SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

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Communication by the Irish Family Planning Association (IFPA) to the Committee of Ministers in relation to the Execution of the European Court of Human Rights Judgment in the case of *A, B and C v Ireland*[1]

Dear Committee Members,

The IFPA is an independent non-governmental organisation that provides the highest quality reproductive healthcare at its clinics and counselling centres. In 2012, IFPA medical clinics provided nearly 17,500 sexual and reproductive health consultations.

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 counselling service delivers a professional and ethically driven service in eleven centres nationwide and provides information and support annually to some 4,000 women and girls experiencing pregnancies that were unplanned, unwanted, or developed into a crisis because of changed circumstances.

The IFPA is recognised as a respected source of expertise because of its proven track record in the provision of sexual and reproductive healthcare services, non-directive pregnancy counselling, education, training for healthcare professionals, advocacy and policy development. The IFPA is regularly called upon by statutory agencies, parliamentary committees, medical associations and service providers to give its expert opinion on a wide range of issues related to sexual and reproductive health and rights.

We base our communication on the provisions of Rule No.9, paragraph 2, of the Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements (adopted by the Committee of Ministers on May 10th 2006 at the 964th meeting of the Ministers' Deputies).

This communication is intended to supplement the information available to the Committee of Ministers at its 1186th meeting, 3-5 December, 2013, regarding the implementation of the judgment of the European Court of Human Rights (ECtHR) in the case of A, B and C v Ireland.

The implementation of this judgment is now at a critical juncture: the Protection of Life During Pregnancy Act 2013[2] (hereinafter "the 2013 Act" or "the Act") has been enacted, but has not yet commenced.

The enactment of this legislation is a significant step, and one which the IFPA has welcomed. However, it is the IFPA's opinion that, as the legislation has not been tested in practice, its adequacy as a measure to give effect to rights cannot be gauged by reference to the text and intent of the Act and the accompanying draft regulations.

It is the IFPA's view that continued enhanced supervision of the case is therefore advisable until such time as a proper assessment of its effectiveness can be made by the Committee.

The IFPA is of the opinion, moreover, that a number of the provisions of and omissions from the 2013 Act raise concerns about the effectiveness of the legislation to vindicate the constitutional right of a pregnant woman whose life is at risk to an abortion.

The Case

Three women, known as Applicants A, B and C, challenged Ireland's restrictive regulation of abortion at the European Court of Human Rights. On December 16 2010 the Grand Chamber of the Court unanimously held that Ireland's failure to implement legislation on abortion in spite of existing domestic case law — the Supreme Court decision in the case of Attorney General v. X and Others[3] ("the X case") — constituted a violation of Article 8 of the Convention.

The Court held that the uncertainty generated by the lack of legislative implementation of Article 40.3.3 of the Irish Constitution and, more particularly, by the lack of effective and accessible procedures to establish a right to an abortion under that provision, has resulted in a striking discordance between the theoretical right to a lawful abortion in Ireland and the reality of its practical implementation.

The Court highlighted the following three particular issues that need to be addressed by the Government:

(i) Legislative criteria or procedures that allow for legal certainty for women and their doctors in assessing whether a pregnancy presents a "real and substantial risk to the life of the pregnant woman";

(ii) A legal framework to examine and resolve differences of opinion between a woman and her doctor or between doctors;

(iii) The continued existence of criminal provisions (1861 Offences Against the Person Act) which constitute a significant chilling factor for both women and their doctors in the medical consultation process, regardless of whether or not prosecutions have in fact been pursued under that Act.

The case of Tysiac v Poland4 is also of relevance, as the Court stated that (1) where abortion is lawful, the State must not structure its legal framework in a way that would limit real possibilities to obtain it; (2) in order to fulfil its obligations under the Convention, the State must ensure that the law is formulated to alleviate the chilling effect.

