SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

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26 June 2017

Re: Supplementary information on Ireland in relation to sexual and reproductive health and rights for the consideration of the Committee Against Torture at its 61st session (24 July–11 August 2017)

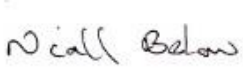
Dear Honourable Committee Members,

The Irish Family Planning Association (IFPA) submits these remarks based on its experience in providing reproductive healthcare services to women and girls. The submission draws on the experiences of IFPA clients, with a focus on the barriers they encounter when trying to access abortion. It also addresses the particular sexual and reproductive health needs of migrant women and girls, including those who have experienced female genital mutilation (FGM). We also respectfully suggest a number of recommendations.

Since 1969, the IFPA has worked to promote and protect basic human rights in relation to reproductive and sexual health, relationships and sexuality. The IFPA provides the highest quality reproductive healthcare at its two medical clinics in Dublin and eleven pregnancy counselling centres across Ireland. Our services include non-directive pregnancy counselling, family planning and contraceptive services, medical training for doctors and nurses, free post-abortion medical check-ups and educational services. In 2016, the IFPA medical clinics provided sexual and reproductive health services to over 12,000 clients and provided information and support to more than 3,000 women and girls experiencing pregnancies that were unplanned, unwanted or that had developed into a crisis because of changed circumstances. In 2014, the IFPA opened the first FGM Treatment Service in Ireland, which provides free specialised medical and psychological care to women and girls who have experienced FGM. On the basis of this track record, the IFPA is recognised as a respected source of expertise in the provision of sexual and reproductive healthcare services, advocacy and policy development.

I hope that the information provided in this submission will be useful to the Committee in its review of Ireland's compliance with the Convention. Please do not hesitate to contact me should you have any questions.

Yours sincerely,



Niall Behan
Chief Executive Officer

Submission by the Irish Family Planning Association (IFPA) in relation to the review by the Committee Against Torture (CAT) of Ireland's compliance with the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The Irish Family Planning Association (IFPA) makes this submission in order to supplement the information provided in the State report submitted by the Government of Ireland (CAT/C/IRL/2). The submission focuses on sexual and reproductive health and rights issues in Ireland.

The submission draws on the experiences of IFPA clients, with a focus on the barriers they encounter when trying to access abortion. It also addresses the particular sexual and reproductive health needs of migrant women and girls, including those who have experienced female genital mutilation (FGM). We also respectfully suggest a number of recommendations.

The submission is structured as follows:

1. Denial of abortion services

1.1 The restrictive laws on abortion and the failure of legislation to guarantee even existing limited right to abortion where there is risk to life

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

Legal framework

The limited right to abortion was established in a 1992 Supreme Court ruling.[1] The *Protection of Life during Pregnancy Act 2013* (hereafter the 2013 Act) was enacted on foot of a 2010 judgment of the European Court of Human Rights[2] which found Ireland in violation of the European Convention on Human Rights for its failure to give effect to the right to abortion in cases of risk to life.

The IFPA is of the view that the 2013 Act does not ensure practical and effective exercise of the constitutional right to life-saving abortion, and draws the attention of the Committee to the relevant observations on the Act by the national human rights institution, the Irish Human Rights Commission (now the Irish Human Rights and Equality Commission).[3]

Protection of Life during Pregnancy Act 2013

Certification of eligibility under the Act. The test to be applied under the Act is onerous and unworkable in clinical practice in many circumstances. The Act includes separate provisions for the certification of cases of non-emergency physical threat to life (section 7), medical emergencies (section 8), and cases of risk to life from suicide (section 9). Certification involves a two-part test based on the 1992 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.

Review process and certification. More onerous provisions apply to cases where risk is of suicide than in circumstances of physical risk to life: this is discriminatory. Decision-making is in the hands of medical specialists and is different under each section. One doctor can make the decision in emergency cases. A pregnant woman who asserts her right to abortion because of physical risk to life under Section 7 must be examined by two medical practitioners (an obstetrician and a specialist in a relevant area). However, the requirements for certification are more onerous in cases of suicide risk than when there is physical risk to life. Section 9 provides that three specialists—two psychiatrists and an obstetrician—must jointly certify a woman's legal entitlement to the "medical procedure". If certification is refused under section 7 or section 9, the pregnant woman, or someone acting on her behalf, can seek a second opinion or initiate a formal review procedure. She will then be examined by a review panel of the same number and specialisations as under Sections 7 and 9, depending on the nature of the risk to life. A review procedure was a requirement of the *A, B and C v Ireland* judgment, but these provisions place significant burdens on women, particularly a pregnant woman who asserts suicide risk, and is, by definition, extremely vulnerable: she will, if she is denied certification and seeks a review of the decision, be subjected to examinations by four psychiatrists and two obstetricians.

