Irish Family Planning Association

Submission to the Working Group on the Protection Process

March 2015

CONTENTS

INTRODUCTION

The Irish Family Planning Association (IFPA)

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 2013, the IFPA medical clinics provided sexual and reproductive health services to over 16,400 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. The IFPA is recognised as a respected source of expertise because of its proven track record in the provision of sexual and reproductive health care services, advocacy and policy development.

Highlighting reproductive health needs of women asylum seekers

As the leading provider of sexual and reproductive health services in Ireland, the IFPA sees many clients who are in direct provision. Serious concerns about women asylum seekers' access to quality sexual and reproductive health care led the IFPA in 2009 to initiate the Majira Project[1], aimed at improving the sexual and reproductive health of asylum seekers and refugees living in Ireland. This project concluded with the publication of *Sexual Health and Asylum*: *Handbook for People Working with Women Seeking Asylum in Ireland*. In 2014, the IFPA opened the first specialist treatment centre in Ireland for women who have undergone female genital mutilation. The IFPA has a long track record of highlighting issues in relation to sexual and reproductive health and asylum—including in relation to access to abortion services outside the State—with policy makers and international human rights bodies.

The IFPA is deeply concerned about the harms caused by inadequate sexual and reproductive services to the physical and mental health and wellbeing of women, girls and families who are living in direct provision. We know from our services that some women and couples who wish to limit their family size, often in the interests of the wellbeing of their children, have been unable to do so. We also know from our services of women who are pregnant, and have made a decision that they cannot continue the pregnancy, being unable in spite of all their efforts to access abortion services outside the State. We know of women who have attempted to gain entry to another state without a visa and who have been refused entry, women who resort to illegal and potentially unsafe methods to end the pregnancy, women are forced to parent against their will.

The 2014 case of Ms Y, who was unable to access abortion outside Ireland, or, ultimately, under the Protection of Life During Pregnancy Act, highlighted the reality facing women asylum seekers and the urgent need for clear and transparent supports by the State for pregnant women living in direct provision who experience an unplanned or crisis pregnancy. The barriers asylum seeking women face in accessing abortion services outside Ireland were highlighted in the IFPA Annual Report 2013.[2]

[1] IFPA (2010) *Sexual Health and Asylum, Handbook for People Working with Women Seeking Asylum in Ireland*. Available from: http://www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf

[2] IFPA (2013) *IFPA Annual Report 2013: Access, Choice and Advocacy*. Available from: http://www.ifpa.ie/sites/default/files/documents/annual-reports/ifpa_annual_report_2013.pdf

The IFPA welcomes the establishment of the Working Group to examine improvements to the Protection process and the Direct Provision system. The IFPA makes this submission with the aim of assisting the Working Group in developing recommendations regarding fulfilment of the right of asylum seeking women to sexual and reproductive health care, including access to abortion services outside the State.

The IFPA is of the view that the provision of sexual and reproductive health care to women in direct provision falls short of the requirements of accessibility and acceptability of health information and services.

> In minority ethnic communities where men are traditionally spokespersons for the family, the health and social support needs of women may seldom be identified or acknowledged. While little data is available in Ireland around the health needs of women from minority ethnic groups and cultures, it is acknowledged that this group reports increased levels of depression and poor health.
>
> Issues around maternity and reproductive health are also reported to be emerging areas of concern. In most cultures, including Ireland, rape and domestic violence are taboo issues, and women who have experienced such violation are less likely to seek help or treatment. 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.
>
> ***HSE National Intercultural Health Strategy 2007***[3]

> Both international and national evidence shows the impacts of health inequalities across socio-economic groups. Variations in crisis pregnancy experience, STI and sexual health behaviours demonstrate inequalities across the population, reinforcing the relationship between poverty, low educational attainment and poorer sexual health outcomes. In addition risk factors such as low self-esteem, low educational aspirations, and factors at the psychological, situational and relational levels lead to a range of negative health behaviours….On the other side, interventions designed to enable young people take responsibility for their sexual health and behaviours and to delay the onset of early first sex, when effective, will have a direct positive impact on other health behaviours. In light of these layered inter-linkages, it is important that the public health policy identifies a set of measures that will instil better coordination and synergy across public health areas and activities.
>
> ***HSE Crisis Pregnancy Programme***[4]

[3] 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

[4] Op cit, note 3

IFPA RECOMMENDATIONS

According to the HSE Crisis Pregnancy Programme (CPP), "Good sexual health as an "intrinsic part of what it is to be human; it is a universal component of human development and wellbeing, central to relationship and family formation, community development and sustainability and in its broadest sense, it is a signifier of the kind of culture and society we live in."[5] The HSE *Family Planning Policy Guidelines for Health Boards*[6] and its *National Intercultural Health Strategy*[7], as well as reports such as the recent United Nations Refugee Agency (UNHCR) report, *Towards a New Beginning: Refugee Integration in Ireland*[8], 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 in the context of women's access to sexual and reproductive health services.

