Submission to the Citizens' Assembly

A health and rights approach to abortion in Ireland

Irish Family Planning Association

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ifpa
SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

Contents

IFPA position on the Eighth Amendment

The Irish Family Planning Association (IFPA) believes that Article 40.3.3, the Eighth Amendment of the Constitution, is irreconcilable with the State's obligation to its citizens to guarantee the highest standard of reproductive health. The problem is not its legal ambiguity: It is the fact that its impacts, including the denial of abortion services to women in Ireland, are harmful to women's health. It is the firm view of the IFPA that the Eighth Amendment must be repealed, and replaced with a regulatory framework to guarantee that women in Ireland have the right to legal abortion services and that these services are accessible, affordable, of high quality and respect women's dignity and right to confidentiality and privacy.

International evidence is unambiguous: Countries that have lowered the abortion rate have not achieved this through criminalising abortion. They have achieved it through a combination of primary prevention-including high-quality comprehensive sexuality education and the provision of access to reliable and affordable contraception, the provision of safe abortion services—secondary prevention, post-abortion contraception counselling and services, and the provision of abortion services.[1]

Constitutional declarations such as the Eighth Amendment prevent the development of the kind of practical policy solutions that a complex issue such as abortion requires. Repeal of the Eighth Amendment will free the Government to draw on the wealth of technical, ethical, legal and medical guidance that has been developed by international standard setting bodies to assist states with the development of a practical and appropriate health system and regulatory approach to abortion.

The World Health Organization has drawn on the research and technical knowledge of medical, legal and health policy experts from across the world to develop best practice guidelines on the provision of abortion services. The International Federation of Gynecology and Obstetrics (FIGO) and the Royal College of Obstetrics and Gynaecology in the UK have also developed ethical and technical guidelines on all aspects of abortion. In addition, the issue of abortion is settled in virtually all other European states. The Irish Government, therefore, can draw on the regulatory models of other countries that have found appropriate ways to strike a balance between regulation of abortion and access to services.

The citizens of Ireland are entitled to expect that our laws are of the highest standard. Ireland's laws on abortion have been criticised by every United Nations human rights monitoring body, every international court and every international human rights mandate that has reviewed Ireland's implementation of human rights. In devising future regulation of abortion, after repeal of the Eighth Amendment, the Government must be informed by international human rights law, specifically the requirements of the right to the highest attainable standard of reproductive health.

Sources for this submission

This submission is primarily based on direct experience from the IFPA's services: the experiences of IFPA pregnancy counselling clients who have chosen to terminate a pregnancy, clients who attend for post-abortion counselling and medical services and IFPA doctors and pregnancy counsellors who provide services to these clients.

In addition, the IFPA periodically organises consultations and public seminars with lawyers, healthcare professionals, policy makers, academics and civil society organisations on the topic of abortion, human rights and law reform. We have drawn on the expert contributions to these events throughout this submission.

To represent the experience of our clients, case vignettes are included throughout to illustrate the wide range of reasons why women seek abortion and the barriers they face in doing so. None of these vignettes is based on any individual experience; each draws on the accounts of a number of different women. The names used have been chosen randomly. We have also changed potentially identifying details, such as place names, locations of airports and names of hospitals.

Glossary of terms

Abortion
The intentional ending of a pregnancy.

Abortion pill
The abortion pill is a medicine that ends a pregnancy in its early stages. The abortion pill should not be confused with the "morning after pill" which is a colloquial term for one form of emergency contraception. See also: Early medical abortion.

Abortion on demand / request
When a woman can access an abortion, based on her own decision about her health and wellbeing, without having to give reasons or establish that her case falls within defined legal criteria.

Access to health care
According to international human rights principles, the highest attainable standard of health requires that health services are accessible, affordable and acceptable to all on an equal basis with others. Services should be within reasonable distance, not prohibitively expensive, of good quality and delivered without discrimination.

Barriers to access health care
Laws, regulations, policies and practices that interfere with equitable access to health care, e.g., restricting access to information, requiring authorisation from multiple medical professionals or use of conscientious objection (see below) to refuse care or fail to refer a patient.[2]

Amniotic fluid
The fluid contained within the amnion that surrounds the foetus in the womb and protects it from external pressure.

Anencephaly
A congenital abnormality where the roof of the skull is defective and the underlying brain tissue is underdeveloped or absent.

Carrying a pregnancy to term
Completing the pregnancy, typically at between 37 and 42 weeks, and giving birth.

Conscientious objection
A moral objection to providing a particular procedure or treatment, for example on religious grounds. The Irish Medical Council is clear that conscientious objection only allows medical professionals to refuse to carry out a procedure. It does not extend to other healthcare staff or allow a medical professional to refuse to discuss treatment or deny women's access to legal reproductive health care. Healthcare professionals have a duty to refer onwards if they are unwilling to carry out a procedure themselves.[3]

Dilation and curettage
Dilation and curettage (D&C) is a procedure to remove tissue from inside a woman's uterus. Doctors perform dilation and curettage to diagnose and treat certain uterine conditions—such as heavy bleeding—or to clear the uterine lining after a miscarriage or abortion.

Direct Provision
Direct Provision is intended to provide for the welfare of asylum seekers and their families as they await decisions on their asylum application. An allowance of €19.10 per adult and €15.60 per child is provided by the State, and people seeking asylum are not permitted to work. The IFPA has many concerns about inadequate access of women and girls to reproductive health services while living in Direct Provision.

Early medical abortion
Abortion carried out using the medicine mifepristone, also called the abortion pill. Mifepristone works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down and the pregnancy cannot continue. Mifepristone treatment is followed by another medicine called misoprostol, which makes the womb contract, causing cramping and bleeding similar to a miscarriage. For more information, see IFPA website.

Eclampsia
A potentially life-threatening condition that can occur during the second half of pregnancy. It can include high blood pressure, fluid build-up and too much protein in the urine, which can lead to convulsions and coma. Eclampsia can be prevented by careful monitoring of blood pressure and urine during prenatal care.

Ectopic pregnancy
A pregnancy that occurs outside the uterus, often in a fallopian tube.

Embryo
The developing organism from the fourth day after fertilisation to the end of the eighth week.

Emergency contraception
A method of preventing fertilisation by preventing or delaying ovulation.

Fertilisation
When the nucleus of the sperm cell penetrates the egg cell.

Foetus
Developing baby, prenatal human between the embryonic state and birth.

Gestation
Process of being carried in the uterus from conception to birth. The duration of a pregnancy.

Health
The WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Implantation
When the fertilised egg settles into the uterus wall.

Induced abortion
Abortion, the intentional ending of a pregnancy.

Infertility
Inability to produce offspring.

Informed consent
Consent given voluntarily, by a competent person, able to fully understand the benefits and potential risks of their decision.

Maternal mortality
Death of a woman due to pregnancy or birth-related problems.

Miscarriage
Natural ending of a pregnancy before the foetus is viable (also known as *spontaneous abortion*).

Obstetrics and gynaecology
Branch of medicine that deals with pregnancy, childbirth and the female reproductive system.

Pelvic inflammatory disease (PID)
An infection of the female upper genital tract, including the womb, fallopian tubes and ovaries. If diagnosis and treatment are not performed in a timely manner, PID may cause sepsis, septic shock and even death. Long-term health consequences can occur, including ectopic pregnancy, tubo-ovarian abscess, infertility, pain during intercourse and chronic pelvic pain.

Pregnancy counselling
Non-directive pregnancy counselling services for women and their partners who are experiencing an unplanned pregnancy or a pregnancy that has become a crisis. The IFPA's pregnancy counselling service is funded by the HSE. This service is free and operated by professional and accredited counsellors and psychotherapists at twelve locations nationwide. Counsellors provide information on all the options open to a pregnant woman: adoption, parenting and abortion.

Pregnancy counselling and men
Pregnancy counselling can offer men affected by a crisis pregnancy a place to discuss their feelings. Men can attend counselling alone or with their partner (if that is what she wants). The decision about the pregnancy always lies with the woman.

Rogue agency
An anti-abortion agency whose sole purpose is to prevent women from having abortions. They misinform and intimidate women to achieve this aim.

Sentience
Sentience is the capacity to feel pain or to feel pleasure, and is regarded by many moral theorists as the characteristic of living things which justifies rights-bearing status. According to the Royal College of Obstetrics and Gynaecology, 24 weeks gestation is the earliest moment when sentience is possible; as the foetal brain's cortex and neurological peripheries are not integrated before then.

Sexual and Reproductive Health

This requires full access to high-quality information, education and health services regarding sex, sexuality, conception, contraception, safe abortion and sexually transmitted infections.

Spontaneous abortion
See miscarriage.

Trimester
First, second or third period of three months of a pregnancy.

Viability
Point at which a foetus could survive outside the woman's body.

About the IFPA

A leading provider of sexual and reproductive health services

The IFPA is Ireland's leading sexual and reproductive healthcare provider. Since 1969, the organisation has worked to promote and protect basic human rights in relation to sexual and reproductive health. In 2015, the IFPA provided more than 12,000 sexual and reproductive health consultations at our medical clinics in Dublin city centre and Tallaght. Among the services provided were cervical screenings, contraceptive services and screenings for sexually transmitted infections.

Our medical staff of nine doctors and six nurses work at two medical clinics in Dublin city centre and Tallaght. The IFPA's team of 11 professional and accredited counsellors and psychotherapists work in the Dublin clinics and at our counselling centres across Ireland.

Since 1992, we have provided confidential and non-directive pregnancy counselling services to women and their partners who are experiencing an unplanned pregnancy or a pregnancy that has become a crisis. We support a woman's choice about her pregnancy in all cases, whether that choice is abortion, parenting or adoption.

The IFPA is the only nationwide pregnancy counselling agency that provides abortion information. 50% of women who attend for pregnancy counselling services in Ireland attend an IFPA service.

With a strong track record in providing high-quality medical, counselling and education services, the IFPA is a respected authority on sexual and reproductive health and rights and is regularly called upon to give expert opinion and advice.

Vision

The IFPA envisages an Irish society where all people can enjoy a fulfilling sex life and can make informed choices in their sexual and reproductive lives; where there is full access to high-quality information, education and health services regarding sex, sexuality, conception, contraception, safe abortion and sexually transmitted infections.

Mission

The IFPA, its members, affiliates and supporters:

- Promote and protect individual basic human rights in reproductive and sexual health, relationships and sexuality.
- Promote and defend the right of all persons, including young people, to decide freely the number and spacing of their children (if any), so that every child is a wanted child.
- Are committed to obtaining equal rights for women and young people, and to their empowerment in obtaining full participation in, and benefit from, social, political and economic development.
- Are committed to working in alliance with all those who share our aims, and in co-operation with interested government and non-governmental bodies.

An advocate for the right to reproductive health

The IFPA promotes the right of all people to sexual and reproductive health information and dedicated, confidential and affordable healthcare services.

Motivated by the suffering caused by the State's blanket ban on contraception, the IFPA was established by seven volunteers in 1969. Since then the IFPA has been to the fore in setting the agenda for sexual and reproductive health and rights both nationally and internationally.

Today the IFPA offers a comprehensive range of services which promote sexual health and support reproductive choice on a not-for-profit basis.

At various times, the law in Ireland has restricted the IFPA's ability to provide services to our clients. This, in turn, has led to our involvement in high-profile legal cases, including landmark cases such as *McGee v. Attorney General*[4] in 1973, which established the constitutional right to avail of contraception.

The IFPA has also supported cases in relation to the ban on the sale of contraceptives and censorship of family planning leaflets. Most recently, the IFPA gave counselling and practical support to three women in the case known as *A, B and C v. Ireland.*[5] This case led the European Court of Human Rights to find Ireland in breach of the European Convention on Human Rights for its failure to give effect to the constitutional right to abortion where a woman's life is at risk.

The IFPA has been raising the issue of Ireland's abortion laws before United Nations human rights monitoring bodies since the 1990s: Every such expert body that has considered the law in Ireland has been critical of its denial and criminalisation of abortion.

1. Introduction

1.1 Why does the IFPA believe the Eighth Amendment should be repealed?

The principal barrier to reform of Ireland's abortion laws is Article 40.3.3 of the Constitution. Article 40.3.3, known as the Eighth Amendment, was inserted into the Constitution after a referendum in 1983. It states:

> *"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."*

It has been interpreted by the Supreme Court to mean that abortion is prohibited in all circumstances, except where there is a risk to a woman's life, as distinct from her health.[6]

- The Eighth Amendment causes a range of harms to pregnant women's health. It prevents doctors from acting in the best interests of their patients. It harms pregnant women's physical and mental health, and their rights to dignity and bodily integrity. In some cases, it endangers a woman's right to life.
- The Eighth Amendment prohibits access to abortion in all cases, except where a woman's life is at risk. Abortion is not available in Ireland in cases of risk to a woman's health and wellbeing, or in cases of rape or foetal anomaly.
- The Eighth Amendment forces at least nine women a day to leave Ireland to access medical treatment that is taken for granted in almost every other European state. At least 165,438 women and girls have taken this journey since 1983 because of an unplanned or unwanted pregnancy, or a pregnancy that has developed into a crisis because of changed circumstances.
- The Eighth Amendment leaves women who cannot travel with no option but to obtain illegal, and potentially unsafe, medication online to self-induce an abortion or to continue with the pregnancy against their wishes. When women access the abortion pill, or medication purporting to be an abortion pill, online, they do so without medical supervision. If complications arise, fear of prosecution can deter or delay women from seeking medical attention, risking damage to their health. Denial of abortion, being forced to travel to another state for abortion, and being forced to continue with a pregnancy all cause harms to women's physical and mental health.
- The Eighth Amendment prevents doctors from acting in the best interests of their patients. In order to perform a lawful abortion, doctors must allow a woman's condition to deteriorate until a risk to her health is unambiguously a risk to her life.
- The Eighth Amendment has led to laws that are discriminatory, unworkable and stigmatising of women. The *Protection of Life During Pregnancy Act 2013* (hereafter, "the PLDPA") includes onerous procedures for access to lawful abortion; these procedures are more onerous when the risk to life is from suicide. The Act criminalises abortion in all cases except risk to life, with a maximum possible sentence of 14 years imprisonment.
- The Eighth Amendment discriminates against women, as it criminalises health services that only women need. This has a disproportionate impact on women in poverty or

living on low income, asylum-seeking and undocumented women who cannot travel freely to other states, women with disabilities, minors and other women who, for whatever reason, cannot travel abroad.