In July 2013, after a lengthy process of parliamentary scrutiny, the Protection of Life During Pregnancy Act was approved by the Oireachtas (parliament) and signed into law by the President. The Act provides that two doctors must confirm that there is a physical threat to the life of the pregnant woman.[5] In medical emergencies, one doctor may make the decision.[6] Where the threat arises because of risk of suicide, three doctors—a woman's obstetrician and two psychiatrists—must agree that a her life is at risk.[7] The Act includes a review procedure to cover situations where there is disagreement as to whether a risk to life exists.[8] A medical practitioner, nurse or midwife who has a conscientious objection must make arrangements for the transfer of care of the pregnant woman concerned to another practitioner.[9] The right to conscientious objection does not override the duty to provide care in emergency cases. The Act includes a maximum 14-year sentence for any person who intentionally destroys unborn human life, except in the narrow circumstances covered by the Act.[10] The Act defines "unborn" as "commencing after implantation in the womb of a woman".[11]

According to section 1 (2), the Act "shall come into operation on such day or days as the Minister may appoint by order or orders either generally or with reference to any particular purpose or provision and different days may be so appointed for different purposes or provisions."

In August 2013, the authorities submitted an action report to the Committee of Ministers. The report states that the Act will not come into operation until the end of 2013. The report includes draft regulations to be made by the Minister for Health in the exercise of the powers conferred on her/him by sections 4 of the Act.

The IFPA is of the view that concerns arise in relation to the effectiveness of the 2013 Act to fulfil the requirements of the Court and to the Act's compliance in general with human rights standards.

1. Concerns in relation to the overall effectiveness of the 2013 Act to meet the requirements of the Court

- The IFPA is of the view that the retention of severe criminal penalties—a maximum penalty of fourteen years applies and could apply to pregnant women and to doctors—is ineffective, disproportionate and inconsistent with the State's obligations under the European Convention on Human Rights and international human rights law generally. In the opinion of the IFPA, the inclusion of the new criminal offences will not only maintain, but substantially reinforce, the chilling effect that was recognised by the Court.

- The IFPA is also of the view that the Act imposes unnecessary burdens on women and in this way insufficiently vindicates the right to life of pregnant women whose lives are at risk. The IFPA is of the opinion, moreover, that the Act imposes unreasonable bureaucratic obstacles on doctors, and in doing so, unacceptably interferes with the therapeutic relationship between a woman and her doctors and infringes upon the principles of dignity and personal autonomy that are at the heart of the right guaranteed under Article 8 of the Convention.

- Furthermore, as a provider of medical services, the IFPA is of the view that the legislation does not place sufficient emphasis on the duty of care of health service providers to ensure that women can exercise their constitutional right.

  The 2013 Act is now the primary source of information for medical practitioners and health service institutions in relation to the law on abortion in Ireland.[12] While the Act governs the provision of abortion services by *hospitals* where a woman's life is at risk, it is silent on the responsibilities of a primary care provider to whom a woman presents in the early stages of pregnancy and expresses concern that her pregnancy will pose a risk to her life if it continues.

  The Act does not contain provisions, nor has the Department of Health produced guidelines or protocols on best practice on the part of the treating doctor in such a case. There is therefore no clear referral pathway such that a woman is assured of access to medical professionals who are empowered under the Act to certify that a risk to life exists. Nor is there clarity in relation to the responsibility of the healthcare system to a woman who is refused certification on the basis that her physical or mental health condition does not amount to a risk to life.

  In the opinion of the IFPA, the absence of a policy outlining health professionals' duty of care to women will have significant impacts on the care of women who are concerned that a pregnancy involves risk to life. There is no indication in the government's action report of August 2013 that plans are in place for the development of guidelines, protocols and processes of accountability that would lift the understanding of abortion to save a woman's life out of the context of criminal law and situate it within the context of best medical practice in reproductive healthcare.

- **The Act further omits any provisions that would ensure access to treatment under the Act by women and girls from social groups that tend to encounter difficulties in accessing medical practitioners, or for whom making an application for a review**

of a decision in writing is likely to pose difficulties: e.g. women or girls from lower socio-economic backgrounds or geographic areas with limited access to or lack of choice regarding healthcare, women or girls of ethnic minority backgrounds, including asylum seekers and refugees, or undocumented migrants; women or girls who are functionally illiterate or have intellectual disabilities. (The Irish Human Rights Commission (IHRC) has expressed similar concerns.[13]) Women and girls in these circumstances are also likely to encounter barriers to and delays in the exercise of their right to travel if they are either unable to access the services covered by the Act or if it is decided that it is their health rather than their life that is at risk, and are therefore refused treatment under the Act.

2. Concerns in relation to specific provisions of the Act

- **Sections 7, 8 and 9**

> *The 2013 Act provides14 that two doctors must confirm that there is a physical threat to the life of the pregnant woman. In medical emergencies, one doctor may make the decision.15 In non-emergency cases, the certifying doctors must, with a woman's consent, make every effort to consult with her general practitioner.*[16]

As a primary health care provider, the IFPA's particular concern is that, where there is a risk to a pregnant woman's life, she is assured of timely access to appropriate services.

