board, the number of abortion-inducing drugs seized by the Customs Authority is increasing each year. Last year, 60 importations (1,017 pills) were seized. This is up from the figure of 25 intercepted importations (of 438 pills) in 2013.[26] Many more importations are not intercepted, either because those selling them change the packaging regularly to avoid detection and because many women have them sent to addresses in Northern Ireland.[27]

3. The health impacts of the law in regard to information about abortion services in other countries (Reply of Ireland: paragraph 124)

The Fourteenth Constitutional Amendment[28] protects the right to obtain information about abortion services in other countries, subject to certain conditions. The *Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act 1995* stipulates that women who seek information on abortion can only obtain it if they are also given information and counselling on "all the options available to the woman in her particular circumstances". The law does not regulate the existence of "rogue" counselling agencies established to manipulate women's choices and withhold information about abortion.

Impacts on access to the right to health

The Reply of Ireland to Question 23 does not address any of the following issues:

3.1 The regulation of women's right to information on abortion is an unwarranted interference with women's right to make autonomous decisions about their own health care. It also impacts on doctors' ability to act in their patients' best interests. In her 2013 report on the situation of human rights defenders in Ireland, the UN Special Rapporteur Margaret Sekaggya highlighted that the provisions of the Information Act can pose significant barriers for counsellors and potentially restrict women's access to information on sexual and reproductive rights: *"Moreover, the provision can restrict the ability of defenders to make contact with some women who may not be able to attend a face-to-face*

[23] Reception and Integration Agency. *Direct provision*. Available at http://www.ria.gov.ie/en/RIA/Pages/Direct_Provision_FAQs
[24] UK Border Agency https://www.gov.uk/browse/visas-immigration
[25] Netherlands Embassy in Ireland http://ireland.nlembassy.org/services/consular-services/visa.
[26] Customs seized 1,017 abortion pills last year: http://www.thejournal.ie/ruth-coppinger-abortion-pills-2060811-Apr2015/
[27] The Irish Times: July 27, 2013. *Abortion law: what comes next?* Available at http://www.irishtimes.com/news/health/abortion-law-what-comes-next-1.1476187.
[28] Text of Amendment available at: http://www.irishstatutebook.ie/1992/en/act/cam/0014/index.html.

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."[29]

3.2 In the context of strict regulation of information, the emergence of 'rogue agencies'—unregulated agencies that actively provide misleading or inaccurate information about abortion and abortion services in order to prevent women from accessing abortion is of concern. These 'rogue agencies' present themselves as legitimate crisis pregnancy centres that provide impartial information on options for women who have an unplanned pregnancy.[30] However, women who have unwittingly used these services have reported that they were shown videos of ultrasounds and a late-term abortion procedure. The women were also provided with unfounded information about the negative repercussions of terminating a pregnancy and harassed by follow-up phone calls.[31] Despite calls by advocacy groups and politicians, no regulation of these agencies has taken place.[32]

4. The impact of the law on women asylum seekers (Reply of Ireland: paragraph 123)

Women who cannot exercise the constitutionally guaranteed right to travel for an abortion constitute an increasing cohort of the IFPA's clients. The IFPA has repeatedly raised concerns about the impact of Ireland's abortion laws on women who already experience disadvantage. Indeed the IFPA first raised the specific needs of women asylum seekers with an unplanned or crisis pregnancy in 2002. But little has changed since then. While the Constitution guarantees the right to travel for abortion, many women – women in poverty or on low income, young women, women in state care, women experiencing domestic violence, women with travel restrictions – cannot exercise this right due to an array of legal, social and economic barriers. The ***Health Services Executive (HSE) in its National Intercultural Health Strategy 2007***[33] highlighted that, "Issues around maternity and reproductive health are also reported to be emerging areas of concern. …. Unwanted pregnancy and / or sexually transmitted infections may be a result of sexual violence, further isolating women in such circumstances. Anecdotal evidence points to migrant women accessing unsafe or backstreet abortions. This is due to the legislative ban on termination of pregnancy in Ireland and the fact that, because of their precarious residence status, many women are afraid to travel to their home countries for such terminations."