- The Eighth Amendment violates international human rights standards. Numerous international human rights monitoring bodies, human rights organisations, and the World Health Organization, condemn the criminalisation of abortion and have consistently criticised Ireland's restrictive abortion laws.
- The Eighth Amendment does not reflect the will of the Irish people. Opinion polls reliably show support for abortion on broader grounds than risk to life. There has never been a referendum to broaden the grounds for abortion. Proposals in 1992 and 2002 to further restrict the grounds for abortion (by excluding suicide) were rejected.

Constitutional clauses do not solve practical problems.[7] Constitutional clauses on abortion force policy-makers, doctors and politicians to view abortion within a uniquely legal framework and impede doctors' use of clinical judgement. They create legal uncertainty and, when cases come before the courts, and must be resolved through constitutional reasoning, the courts must decide between competing rights.

The IFPA is firmly of the view that abortion cannot be dealt with adequately or appropriately by means of a constitutional provision.

> *"As a medical professional and practitioner we have many challenges for our patients which we see on a daily basis. My difficulty is that clinical decision making is distorted by our current Constitution and the same time our Constitution protects women who wish to travel outside of Ireland [for abortion]. Our primary consideration should be clinical, it should not be legal and sometimes we find clinical decision making is distorted, and this is not a good thing."*
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> – Dr Rhona Mahony, Master of the National Maternity Hospital

1.2 Why the IFPA is not in favour of reform that allows abortion only in exceptional cases

The IFPA has years of experience of listening to and providing information and counselling to women experiencing unplanned pregnancy or a pregnancy that has become a crisis. From this experience, we know that the issues involved in a woman's decision to seek abortion are complex, personal and private.

The experiences of our clients in relation to the PLDPA informs our view that restrictive abortion laws that allow abortion on very limited, narrowly defined grounds—such as severe or fatal foetal anomaly or rape—are inadequate. It is well documented[8] that in countries where laws are so limited in scope, those laws fail to guarantee access to lawful services to all the women who are eligible.

And some women who are potentially eligible for lawful abortion under the PLDPA travel for safe abortion services elsewhere. In fact, three of our 2015 clients who believed that their pregnancy put their lives at risk, chose to travel abroad, rather than subject themselves to the certification process under the Act.

The IFPA is of the view that a law that criminalises abortion, but includes exceptions where a woman has been raped or received a diagnosis of severe or foetal anomaly, would, in the same way, fail to meet the needs of the very group it aimed to serve.

All women have the right to confidential, sensitive health services and to access these with dignity. At the IFPA, we believe that where a woman is pregnant due to rape, or has received a diagnosis of foetal anomaly, particular obligations in relation to confidentiality, sensitivity and dignity arise.

In the case of foetal anomaly, if a law includes an exception on this ground, this will inevitably lead to scenarios where doubt or disagreement arises among doctors about whether a particular anomaly is "fatal" or sufficiently "severe". Such scenarios would compound the distress and trauma that women already experience on learning of a foetal anomaly.

In the IFPA's view, any future law that aims to provide safe abortion services to women survivors of rape must avoid criminal sanctions and overly prescriptive and cumbersome provisions and procedures. A set of procedures similar to those included in the PLDPA—i.e., assessment of the woman by an expert panel, a medical examination or an enquiry process to determine whether a rape has taken place—would have the effect of further stigmatising and traumatising the woman.

The only way to ensure that survivors of rape and women who have received a diagnosis of severe or fatal foetal anomaly can access abortion, if that is their choice, is to recognise that pregnancy in these circumstances can be a deeply traumatic event that can implicate women's mental health. Abortion then should be freely available because safeguarding the woman's health in this situation requires that she have access to the means to end a pregnancy that is intolerable to her.

Many European countries make special provision for rape and foetal anomaly, but they do so to allow women in these cases to access abortion after the time limit that applies to abortion on request.

Unplanned pregnancy is a public health issue. Women's reproductive health needs are complex. Governments must devise clear, health-focused, practical and workable policies, provide quality services to address these needs and ensure that women can access these services.

1.3 How could we value prenatal life if the Eighth Amendment is repealed?

The IFPA considers that the current legal position, whereby the Constitution gives an equal right to prenatal life as to a pregnant woman and the law criminalises women who have abortions, is simply wrong. It requires women, rather than the State, to bear all the weight of the public duty to vindicate foetal life. It is cruel, inhuman and degrading to women.

Many constitutions and laws in other countries include provisions that respect prenatal human life. It is our firm view that if the State wishes to defend and vindicate unborn life, it should do so without criminalising women's reproductive decisions. For example, the legislature could adopt positive measures to vindicate unborn life, by investing in pregnancy-related care, reducing recurrent miscarriages and stillbirths or ensuring that the social and economic conditions that make pregnancies wanted exist for all women.[9]

1.4 How have states achieved low abortion rates?

Best international practice is that any country that offers abortion offers a combined service including contraceptive services. States that have achieved significant reductions in their abortion rates have done so by a combination of liberalising their abortion laws and ensuring that the women who have abortions are offered contraception information and services. Immediately after the abortion there is a discussion of prevention and methods such as long-acting reversible contraception. As a result of such policies, the rate has come down dramatically, for example, in France, Turkey and Italy.

The reduction in abortion rates is because legal institutional abortion services provide an opportunity for family planning counselling and the provision of effective contraception.

2. Irish women and abortion

2.1 Why do women have abortions?

A woman's reasons for choosing to end a pregnancy are intensely personal and complex. They relate to her particular context and personal and social situation. A woman has to weigh up her options and come to a rational decision that is right for her in her particular circumstances. Some women internalise feelings of shame. For some women, abortion is the "best worst" option. Whatever her reasons, no woman takes the decision to have an abortion lightly.

The IFPA knows from our services that the women who choose abortion make a conscientious decision based on their knowledge of their own personal circumstances. They opt for abortion because it is the right choice for them—and for their families—in what is often a difficult and distressing situation.

Among the reasons why women seek abortion are: lack of access to contraception; risk to the woman's health; when the pregnancy is a result of rape; when there is a diagnosis of severe or fatal foetal anomaly; financial worries; relationship issues; failure of contraception; and when the pregnant woman knows that continuation of the pregnancy is not in her or her family's best interests.

2.2 Who are the women who have abortions?

In 2015, women from every single county in Ireland travelled to the UK to access safe and legal abortion services.

Most Irish women having abortions are in their twenties. The statistics gathered by the UK Department of Health (see Appendix 2) show that the majority of women in Ireland who have abortions at clinics in the UK are between 20 and 39 years of age (84% in 2015). Teenagers and women over 39 account for 7.5% and 8.5%, respectively.

The vast majority of IFPA clients who access abortion do so in the first trimester. However, some women are in the care of maternity services when they receive a diagnosis of foetal anomaly, or of risk to their health as a result of pregnancy.

The women who have abortions come from all stages and walks of life. Many already have children. They know what it means to be a mother; for them, the need to care for their children is the primary reason they decide not to continue with another pregnancy.

While the law does not stop women from travelling for abortion, not all women can travel. At the IFPA, we know that lack of access to safe and legal abortion services in Ireland particularly affects women who are already burdened by inequality.

Marginalised groups of women, such as women with travel restrictions, minors, women in State care, women experiencing domestic violence and women living in poverty, are disproportionately impacted by Ireland's abortion laws because they face profound legal, social and economic barriers if they wish to travel abroad to end a pregnancy.

2.3 How do women in Ireland access abortion?

Because Irish law prohibits abortion in all cases, except when a woman's life is at risk, most women travel to the UK to access safe and legal abortion services there.

Between 1980 and 2015, at least 165,438 women and girls in Ireland accessed UK abortion services, with 3,451 women recorded in 2015. Some women travel to other European countries, such as the Netherlands.

These numbers are an underestimation, as not all women will provide their Irish addresses at UK abortion clinics, and many who are unable to travel to another country access the abortion pill online.

2.4 Why do women attend pregnancy counselling?

Most, but not all, women who come to pregnancy counselling have made their decision. If they have chosen to end the pregnancy, most have already found all the information they need online or from friends.

But many women seek to confirm the accuracy of this information. They have questions about the risks associated with abortion, the procedure itself, other medical issues and practical issues such as cost. Women don't know what to expect: They want to know what the clinic is like; they have concerns about how they will be treated.

Counselling allows women to discuss any vulnerabilities they are feeling and allay any anxieties that are particular to their individual set of circumstances. IFPA pregnancy counselling is a protected space where there can be intimate disclosures and exploration of women's abortion narratives, without the fear of being subjected to judgement or disapproval. This space can also help discharge the negativity associated with abortion stigma and the negative attitudes of other people.

Indeed, this counselling space can be the only context where a woman can discuss her pregnancy and her abortion decision in a confidential manner and without fear of being judged or criticised.

3. Legal framework

Article 40.3.3 of the Irish Constitution 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."[10] This article gives a foetus an equal right to life with a pregnant woman. It has been interpreted by the Irish Supreme Court to mean that abortion is prohibited in all circumstances, except where there is a risk to a woman's life, as distinct from her health.[11]

In all other cases abortion is criminalised, with a maximum sentence of 14 years' imprisonment.[12] Andorra and Malta are the only European countries with equally or more restrictive laws on abortion. While the rights to travel for and receive information about abortion are guaranteed in the Constitution, access to information is regulated by the "Abortion Information Act".[13] This Act requires that information about abortion services can only be given to a woman if she is also given information about parenting and adoption.

Ireland's abortion laws have been criticised by successive UN Treaty Monitoring Bodies—the UN Human Rights Committee, the UN Economic, Social and Cultural Rights Committee, the UN Committee Against Torture and the Committee on the Elimination of Discrimination Against Women—as irreconcilable with women's human rights, including the right to the highest attainable standard of physical and mental health[14] (see Appendix 3).

3.1 Protection of Life During Pregnancy Act 2013

> *"I think that the lack of the woman's say in the Act is quite extraordinary. As a doctor, if you had a patient who was going to have any other procedure and you outlined the risk, it would be them up to them to decide if the risk is acceptable or not. In this situation, it is doctors who are deciding, based on the law, that the risk is not sufficient. The woman doesn't have the choice to make that decision for herself."*
>
> – Dr Caitriona Henchion, IFPA Medical Director

Access to lawful abortion in cases of risk to life is regulated by the Protection of *Life During* Pregnancy Act 2013 (PLDPA). The PLDPA was introduced in order to implement the 1992 of the Supreme Court in the *X case* and the 2010 decision of the European Court of Human Rights in *A, B and C v. Ireland.* The PLDPA is intended to provide for lawful access to abortion where a pregnant woman's life is immediately at risk, including from suicide. The Act created a new criminal offence of intentional destruction of unborn human life, with a maximum 14-year sentence of imprisonment. This is despite the recommendation of numerous international human rights bodies, as well as the World Health Organization, that abortion should be decriminalised (see Appendix 8).

The PLDPA sets out the procedures for establishing entitlement to a lawful abortion. It 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.[15]

Decision-making is in the hands of medical specialists and is different under each above-mentioned section of the Act. 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). Section 9 (risk from suicide) provides that three specialists—two psychiatrists and an obstetrician—must jointly certify a woman's legal entitlement to an abortion.

If certification is refused under section 7 or 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. The role of the psychiatrists in this process is not to provide treatment, but only to examine the woman to determine whether she is at risk of suicide. The PLDPA provides for conscientious objection of healthcare providers: There is cause for concern about widespread claims of conscientious objection resulting in refusal of care, particularly where the risk to life arises because of risk of suicide.[16]

If a risk to life identified by a doctor were later deemed not significantly "real and substantial" to satisfy the test established by law, a doctor could be prosecuted under the Act. In such circumstances, where an error in clinical judgement is potentially punishable by 14 years imprisonment, the chilling effect on doctors of the criminalisation of abortion remains.

A Guidance Document[17] has been issued to medical practitioners on the implementation of the Act. However, it is entirely procedural and does not provide clinical guidance.[18] The State informed the UN in 2015 that clinical guidance on how risk to life should be determined was "a matter for health professional bodies".[19] However, no such clinical guidance has been developed.

In the view of the IFPA, the PLDPA is a poor legislative model and has failed to establish the limited right to abortion in practice.[20] Its procedures are complicated. They are also discriminatory because the Act includes more onerous decision-making processes if the risk to life is from suicide than when a physical health risk is present.