Women and girls may live in direct provision during significant periods of their life course, during which time access to quality sexual and reproductive health care and information is of critical importance to their physical and mental health and well-being. Many women and girls live in direct provision centres during some of the most critical years of their reproductive lives, including the onset of puberty, first sexual experience, short and long-term relationships, marriage, and pregnancy. It is critical that women and girls of reproductive age—i.e. from 15 to 49—have the information and means to protect themselves from unplanned pregnancy and sexually transmitted diseases (STIs), and to control their fertility and plan the number and spacing of their children.

The financial implications of unintended pregnancy and STIs within Ireland go far beyond short-term medical costs: they have an impact on a range of public sector costs. Research in the US has shown that in 2010, for every $1 invested in publicly funded family planning services, $7 was saved in other public expenditures that otherwise would have been needed.[9] Research has further shown that unplanned pregnancies cost the US tax payer an estimated $11 billion each year.[10] Ensuring that all women and girls in direct provision - a tiny proportion of the population as a whole - have access to sexual and reproductive health services would not require prohibitive additional spending in the context of the health budget. But it would result in long-term savings and economic benefits for the State, and in significantly better health outcomes and living standards for women asylum seekers.

Having access to contraceptive methods at a location and time that meets the needs of women is vital to minimising the risks and consequences of unplanned pregnancies. However, in 2012 the CPP highlighted that some migrant women still 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, either because they do not know about the services available or how to access them.[11]

---

[5] Crisis Pregnancy Programme October 2011 *Submission to the Department of Health on Your Health is Your Wealth – Public Health Policy Framework 2012-2020*, Available from: http://crisispregnancy.ie/wp-content/uploads/2012/04/HSECPP_Public-Health-Policy-Framework_submission_FINAL.pdf

[6] HSE (1994) *Family Planning Policy Guidelines for Health Boards*. Available from: http://lenus.ie/hse/bitstream/10147/251197/1/FamilyPlanningPolicyGuidelinesForHealthBoards.pdf

[7] Op cit, note 4

[8] UNHCR (May 2014) *Towards a New Beginning: Refugee Integration in Ireland*. Available from: http://www.refworld.org/docid/52ca8a6d4.html

[9] Guttmacher Institute October 2014 *Publicly Funded Family Planning Services in the United States,* Available at http://www.guttmacher.org/pubs/fb_contraceptive_serv.html#15. This study was limited to public insurance costs for pregnancy and for the first year of infant care.

[10] Op cit, note 3

[11] 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

Health services, including sexual and reproductive health services, should respect women's constitutional rights and should meet the World Health Organisation's requirements in relation to:

- Availability
- 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)
- Quality

Based on the IFPA's consultation with migrant women, our experience as a health services provider, and on international human rights norms and best practice in relation to health care, the IFPA makes recommendations towards the achievement of better access to sexual and reproductive health services for women and girls living in direct provision under seven headings:

1. **Choice of service provider and family planning / contraceptives**
2. **Access to quality, appropriate information about services and rights**
3. **Affordability of sexual and reproductive health care**
4. **Continuity of care**
5. **Confidentiality**
6. **Privacy**
7. **Right to travel and access to abortion**

1. CHOICE OF SERVICE PROVIDER AND FAMILY PLANNING / CONTRACEPTIVES

The HSE's *Family Planning Policy Guidelines for Health Boards* outlines a number or criteria that must be met in order to meet the objectives of a comprehensive family planning service. According to the Guidelines, a comprehensive family planning service should "provide choice in relation to service provider".[12] Existing practice is to ensure women have choice of provider in the context of sexual and reproductive health. It is common for arrangements to be made so that women are referred to women doctors if this is their preference, other general practices or to reproductive health organisations such as the IFPA, which provide an alternative to family doctors.

Lack of choice of provider has significant impacts on women's access to services:

- For some women, receiving sexual and reproductive health care from a male will be culturally inappropriate and may deter women from seeking care;[13]
- Women may be reluctant to express problems, ask questions or consent to physical examinations such as cervical screening, STI testing or insertion of an intrauterine device (IUD) with a male health service provider;[14]
- Some primary health care providers may refuse care on the basis of a personal conscientious objection to contraception or abortion.[15]

Recommendations
Women asylum seekers should have a choice of reproductive health provider.

1.1 Ensure choice of health service providers for asylum seekers, including access to a female health care provider.

1.2 Ensure that health service providers who are allocated to direct provision centres have received training on interpersonal and intercultural communication.

1.3 Ensure that risk of FGM is incorporated into the general medical history intake process and that clinical staff have undergone training to recognise FGM and provide appropriate care or referral.