The IFPA knows from our services that women tend to present to primary care providers at a stage when the risk is not imminent, but is nonetheless real and substantial, for example, because of an underlying health condition or complications with a previous pregnancy. Indeed, this was the situation of Applicant C in *A, B and C v Ireland*. The omission in the legislation of clear referral pathways from primary care level is of particular concern in this regard, as such omission may lead to delayed access to services, which is strongly associated with subsequent adverse health outcomes.[17] Delays in decision-making could make the difference between a minor procedure and a more invasive procedure that would involve more risk for a woman whose health is already compromised.

It is the view of the IFPA that hospitals, and, more particularly obstetrics units, which are the only designated "appropriate institutions" for terminations under the Act, are not necessarily the appropriate settings for the treatment of all women. In many cases an early medical abortion administered at primary care level is likely to be a woman's preferred option.

The IFPA is of the view that without specific reference to a duty of care to ensure that young women and girls, particularly those in the care of the State, are facilitated to access speedy care pathways, the legislation will fail to give sufficient legal clarity in regard to such cases and that further cases will come before the courts.

- **Section 9**

> *Where the threat to a woman's life arises because of risk of suicide, three doctors—a woman's obstetrician and two psychiatrists, one of whom must be a psychiatrist "who provides or has provided mental health services to women in respect of pregnancy, childbirth or post-partum care"[18]—must agree that a her life is at risk.[19] Where a woman seeks treatment under section 9 of the legislation on the grounds that the risk to her life arises from a risk of suicide, the requirements of the Act for certification are more onerous than in the case of physical risk to life. The pregnant woman must be examined by three, rather than two specialists (two psychiatrists and an obstetrician). The certifying doctors must, with a woman's consent, make every effort to consult with her general practitioner.*[20]

The IFPA is also of the view that the provisions of these sections place an undue burden on women. The Expert Group established by the authorities to advise on the implementation of the A, B and C case expressed the view that limiting the numbers of doctors responsible for decision-making would keep the process as close as possible to the normal doctor/patient relationship and avoid creating unnecessary and unwelcome burdens on the patient and the treating doctor.[21] The provisions requiring the involvement of an obstetrician in making a decision and consultation with a woman's general practitioner will lead in some cases to four doctors being involved in decision-making.

The IFPA is concerned that the emphasis in the Act on obstetric care and the involvement of perinatal psychiatrists and obstetrics specialists in decision-making about section 9 cases will act as a barrier to access by some women and girls who become suicidal as a result of pregnancy to the services they require and entitled to by law. The Act provides that a woman must be examined by a psychiatrist "who provides or has provided mental health services to women in respect of pregnancy, childbirth or post-partum care". Such perinatal psychiatrists specialise in the treatment of pregnant women who have an underlying mental health condition; their role is to manage a woman's pregnancy to delivery stage. Unlike general psychiatrists or community psychologists, perinatal psychiatrists are unlikely in the general course of their practice to see pregnant women or girls in whose case a pregnancy is itself the adverse live event that causes her to become desperate and suicidal. This was precisely the situation of the 14-year-old in the *X case*, i.e. the Supreme Court case that held that Article 40.3.3 of the Constitution implies a right to abortion in order to save the life of a pregnant woman.

- **Sections 10, 11, 12 and 13**

> *The Act includes a review procedure to cover situations where there is disagreement as to whether a risk to life exists.*[22]
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> *A review panel is to be established from whose members review committees will be convened when applications for reviews are received.*[23] *The panel will consist of medical practitioners identified for appointment by the Institute of Obstetricians*

and Gynaecologists, the College of Psychiatrists in Ireland, the Royal College of Surgeons in Ireland and the Royal College of Physicians in Ireland.[24]

Once an application for a review is received, the review committee must be convened within 3 days, [25] *and the review must be completed within 7 days from the date the review committee is established.*

The same number of doctors must review a contested decision under section 10 as are required to make the decision under sections 7 and 9, i.e. two doctors where there is risk to life because of physical health grounds,[26] *and in the case of risk of suicide, the pregnant woman must be examined by three doctors, two of whom must be psychiatrists.*[27]