Case study 1: "Mary"

Mary is in the early stages of an unplanned pregnancy. This is causing her extreme distress. She has a history of mental illness, with previous episodes of suicidal ideation and intent. Because of this, she does not feel able to continue with the pregnancy. Her GP makes judgemental comments about abortion. He does not give her information about pregnancy counselling. Mary feels completely unsupported by her GP, and this upsets her greatly.

Mary attends the IFPA for pregnancy counselling. As she may be eligible for a termination under the Protection of Life During Pregnancy Act 2013, the counsellor explains the assessment procedures under Section 9 of the Act, which deals with risk of loss of life from suicide.

On hearing about the complicated procedures under the Act, Mary worries that going through it may exacerbate her mental health issues. At this point, due to her medical history, she has already attended two psychiatrists at her local regional hospital, as well as her GP. She is shocked by the certification process under the Act: She'll have to be assessed by two psychiatrists and an obstetrician in order to be certified as eligible for an abortion under the Act, and by two more psychiatrists and a further obstetrician if she has to seek a review of the initial decision.

The thought of the assessment process exacerbates her already heightened sense of anxiety about the pregnancy. She doesn't want to wait, but wishes to end the pregnancy as soon as possible. She is further concerned that, if her request for a termination is refused, a lot of time will have elapsed, and she will then have to face the stress and expense of arranging an abortion outside the State.

Outcome: Although she is eligible to apply for a termination under the Protection of Life During Pregnancy Act, Mary worries about the potential delays involved in the process. This, and the uncertainty as to the outcome, makes her reluctant to subject herself to the process. She decides that her only realistic option is to travel to the UK for a termination as soon as possible.

4. The harms of Ireland's abortion laws

> *"Access to abortion in Ireland is largely dependent on a woman's resources—financial resources, educational level, ability to speak English and support of family and friends. Without any one of those things their access may simply not exist. That's clearly an inequality and inconsistent with any sort of international human rights standards."*
>
> – Dr Caitriona Henchion, IFPA Medical Director

The IFPA has provided information and support to thousands of women who wish to end a pregnancy. In the sections that follow, we explain the many harms women experience because of the Eighth Amendment of the Constitution.

4.1 Access to information

Women who decide to have an abortion outside Ireland need information about abortion services that are legally available in other countries. However, access to this information is restricted by The Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995, more commonly known as the "Abortion Information Act".

The Abortion Information Act requires that information on abortion must be given directly to the woman, and only if they are given information, counselling and advice about all the options available to them. The Act prohibits service providers, such as doctors and counsellors, from making an appointment for an abortion in another state on behalf of their client. Infringement of the legislation is subject to criminal sanctions.

> *"This legislation assumes that women need the assistance of someone else in making a decision, that [a woman's] own ability to make a decision about her reproductive health, her body, her pregnancy is inadequate. This is a form of state control, based on harmful stereotypes about women, that constrains and limits women's reproductive rights. No other type of counselling or psychotherapy in this country is regulated either by the State or any other body – nor is any other type of counselling subjected to fear of prosecution by the law of the land. The law stands in the way of women exercising their considered, conscientious choice about their pregnancy."*
>
> – Evelyn Geraghty, IFPA Director of Counselling

The Abortion Information Act locates abortion counselling and post-abortion medical care outside mainstream health care. This reinforces stigma and harmful gender stereotypes, further marginalising and deterring women from accessing services, including post-abortion medical care.

It is the view of the IFPA that the Abortion Information Act only causes harm, without deterring women from seeking abortion. Its only aim is to vindicate the right to life of the unborn, without giving any consideration to protecting women's health. The Abortion Information Act does not even regulate the existence of rogue agencies, which misinform and intimidate women to prevent them from having abortions. These "rogue agencies" present themselves as legitimate

crisis pregnancy centres that provide impartial information on options for women who have an unplanned pregnancy.

4.2 The requirement to travel

Since 1980, more than 165,000 women and girls have travelled from Ireland to another state to access abortion services. Each of these women experienced all of the financial, physical and emotional burdens involved in travelling for healthcare services that are criminalised in Ireland.

These burdens include the need to raise significant funds, organise child care, negotiate time off work and make travel and accommodation plans.

The obligation by Irish law to leave the country to have an abortion deprives women of dignity, exposes them to stigma and is degrading. Our clients express frustration, anger and disbelief that they must travel to avail of a medical procedure that they believe should be available in their own country.

Through our counselling services, particularly post-abortion counselling, the IFPA is acutely aware of the psychological hardship associated with denial of abortion services. For some women, the most difficult aspect is the abdication of responsibility by the health service. Women and their partners have told IFPA counsellors that they were made to feel stigmatised, “like criminals” or like “displaced persons”.

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

Serious risks to Irish women’s health and wellbeing associated with abortion—including infection, haemorrhage and prolonged emotional trauma—are augmented by the need to travel for abortions due to the limitations under the Eighth Amendment. This is an inherent systemic problem and thus these risks will not be minimised by alterations to clinical practice or “better care” in maternity and reproductive health services. Abortion travel sustains these risks and they will only be neutralised when abortion travel is not required.[21]

Case study 2: "Róisín"

Róisín is unemployed and living in poverty. She becomes pregnant unintentionally. She has two children, both in foster care as a result of problems she experienced with drug dependency. She had a history of mental illness during her pregnancies, and was battling depression at the time of her third pregnancy. She has remained sober for a year and is working with social workers to try to regain custody of her children. She knows that having another child at this moment of her life would jeopardise her health and her chances of regaining custody of her children. She decides to travel to England to have an abortion.

Róisín approaches a religious charity and seeks financial assistance. She discloses her situation to a case-worker, who takes detailed notes. A week later, she is told that because of the charity's ethos, she won't be helped to access an abortion. She borrows money from a money lender at a high interest rate. She travels to England alone and in secrecy and has an abortion at 9½ weeks pregnant. She is careful not to alert the social workers or miss a contact visit with her children.

She returns to Ireland the day after the abortion for her contact visit with her youngest child. On her return home, she begins to bleed profusely and has to ask a neighbour to call an ambulance.

Outcome:
In post-abortion counselling, Róisín tells the IFPA counsellor that although she experienced pain, nausea and bleeding for weeks after, she did not seek further medical advice. She feels humiliated and degraded by her experience with the religious charity. She is still struggling with depression, and firmly believes the abortion was the right decision for her.

4.3 Inability to travel

The State relies on women travelling for abortion as a means of avoiding the public health crisis of unsafe and clandestine abortion that would otherwise ensue. But not all women can travel at will. The exercise of the right to travel is only a real option for those who have or can access the financial means to do so and who can travel freely between states.

The IFPA sees many women and girls in circumstances of extreme vulnerability. Increasingly our services are used by women who experience multiple forms of disadvantage and for whom access to the right to travel is difficult, complicated and, in some cases, impossible.

The need to travel to access abortion services disproportionately affects vulnerable and disadvantaged women and girls. This includes those who cannot raise the necessary funds to travel abroad, who are in the care of the State, who experience difficulties and delays in travelling abroad or who cannot leave Ireland because of immigration restrictions. Undocumented and asylum-seeking women and girls experience particularly profound barriers to access to services outside the State.

Case study 3: "Cecile"

Cecile attends pregnancy counselling with her husband, Adam. She speaks little English. She has become pregnant after her contraception failed. Adam and Cecile have applied for asylum in Ireland and are currently living in the Direct Provision system while they await the outcome of their application. They live in an accommodation centre outside Cork city and share a single room with their two young children. The couple does not have the right to work in Ireland, so the only income they have is a weekly personal allowance of €19.10 per adult and €15.60 per child.

They do not want to continue the pregnancy in these circumstances. Cecile wants to end the pregnancy as soon as possible. Until they spoke to other residents in their accommodation centre, they had no idea abortion was not available in Ireland.

The IFPA pregnancy counsellor explains the law on abortion in Ireland and the steps Cecile will have to go through in order to access an abortion outside Ireland. If Cecile wishes to terminate her pregnancy, she will need to travel abroad to access abortion services. She will have to seek permission to leave the accommodation centre and return again, and apply for an exceptional needs payment from her community welfare officer to cover the expenses.

As Cecile is undocumented and without a passport, she will need to apply for a temporary travel document (€80). She will then need to apply for a re-entry visa (€60) from the Department of Justice and a visa from the country to which she will be travelling (€60–€100, depending on country). Both are located in Dublin, so they'll have expenses for the trip from Cork to organise these. It can take more than eight weeks to organise all this documentation.

In addition to the cost of the travel documents, the couple will also need to pay for flights, accommodation and the abortion procedure itself. An abortion procedure can cost from €600 to €2000, depending on the clinic and the stage of gestation.

Cecile is horrified that she will have to disclose her situation to all of these agencies, and dismayed at the huge financial cost involved.

Outcome: The couple tell the counsellor they will try to apply for the necessary travel documents. They return to the IFPA some weeks later. The economic and legal barriers to accessing a safe abortion proved insurmountable for them. Cecile tells the counsellor she feels she has no other option but to continue the pregnancy and parent against her wishes.

4.4 Impact of criminalisation of abortion

> *"[T]he criminal law is itself a source of harm; it produces harm. The harms of criminalisation adversely impacts health outcomes, and denies doctors and healthcare providers the enabling legal environment they need to provide medical services in a way that comply with professional and ethical standards of care."*
>
> – Professor Rebecca Cook, Professor Emerita & Co-Director, International Reproductive and Sexual Health Law Programme at the University of Toronto

In Ireland, harsh criminal sanctions apply for abortion in any circumstance other than where a woman's life is at risk.

In its 2010 judgment in *A, B and C v. Ireland*, the European Court of Human Rights considered that the existence of criminal penalties for having or assisting in an unlawful abortion constituted a significant "chilling factor" for both women and their doctors.

The Protection of Life During Pregnancy Act 2013 did not address the chilling effect highlighted by the European Court of Human Rights, but substantially reinforced it by introducing a maximum sentence of 14 years imprisonment.

Criminal abortion laws do not affect the overall incidence of abortion; they just make it unsafe.[22] In Ireland, the public health problem of unsafe abortion has largely been avoided due to the close proximity of the UK, where safe and legal abortion services are available.

Although criminalisation does not deter women from travelling for abortion or accessing medications online, it does deter some women from seeking medical advice in cases where post-abortion complications arise. Delay in seeking medical advice may result in risk to women's health or, in certain circumstances, her life.

Criminal laws on abortion stigmatise women seeking to terminate a pregnancy and the healthcare providers who treat them. In June 2016, the UN Human Rights Committee found that Ireland's criminalisation of abortion caused a woman, Ms Amanda Mellet, shame and stigma and that her suffering was further aggravated by the obstacles she faced in getting information about the appropriate medical options.[23] Ms Mellet was denied an abortion in Ireland in 2011 after learning that her pregnancy had a fatal foetal impairment. She subsequently travelled to the United Kingdom to undergo the procedure.

The UN Special Rapporteur on the right to health has stated that barriers arising from criminal laws and other laws and policies affecting abortion must be removed in order to ensure the full enjoyment of the right to health. The Rapporteur also highlighted that criminalisation of reproductive health services has no health benefits and shifts the burden of realising the right to health from the State onto the pregnant woman.[24]

4.5 Gender inequality

> *"[T]here is no impediment to men seeking and obtaining any required medical intervention to protect not only their life but also their health and quality of life.…[I]t can truly be said that the right of pregnant women to have their health protected is, under our constitutional framework, a qualified right as is their right to bodily integrity. …This is a republic in which we proclaim the equality of all citizens, but it is a reality that some citizens are more equal than others."*
>
> – former Minister for Justice, Alan Shatter[25]

Criminalising medical treatment that only women need is a form of discrimination.[26] The prohibition and criminalisation of abortion in Ireland perpetuates gender inequality because it restricts the provision of reproductive health services that only women require. This

discrimination is felt most acutely by women who experience multiple, intersecting forms of disadvantage, such as asylum-seeking women, poor women and minors.

The nature of the laws on abortion also maintains harmful gender stereotypes about the role of women in society and their autonomy and independence as human beings.

The way in which information about abortion is regulated frames women as irrational and untrustworthy and treats them as though they are incapable of making rational decisions about their pregnancies.

The criminalisation of abortion in all circumstances except where a woman's life is at risk reduces women to reproductive instruments. This subjects them to a gender-based stereotype that women should continue their pregnancies regardless of circumstances, because their primary role in society is to be mothers and caregivers.

The Eighth Amendment must be repealed in order to ensure the equal treatment of women in Ireland in matters of health care and the respect of their autonomy and bodily integrity.

> *"The view that differences in treatment that are based on biological differences unique to either men or women cannot be sex discrimination is inconsistent with contemporary international human rights law... Under such an approach, apparently it would be perfectly acceptable for a state to deny healthcare coverage for essential medical care uniquely required by one sex, such as cervical cancer, even if all other forms of cancer (including prostate cancer for men) were covered. Such a distinction would not, under this view, treat men and women differently, because only women contract cervical cancer, as a result of biological differences unique to women. Thus there would be no comparable way in which men were treated differently.*
>
> *Modern gender discrimination law is not so limited. The right to sex and gender equality and non-discrimination obligates states to ensure that state regulations, including with respect to access to health services, accommodate the fundamental biological differences between men and women in reproduction and do not directly or indirectly discriminate on the basis of sex. They thus require states to protect on an equal basis, in law and in practice, the unique needs of each sex."*
>
> – Ms Sarah Cleveland, member of the UN Committee on the Elimination of Discrimination Against Women (CEDAW)

5. Women's health

5.1 Abortion when there is a risk to the woman's health

> *"[I]f there's going to be a permanent injury to a woman's health, then termination should be offered. Because sometimes it is difficult to differentiate between a severe illness which is going to give rise to death, and a severe illness which can be reversed – it might be just a knife-edge."*
>
> – Professor Sir Sabaratnam Arulkumaran, chair of a panel of inquiry into the death of Savita Halappanavar

No other country in Europe makes the distinction that is made in Irish law, permitting abortion to save a woman's life, but not to preserve her health. From the perspective of a medical services provider, there is no bright line between life and health. The serious risk posed to pregnant women's health—for example by heart and vascular diseases, pulmonary diseases, kidney diseases, oncological, neurological, gynaecological, obstetric and genetic conditions—may become a risk to life in particular circumstances. A condition may be accelerated by pregnancy and life-expectancy shortened as a result.