Criminal provisions. Ignoring the recommendations of international human rights bodies[4] and of World Health Organization[5], the Irish Government chose to enact legislation that fully secured the most restrictive possible approach to Article 40.3.3. The law retains harsh criminal sanctions for women and their doctors of 14 years' imprisonment if an abortion is carried out for any reason other than to save a life.[6]

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

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

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

Harms caused by the 2013 Act

The constitutional, legislative and regulatory system necessitates a medically unsound distinction between risk to the life of a pregnant woman and risk to her health. Such a distinction can put women's lives at risk and prevent medical practitioners from acting in women's best interests: doctors must wait until a woman's condition has deteriorated from risk to health to risk to life before a lawful termination of pregnancy can be carried out.

The operation of the Act is particularly egregious in cases of suicide risk. The impact of Section 9 of the Act can be to restrict access rather than to fulfil the intent of *A, B and C v Ireland* to positively ensure pathways for accessing lawful abortion.

Psychiatrists' assessment of risk of suicide under the Act can be excessively restrictive and based on non-medical considerations. In a recent case[8], a girl who was deemed suicidal and wanted an abortion was detained in a psychiatric unit because her psychiatrist said an abortion was "not the solution". Ultimately, a court ordered she could be discharged from the unit. In June 2017, it was reported that two migrant women were initially denied abortions despite having attempted suicide.[9] Media reports indicate the first woman was eventually offered an abortion under the 2013 Act after her third suicide attempt, while the second woman's abortion was eventually approved under the Act after two initial refusals of care.

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 requirement that the assessing doctors have due regard to the right to life of the foetus has also led to unacceptable harms to women.

In the first known case of a decision under the 2013 Act a young woman asylum seeker living within Ireland's direct provision system was pregnant as a result of rape. Newspaper reports indicate that the young woman, known as Ms Y, was admitted to hospital and assessed under Section 9 of the 2013 Act at around 22 or 23 weeks pregnant, and that a panel of two psychiatrists and an obstetrician found that her life was at risk from suicide. However, rather than authorise an abortion, a plan was put in place to deliver a live neonate by caesarean section. Ms Y went on hunger strike in protest. Lawyers acting on behalf of the governmental Health Service Executive obtained a High Court order to forcibly hydrate and sedate her. It is understood that Ms Y was not forcibly hydrated, ultimately ended her hunger strike, and consented to a caesarean delivery, which was carried out in August 2014 at approximately 25 weeks of pregnancy. Had she refused consent, the hospital was preparing to seek further orders to authorise the performance of the caesarean section without her permission. [10]

1.2 The need for women to travel outside of Ireland to access safe and legal abortion services

Ireland forces women to travel to other states for safe and legal abortion. This is an abdication of state responsibility and shifts the entire responsibility and burden of seeking care onto women.

Incidence

The UK Department of Health releases annual statistics on the number of women and girls from the Republic of Ireland who accessed services at abortion clinics in England and Wales. Between 1980 and 2016, based on the UK Department of Health statistics, at least 168,703 women and girls who accessed UK abortion services provided Irish addresses. In 2016, 3,265 women and girls gave Irish addresses at UK abortion services. This number is an underestimation, as not all women provide their Irish addresses at UK abortion clinics. Some women also travel to other countries, such as the Netherlands.[11]

The prohibition and criminalisation of abortion in Ireland restricts the provision of reproductive health services that only women require. Due to the restrictive legal framework, the vast majority of women who seek to end a pregnancy must travel to access abortion services, even in cases of serious risks to their health and where their pregnancy is the result of a crime such as rape or incest. Forcing women to rely entirely on their own resources to obtain the reproductive healthcare they need in another country involves significant harms to women's health and well-being. Women are forced to choose between continuing an unintended or crisis pregnancy to term, seeking safe abortion services in another state, ending the pregnancy in Ireland in a clandestine manner—outside appropriate care pathways and at the risk of prosecution—or parenting against their wishes and contrary to their well-being.

The UN Special Rapporteur on the right to health has stated that the criminalisation of reproductive health services is a violation of the right to health and shifts the burden of accessing the right from the state onto pregnant women.[12] The Irish State criminalises abortion and justifies its restrictive laws on abortion by providing for the right to travel to other jurisdictions to access services, and to obtain information about abortion services. The constitutional right to travel to access abortion services is contained in the Thirteenth Amendment of the Constitution.[13]

Delayed access to care

The need to organise healthcare for themselves means that women from Ireland tend to have abortions later than women living in the UK: only 69% of residents of Ireland who access services in the UK do so before 10 weeks, compared with 81% of UK residents.[14]

The World Health Organization is unambiguous: delays in accessing abortion services can result in increased risks to women's health.[15] The need to organise finances, and also the logistics of travel, accommodation, childcare, negotiating time off work etc. leads to a delay between a woman's decision to have an abortion and the time when she can avail of the procedure.