A person who was previously consulted by the pregnant woman is disqualified from participating in a review committee.[28]

In making its decision, the review committee must examine the pregnant woman.[29] *The pregnant woman or someone acting on her behalf has a right to address the review committee.*[30] *The review committee may require a woman's doctor or former doctor to produce documents or records or to appear before the committee.*[31]

In summary, if a woman is refused certification and subsequently appeals, she will be subjected to examination by a further two psychiatrists and an obstetrician. Such a requirement will inevitably increase the mental anguish and suffering of a vulnerable person. In addition, no supports are explicitly included in the Act to ensure access to the review process for women and girls with intellectual disabilities, women and girls who do not have literacy skills or women and girls whose first language in not English.

The IFPA shares the view of the IHRC that the intrusive nature of the review procedures could of themselves be viewed as unjustifiably infringing the woman's right to respect for her private and family life under Article 8 of the ECHR.[32]

- **Section 17**

Section 17: *The Act recognises an individual right to conscientious objection, however there is no right to refuse care in emergency cases.33 Furthermore, a medical practitioner, nurse or midwife who has a conscientious objection must make arrangements for the transfer of care of the pregnant woman concerned to another practitioner.*[34]

Refusal of care—rather than the duty to care—is located within the sphere of conscience. The right to conscientious objection under section 17 applies to individuals; the Act does not explicitly place a corresponding duty on health service institutions to ensure that women receive care. Conscientious objection provisions have been used in many jurisdictions to refuse care to women.[35] In this context, the insufficiently robust provisions of the Act, and the omission of sanctions in the case of refusal of care, may either act as a barrier to access to lawful care in cases where a woman's life is at risk or result in women's lives being harmed or endangered.

- **Section 22**

> ***Section 22:*** *The Act criminalises any person who intentionally destroys unborn human life, except in the narrow circumstances covered by the Act.*[36] *The maximum penalty for this offence ("destruction of unborn human life") is fourteen years imprisonment.*[37] *This penalty applies equally to pregnant women and abortion providers. The consent of the Director of Public Prosecutions is required for a prosecution to be brought.*[38]

The Court considered that the existence of criminal penalties for having or assisting in an unlawful abortion constitutes a significant "chilling factor" for both women and their doctors. The 2013 Act maintains the legal position whereby abortion is lawful only to save a pregnant woman's life, and is criminalised in all other circumstances, including where there is a risk to a woman's health and well-being. The IFPA is concerned that the 2013 Act does not adequately address the chilling effect highlighted by the European Court of Human Rights, and may, in fact, substantially reinforce it. The new offence of intentional destruction of unborn life carries a maximum penalty of 14 years imprisonment, which is applicable to a pregnant woman or another person who carries out an abortion in any circumstances except where a woman's life is at risk. The IHRC has questioned the proportionality of this provision, especially in regard to vulnerable women.[39]

The scope of the offence of intentional destruction of unborn life is also of concern: it appears to be sufficiently widely drafted to criminalise women and girls who obtain medication from an online or other provider and self-induce abortion. The IFPA knows from our services that women and girls who self-induce abortion may be deterred from or delayed in accessing post-abortion medical care for fear of prosecution, and may thereby endanger their health. The effect of section 22 is that it remains a crime to provide an abortion in the interests of a woman's health, where the pregnancy is the result of a crime and in cases of fatal foetal abnormality.

- **Sections 15, 20, 21, 23 and Draft Regulations**

> ***Section 15:*** *An annual report must be submitted by the Health Services Executive on the operation of the review process*[40]*; this report must omit details that could identify either women who have applied for reviews or doctors who have carried out such reviews.*[41] *This report is to be laid before each House of the Oireachtas (parliament).*[42]
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> ***Section 20:*** *All abortions carried out under the Act must be notified to the Minister for Health*[43] *and such notification must include the Medical Council Registration number of a doctor*[44] *who carries a termination under the legislation and the name of the institution where it was carried out.*[45]
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> ***Section 21:*** *The Act includes ministerial powers to suspend abortion services, other than in emergency cases, if she or he believes that there is a serious risk of failure to comply with the 2013 Act.*[46]

Section 23: *the Act extends the criminal liability for the offence under section 22 to bodies corporate.*