Example 1: Pelvic inflammatory disease
If diagnosis and treatment are not performed in a timely manner, pelvic inflammatory disease—an infection of the female upper genital tract, including the womb, fallopian tubes and ovaries—may cause sepsis, septic shock and even death. If the woman survives, long-term health consequences can occur, including ectopic pregnancy, tubo-ovarian abscess, infertility, pain during intercourse and chronic pelvic pain.

Example 2: Diabetes
At the same time, pregnancy may exacerbate the risk to women of pre-existing conditions such as epilepsy, diabetes, cardiac disease, auto-immune conditions and severe mental illness. For example, diabetes does not pose a risk to a woman's life during pregnancy, but can leave her with severe permanent injury, including organ damage, renal failure or blindness.

5.2 What happens in other countries?

Best medical practice is to intervene when a serious health risk presents, rather than wait for a situation to deteriorate. In countries where abortion is legal, given the severity of the risk to her health, doctors would discuss termination of the pregnancy as a treatment option and provide the procedure if this is a woman's wish.

This is not an option in Ireland. Nor is appropriate referral. By law, doctors cannot make referrals for abortion procedures in other states. Furthermore, in the IFPA's experience, in cases where a woman's medical history gives rise to concerns about possible complications in her treatment, even if she is attending a hospital, it is not the norm for the Irish health institution to proactively communicate with the doctor who is to carry out the termination

(although this does occur in some cases). Unlike any other medical treatment situation, therefore, the continuum of care is broken: The onus shifts to the patient to make contact with a doctor outside Ireland and to provide her medical history. This doctor is unlikely to have the opportunity to discuss her case with the treating doctor involved in her antenatal care prior to the abortion.

> "*Take a case where a woman has a medical condition, that is not life-threatening, but, for example, somebody who's had previous blood clots and they're on anti-coagulants and they're saying they're going to travel for a termination.*
>
> *If that person was travelling or going within the State for any other medical condition, I would make sure that a referral letter and a contact was made, so that any surgeon that was going to perform a procedure on them would be aware that they had a risk of clots and that they were potentially a bleeding risk.*
>
> *But in this case, I have to say [to the woman], 'You need to tell them this, it's very important and I can give you a letter and you can take it with you.' And I have to come up with some sort of wording that says, 'This woman might come to see you and if she does this is her medical history' rather than actually ensuring that her medical information gets to the person who needs to get it.*
>
> *Then if that woman arrives at a clinic, having self-referred, it may turn out that because of this medical condition, they can't actually see her in this clinic, and she needs to be referred to a hospital. But maybe the hospital isn't actually taking anybody the day she arrives. She's going to have to go home and come back next week.*
>
> *And if that woman hasn't got enough money to go home and come back next week, that's her opportunity gone. But again, we can't actually refer her to the correct place in the first instance. So I think that's just a totally unacceptable level of medical care; it wouldn't be accepted in any other aspect [of healthcare], so it shouldn't be accepted in this case.*"
>
> – Dr Caitriona Henchion, IFPA Seminar December 2016

5.3 What happens in Ireland?

Women living in Ireland whose pregnancy causes risks to their health that stop short of risk to life must leave the State to access such interventions because no lawful services are available and because abortion in such circumstances is criminalised in Ireland.

The burden of accessing this service is placed on the woman rather than the healthcare system. Women who make this journey for medical reasons do so in a legal context that means standard medical referral protocols may not be applied.

Women in this context must leave the mainstream healthcare service. They must make their own way to a private medical facility in another country without the protection of the protocols that apply in other situations where people travel for health care. While some doctors make ad hoc arrangements, we know of women who have travelled without medical files detailing their medical history or proper referral by their doctor.

It is critical that medical service providers are assured by Government that accessible and appropriate services will be put in place. Women must have confidence that their decision will be respected, free of discrimination, coercion or stigma and that their rights will be vindicated in full.

Case study 4: "Jana"

Jana is a married mother of one living in Galway. Her first pregnancy was very difficult and took a serious toll on her health. When she learns she is pregnant for a second time, she worries about how she'll care for her two year-old daughter if she has the same problems as her first pregnancy.

Her GP advises her that she may experience similar medical problems in a second pregnancy. Jana asks her GP about terminating the pregnancy. He tells her that because of the law, he can't make a referral for her to an abortion clinic in the UK.

Jana finds information online about an abortion clinic in the UK, and arranges her appointment. She knows that because of her health issues, ending the pregnancy is the right decision for her and her family. She worries about how she and her husband will pay for the abortion, but thinks she might be able to borrow some money from her parents.

Outcome: Jana has an early medical abortion at a clinic in the UK and returns home the same day. The abortion medicine begins to take effect at the airport, and there is a lot of bleeding. She has to change her clothes. The bleeding continues for the duration of the flight and the bus journey home from Shannon airport. She finds the experience extremely distressing and embarrassing.

Jana returns to the IFPA for post-abortion counselling. She is upset and angry that she had to travel to London to access abortion services.

5.4 Abortion in cases of severe or fatal foetal anomaly

Women who opt for abortion in the case of a risk to their health or a diagnosis of severe or fatal foetal anomaly experience an abrupt cessation of care and abandonment by the Irish health service.[27] 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.

The IFPA takes a women-centred approach to situations where there has been a diagnosis of severe or fatal foetal anomaly and we double the length of our counselling sessions for women (and their partners) who have received such a diagnosis.

The costs involved in accessing safe abortion services are high; and 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.

Putting clearer pathways, protocols and guidelines in place within the current law would not be sufficient to support women in these circumstances: Women must be able to access the health services they require in the country where they live.

5.5 Use of the abortion pill in Ireland

> *"I have certainly come across women who have taken [unknown medications that they thought were abortion pills*]*. It came in a box with no instructions and no ingredients written on it. . . . Now how can you possibly say it's okay to take stuff from the web. You don't know where they're actually going to get it or what they're going to get and whether there's going to be anything in it or whether it's going to be something unsafe. You have to apply the same principle you would to anything else. If someone decided they were going to get heart medicines online, you'd say, 'No, go and get [it] from a proper, reliable source'. . . . It's a half measure, it's not an acceptable standard of care."*
>
> – Dr Caitriona Henchion, IFPA Medical Director

Women in Ireland are increasingly importing medication and risking prosecution by self-inducing abortion. While there are sources of reliable medication (the abortion pill), women may access sites selling ineffective or harmful medication. In all cases, women must import and self-administer medication with either no medical advice or supervision, or with only online support.

There are many reasons why women are turning to this method. For example, the cost is significantly lower than travelling and paying for flights, accommodation and the abortion procedure. Furthermore, in a climate where abortion remains heavily stigmatised, women do not have to make excuses about why they are not around: Taking the abortion pill at home means they are less likely to need to take time off work or to find someone to collect their children from school.

No official figures exist for use of the abortion pill in Ireland.[28] A 2016 paper in the British Journal of Obstetrics and Gynaecology[29] estimates that 1,600 women in Ireland and Northern Ireland had abortion pills sent to them by one web-based service over three years.

The IFPA regularly treats women who incur risks to their health when complications arise after using the abortion pill, as they are deterred or delayed by fear of prosecution from going to their doctor or presenting at a hospital.

Case study 5: "Miriam"

Miriam is shocked and scared when she discovers she is pregnant. She is in a new relationship and doesn't feel she can talk to her partner about it. She doesn't think that they are emotionally or financially ready to become parents.

The only person she tells is her older sister, who lives in Canada. She is afraid that other family members—and even close friends—will judge her for wanting an abortion.

Miriam decides to travel to the UK for a termination, but after researching the costs of flights, accommodation and the abortion procedure online, she realises there is no way she can afford this option. Her sister tells her about the abortion pill. They contact an online organisation for information. Miriam is very scared about doing something illegal. She also fears that ordering medication over the internet might be dangerous. But this is the only option she can afford.

Miriam is on her own when she takes the pills. The experience is very frightening. She doesn't know what to expect and isn't prepared for the pain involved. She bleeds very heavily. She doesn't know where to turn. Afterwards, she is worried that the pills might not have worked.

Outcome: Miriam goes for post-abortion counselling. But she is afraid to go for a post-abortion medical check-up in case the doctor reports her to the Gardaí. She lives in a small town and is also worried about people finding out she had an abortion. The counsellor advises her to make an appointment with the IFPA for a free post-abortion medical check-up and stresses that the doctor will not report her to the police.

5.6 Post-abortion care

> *"Stigma can be described as a defective mark, a tainted attribute that spoils identity. It disqualifies an individual from full social acceptance. It cuts stigmatised people off from society. It provokes hostility towards them; it provokes hatred towards the labelled person."*
>
> – Professor Rebecca Cook, Professor Emerita & Co-Director, International Reproductive and Sexual Health Law Programme at the University of Toronto

The IFPA provides free post-abortion counselling and post-abortion medical check-ups for any woman who has had an abortion. Women can attend post-abortion counselling regardless of when they had their abortion.

The uptake of post-abortion counselling in Ireland is consistent with the experience of countries where abortion is legally available, i.e., women access post-abortion counselling in relatively small numbers. This reflects comprehensive international research which has shown that abortion does not have negative psychological impacts for the vast majority of women.[30] In the Irish context, research by the Sexual Health and Crisis Pregnancy Programme in 2010 found that that 87% of women in Ireland who have had an abortion said it was the right outcome for them.[31]

For the women who do attend post-abortion counselling with the IFPA, a common theme in their experiences is the stigma they feel for having undergone a termination of pregnancy.

Abortion stigma is produced, reproduced and reinforced at individual, community, institutional, cultural and legal levels. Stigma attaches to women and girls who seek abortions or who have had an abortion—who are frequently ostracised and discriminated against, shamed and silenced—and to those who help women and girls to access abortion.

Abortion stigma is pervasive even in countries where abortion is lawful and readily accessible: In Ireland, stigma interacts with and is exacerbated by the provisions of the law and the necessity to travel outside the State to access services that are not only denied, but are criminalised. The way that abortion stigma and abortion law reinforce each other means that accessing safe abortion services is even more difficult for groups living in vulnerable situations.

> *"Here are some of the examples of stigma that women have said to me: 'I can't talk about this at home: My granny is pro-life, she comes up every year on the bus to the march.' Women refer to what they've heard on the radio on the way to counselling, or what they've seen on TV. 'What they're saying on the radio is wrong; they don't know the reality of what I have to go through.' 'I want to throw my shoe through the TV'."*
>
> – Evelyn Geraghty, IFPA Director of Counselling

The stigma women in Ireland experience around abortion will not disappear with repeal of the Eighth Amendment. Women tell the IFPA of the hostile and judgemental attitudes of some healthcare providers. Some women are reluctant to speak openly about abortion to their GP. They fear judgement and condemnation. They do not trust that what they disclose will remain confidential. Therefore, if/when the Eighth Amendment is repealed, women-centred and rights-based pregnancy counselling must be part of the framework for safe and legal abortion services.

Recommendations

> *"Good reproductive health should be viewed as a public health concern, which apart from the provision of safe and high-quality abortion services, should include having sex and relationship education in the national school curriculum, so you have primary prevention. And then access to family planning and contraceptive services. So first prevention, and facilitate safe abortion care, and at that time do secondary prevention by providing contraception soon after the abortion."*
>
> – Professor Sir Sabaratnam Arulkumaran, chair of a panel of inquiry into the death of Savita Halappanavar

In order to ensure that women in Ireland are guaranteed the highest attainable standard of reproductive health and rights, the IFPA respectfully suggests that the Citizens' Assembly make the following recommendations to the Oireachtas:

- Repeal the Eighth Amendment of the Constitution.
- Repeal the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995, more commonly known as the 'Abortion Information Act'.
- Repeal the Protection of Life During Pregnancy Act 2013.
- Review legislative models in European and other jurisdictions where abortion services are safe, legal and accessible.
- Implement the best international practice and standards of the World Health Organization, the International Federation of Gynaecology and Obstetrics (FIGO) and the Royal College of Obstetricians and Gynaecologists to ensure a women-centred and rights-based legislative and policy framework for abortion in Ireland.
- Implement the recommendations of UN expert treaty monitoring bodies in relation to the provision of accessible safe and legal abortion services.
- Ensure access to safe and legal abortion services in law and in practice for any woman who needs them.

Appendices

Appendix 1: Abortion in Ireland: Legal timeline

Note: Extensive timeline available on the IFPA website

1861 The Offences Against the Person Act criminalises women who "procure a miscarriage", or anyone who assists her. The maximum sentence is life imprisonment.

1983 The Eighth Amendment (Article 40.3.3), giving the "unborn" an equal right to life with a pregnant woman, is inserted into the Constitution after a **referendum**.