2. ACCESS TO QUALITY, APPROPRIATE INFORMATION ABOUT REPRODUCTIVE SERVICES AND RIGHTS

A combination of factors, including isolation of direct provision centres from the wider community, can impede access to and understanding of information about health services. In a recent report,[16] the UNHCR has highlighted that while in theory refugees have access to the same channels of information as an Irish person, in practice, refugees face additional barriers which pose problems when trying to access information.[17] The report highlights a number of challenges in accessing services, among them that in order to understand the myriad information available, individuals need to have an understanding of these services, how they operate, and what is reasonable to expect from

[12] Op cit, note 6
[13] Op. cit, note 1, page 13
[14] Ibid.
[15] Ibid.
[16] UNHCR (May 2014) *Towards a New Beginning: Refugee Integration in Ireland*.
[17] Ibid., 53

them. Lack of knowledge of rights and lack of specialised training on the part of frontline staff were also highlighted as barriers.

In this context, women asylum seekers may not be aware that free, confidential and non-judgmental sexual and reproductive health services are available and they are entitled to access these services. Women may not know how to access relevant services, which agency or department to direct their queries or what to expect in different health care settings.

Access to quality, appropriate information about services and rights is a cornerstone of Irish health policy. The HSE's *Family Planning Policy Guidelines* recognise 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".[18] A key guiding principle for service user involvement, as stated by the HSE *National Strategy for Service User involvement in the Irish Health Service* is that "service users should be centrally involved in their own care".[19] Furthermore, service user involvement "must be based on inclusion, diversity and equity – health services must engage socially excluded groups including those who are socio-economically disadvantaged".[20]

The HSE recognises that the ability to communicate can be compromised in health care settings which are stressful and where specialised terms and other unfamiliar language are used.[21] However, poor communication and language barriers are often reported by women seeking asylum and service providers as an immediate obstacle to care. While GPs can avail of a free phone interpretation service in Dublin, uptake is quite low both because of lack of training and concerns that using interpreters would increase time-use.[22] While informal strategies, such as reliance on friends and family to interpret are often used,[23] this is not appropriate and is likely to inhibit clear disclosure of sexual and reproductive health matters.[24] [25]

Lack of knowledge and information combined with language barriers and poor communication can lead to the following scenarios:

- Women asylum seekers lack the information they need to protect themselves from unplanned pregnancy and STIs, and are unaware of the existence of pregnancy counselling services;
- Women asylum seekers are unaware of national cancer screening programmes, such as BreastCheck and CervicalCheck, and breast and cervical cancers may be undetected and untreated;

[18] Op cit, note 4, page 6
[19] HSE (2008) *National Strategy for Service User Involvement in the Irish Health Service 2008 – 2013.* 11. Available from: http://www.hse.ie/eng/services/publications/corporate/Your_Service,_Your_Say_Consumer_Affairs/Strategy/Service_User_Involvement.pdf
[20] Ibid.
[21] HSE (2010) *Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health Related Material into Other Languages* 3. Available from: http://lenus.ie/hse/bitstream/10147/207010/1/Lostintranslation.pdf
[22] The Integration Centre (2012) *Roadmap to Integration 2012*. 31. Available from: https://www.pobal.ie/Publications/Documents/EIF%20Roadmap-to-Integration-2012.pdf
[23] Ibid.
[24] Op cit, note 1
[25] MacFarlane, A., Dr. O'Reilly-de Brún,M. and Nurse, D. (2009) Guidelines for Communication in Cross-Cultural General Practice Consultations.

- Women who have been subjected to female genital mutilation are unaware of the health consequences of this procedure or that free services exist in Ireland[26] for appropriate treatment;
- Women delay presentation to services, which increases risk of health complications and can cause extreme stress and anxiety.
- Poor communication inhibits women's informed consent to sexual and reproductive health services and follow up; lack of informed consent causes confusion and distress for women resulting in a breakdown of trust between patients and health care providers and can lead to non-compliance with recommended management of care (e.g. use of medication);
- Women are not aware that they are entitled to receive as much information as they need and in a way that they understand, in order to make a voluntary choice.[27]
- Women are not aware that they have the right to refuse services, screening or treatment even if refusing may result in harm to themselves;[28]
- With children, family members or friends interpreting, women are reluctant to disclose relevant and sensitive sexual and reproductive health issues, ask questions and/or feel confident that the information will not be shared with community members.[29]

Recommendations

Given the particular vulnerability and isolation from the population at large of asylum seekers in direct provision, information provision must take into account the particular circumstances and experiences of the group.

2.1 Accessible information should be developed and provided in a number of languages and formats in relation to:

2.1.1 Sexual and reproductive health, including regular and emergency contraception, STIs, pregnancy, cervical cancer and breast cancer and related screening programmes and services;

2.1.2 Irish law and the rights of asylum seekers in relation to age of consent to sex, confidentiality, contraception, abortion and abortion information (this is dealt with in more detail below).