From September 2013 to September 2014, 26 women with travel restrictions, including women asylum seekers, attended the IFPA's counselling service and indicated that they wanted an abortion. At least five of these women continued with the pregnancy and parented against their wishes. At least four women were considering or had taken medication to self-induce an abortion. 17 women did not return to the IFPA. It is not known if these women were able to obtain the documentation to travel, if they managed to travel without documentation, if they obtained medication to self-induce an abortion, if they were forced to continue with the pregnancy and parent against their wishes.

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[29] Report of the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya. Addendum Mission to Ireland (19–23 November 2012) A/HRC/22/47/Add.3; 26 February 2013.
[30] Irish Family Planning Association (2006) *Briefing Document on Rogue Crisis Pregnancy Agencies*, Dublin: IFPA, p.3.
[31] Human Rights Watch (2010) *A State of Isolation: Access to Abortion for Women in Ireland*, USA: HRW, p.26.
[32] Irish Family Planning Agency (2006) *Briefing Document on Rogue Crisis Pregnancy Agencies*, Dublin: IFPA, pp.6-7.
[33] HSE (2008) *National Intercultural Health Strategy 2007 – 2012.* Available from: http://www.hse.ie/eng/services/Publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf

Impacts on women's health

The Reply of Ireland does not address the following issues. Indeed, when questioned about these issues by the Human Rights Committee during its examination of Ireland's implementation of the ICCPR, a representative of the authorities stated that there was "no solution" to this.[34]

4.1 Not all women can travel freely between states. The requirement to travel for abortion has discriminatory impacts on women living in poverty or on low incomes, migrant women, minors, women and girls in the care of the state, women asylum seekers, and undocumented women. Lack of access to safe abortion services therefore particularly affects women who are already burdened by inequality.

4.2 Many women need two travel visas – a re-entry visa to leave and return to Ireland and another visa to enter the country where the abortion provider is located.

If a woman is undocumented and without a passport, she must apply for a temporary travel document before applying for a re-entry visa.

A re-entry visa must be applied from the Irish Naturalisation and Immigration Service office. A temporary travel document must be obtained from the Department of Justice and Equality. The twelve page application form must be stamped by a Garda. The form requires personal identifying details, immigration history, a letter confirming attendance at a counselling service, and biometric passport photographs.

If the documents are issued, the second, and more complex, stage begins of applying for an entry visa for the country where the abortion clinic is located. To apply for an entry visa to the Netherlands, a woman must submit at least twelve pieces of documentation in person at the Dutch embassy. This includes an application form, a copy of a registration card of the Garda National Immigration Bureau, a current bank statement showing adequate funds, and a copy of medical travel insurance. Confirmation of a clinic appointment, accommodation and flight tickets are also required – all which can only be booked with a credit card. In total it can take more than eight weeks to organise travel documentation.

Such delay has a significant impact on a woman's physical and mental health, particularly where a woman has an underlying health condition.

4.3 Adult asylum seekers receive a weekly allowance of €19.10 from the State. Yet in order to access abortion lawfully, a woman must pay many multiples of this amount for travel document application fees, transport to and from embassy and government offices, flights, abortion provider fees, accommodation and indirect costs, such as childcare. A re-entry visa and a temporary travel document cost €60 and €80 respectively and must be paid with a bank draft or postal order.[35] An entry visa to the Netherlands costs €60, a UK visa costs £85. An abortion procedure can cost €600 to €2,000, depending on the clinic and the stage of gestation.[36]

5. Asylum seekers' access to contraception and reproductive health care (Reply of Ireland: paragraph 77)

The Reply of Ireland states that the Reception and Integration Agency (RIA) seeks to ensure that the material needs of residents, in the period during which their applications for international protection