1992

- **The *X case***: In a case where X, a 14-year-old girl, is pregnant as a result of rape, the Supreme Court holds that where there is a real and substantial risk to life (as distinct from health), including risk of suicide, and this threat can only be averted by the termination of pregnancy, a woman or girl has the right to an abortion in Ireland.
- The European Court of Human Rights rules that the legal **ban** on organisations imparting **information on abortion** services legally available in other countries is **disproportionate** and a risk to the health of women seeking abortions outside the State.
- The Government puts forward **three possible amendments** to the Constitution in a **referendum**: Amendments guaranteeing the right to travel for abortion and to information on abortion **pass**, while an amendment to limit the *X case* is **rejected**.

1995 The Regulation of Information (Services outside the State for the Termination of Pregnancies) Act is enacted.

1996, 1999, 2000 Three parliamentary processes make inconclusive recommendations on expanding abortion regulation in Ireland.

1997 *Miss C case*: A 13 year old who is pregnant as a result of rape is allowed to travel to obtain an abortion by virtue of the Supreme Court judgment in the 1992 *X case.*

2001 The Crisis Pregnancy Agency is established by the State to reduce the number of crisis pregnancies and abortion, as well as to provide counselling and medical services after crisis pregnancy.

2002 A **referendum** is held on an amendment to further restrict abortion (removing the suicide ground) and to further criminalise abortion. It is **rejected**.

2006 *D v. Ireland* is ruled inadmissible by the European Court of Human Rights because the case did not go through the Irish Courts.

2007 *Miss D case*: A 17 year old in the care of the State with an anencephalic pregnancy is stopped from travelling by the State but the High Court rules that she has the right to travel for an abortion.

2010

– ***Michelle Harte***, who became pregnant whilst receiving treatment for cancer, is forced to travel to the UK for an abortion while severely ill, as Cork University Hospital refused to authorise an abortion, although this was medically advised.

– ***A, B and C v. Ireland***: The European Court of Human Rights unanimously rules that Ireland's failure to implement the existing constitutional right to a lawful abortion when a woman's life is at risk violates Applicant C's rights under Article 8 of the European Convention on Human Rights.

2012

- **October:** Savita Halappanavar dies in Galway University Hospital after she was refused a termination during inevitable miscarriage because a foetal heartbeat was detectable.
- **November**: An expert group appointed by the Government recommends that legislation is necessary to address the A, B and C judgement.
- **December:** The Government announces plans to introduce a combination of legislation and guidelines to implement the judgment in the case of *A, B and C v. Ireland*.

2013 The Protection of Life During Pregnancy Act is signed into law by President Michael D. Higgins; the Act comes into effect on 1 January 2014.

2014 A young migrant woman, known as Ms Y, who is pregnant as a result of rape, seeks an abortion on the grounds of suicide under the 2013 Act. She is found eligible under the Act, but because of the stage of gestation, only offered the option of early delivery by caesarean section.

2011–2016:

Five United Nations human rights bodies examine and criticise Ireland's restrictive abortion laws.

2012–2016:

Seven private members bills are put forward in parliament to expand grounds for abortion in Ireland. All are defeated.

2016

- **May**: The new Government commits to establishing, within six months, a Citizens' Assembly, which will be asked to make recommendations to parliament on further constitutional changes, including on the Eighth Amendment. The first meeting of the Citizens' Assembly takes place on October 15, and the first topic considered is the Eighth Amendment, over the course of four meetings.
- **June**: In its decision about a complaint made by Ms Amanda Mellet, the UN Human Rights Committee finds that Ireland's abortion laws violated Ms Mellet's right to freedom from cruel, inhuman or degrading treatment, as well as her right to privacy.

Appendix 2: Abortion in Ireland: Statistics

Between January 1980 and December 2015, at least 166,951 women and girls travelled from the Republic of Ireland to access abortion services in another country.

UK

The UK Department of Health releases annual **statistics** on the number of women and girls who present addresses from the Republic of Ireland at abortion clinics in England and Wales.

In 2015, the year for which the most recent figures are available, 3,451 women and girls in Ireland, or just over nine a day, travelled to the UK to access abortion services.

Between 1980 and 2015, at least **165,438** women and girls in Ireland accessed UK abortion services.

It is important to note that these numbers are an underestimation as not all women will provide their Irish addresses at UK abortion clinics for reasons of confidentiality or otherwise, while many women who are unable to travel to another country for abortion services access the abortion pill online.

Other countries

Women living in Ireland also access abortion services in other European countries. See recorded figures for the Netherlands from 2006 to 2013 further below.

Women from the Republic of Ireland Accessing Abortion Services in England and Wales 1980–2015

Source: UK Department of Health

Year	All ages	Under 16	16-17	18-19	20-24	25-9	30-34	35-9	40 and over	Not stated
2015	3,451	18	58	187	832	768	693	603	292	-
2014	3,735	21	84	168	918	865	799	586	294	-
2013	3,679	21	90	213	911	884	746	558	256	-
2012	3,982	32	92	223	1,082	964	777	549	263	-
2011	4,149	37	111	295	1,109	1,051	755	534	257	-
2010	4,402	41	115	303	1,181	1,137	789	565	271	-
2009	4,422	38	155	291	1,234	1,164	759	523	258	-
2008	4,600	27	140	344	1,296	1,232	841	499	221	-
2007	4,686	47	147	350	1,387	1,282	790	474	209	-
2006	5,042	39	194	419	1505	1370	824	491	200	-
2005	5,585	39	173	482	1759	1451	860	541	280	-
2004	6,217	49	209	540	1963	1663	951	607	235	-
2003	6,320	42	242	552	2090	1597	954	579	264	-
2002	6,522	54	245	615	2258	1604	928	552	263	1

Year	All ages	Under 15	15	16-19	20-24	25-29	30-34	35-39	40-44	45 and over	Not stated
2001	6,673	12	29	903	2,404	1,685	875	508	239	18	-
2000	6,391	10	17	857	2,243	1,631	853	549	216	15	-
1999	6,226	8	25	894	2,301	1,519	749	502	196	31	1
1998	5,891	7	20	871	2,137	1,489	686	462	195	23	1
1997	5,340	10	30	782	1,986	1,235	645	448	178	26	-
1996	4,894	6	22	738	1,871	1,107	608	351	171	19	1
1995	4,532	7	18	673	1,763	943	561	382	162	23	-
1994	4,590	9	28	591	1,856	987	545	387	172	15	-
1993	4,402	9	28	622	1,678	924	561	372	186	22	-
1992	4,254	5	15	696	1,610	855	529	372	156	16	-
1991	4,154	7	14	679	1,511	845	521	385	174	18	-

Year	All ages	Under 20	20-34	35+	Unstated
1990	4,064	667	2,881	516	-
1989	3,721	588	2,624	509	-
1988	3,839	556	2,768	514	-
1987	3,673	512	2,671	490	-
1986	3,918	569	2,858	491	-
1985	3,888	574	2,827	487	-
1984	3,946	556	2,904	484	2
1983	3,677	559	2,680	435	3
1982	3,650	555	2,697	397	4
1981	3,603	556	2,655	375	17
1980	3,320	495	2,494	326	5

Women from the Republic of Ireland Accessing Abortion Services in the Netherlands 2006–2013

Source: HSE Sexual Health and Crisis Pregnancy Programme

Year	Number
2014	16
2013	12
2012	24
2011	33
2010	31
2009	134
2008	351
2007	451
2006*	461

*First year of data collection

Appendix 3: Recommendations to Ireland by United Nations (UN) treaty monitoring bodies and the Universal Periodic Review (UPR)

The IFPA has a strategy of monitoring the Irish Government's implementation of international human rights standards and of highlighting Ireland's prohibitive regulation of abortion and the discriminatory nature of its application to the expert committees that have responsibility for monitoring the implementation of relevant covenants and conventions. The IFPA, as a national reproductive health services provider, is in a unique position to engage in this kind of advocacy. The organisation can provide credible, evidenced-based submissions and presentations that are rooted in the experience of our clients and health professionals, including the IFPA pregnancy counsellors who engage directly with the affected rights holders — women who are denied services by the abortion ban.

UN Committee on the Rights of the Child (CRC)

2016 The Committee is concerned about the Protection of Life During Pregnancy Act of 2014, which only allows for abortion when there is a "real and substantial risk" to the life of the mother and criminalises abortion even in instances where the pregnancy results from rape, incest, or in cases of severe foetal impairment. Furthermore, the Committee is concerned that the term "real and substantial risk" prevents doctors from being able to provide services in accordance with objective medical practice. The Committee is also concerned at the severe lack of access to sexual and reproductive health education and emergency contraception for adolescents.

In the light of its General Comment No. 4 (2003) on adolescent health, the Committee recommends that the State party:

> **(a) Decriminalise abortion in all circumstances and review its legislation with a view to ensuring children's access to safe abortion and post-abortion care services; and ensure that the views of the pregnant girl are always heard and respected in abortion decisions.**
>
> **(b) Develop and implement a policy to protect the rights of pregnant teenagers, adolescent mothers and their children and combat discrimination against them.**
>
> **(c) Adopt a comprehensive sexual and reproductive health policy for adolescents and ensure that sexual and reproductive health education is part of the mandatory school curriculum and targeted at adolescent girls and boys, with special attention on preventing early pregnancy and sexually transmitted infections.**
>
> **(d) Take measures to raise awareness of and foster responsible parenthood and sexual behaviour, with particular attention to boys and men.**[32]

UN Committee on Economic, Social and Cultural Rights (CESCR)

2015: ***Sexual and reproductive health***

The Committee is concerned at the State party's highly restrictive legislation on abortion and strict interpretation thereof. It is particularly concerned at the criminalisation of abortion, including in the cases of rape and incest and of risk to the health of a pregnant woman; the

lack of legal and procedural clarity on what constitutes a real substantive risk to the life, as opposed to the health, of the pregnant woman; and the discriminatory impact on women who cannot afford to get abortion abroad or access to the necessary information. It is further concerned at the limited access to information on sexual and reproductive health (art. 12).

The Committee recommends that the State party take all necessary steps, including a referendum on abortion, to revise its legislation on abortion, including the Constitution and the Protection of Life During Pregnancy Act 2013, in line with international human rights standards; adopt guidelines to clarify what constitutes a real substantive risk to the life of a pregnant woman; publicise information on crisis pregnancy options through effective channels of communication; and ensure the accessibility and availability of information on sexual and reproductive health.[33]

UN Human Rights Committee (HRC)

2014 The Committee reiterates its previous concern regarding the highly restrictive circumstances under which women can lawfully have an abortion in the State party owing to article 40.3.3 of the Constitution and its strict interpretation by the State party. In particular, it is concerned at: (i) the criminalisation of abortion under section 22 of the Protection of Life During Pregnancy Act, including in cases of rape, incest, fatal foetal abnormality and serious risks to the health of the mother, which may lead to up to 14 years of imprisonment, except in cases that constitutes a "real and substantive risk" to the life of a pregnant women; (ii) the lack of legal and procedural clarity concerning what constitutes "real and substantive risk" to the life, as opposed to the health, of the pregnant women; (iii) the requirement of an excessive degree of scrutiny by medical professionals for pregnant and suicidal women leading to further mental distress; (iv) the discriminatory impact of the Protection of Life During Pregnancy Act on women who are unable to travel abroad to seek abortions; (v) the strict restrictions on the channels via which information on crisis pregnancy options may be provided to women and the imposition of criminal sanctions on healthcare providers who refer women to abortion services outside the State party under the [Abortion] Information Act 1995; and (vi) the severe mental suffering caused by the denial of abortion services to women seeking abortions due to rape, incest, fatal foetal abnormality or serious risks to health (arts. 2, 3, 6, 7, 17, 19, 26).

The State party should:

(a) Revise its legislation on abortion, including its Constitution, to provide for additional exceptions in cases of rape, incest, serious risks to the health of the mother, or fatal foetal abnormality.

(b) Swiftly adopt the Guidance Document to clarify what constitutes a "real and substantive risk" to the life of the pregnant woman.

(c) Consider making more information on crisis pregnancy options available through a variety of channels, and ensure that healthcare providers who provide information on safe abortion services abroad are not subject to criminal sanctions.[34]

2008 Recommendation 13 on Article 6 of the Covenant: The Committee reiterates its concern regarding the highly restrictive circumstances under which women can lawfully have an abortion in the State party. While noting the establishment of the Crisis Pregnancy Agency, the Committee regrets that the progress in this regard is slow (arts. 2, 3, 6, 26).

The State party should bring its abortion laws into line with the Covenant. It should take measures to help women avoid unwanted pregnancies so that they do not have to resort to illegal or unsafe abortions that could put their lives at risk (art. 6) ***or to abortions abroad*** (arts. 26 and 6).[35]

UN Committee Against Torture (CAT)

2011 The Committee notes the concern expressed by the European Court of Human Rights about the absence of an effective and accessible domestic procedure in the State party for establishing whether some pregnancies pose a real and substantial medical risk to the life of the mother (case of *A, B and C v. Ireland*), which leads to uncertainty for women and their medical doctors, who are also at risk of criminal investigation or punishment if their advice or treatment is deemed illegal. The Committee expresses concern at the lack of clarity cited by the Court and the absence of a legal framework through which differences of opinion could be resolved. Noting the risk of criminal prosecution and imprisonment facing both the women concerned and their physicians, the Committee expresses concern that this may raise issues that constitute a breach of the Convention. The Committee appreciates the intention of the State party, as expressed during the dialogue with the Committee, to establish an expert group to address the Court's ruling. The Committee is nonetheless concerned further that, despite the already existing case law allowing for abortion, no legislation is in place and that this leads to serious consequences in individual cases, especially affecting minors, migrant women, and women living in poverty (arts. 2 and 16).