2.2 A sexual and reproductive health promotion outreach strategy to direct provision centres should be developed; this should involve:

2.2.1 Provision of regular sexual and reproductive health outreach clinic services to provide information, treatment and advice on all aspects of sexual and reproductive health.

2.2.2 Partnership with migrant-led organisations and sexual and reproductive health organisations;

[26] The IFPA operates a free clinic for women who have undergone FGM at the Everywoman Centre in Dublin 1: https://www.ifpa.ie/Sexual-Health-Services/FGM-Treatment-Service
[27] Ibid.
[28] Ibid.
[29] Ibid.

2.2.3 Participation of asylum seeking women in the design and delivery of targeted health promotion campaigns.

2.3 Asylum seekers must be afforded an environment of trust and respect as service users. Those who provide health services to direct provision centres should:

2.3.1 Receive training in cultural competency, including working with interpreters;

2.3.2 Use professional, trained and accredited interpreters, who can translate in person or over the phone;

2.3.3 Allocate appropriate additional time to consultations that involve interpreters.

3. AFFORDABILITY OF SEXUAL AND REPRODUCTIVE HEALTH CARE

The cost of sexual and reproductive health services has a direct impact on the ability of asylum seekers to access such services and on contraceptive choices. Women often use less reliable and more expensive forms of contraception, such as the oral contraceptive pill, because they cannot afford the initial outlay for a more effective long-term contraception such as the contraceptive implant or IUD. The IFPA regularly waives fees for asylum seekers however, this is not the case for all GPs and other sexual and reproductive health care providers.

The cost of condoms is prohibitive for asylum seekers who currently receive a weekly adult allowance of €19.10 per week. Condoms are not freely available in reception centres nor are they available on the medical card.[30] Condoms are the only contraceptive device that can protect against both unplanned pregnancy and most STIs.

All people living in asylum are offered free STI testing, including HIV testing, as part of their general health screen upon making an application to be considered a refugee in Ireland. However, beyond this, STI screening is not available on the medical card at private sexual health clinics or from GPs. The Guide Clinic[31] at St. James's Hospital has a free walk-in STI/HIV clinic, offering screening and treatment for STIs. However, due to the policy of dispersal in Ireland, the cost of transportation is a deterrent to many asylum seekers in accessing sexual and reproductive health services.[32]

Recommendations
Cost should not be a barrier to women asylum seekers' access to appropriate sexual and reproductive health care.

3.1 All methods of contraception should be provided to asylum seekers free of charge.

3.2 The additional costs of long-term contraception should be waived in the case of asylum seekers.

[30] Ibid, 20
[31] The Guide Clinic is the largest, free STI, HIV and Infectious Disease service in Ireland. More information available from: http://www.guideclinic.ie/
[32] Ibid., 13

4. CONTINUITY OF CARE

The policy of dispersal causes disruption in women's continuity of care; lack of appropriate referral and transfer of files can result in lack of timely access to necessary and appropriate sexual and reproductive health services. Smaller cities and towns may not have appropriate or adequate services.

- Interrupted access to services can leave women without refill prescriptions for oral contraceptives, and increase risk of unplanned pregnancy. [33]

- Women who test positive for STIs, including HIV, shortly after making their asylum claim in Dublin may be dispersed to other parts of the country before appropriate follow up counselling and care can be put in place and dispersed to a location where there are inadequate services.

Recommendations
Transfer from one direct provision centre to another should in no circumstances have negative consequences on women's sexual and reproductive health or leave women without the means of ensuring contraception, pregnancy counselling and other needs.

4.1 Protocols in relation to dispersal should include procedures for referral, with a woman's consent, to a new health care provider.

4.2 Such referral must respect a woman's right to a choice of health care provider and her rights to confidentiality and privacy.

4.3 The onward referral and transfer of medical records should be done with the consent of women.

5. CONFIDENTIALITY

Confidentiality is a fundamental principle of medical ethics and is central to the trust between patients and health care professionals.[34] Ensuring confidentiality is integral to the provision of any sexual and reproductive health service. Many women seeking asylum are reluctant to talk about sexual and reproductive health issues because they fear that information about their experiences or behaviour will become known in their community.[35]

For example:

- In some accommodation centres non-medical staff may arrange medical appointments for women or receive privileged correspondence on behalf of women; private information may be communicated to the staff member and/or the woman in a way that breaches a woman's right to confidentiality;

- Fear of breach of confidentiality can deter women from disclosing relevant information, asking questions or expressing concerns.

[33] Ibid., 20
[34] Ibid.
[35] Ibid., 12

- Women may withhold information and fail to seek appropriate medical care because of a fear that any information disclosed about health status or use of sexual and reproductive health services could affect the outcome of an asylum application.