Draft Regulations*. The regulations cover: the form of application for a review of a medical opinion under section 10; the form of certification of a procedure under sections 7, 8 and 9; and the form of notification of a procedure to the Minister under section 19. Doctors must certify (1) that there is a real and substantial risk to life and give clinical details; (2) that other treatments, if any, were considered; (3) that "in our reasonable opinion (being an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable) that risk can* ***only*** *be averted by carrying out a medical procedure" referred to in the relevant section of the Act. (Emphasis in the original.)*

Taken together, the provisions in sections 15, 20 and 21 represent an unprecedented and unwarranted degree of ministerial and parliamentary scrutiny of an aspect of healthcare. No other medical procedure is the subject of a report which is laid before parliament. While the chilling effect is usually used to describe the impact of criminal laws on the provision of lawful services, it is the view of the IFPA that these provisions will similarly act to prevent the provision of lawful abortion services. The IHRC has cautioned that the extension of criminal liability to bodies corporate may well lead hospitals to err on the side of caution and implement restrictive internal governance procedures which reinforce the chilling effect and act as a barrier to effective access to lawful reproductive health services.

It is the IFPA's view that the draft regulations are framed in excessively restrictive terms and place disproportionate emphasis on the requirement to "preserve unborn human life" and may thereby act as a deterrent or give insufficient clarity to medical practitioners, particularly if no guidelines are published that clearly place the Act and the regulations in the context of best medical practice to vindicate the right to life of a pregnant woman.

We hope that the Committee will find this communication useful in the deliberations on the execution of this judgment. Should you need further information, please do not hesitate to contact me.

Respectfully yours,

Niall Behan

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Niall Behan
Chief Executive Officer

References

[1] A, B and C v Ireland, Application No. 25579/05. GC. Judgment 16 December 2010. [2010] ECHR 2032

[2] Protection of Life During Pregnancy Act 2013. Act Number 35 of 2013. Available from http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf

[3] [1992] 1 IR 1

[4] *Tysiac v Poland*, 2007, Application 5410/03

[5] S.7

[6] S.8

[7] S.9

[8] Ss 10 to 14

[9] S. 17

[10] S.22

[11] S.2 (1)

[12] In Ireland, the sources of policy in relation to care of women who have abortions because of risk to life are diverse; they include the Constitution, legislation, the common law, including the X case, and the 2010 judgment of the European Court of Human Rights in A, B and C v Ireland. These texts are not amenable to interpretation by non-lawyers and are largely framed in restrictive terms. The only binding health service policy outlining the duty of care of healthcare professionals towards women who have lawful abortions to save their lives or who avail of abortions in other states is the Irish Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners, which is not, of its nature, a protocol for clinical care and does not outline a care pathway.

[13] Irish Human Rights Commission Observations on the Protection of Life During Pregnancy Bill 2013. Available from: http://www.ihrc.ie/download/pdf/ihrc_observations_protection_of_life_in_pregnancy_bill_2013.pdf

[14] S.7.(a)

[15] S. 8

[16] S.7(3)

[17] Royal College of Obstetricians and Gynaecologists: The Care of Women Requesting Induced Abortion. February 2012. At page 43. Available from http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf; World Health Organisation: Safe abortion: technical and policy guidance for health systems. 2nd edition 2012. At page 106. Available from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.

[18] S.9.3

[19] S.9.1.(a)

[20] S.9(4)

[21] Report of the Expert Group on the Judgment in A, B and C v Ireland November 2012. Page 34 and 35.

[22] S.10

[23] S.11

[24] S.11.(3)

[25] S.12.(1)

[26] S.12 (2)

[27] S.12.(3)

[28] S.12.(5)

[29] S.13.(2)

[30] S.14.(1)

[31] S.14.(2)

[32] Op cit, para 60, page 26

[33] S.17.(2)

[34] S.17.(3)

[35] The issue of refusal of care in the context of conscientious objection clauses arose in P. and S. v. Poland (No. 57375/08 Eur. Ct. H.R. (2008)). Refusal of care in the context of conscientious objection

clauses is the subject of a case before the European Committee of Social Rights: International Planned Parenthood Federation European Network (IPPF EN) v. Italy. Complaint No. 87/2012. 3 September 2012.

[36] S.22.(1)

[37] S.22.(2)

[38] S.22.(3)

[39] Op cit, para 101, page 43

[40] S.15.(1)

[41] S.15.(3)

[42] S.15.(4)

[43] S.20

[44] S.20.(a)

[45] S.20.(c)

[46] S.21.(a)