The Committee urges the State party to clarify the scope of legal abortion through statutory law and provide for adequate procedures to challenge differing medical opinions as well as adequate services for carrying out abortions in the State party, so that its law and practice is in conformity with the Convention.[36]

UN Committee on the Elimination of Discrimination against Women (CEDAW)

2005 The Committee reiterated its "concern about the consequences of the very restrictive abortion laws [in Ireland]".

The Committee urges Ireland "to continue to facilitate a national dialogue on women's right to reproductive health, including on the very restrictive abortion laws".[37]

1999 "The Committee is concerned that, with very limited exceptions, abortion remains illegal in Ireland. Women who wish to terminate their pregnancies need to travel abroad. This creates hardship for vulnerable groups, such as female asylum seekers who cannot leave the territory of the State."[38]

Universal Periodic Review

The Universal Periodic Review (UPR) is a peer-to-peer review process of the 193 UN member states. Each state voluntarily submits for a review of their domestic human rights record every four-and-a-half years. The review takes places before the UN Human Rights Council and highlights any gaps in human rights fulfilment and protection in the State under review. Ireland has been reviewed twice, in 2011 and 2016.

2016 UN member states are concerned with Ireland's restrictive abortion laws. Fifteen countries issue recommendations on Ireland’s abortion laws.

UN member states recommend that the State party:

(a) Bring abortion laws into line with international human rights standards in law and in practice (Germany, Norway, India, Republic of Korea, Slovakia and Sweden).
(b) Widen the grounds for abortion (Switzerland, Slovenia, Netherlands, Iceland, Lithuania, Czech Republic and Uruguay).
(c) Decriminalise abortion and safeguard reproductive rights (Iceland, Denmark, the former Yugoslav Republic of Macedonia, Slovenia, United States of America, France and Canada).

2011 UN member states are concerned with Ireland's restrictive abortion laws. Six countries issue recommendations on Ireland’s abortion laws. Finland, Germany and France ask advance questions about the law on abortion in Ireland.

UN member states recommend that the State party:

(a) Bring abortion laws into line with international human rights standards in law and in practice (Norway).
(b) Widen the grounds for abortion (Denmark and Slovenia).
(c) Decriminalise abortion and safeguard reproductive rights (Spain).
(d) Legislate to give effect to the right to lawful abortion if a pregnant woman’s life is at risk (United Kingdom and Netherlands).

Appendix 4: IFPA Multimedia

Women's experiences

Women Have Abortions Every Day

This short film features four women's stories and highlights that abortion is just one of many decisions a woman may make in her life. Every woman's decision happens within a personal context. Only she can decide what's right for her at that particular time. Women Have Abortions Every Day is only two minutes long and is the most-watched clip on the IFPA website.

Viewing time: 2 minutes.

Men's experiences

Men Engage

IFPA pregnancy counselling services are there to support men too. Our Men Engage video highlights the ways that men can support their partners through an unplanned or unwanted pregnancy, or a pregnancy that has become a crisis in a woman's life. The key message, as Evelyn Geraghty, IFPA Director of Counselling, makes clear in this short film is, "While a woman's decision is never made in complete isolation, the decision, nonetheless, ultimately lies with her".

Viewing time: 3.5 minutes.

The impact of the law

Abortion in Ireland

The IFPA produced this video in 2012, before the introduction of the Protection of Life during Pregnancy Act. Although legislation was introduced in 2014, because the new law only allowed for abortion in case of risk to life, almost nothing has changed since this video was produced. According to the statistics produced by the UK Department of Health, in 2015, 3,451 women and girls in Ireland, or just over nine a day, travelled to the UK to access abortion services. And, increasingly, women are risking prosecution and accessing the abortion pill online.

Viewing time: 2.5 minutes.

Emergency Contraception

Emergency Contraception

Misunderstandings about how emergency contraception works contribute to the perception that it is a form of abortion. Our emergency contraception animation explains how it works, why it has nothing to do with abortion and why “morning after pill” is a misnomer.

Viewing time: 4 minutes.

Appendix 5: Supporting best medical practice in Ireland's abortion laws: Expert views

Context

In December 2016, the IFPA brought together a panel of international experts on reproductive healthcare at a Dublin seminar. In doing this, we wanted to draw on their extensive expertise on best medical practice in relation to abortion. We also wanted to share our experiences, as healthcare providers, of how Ireland's abortion laws, including the Eighth Amendment, prevent us from providing women with the best quality care. Below is a summary of the key points from each of the speakers' presentations. Listen to the podcast in full on our website.

Presentations

Dr Caitriona Henchion

An experienced healthcare professional who has worked as Medical Director of the IFPA for eight years, Dr Henchion heads up the IFPA's post-abortion services and has extensive experience of women's health needs in this context.

The IFPA's Medical Director, Dr Caitriona Henchion, described the difficulties associated with operating as a healthcare provider in the context of Ireland's abortion laws, including the Protection of Life During Pregnancy Act (2013) and the Regulation of Information Act (1995) in particular.

For the 2013 Act, Dr Henchion explained, the guidance available fails to instruct doctors on how to make the distinction between the risk to a woman's health and risk to her life. They don't address the types or levels of risk to life that must be present before an abortion is allowed to be carried out. She described how, because neither women nor their doctors are sure about when and how a woman can qualify to access abortion under this Act, there are significant problems with accessing even this very limited right to abortion in Ireland.

Because of this, Dr Henchion said, doctors are reluctant to advise women to try to obtain abortions under the Act, for fear of causing delays. Dr Henchion emphasised that women who are considering their eligibility for abortion under the 2012 Act are ill, often with complex problems. In such situations, it is necessary to act quickly, which the 2013 Act does not permit.

Dr Henchion noted the lack of a woman's input into this decision-making process. With any other procedure, she said, a person would weigh up the associated risks and come to a decision privately, in consultation with their doctor and family. But in the case of abortion in Ireland, the decision is taken away from the woman entirely.

Dr Henchion highlighted a number of ways that Ireland's abortion laws impede best medical practice. For example, a woman who has a medical condition should have a proper referral, to pass on relevant information about the medical condition. But women who travel for abortions are denied this continuity. These women bear the sole responsibility for communicating the appropriate information, rather than the doctor ensuring this information is passed on. "That's a totally unacceptable level of medical care", Dr Henchion said.

Essentially, Dr Henchion explained, "Access to abortion in Ireland is largely down to a woman's resources. . . . That is clearly an inequality that's inconsistent with any human rights standards".

Professor Emeritus Sir Sabaratnam Arulkumaran

Distinguished obstetrician and former president of the Royal College of Obstetricians and Gynaecologists, the International Federation of Gynecology and Obstetrics (FIGO), and the British Medical Association, Prof Arulkumaran was also chair of a panel of inquiry into the death of Savita Halappanavar.

Professor Arulkumaran drew on the ethics guidelines of the International Federation of Gynecology and Obstetrics and (FIGO). These guidelines are devised by a committee of leading Obstetricians and Gynaecologists that comes together to examine international issues, practices and consensus. This committee's conclusion on abortion is that a woman's right to autonomy, coupled with the danger posed by unsafe abortion, provides an ethical imperative to provide safe abortion services for medical and non-medical reasons.

Women do not make the decision to have an abortion lightly, Professor Arulkumaran said. They often make these decisions in difficult and complex circumstances. And yet, where abortion is prohibited and carries penalties, he said, "[the woman] is treated like a criminal". Professor Arulkumaran described this situation as "unacceptable" and "inappropriate".

The Professor asked the audience to imagine what Ireland might be like if Ireland did not have the UK close by. Unsafe abortion, he explained, causes suffering and deaths. It is a leading cause of mortality in countries where abortion is illegal. By contrast, Professor Arulkumaran outlined, abortion is safe. "Decriminalisation dramatically reduces mortality", he said.

Professor Arulkumaran explained that while criminalisation does not decrease the rate of abortion, it does impact on its safety. This is evidenced by the example of South Africa, where legalisation of abortions dramatically decreased maternal deaths. One reliable way to decrease the rate of abortion, he noted, is to use the opportunity of women's contact with abortion services, to provide contraceptive options. "By punishing you are not going to bring abortion down", he emphasised.

Speaking in relation to the case of Savita Halappanavar, Professor Arulkumaran noted that in this case, the only way that Ms Halappanavar's life could have been saved would have been to terminate the pregnancy earlier. In this case, this was not done due to an over-emphasis on the presence of a foetal heartbeat, and Ms Halappanavar tragically lost her life. However, Professor Arulkumaran was critical of the focus on loss of life alone, without consideration of women experiencing permanent injury as a result of traumatic pregnancy.

Professor Arulkumaran emphasised that advocating for the right to safe abortion is not denying that the foetus has a moral value. But rather, he said, we must establish the appropriate balance between this moral value and the moral value of a woman who is already alive, and the rights to which she is entitled.

Professor Rebecca Cook

An expert on sexual and reproductive health and rights law, Professor Emerita and Co-Director of the International Reproductive and Sexual Health Law Programme at the University of Toronto, Professor Cook also acts as ethical and legal issues co-editor of the International Journal of Gynecology and Obstetrics, the official publication of FIGO.

In her presentation, Professor Cook outlined the significance of Professor Arulkumaran's report on the case of Savita Halappanavar, as well as the UN Human Rights Committee ruling on the case of Amanda Mellet. These reports, she said, are "extremely significant for re-framing the debate here in Ireland".

The Arulkumaran report, she said, is significant in that it establishes the facts of that case, and attributes these facts to Ireland's abortion laws. The report, she said "names the problem as one of injustice". Professor Cook said that the facts of the Arulkumaran report clearly show that Ireland's legislative framework does not provide doctors with the enabling legal environment they need to provide best care to women. Indeed, it is also a recognition that the criminal law directly causes harms. This recognition of the harms caused directly by the criminal law, according to Professor Cook, demonstrates that there is a pressing need for remedy, in the form of "social and legal reforms".

In relation to the case of Amanda Mellet, Professor Cook highlighted how this judgement demonstrates directly the way in which criminalisation of abortion amounts to cruel, inhuman and degrading treatment of women. It also exposes the unequal application of the law, as denying a treatment that only women need constitutes discrimination. Professor Cook noted that in her acceptance of the Government's offer of €30,000 compensation, Ms Mellet called for legal changes that stop stigmatising women who need abortions. "Can Ireland continue to suspend the rights of women while they are pregnant?" Professor Cook asked.

Professor Cook examined the sources of this stigma associated with abortion. Some of these, she explained, are associated with attitudes to sex. Namely, that there is blame to be associated with non-procreative sex. Other sources of stigma are focused on the foetus and its personification. This is related to the belief that the prohibition of abortion is necessary to protect the State's interest in pre-natal life. This interest is legitimate, she noted. However, criminalisation of abortion is not an effective or proportionate means to achieve this end. Rather, a workable solution must concurrently respect and protect the rights of the woman.

In conclusion, Professor Cook warned that while the Eighth Amendment of the Constitution remains, there can be no progress for women's reproductive health rights in Ireland, and doctors will continue to be "forced to discriminate against women".

Listen to the podcast of the full presentations on our website.

Appendix 6: Rebecca Cook address to the IFPA Winter Seminar 2016

The Irish Family Planning Association, Annual Seminar, December 7, 2016
Remarks by Rebecca Cook
Professor of Law Emerita, Faculty of Law, University of Toronto

Introduction

Let me begin with a hearty congratulations to the IFPA for what you have accomplished in your 47 years to achieve reproductive justice. What courage, perseverance and fortitude you have all shown! It is a particular pleasure to be back in Dublin as I derive strength, insights and inspiration from you all.

A special thanks to Professor Sir Arulkumaran for *The Final Report of the Health Service Executive Investigation of Incident* of Savita Halappanavar's death in 2012.[1] In addition to the important recommendations for ensuring hospital systems are in place to avoid such deaths in the future, Arul's report is significant for reframing the larger debate on abortion in Ireland.

The purpose of my talk this evening is to show how the Arulkumaran report, together with the *Mellet* decision of the HRC, might be used as you consider the future of your abortion law in Ireland.

A. The Arulkumaran report, 2013

In short:
1. It established the **facts** of Savita's death.
2. It **attributed** the facts of her death to the criminal abortion regime. In other words, it established a causative link between the facts and the criminal law.
3. It **named** the problem as one of injustice, in addition to naming the inadequacies of medical and health systems.

Let me proceed by discussing the importance of facts to your advocacy efforts, the significance of attributions and the power of naming.[2]

1. The facts

The **first** reason why the Arulkumaran report is significant: It presents the facts of how and why Savita died.

The report establishes key causal factors, contributory factors, and incidental factors of her death.

Facts matter. Yes, the established facts are primarily medical facts, and nonmedical people like me can hardly pronounce the medical terms. Because of the medical nature of the report, I fear that its importance to your advocacy might have been overlooked.

Most advocacy efforts, whether they be political, social or legal, start with the documentation of the facts. Facts can be established through an official death certificate of a pregnant woman's death.