- The HSE Family Planning Guidelines for Health Boards asserts that a comprehensive family planning services should "respect the confidentiality of its clients".[36]

Recommendations

5.1 A confidentiality protocol should be in place in direct provision centres to prevent the disclosure of any personal information of asylum seekers in direct provision, unless patient consent is provided. To prevent inappropriate disclosure, consent to any transfer of patient information should be obtained.

5.2 Asylum seekers should be provided with information explicitly assuring them that all services provided are confidential; that health services provided will not impact on their asylum application and that their health status is not relevant to their asylum claim.

6. PRIVACY

The right to privacy is of particular importance with regard to sexual and reproductive health. AkiDwA's 2010 survey of women's experiences of seeking asylum in Ireland's reception and asylum system reported that women had "regularly been asked to describe intimately personal female health conditions to the nurse in a waiting room filled with fellow residents and other patients".[37] When women opt to end a pregnancy, the process of organising to travel for abortion may involve multiple disclosures of a private situation in order to obtain information and financial support and to acquire documents allowing them to travel.[38]

Recommendations

As asylum seekers in direct provision have limited privacy from other residents, family members and accommodation centre staff, it is important that specific measures are taken to safeguard the rights of asylum seekers in the area of sexual and reproductive health.

6.1 Work practices within reception centres should ensure women's privacy, particularly with regard to correspondence.

6.2 A privacy protocol should be in place in all direct provision centres and all working staff should receive training in its implementation.

[36] Op cit, note 6

[37] Akidwa (2010) *Am Only Saying it Now, Experiences of Women Seeking Asylum in Ireland*. 18. Available from: http://akidwa.ie//publications/AmOnlySayingItNowAkiDwA.pdf

[38] IFPA (June 2014) Comments of the Irish Family Planning Association (IFPA) in respect of the Fourth Periodic Review of Ireland under the International Covenant on Civil and Political Rights (ICCPR). Available from: https://www.ifpa.ie/sites/default/files/documents/submissions/irish_family_planning_association_re_4th_periodic_review_of_ireland.pdf

7. RIGHT TO TRAVEL AND ACCESS TO ABORTION[39]

Legal Framework

The law on abortion in Ireland derives from the Constitution, case law and legislation.

Article 40.3.3 of the Constitution of Ireland states that:

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

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

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

The Protection of Life During Pregnancy Act 2013

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 wellbeing.

Doctors are required under Irish law to make a distinction between risk to a pregnant woman's life, in which case abortion is lawful, and risk to her health or her quality of life, which is criminalised.

Abortion is unlawful in Ireland except where there is a risk to the life of a pregnant woman. Where abortion is lawful under the Protection of Life During Pregnancy Act 2013,[40] a woman must be assessed by a panel of doctors who will certify whether she is eligible for a termination of pregnancy under the Act. Unlike countries where abortion is legal, termination of pregnancy has been interpreted in Irish law to include early delivery of a viable foetus. Even if a woman is certified as eligible for a lawful abortion under the Act, she may, in spite of her express wish to have an abortion, be forced to parent, regardless of the distress that the prospect of any outcome except abortion causes her.

The Irish State relies on the provision of abortion services in other states, in particular the UK, to avoid the public health crisis of maternal mortality because of unsafe abortion.[41] According to the World Health Organisation, every pregnant woman considering a termination should receive adequate information in order to make a choice about abortion and its risks.[42] In Ireland the right to receive information about abortion is enshrined in the Constitution. However, only women who can exercise their constitutional right to travel can access abortion services. The IFPA has seen many clients who are living in direct provision and are unable to travel because of visa and other travel document requirements or because of financial or other reasons.

[39] Op cit., note 2, page 12; op cit, note 38; IFPA (August 2013), *Submission to the UN Committee Against Torture*. Available from: http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/IRL/INT_CAT_NGO_IRL_15591_E.pdf

[40] 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.

[41] Op. cit., note 2, page 10

[42] World Health Organization (2012*) Safe abortion: technical and policy guidance for health systems*. 2nd edition. 106. Available from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.

There is precedent for the State accepting a positive obligation to facilitate women to travel for abortion. The IFPA is aware of a number of cases where the Health Service Executive (HSE) has supported minors, who are in the care of the state, and are pregnant and wish to avail of abortion, to travel in order to access such services. The IFPA has worked with the HSE to facilitate minors to travel in some of these cases. However, in other cases, the constitutional right to travel for abortion is interpreted as a negative right, i.e. that the State does not prevent women from travelling for abortion. In the case of asylum seekers, this approach amounts to a derogation of the State's responsibility as duty holder.