[34]Ireland at the UN: We have 'no solution' for women who can't afford to travel for an abortion. Journal.ie July 15 2014. Available at: http://www.thejournal.ie/ireland-unhrc-day-twp-1572161-Jul2014/.
[35]Irish Naturalisation and Immigration Service: http://www.inis.gov.ie/en/INIS/Pages/Re-entry%20visas
[36] Irish Family Planning Association. IFPA annual report 2013. Available at: http://www.ifpa.ie/sites/default/files/documents/annual-reports/ifpa_annual_report_2013.pdf.

are being processed, are met. This is not the case with **access to reproductive health care.** The HSE's *Family Planning Policy Guidelines for Health Boards 1994* recognises the need to "pay particular attention to the information and service needs of disadvantaged and/or at risk groups" and that in this context flexibility would be required "in relation to the methods of delivery e.g. outreach may be desirable".[37] The particular health care and health information needs of asylum seekers have been recognised in subsequent policy documents, for example, the HSE *National Intercultural Health Strategy*[38], as well as reports such as the recent United Nations Refugee Agency (UNHCR) report, *Towards a New Beginning: Refugee Integration in Ireland*[39], highlight that isolation, difficulties in accessing information, lack of choice of provider, cost, language barriers and communication barriers all act to limit asylum seekers' access to health services.

The IFPA knows from our clients that barriers are particularly acute for asylum seekers/refugees in the context of women's access to sexual and reproductive health services. In 2012 the Crisis Pregnancy Programme highlighted that some migrant women have problems accessing contraception. This is due to cost, lack of information, problems with changing GPs or a refusal to prescribe contraception. The women consulted by the CPP felt that the Irish health care system does not fully meet their needs, because they do not know about the services available or how to access them.[40]

The IFPA is of the view that the provision of sexual and reproductive health care to women and girls in direct provision falls short of the requirements of the right to health, in particular regarding accessibility (including non-discrimination, physical accessibility, affordability and information accessibility); acceptability (i.e. respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements).

Impacts on access to the right to health

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

5.2 Some women living in direct provision are unable to afford condoms, which are not covered by the state medical card scheme. Other women have been charged a fee of €50 (equivalent to two and a half weeks' allowance) for a fitting of a long-acting contraceptive: the contraceptive device is covered by the medical card scheme, but insertion and removal are not. (The IFPA waives these fees in the case of asylum seeking women.

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

5.4 Many adolescents and children in direct provision are not informed about sexually transmitted infections and contraception, and are therefore effectively denied adequate, age-appropriate knowledge and understanding of sexuality and relationships as positive aspects of life, and about how

[37] HSE (1994) *Family Planning Policy Guidelines for Health Boards*. Available from: http://lenus.ie/hse/bitstream/10147/251197/1/FamilyPlanningPolicyGuidelinesForHealthBoards.pdf
[38] Supra, note 27.
[39] UNHCR (May 2014) *Towards a New Beginning: Refugee Integration in Ireland*. Available from: http://www.refworld.org/docid/52ca8a6d4.html
[40] Crisis Pregnancy Programme Report No. 25, 2012 *Attitudes to Fertility, Sexual Health and Motherhood amongst a Sample of Non-Irish National Minority Ethnic Women Living in Ireland,* 106 Available at http://crisispregnancy.ie/wp-content/uploads/2012/06/migrant-women-report.pdf

to protect themselves from inappropriate sexual behaviour, sexually transmitted infections and unplanned pregnancy, and are therefore more at risk to sexual exploitation and abuse, STIs and unplanned pregnancy.

Recommendations

Based on the information in this submission and the IFPA's 2014 letter to the Committee,[41] the IFPA respectfully suggests that the Committee make the following recommendations to the State:

1. **Repeal the legislation and the constitutional provisions that criminalise abortion.**

2. **Take measures, including legislative measures, to remove barriers to women's and girls' enjoyment of their right to the highest attainable standard of reproductive healthcare and information.**

3. **Ensure that all children and adolescents, including those with intellectual disabilities, have access to age-appropriate, evidence-based comprehensive sexuality education.**

[41] IRL/INT_CESCR_ICO_IRL_18449_E