In Canada, our abortion law would not have changed but for the facts established by the 1977 Royal Commission on the Operation of the Abortion Law. Prior to 1988 when our Supreme Court held that our criminal abortion provision was unconstitutional in the Morgentaler case, our law allowed for abortions to protect the life and health of the woman, provided a hospital committee, of three doctors, separate from the doctor who performed the procedures, certified that the abortion would be done for these reasons.[3] The Royal Commission found that some hospitals established committees and some did not. 40% of Canadians lived in areas where hospitals could not establish committees because they did not have a sufficient number of doctors. Where hospital committees were established there was no way to ensure that the life and health indications were applied equitably. On average, women experienced delays of up to six weeks in securing an abortion.

Both in Ireland and in Canada, the facts were established by governmentally commissioned reports, legitimating the facts.

2. Attribution

The **second** reason why the Arulkumaran report is important is it attributes the facts of Savita's death to the prevailing criminal abortion regime in Ireland,[4] that is:

- The Eighth Amendment of the Constitution[5]
- The statute law, including:
    - The 1861 Offenses against the Person Act
    - The Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 (Abortion Information Act)
- The case law of the Irish courts, including the 1992 X decision and the 2010 ABC decision of the European Court of Human Rights
- The professional guidelines (Medical Council guidelines) (Nursing Board guidelines)

The Arulkumaran report stands for the proposition that, but for the Irish criminal abortion regime, Savita would not have died.

Let me quote from the report: Key Causal Factor 2: [Irish Law as a Contributory Factor] Institutional Context Factor: The Regulatory Context – Legislative factors affecting medical considerations (pp. 71–73).

"The investigation team is satisfied that concerns about the law . . . impacted the exercise of clinical profession judgement" (p. 69).

"The interpretation of the law related to lawful termination in Ireland . . . is considered to have been a material contributory factor" (p. 73).

Recommendation 4b: Urgent guidance needed for such cases, and "guidance so urged may require legal change" (pp. 17, 74).

Importantly, Arul's report attributes the death to the prohibitive criminal abortion regime. It understands that the criminal law is itself a source of harm; it produces harm.[6] The harms of criminalisation adversely impacts health outcomes, and denies doctors and healthcare providers the enabling legal environment they need to provide medical services in a way that comply with professional and ethical standards of care.

3. Naming

In addition to identifying the harm and attributing it to the criminal abortion regime, the **third** reason this report is significant is it named the problem as one of injustice, requiring legal reform to address that injustice. It shows how unjust the application of life exception to the criminal prohibition of abortion is in Ireland.

Naming is similar to diagnosing, such as diagnosing a disease. A disease has to be named in order for it to be treated.

Similarly, in naming Savita's death as an injustice, Ireland now has to treat this problem as one of injustice. Injustice requires social and legal reforms necessary to treat it, not just as a medical problem needing improvement in hospital systems, but as a violation of human and constitutional rights.

The Arulkumaran report, in establishing the facts of Savita's death, in attributing Savita's death to the criminalisation of abortion, and in naming her death as one of injustice, reframes the abortion debate here in Ireland as matter of fundamental justice.

B. *Mellet v. Ireland* (2016)

The UN Human Rights Committee held that denial of abortion for a fatal foetal anomaly requiring Amanda Mellet to travel violated the International Covenant on Civil and Political Rights (inhuman and degrading-7, privacy-17 and equality before the law-26). In early December, 2016, the Government agreed to compensate Amanda Mellet with €30,000 in recognition of the violations of her rights, but has yet to address in any adequate way how it will prevent future such violations.

As you think about your advocacy to make the necessary legal and policy changes to prevent future such violations, focusing on how the Human Rights Committee in the *Mellet* case found violations of the right to be free from inhuman and degrading treatment and the right to equal application of the law might be useful.

Inhuman and degrading treatment: Criminalisation of abortion degraded and stigmatised her, thus spoiling her identity. In calling for reforms, it might be helpful to articulate the components of stigma production:

Criminal law *marked* Amanda Mellet as different because she was seeking abortion. The health system marked her as different from other pregnant women who carry their pregnancies to term knowing that they have no chance of survival.

It *linked* those differences to undesirable characteristics through stereotyping her as a reproductive instrument.

It *separated* the stereotyped Amanda Mellet from the standard way of treating patients by forcing her to travel.[7]

The separation *justified* the status loss, through degrading her and through the unequal application of the law to Amanda Mellet.

Through each of these components of stigma production, the criminal abortion regime, including the Eighth Amendment, allowed the State to *exert power* through degrading Amanda Mellet.[8]

Equal application of the law: Denial of equality before the law arose because she was stereotyped as a reproductive instrument.

The Human Rights Committee explained that reducing Amanda Mellet to a reproductive instrument because of her pregnant and lower socio-economic statuses, and not treating her according to her own health needs and circumstances, infringes her rights to equal application of the law. The Committee continued by explaining that the prohibition of abortion in Ireland "targets women *because they are women* and puts them in a situation of vulnerability which is discriminatory in relation to men".

In the words of General Recommendation 24 of the Committee on the Elimination of Discrimination against Women, criminalising medical treatment that only women need is a form of discrimination. A concurring opinion elaborated that a state cannot deny women treatment for a cancer that is unique to that sex, such as cervical cancer, in the same way that a state cannot deny men treatment for prostate cancer.

The Committee reasoned that more favourable treatment of women who decide to carry pregnancy with a fatal impairment to term, versus women who terminate such pregnancies, reflects a stereotypical idea that a pregnant woman should let nature take its course, regardless of the suffering involved.

A concurring opinion went further in stating that, "The criminalisation of abortion is itself discriminatory because it places the burden of criminal liability primarily on the [pregnant] woman".

Given that the Human Rights Committee has said that criminalising abortion itself denies equal application of the law, might you want to use the Citizen Committee forums to generate debate about why Ireland has criminalised it. Is it through rationales relating to women, sex and pre-natal life?

The **woman-focused rationales** for criminalising abortion might see women as requiring protection by criminalising unskilled or forced abortion or it might characterise women as perpetrators of wrongs against their proper roles as care-giving mothers in their societies.

Does the woman-focused rationale overlook the importance of constructing pregnant women as rights holders?

Are pregnant women equally entitled to all the rights of any other individuals? But why do societies think they can suspend the rights of pregnant women? Why do societies, including governments, think that they know better what is in the best interest of women and their pregnancies?

The **sex-focused rationales** justify abortion punishment in order to condemn unmarried women seeking to disguise illicit sex causing pregnancy, and married women denying their husbands their children. A related sex-focused rationale is that punishment is justifiable when individuals engage in non-procreative sex, because, allegedly, such engagement is hedonistic.[9]

A sex-focused rationale overlooks the fact that sexual intimacy is an important part of life that strengthens bonds. Consistently with the shift in public health practice, there has been a growing tendency to reframe sexual conduct as respect-worthy and not blameworthy. What must be done to frame sex as respect-worthy, not blameworthy?

Foetal-focused rationales emerge from concepts of ensoulment and personification of foetuses, wrongly denied birth, baptism and eternal life in heaven through abortion. An associated foetal-focused rationale is that the prohibition of abortion is necessary to protect the State's interest in prenatal life.

Empirical evidence shows time and again that criminal abortion laws do not affect the overall incidence of abortion; they just make it unsafe.[10] That is, the evidence is clear that criminal abortion laws are not effective in meeting the State's objective of protecting prenatal life. Certainly the objective of protecting prenatal life is legitimate, but where it is shown that the means chosen to achieve this objective is not effective, and there are other means that are less intrusive on women's rights, the means chosen by the State are disproportionate and therefore constitutionally suspect.

Are the foetal-focused rationales dysfunctional in overlooking the ways the State can actually protect prenatal life consistently with women's rights? For example, by reducing recurrent miscarriages and stillbirths or ensuring that the social and economic conditions that make pregnancies wanted exist for all women?[11]

All of these rationales pervade criminal abortion regimes in most countries, including Ireland.

Whether the rationale for criminalisation of abortion, or for punishing it, is focused on women, sex or the foetus, or all three, increasingly courts understand that the criminal law causes harms. In other words, the criminal law itself creates its own harm and is not a proportionate means to achieve its objective of protecting prenatal life. Importantly, courts in countries such as Canada (1988), Colombia (2006), Germany (1993), Portugal (2010) and Slovakia (2007) have applied the **proportionality** principle to ease abortion restrictions or uphold abortion reforms.[12]

Courts in Germany, Portugal and Slovakia have decided that the protection of prenatal life is best done through means that support women, such as through counselling regimes. These countries have recognised that the protection of prenatal life is an important objective, but it has to be achieved in ways that are consistent with women's rights, and not through the criminal law, or, as in the case of Germany, not through criminal punishment.

Conclusion

As you consider the future of your law through the Citizens' Committee, you have some remarkable resources at your disposal:

- the Arulkumaran Report that provides irrefutable evidence of how the Irish criminal abortion regime, including the Eight Amendment, is an albatross around your necks, an albatross that prevents doctors from treating women according to professional and ethical standards of care, prevents doctors from treating the best interests of their patients, forces doctors, against their will, to discriminate against women on grounds of their pregnant status, and

- the *Mellet* decision of the UN Human Rights Committee that articulates how gender bias and gender ideology pervade the regulation of abortion in Ireland, and how the criminalisation of abortion causes the inhuman and degrading suffering of pregnant women, and violates the right to equal application of the law.

As you generate debate through the Citizens' Committee meetings, consider all areas of the law: criminal law, health law, constitutional and human rights law. These areas co-exist in all legal systems: Sometimes criminal law might dominate the discourse as a way of protecting prenatal life. At other times, a health law might surface as a way of reducing health harms of the criminal law. Constitutional and human rights law emerges periodically, for example, to address indignities and discrimination against women, such as this year's decision of the Human Right Committee in the *Amanda Mellet* case.

Generating public debates about **criminal law,** you might ask, what are the appropriate uses of criminal law in the context of abortion?

 Why do societies criminalise abortion? Criminal abortion law, like crime generally, is a legal and social construct.

 According to what rationales, women-focused, sex-focused or foetal focused rationales, is Ireland criminalising abortion?

Should abortion be categorised as a misdemeanour as it was in the early 1800s, or rather as a felony, a more serious offence? What kind of punishment, if any, is appropriate to exact? Should abortion be criminalised, but not punished, as is the case in Germany?

As you consider the future of your abortion law, generating public debates about how to ensure its fair application, a foundational principle of administrative law that underlies **health law**, and about the professional and ethical delivery of services is critical, including such questions as:

What kind of **ethical guidelines** for the delivery of abortion services, that elaborate basic ethical principles, such as respect for persons, including women's autonomy, protection of the vulnerable, beneficence (positive duty to do good) and maleficence (do no harm) and justice, will be necessary to develop? What kind of training will be needed to ensure the **ethical delivery** of services? See, for example, the FIGO ethical training manual (FIGO Introduction to Principles and Practice of Bioethics: Case Studies in Women's Health, 2012)[13]

Using **constitutional and human rights law** to generate public debate about the proportionate use of the criminal law might be in order. The proportionality principle has been applied to require that the protection of prenatal life be pursued in ways that are supportive of women, such as through appropriate counselling, and not in ways that undermine her rights.

I raise these questions because I know this group, brought together this evening by the IFPA, has what it takes to work together to generate the strategic thinking, consistently with the Arulkumaran Report, through the Citizens' Committee forums.

Let me end where I began with hearty congratulations to the IFPA, and to you all, for your fortitude in finding a way forward in addressing the reproductive injustices that for too long have plagued this society.

1 Sabaratnam Arulkumaran, *The Final Report of the HSE Investigation of Incident 50278 from the time of the patient's self referral to hospital on 21st of October 2012 to the patient's death on the 28th October 2012* (Health Services Executive, June 2013) (death of Savita Halappanavar) (Ireland) [the Arulkumaran Report].

Key Causal Factor 2: Failure to offer all management options to a patient experiencing inevitable miscarriage of an early second trimester pregnancy where the risk to the mother increased with time from the time that membranes were ruptured . . . concerns about the law, whether clear or not, impacted on the exercise of clinical professional judgement (p. 69). From the time of her admission, up to the morning of the 24th of October – the management plan for the patient was to "await events" and to monitor the foetal heart in case an accelerated delivery might be possible once the foetal heart stopped . . . this was because of their interpretation of the law related to pregnancy termination (p. 70).

2 Joanna Erdman, Harm Production: An Argument for Decriminalization, *The Criminal Regulation of Gender, Reproduction and Sexuality* edited by Ali Miller and Mindy Roseman, forthcoming 2017 University of Penn Press.

3 *Morgentaler et al v. R.*, 44 D.L.R. (4th) Part 3, May 19, 1988. In Canada, because therapeutic services were not equitably available, the Court said this is unfair, and therefore a denial of our Charter's security of the person. Consequently, abortion has been decriminalised since 1988. As a result it is now regulated like any other medical procedure to ensure that it is provided safely and according to professional standards of care that are evidence based.

4 Appendix A: "Summary outline of the legal position in Ireland with respect to the regulation of the termination of pregnancy and, in particular, as regards the protection of the right to life of the pregnant woman and of the unborn prepared by Mr. Peter Finlay, SC" (Senior Counsel) includes Constitutional Law, Statutory Law, Case Law, Professional Guidelines. (2013 Arulkumaran pp. 85–96). For developments since 2013, see Maeve Taylor, Women's Right to Health and Ireland's Abortion Law, *Int'l J of Gyn and Obstetrics* 130 (2015) 93–97; Mairead Enright et al (2015) Abortion Law Reform in Ireland: A Model for Change Feminists@Law 5(1). Available at: http://journals.kent.ac.uk/index.php/feministsatlaw/article/view/173/631

5 Article 40.3.3 of the Irish Constitution (Eighth Amendment, 1983) provides that the State recognises 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". Thirteenth and fourteenth amendments, 1992 re travel and information, respectively. The stereotype of women as mothers and homemakers is reflected in article 41.2 of the Irish Constitution:

6 Joanna Erdman, Harm Production, see above; see also CESCR Gen com 22, 2016.

7 See research of Deirdre Duffy and Claire Pierson of Manchester Metropolitan University re abortion-seeking Irish women traveling to Liverpool; Joanna Erdman, The Law of Stigma, Travel and the Abortion-Free Island, *Columbia J. of Gender and the Law*, 33.1: 29 (2016).