The United Nations (UN) Human Rights Committee and Committee Against Torture have expressed concern about the "discriminatory impact" of Ireland's abortion law on women who are unable to travel abroad to seek abortions and the "serious consequences" of the law on migrant women.[43] In a recent review of Ireland's performance under the UN International Covenant on Civil and Political rights (ICCPR), the Human Rights Committee in its concluding observations reiterated its previous concern over "the discriminatory impact" of the Protection of Life During Pregnancy Act "on women who are unable to travel to seek abortions".[44]

Obstacles and barriers to accessing abortion
In the absence of transparent procedures and financial support, women asylum seekers encounter a range of obstacles and barriers that can make it impossible for them to access abortion

- **Lack of clarity about how to access supports.** There is no single state agency with responsibility to ensure that women asylum seekers can travel for abortion: women must engage with a number of different government agencies and non-governmental organisations to access the information and the services they need. Those supports that exist are provided on an ad hoc, case-by-case basis by a combination of state agencies and under-resourced non-governmental organisations, and there is a lack of clarity about how to access supports.

- **Accessing information.** The combination of silence and stigma surrounding abortion in Ireland and the Regulation of Information (Services outside the State for the Termination of Pregnancies) 1995 makes accessing information about abortion problematic for women in direct provision, especially those newly arrived in Ireland and those without social networks. Language barriers and other cultural factors may prevent women from accessing supports and information. Women may be unaware of the law; staff in reception centres may be unaware of free counselling services available or may provide selective or inaccurate information.

- **Financial barriers.** An abortion procedure can cost €600 to €2000, depending on the clinic and the stage of gestation. No financial assistance is available from the State. The costs of travelling are higher for women who are subject to travel restrictions and visa requirements. In addition to clinic fees, flights and accommodation, she must pay travel document application fees, transport costs to and from embassy and government offices, and indirect costs, such as childcare. A re-entry visa and a temporary travel document cost €260 and €280 respectively and must be paid with a bank draft or postal order. An entry visa to the Netherlands costs €260, a UK visa costs €100.

- **Travel documentation process.** Women asylum seekers must apply for a re-entry visa from the Department of Justice and Law Reform and a visa from the country to which they will be

[43] Concluding Observations on Ireland's Initial Report, the Committee Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT), 46TH session, 17 June, CAT/C/IRL/CO/1, para 26.
[44] UN Human Rights Committee, Concluding observations on the fourth periodic report of Ireland. 19 August 2014. CCPR/C/IRL/CO/4

travelling. Some women must also obtain temporary travel documents. Women asylum seekers must also gather extensive supporting documentation and attend the relevant embassies and the Department of Justice and Equality. Women who do not access pregnancy counselling services may not be aware that they can obtain temporary travel documents to allow them to leave and re-enter Ireland. In the IFPA's experience, the UK is less likely to issue entry visas to women with temporary travel documents. Therefore most women with travel restrictions try to travel to the Netherlands. The British Embassy also requires a woman to have an email account so that she can receive a ten-page application form. 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. An entry visa can take in excess of four weeks to be issued.

- **Limits facing service providers.** Pregnancy counsellors are restricted by the Abortion Information Act 1995 in what support they can give to a woman in obtaining travel documentation. IFPA pregnancy counsellors give all the supports they can to assist women asylum seekers to access abortion services. However, pregnancy counselling services by law may only provide counselling and abortion information. It is not within the remit of pregnancy counsellors, or within the law, according to the Abortion Information Act, to advocate or make arrangements for or accompany asylum seeking women through the process of arranging for an abortion. The IFPA can provide a pregnancy test, but must refer women to another provider outside the city centre for a free ultrasound scan in order to determine the stage of gestation.

Impacts of Ireland's abortion law on asylum seekers

The legal restrictions on women's access to abortion has serious health consequences:

- If a woman is unable to travel for an abortion, she will be forced to parent against her will while living in direct provision.
- To avoid this situation, some women resort to illegal and potentially unsafe methods to terminate a pregnancy in Ireland.
- The time necessary to obtain finance and travel documentation can lead to delays and force women to have later abortions.
- Such delay can have a significant impact on a woman's physical and mental health, particularly where a woman has an underlying health condition or when a woman has received a diagnosis of foetal anomaly.
- Later abortions are also more expensive and invasive.
- In some cases, the legal time limits for the procedure may have passed, so women cannot avail of the procedure.

Recommendations within the current legal framework

The failure to provide adequate supports to women asylum seekers who want to end a pregnancy that is unplanned, unwanted or has become a crisis, is causing serious harms to the physical and mental health of pregnant women: the State must take responsibility for ensuring that asylum seeking women can access safe and legal abortion by travelling to a state where abortion is legal.

7.1 Financial support should be made available to women asylum seekers for the costs of accessing abortion services outside the State.

7.2 A protocol and guidance for state agencies and non-governmental organisations on appropriate supports for asylum seeking women who seek abortion services outside the State should be produced and disseminated without delay.

7.3 Information materials for asylum seeking women and the agencies that support them that comprehensively outlines all the documentation required to travel for abortion, the costs involved and the procedures for obtaining financial support, should be published in a variety of languages and formats.

7.4 The burden on women of accessing travel documentation should be reduced, including by the Reception and Integration Agency(RIA) liaison with the Irish Naturalisation and Immigration Service (INIS) to simplify and make transparent the process of acquiring temporary travel documentation and re-entry visas.

7.5 Ongoing supports should be provided for women who are parenting in circumstances where their preferred option was to end a pregnancy but who were unable to travel outside the State.

7.6 Research must be carried out as a matter of urgency to establish a full and detailed picture of:

7.6.1 the costs, barriers and obstacles encountered by women asylum seekers who attempt to access abortion services outside the State;

7.6.2 the impacts on the physical and mental health of women who are unable to access abortion;

7.6.3 the legal and ethical responsibilities to ensure women's access to abortion services of relevant state agencies and government departments.

Appendix 1: Sexual and Reproductive Health

Sexual and Reproductive Health

The World Health Organisation (WHO) describes health as "a state of complete physical, mental and social wellbeing…" and emphasises that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[45] Sexual and reproductive health is recognised in international human rights law as a fundamental human right and indispensable to living a life in dignity.[46]

Sexual and reproductive health (SRH) is a state of physical, emotional, mental and social well-being related to sexuality; it is not only the absence of disease or dysfunction. SRH requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[47]

Sexual and reproductive health and rights (SRHR) encompass a range of human rights that are recognised in national and international law. SRHR can be understood as the right of every person to make choices regarding their own sexuality and reproduction. These rights are universal, interrelated, interdependent and indivisible and include the rights to[48]:

- The highest attainable standard of health in relation to sexuality, including access to SRH care services[49]
- Seek, receive and impart information related to sexuality
- Sexuality education
- Respect for bodily integrity
- Choice of partner
- Decide to be sexually active or not
- Consensual sexual relations
- Consensual marriage
- Decide whether or not and when to have children
- To pursue a satisfying, safe and pleasurable sex life
- Decide freely and responsibly about the number spacing and time of children[50]
- Have the information and the means to do so

[45] WHO Constitution (1948)
[46] UN Economic and Social Council, General Comment No.14 (2000). *The right to the highest attainable standard of health.* E/C.12/2000/4
[47] United Nations (1994). *Programme of Action of the International Conference on Population and Development*. Cairo: United Nations.
[48] International Planned Parenthood Federation (2008). *Sexual Rights: An IPPF declaration*. London: IPPF.
[49] International Covenant on Economic, Social and Cultural Rights, Art. 12.1: State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
[50] Convention on the Elimination of all Forms of Discrimination Against Women, Art. 16(1)(e): State Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: .... (e) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Rights-based approach to Sexual and Reproductive Health

Sexual and reproductive health and rights are basic human rights. Human rights norms and principles should be integrated in the design, implementation, monitoring, and evaluation of health-related policies and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all.

According to the WHO, the principle of equality and freedom from discrimination is central to a rights-based service. Integrating human rights also means empowering people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access.[51]

According to the UN Committee on Economic, Social and Cultural Rights), the right to health is comprised of four elements: availability, accessibility, acceptability and quality. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, affordability and information accessibility.[52] Acceptability means that health care must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.

Gender

The WHO recognises gender as a key determinant of health. This is reflected in the HSE National Intercultural Health Strategy[53], which calls for a gender sensitive approach to service provision. The Strategy notes that "women from all minority ethnic groups and cultures are a particularly vulnerable group" and that the situation "may be compounded in circumstances where they are isolated";[54] the Strategy describes the situation of asylum seeker women as "particularly harrowing".[55]

Women seeking asylum are a diverse population with different cultural, religious, ethnic and linguistic identities. Gender roles and norms can intersect with language barriers and cultural norms so that some women asylum seekers lack social supports outside their immediate family. At the same time, people may not conform to the beliefs or practices that are common in their community.

The provision of sexual and reproductive health care must be approached from a perspective that recognises the interconnectedness of a variety of physical, social and emotional, psychological, cultural, legal, financial and gender-related determinants of health.

[51] WHO. *Human Rights Based Approach to Health*. Available from: http://www.who.int/trade/glossary/story054/en/index.html
[52] WHO & OHCHR. The Right to Health. Joint Fact Sheet WHO/OHCHR 323 August 2007.
[53] Op cit, note 3, page 51
[54] Ibid.
[55] Ibid., 52

Appendix 2: Recommendations by United Nations (UN) Human Rights Bodies

Recommendations by UN Human Rights Bodies in relation to Sexual and Reproductive Health

Right to health

Sexual and reproductive health and rights are a fundamental component of the right to health as provided for in international treaties, agreements and conventions, including the Programme of Action of the International Conference on Population and Development (ICPD); the UN International Covenant on Economic, Social and Cultural Rights (ICESCR); the UN Convention on the Elimination of All Forms of Violence Against Women (CEDAW); and more.