8 Rebecca Cook, Stigmatized Meanings of Criminal Abortion Law, in *Abortion Law in Transnational Perspective* (Cook, Erdman and Dickens eds) 2014 University of Penn Press, 347, 354, citing Bruce Link and Jo Phelan, Conceptualizing Stigma, *Annual Review of Sociology* 27 (2001) 363, 367–376; Maeve Taylor, Abortion Stigma, A

Health Provider's Perspective, in *Abortion Papers Ireland*: vol 2, (Quilty, Kennedy and Conlon eds), 2015 Attic Press, 217.

9 Diarmaid Ferriter, *Occasions of Sin – Sex and Society in Modern Ireland*, and the film *Philomena* provide insights into the harms of the sex-focused rationales for criminalisation to individuals and society.

10 Gilda Sedgh, Susheela Singh, Iqbal H. Shah, Elizabeth Ahman, Stanley Henshaw and Akinrinola Bankole, "Induced Abortion: Incidence and Trends Worldwide From 1995 to 2008", *The Lancet,* 379, No. 9816 (2012): 625-632; World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* 2ed. (Geneva: World Health Organization, 2012).

11 Rebecca J. Cook, "Modern Day Inquisitions", *University of Miami Law Review,* 65, No. 3 (2011): 767–797, 788–789.

12 Veronica Undurraga, Proportionality in the Constitutional Review of Abortion Law, in *Abortion Law in Transnational Perspective* (Cook, Erdman and Dickens eds), 2014 University of Penn Press, 77.

13 FIGO Training manual. Available at: http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/Bioethics%20Training%20Curriculum%202013.pdf

Appendix 7: Abortion access in other European countries

1. A health systems approach to the regulation of abortion

➢ Abortion on request

Most European countries, including Belgium, Germany, the Netherlands and Switzerland, which have some of the lowest abortion rates in the world, have taken a health systems approach to the regulation of abortion.

- First, they have accepted the evidence-based reality that most women who have abortions do so because they are dealing with a crisis or unwanted pregnancy and that allowing these women to access abortion services legally early in pregnancy is a public health imperative.
- Second, they have accepted that there will always be situations later in pregnancy when clinical indications, such as risk to a woman's health or life or situations of foetal impairment, may necessitate allowing women who request abortion services access in practice.

As a result, most European countries have adopted regulatory frameworks that legalise women's access to abortion services on request early in pregnancy, on average up until the first 12 or 14 weeks of pregnancy. Additionally, once the timeframe for legal access to abortion on request passes, all these countries' laws provide that medical professionals may perform abortions later in pregnancy where a woman's health or life is at risk or where there is a severe or fatal foetal impairment. They each set out an ethical framework of time limits and procedures that must be adhered to in these exceptional situations.

Among the countries that regulate abortion in this way are Austria, Belgium, Czech Republic, Denmark, France, Germany, Italy, Portugal, Slovakia, Spain and Switzerland.

The term limits for access to early abortion on request differ but generally range from between 10 weeks to 14 weeks.

The Netherlands, Norway and Sweden take a similar approach but allow slightly longer term limits for access to abortion on request.

➢ Abortion to protect a woman's health

While the laws in Finland, Iceland and the UK do not allow women's early access to abortion on request, their laws specify that women can access abortion when necessary to protect their health (and in other exceptionally defined circumstances). The concept of health is broadly defined with reference to social and economic circumstances and, as a result, in practice women are able to access abortion when they decide it is the best course of action for them in their individual circumstances.

2. An exceptions-based approach to the regulation of abortion

Ireland is one of only a handful of European countries that continue to operate a restrictive exceptions-based approach to abortion. The others are Poland, Malta, Cyprus and the microstates.

These kinds of regulatory frameworks are ineffective, for several reasons.

Firstly, their starting point and framing is negative. They have usually been introduced as part of a law reform process that takes a policing approach to abortion and does not seek to ensure women's access to services in practice. They retain a narrow, distrustful approach to abortion access that makes them dysfunctional and are usually accompanied by a pronounced lack of political will to enable access to services even in the exceptional circumstances they purport to address.

In this context, they usually include a narrow definition of the concept of women's health and they usually set out a very strict series of "qualifiers" or procedures that must be fulfilled prior to access, which make the possibility of meaningful and timely access to services theoretical and illusory.

Secondly, they fail to remove the chilling effect on access to legal services, which is inherent to the criminalisation of abortion. This is because exceptions-based frameworks usually coexist alongside criminal law provisions that continue to criminalise medical practitioners (and sometimes women) who perform abortions outside of the exceptional circumstances covered. The chilling effect of the criminal law means that, in practice, medical professionals are disabled by fear of prosecution or investigation from providing services that are legal.

Appendix 8: Legal and policy considerations for the provision of safe abortion — Guidance from the World Health Organization (WHO)

Summary

- In nearly all developed countries, safe abortions are legally available upon request or under broad social and economic grounds, and services are generally easily accessible and available.
- A health systems approach, as opposed to an exceptions-based model, places women at the centre of their care and ensures that quality abortion services are provided as early as possible and as late as necessary.
- The overall aim of laws and policies on abortion should be to protect women's health and their human rights.
- Legal, regulatory and administrative barriers can deter women from seeking access to care and should be removed.

Background

Abortion laws began to be liberalised in the first part of the 20th century when the extent of the public health problem of unsafe abortion began to be recognised.

From the late 1960s onward, there has been a trend towards liberalisation of the legal grounds for abortion. Since 1985, more than 30 countries have liberalised their abortion laws, while only a few countries have imposed further restrictions in their laws. These reforms have come about through both judicial and legislative action.

32 out of 44 European countries allow abortion upon request of the pregnant woman. In this context, the ultimate decision on whether to continue or terminate her pregnancy belongs to the woman alone.

Abortion on a woman's request

- entitles all women to safe abortion,
- respects the woman's autonomy and decision-making,
- recognises there are multiple reasons for abortion and
- is based on the woman's free choice.

A further four European countries allow access to abortion under broad social and economic grounds. In some criminal or penal codes, abortion throughout pregnancy or up to a set gestational limit is no longer subject to criminal regulation, and has been removed as a distinct offence. In these situations, abortion services have usually been integrated into the health system and are governed by the laws, regulations and medical standards that apply to all health services.

Quality of care

While expanding the legal grounds for abortion in Ireland is critical, of itself it is not sufficient to ensure access to and availability of quality safe abortion services.

Any legislative changes must be accompanied by a set of policies and protocols that will ensure there is an equitable distribution of quality, affordable services across the country, staffed by competent, well-trained healthcare providers.

The provision of information about these safe and legal abortion services is crucial to protect women's health and their human rights. In addition, women who access abortion services should also be able to avail of contraceptive information and services post-abortion.

Good quality of care requires that women are in a position to make informed decisions about their health; and that their autonomy, confidentiality and privacy are respected.

A health systems approach, as outlined above, is woman-centred and aims to provide quality abortion services as early as possible and as late as necessary.

Legal and policy considerations

Abortion rates are similar regardless of the legal position. Laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principal effect is to shift previously clandestine, unsafe procedures to legal and safe ones.

Rather than focusing on reducing abortion, states should instead concentrate on reducing the rates of unintended pregnancy. This is best achieved through the provision of contraceptive information and services, including emergency contraception and a broad range of contraceptive methods, and comprehensive evidence-based sexuality education.

Regulations and policies on abortion should be drafted in a manner that ensures that every woman who is legally eligible has ready access to safe abortion care.

Policies should aim to

- respect, protect and fulfil the human rights of women, including women's dignity, autonomy and equality;
- promote and protect the health of women, as a state of complete physical, mental and social well-being;
- minimise the rate of unintended pregnancy by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education;
- prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications;
- reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services;
- meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as poor women, adolescents, refugee and asylum-seeking women.

Nearly every country in Europe ensures timely and affordable access to good-quality abortion services, delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.

Legal, regulatory and administrative barriers to safe abortion access

Restrictions on access to abortion do not reduce the need for abortion. However, they do lead women to seek services elsewhere—which is costly, delays access and creates social inequities—and are likely to increase the number of women seeking illegal and unsafe abortions.

In circumstances where abortion is restricted, disadvantaged groups—such as women on low incomes and asylum-seeking women—are less likely to have access to safe abortion services.

Laws, policies and practices that restrict access to abortion information and services can deter women from seeking care and create a "chilling effect" for the provision of safe, legal services. Examples of these barriers include restrictions on access to information, a third-party authorisation requirement and conscientious objection.

Removing barriers ensures the best health outcomes for women because all legal grounds other than abortion on request are implemented at the discretion of the healthcare provider or another third party. These models create delays that increase the risks of abortion and can facilitate unwarranted denials of services. In practice, particularly in countries that lack a benevolent provider culture, abortion on request is needed to ensure abortion access and availability in practice.

The vast majority of exceptions-based laws do not give rise to access in practice. Often this is because these laws are too strictly written or the State lacks the political will to implement the abortion laws.

The fundamental problem with all exceptions-based models is that someone else decides. They are paternalistic models that deny women's autonomy and bodily integrity by design.

Exceptions-based abortion legislation does not work because it is based on a distrust of women and a distrust of doctors; criminal provisions remain in place; and barriers are erected to minimise access to services.

The respect, protection and fulfilment of women's human rights require that comprehensive regulations and policies be in place, and they address all barriers to ensure that abortion is safe and accessible.

Appendix 9: Additional barriers to access to the highest standard of reproductive health

Contraception

A number of studies and reports,[39] have identified barriers preventing young people from accessing contraception. These include regional disparities in the quality and availability of services, stigma and lack of confidentiality. In addition, the 2010 Irish Contraception and Crisis Pregnancy Study[40]identified the cost of contraception as a significant access barrier for young people. For example, the high price of condoms, which are not available under the medical card scheme, and the high cost of a GP visit to renew a prescription for the contraceptive pill constitute real barriers for young people, not all of whom have medical cards.

The legal status of prescribing contraception to young people under the age of 16 is very unclear.[41] This poses a major dilemma for doctors, who are ethically required to provide a confidential service that is in the best interest of their client. The situation is further complicated by the fact that the age of sexual consent in Ireland is 17.[42]

This legal ambiguity can give rise to scenarios such as medical professionals refusing to provide sexual health services (including emergency contraception) to young people or doctors violating principles of confidentiality by contacting the young person's parents against their express wishes.

A 2011 report[43] by the Law Reform Commission recommended legislative reforms to allow for the views of mature teenagers to be taken into account in the context of consenting to or refusing medical treatment. Giving young people the ability to consent to their own medical care would be a major step towards keeping young people safe and healthy.

The recommendations of the report have not been implemented.

Migrant and asylum-seeking women and girls

Migrant women and adolescents tend to experience additional barriers to access, due to language barriers, cultural reasons and lack of familiarity with the health services in Ireland.

Asylum seekers face particular barriers: 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.

The IFPA is deeply concerned about the harms caused by inadequate sexual and reproductive health 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.[44]

Relationships and Sexuality Education (RSE)

Ireland's first National Sexual Health Strategy was published in October 2015, covering the period 2015–2020. A key goal of this document is that everyone living in Ireland will receive "comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services".[45]

The most recent Health Behaviour of School Age Children report,[46] launched in December 2015, uses data from 2014, and shows that 27% of 15–17 year olds report that they have ever had sex. Of those who report ever having had sex, 33% report that they used the birth control pill as a form of contraception at last intercourse; 73% report that they used condoms as a form of contraceptive at last intercourse. Between 2001 and 2015, the number of births to teenagers decreased by 62%. In 2015, 1,187 babies were born to women aged under 20, accounting for less than 2% of total annual births.[47]

Although relationships and sexuality education (RSE) is mandatory in schools, schools and teachers have significant freedom in defining the content. This results in unequal implementation across the country. Guidelines[48] on appropriate content have been issued by the Department of Health, but they are not compulsory. Schools can decide on the content of RSE based on moral or ethical considerations.[49] As a result, there is uneven implementation of sexuality education across the country and the quality of information provided varies greatly.

In particular, not all schools provide comprehensive information on the full range of contraceptive methods.[50]

A 2013 Department of Education report found that 39 of 63 schools inspected displayed "evident weaknesses" in the quality of planning RSE at senior cycle.[51]

People with intellectual disabilities

Section 5 of the Criminal Law (Sexual Offences) Act 1993 makes it a crime for a person to have sex or attempt to have sex with a person who is "mentally impaired" unless they are married to each other. The IFPA is of the view that section 5 exercises a chilling effect, whereby people with intellectual disabilities are denied knowledge and understanding of sexuality and relationships as positive aspects of life, and about how to protect themselves from inappropriate sexual behaviour, sexually transmitted infections and unplanned pregnancy. This leaves people with intellectual disabilities at risk of abuse, sexual exploitation, unplanned pregnancies and sexually transmitted infection.

Further reading

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