Article 12 of ICESCR recognises the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[56] As Ireland is signatory to the Covenant, it is bound by its provisions.

General Comment No 14 on the right to the highest attainable standard of health, issued by the UN Committee on Economic, Social and Cultural Rights (UNCESCR) sets out what the right entails. The General Comment states that the right to health is not restricted to referring only to access to adequate healthcare but extends to include the underlying determinants of health, including access to health-related education and information, including on sexual and reproductive health.[57] It establishes the obligation to adopt adequate measures to guarantee women's access to health and medical care, with no discrimination whatsoever, including access to family planning services.

Gender and the right to health

The UNCESCR General Comment 14 pays particular attention to the issue of women and the right to health. The Committee asserts that States Parties to the Covenant should "eliminate discrimination against women" and that:

> "The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[58]

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

The CEDAW Committee has held that discrimination based on sex and gender is inextricably linked to other factors, including pregnancy, general health status, ethnic minority status and socio- economic status.[59]

---

[56] International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, UN Doc. A/6316 (1966) Article 12

[57] General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR), E/C.12/2000/4, 11 August 2000. Para 11. Available at: http://www.refworld.org/docid/4538838d0.html.

[58] General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR), E/C.12/2000/4, 11 August 2000. Para 21. Available at: http://www.refworld.org/docid/4538838d0.html.

[59] Cook, R (2013) *Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision*. Journal of Law, Medicine and Ethics. Volume 41. Issue 1. Spring 2013. 103.

Participation (rights-based approach)

Important to the right to health, as affirmed in General Comment No 14, is "the participation of the population in all health-related decision-making at the community, national and international levels."[60]

Right to travel and abortion

According to the World Health Organization (WHO), every pregnant woman considering a termination should receive adequate information in order to make a choice about abortion and its risks.[61] (In Ireland the right to receive information about abortion is enshrined in the Constitution.)

In *Alyne da Silva v Brazil*[62], the CEDAW Committee held that governments have a human rights obligation to guarantee that all women in their countries—regardless of income or racial background—have access to timely, non-discriminatory, and appropriate maternal health services.

In the Alyne case the CEDAW Committee found a violation of human rights in circumstances where multiple and intersecting aspects of disadvantage and discrimination were at issue. The CEDAW held that discrimination based on sex and gender is inextricably linked to other factors, including pregnancy, general health status, ethnic minority status and socio-economic status.[63]This focus on vulnerable populations within a state is of particular relevance to the situation of women asylum seekers in Ireland who experience the barriers outlined above to their access to the right to travel to avail of services that only women require.

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has stated that the criminalisation of reproductive health services is a violation of the right to health and shifts the burden of accessing the right from the state onto a pregnant women.[64]

Several international human rights bodies including the UN Human Rights Committee, the CEDAW Committee, the European Court of Human Rights and more, have expressed concern over Ireland's severely restrictive abortion laws.

In 1999, the CEDAW Committee stated that the need for pregnant women to travel abroad for abortion "creates hardship for vulnerable groups, such as female asylum seekers who cannot leave the territory of the State".[65]

In its 2011 Concluding Observations on Ireland's Initial Report, the UN Committee Against Torture highlighted that Irish law results in "serious consequences in individual cases, especially affecting minors, migrant women, and women living in poverty".[66]

In its Concluding Observations to Ireland at its ninety-third session, July 2008, the Human Rights Committee urged the State to take measures to help women avoid unwanted pregnancies so that

[60] General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR), E/C.12/2000/4, 11 August 2000. Para 11. Available at: http://www.refworld.org/docid/4538838d0.html.
[61] World Health Organisation (2012*) Safe abortion: technical and policy guidance for health systems*. 2nd edition. 106. Available from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.
[62] Alyne da Silva Pimentel (deceased) v. Brazil, U.N. Doc CEDAW/C/49/D/17/2008, August 10, 2011
[63] Cook, Rebecca. 2013. *Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision*. Journal of Law, Medicine and Ethics. Volume 41. Issue 1. Spring 2013. Page 103.
[64] 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.
[65] CEDAW Concluding Observations, 21st session, 25 June 1999, CEDAW/C/SR.440 and 441.
[66] Concluding Observations of the Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 46th session, 17 June 2011, CAT/C/IRL/CO/1, para 26

they do not have to resort to illegal or unsafe abortions that could put their lives at risk (article 6) or to abortions abroad (articles 26 and 6).

In 2014, the Human Rights Committee reiterated its concern voiced in 2011, regarding the highly restrictive circumstances under which women can lawfully have an abortion in the State.[67]

[67] Human Rights Committee, 111th Session, Concluding observations on the fourth periodic report of Ireland, UN Doc CCPR/C/IRL/CO/4, 19 August 2014.