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

Certain groups of women face particular barriers and delays in leaving the state to access services. This discrimination is felt most acutely by women who experience multiple, intersecting forms of disadvantage, such as asylum-seeking women, undocumented women, poor women and minors.

Costs

The costs involved in accessing safe abortion services are high. Travelling to the UK for a surgical abortion below 14 weeks of gestation costs at least €1000. Abortion in cases of foetal anomaly costs more due to the duration of the treatment, which can last 4-5 days. This is due to the fact that foetal anomalies are not usually detected until the later stages of a pregnancy, resulting in longer and more complex medical treatment. There is no state support for women to access abortion, even when they have inadequate financial resources.

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

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

Women diagnosed with pregnancy involving foetal anomaly

Women who receive a diagnosis of severe or fatal foetal anomaly experience particular harms: women who have been receiving care within mainstream maternity services experience an abrupt cessation of care should they wish to consider opting for termination of the pregnancy. Denied access to abortion because of the law, they are obliged to undertake all the responsibility and cost of accessing therapeutic abortion outside the state (albeit with the support of agencies, such as the IFPA, that are funded under the HSE Sexual Health and Crisis Pregnancy Programme). The denial of abortion to women in these circumstances was described as "a great cruelty" by then Minister for Justice, Mr Alan Shatter, in 2013.[16] The UN Human Rights Committee has held in two cases, *Mellet v Ireland* (June 2016)[17] and *Whelan v Ireland* (June 2017)[18], that Ireland's abortion laws violated the women's right to freedom from cruel, inhuman or degrading treatment, as well as their right to privacy. The

Committee also found that Ireland's abortion laws constitute discrimination against women on grounds of sex and denies them equal protection of the law. The ruling is the first time that, in response to an individual complaint, an international human rights court or committee finds that the criminalisation of abortion in itself results in human rights violations. The ruling called on the Government to act promptly and effectively to redress the harm suffered and reform its laws to ensure other women do not face similar human rights violations. An ex gratia payment was made to Ms Mellet in November 2016.

Growing trend of self-inducing abortion

Restricted access to abortion services and information, and the financial burden of travel can lead women to seek illegal and potentially unsafe abortion-inducing drugs. The IFPA knows from its services that women who cannot travel for abortion services are increasingly importing medication and risking prosecution by self-inducing abortion. No official figures exist for use of the abortion pill in Ireland. A 2016 paper in the *British Journal of Obstetrics and Gynaecology* estimates that 1,600 women in Ireland and Northern Ireland had abortion pills sent to them by one web-based service over a three year period.[19]

While there are sources of reliable medication (the abortion pill), women attempting to purchase this online risk obtaining ineffective or harmful medication instead. When women import and self-administer medication, they do so with either no medical advice or supervision, or only online support. By any Irish and international healthcare standards, this is an unacceptable level of care, fraught with clinical risk, that would not be tolerated in relation to any other healthcare service.

The IFPA has treated women who have incurred risks to their health when complications arose after using the abortion pill, because they were deterred or delayed by fear of prosecution from going to their doctor or presenting at a hospital.

Stigma

Criminal laws on abortion stigmatise women who need to terminate a pregnancy and the healthcare providers who treat them. For the women who attend post-abortion counselling with the IFPA, common themes in their experiences are the burdens of internalised and experienced stigma for having undergone a termination.

Abortion remains heavily stigmatised in Ireland and, for many women, the burdens of travelling for termination are exacerbated by the 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.

Stigma around accessing abortion services and the chilling effect of the criminal sanctions contained in the law can cause delays seeking aftercare, resulting in further risks to women's health. Because of abortion stigma and the chilling effect of criminalisation within health services in Ireland, most women, even women who have underlying medical conditions that can make abortion more complicated, must travel for abortions abroad without a referral letter from their doctor outlining their medical history. This would not happen in accessing any other medical treatment, in particular in the case of a patient with a life-threatening illness.[20]

In *A, B and C v Ireland,* the European Court of Human Rights recognised that the requirement to travel for abortion involves stigma and amounts to an interference with rights

under the Covenant (the dissenting minority of six judges argued that the requirement to travel is of itself a violation of the Convention).

1.3 The health impacts of the law in regard to information about abortion services in other countries

The Fourteenth Amendment of the Constitution[21] protects the right to obtain information about abortion services in other countries, subject to certain conditions. The *Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act 1995* stipulates that women who seek information on abortion can only obtain it if they are also given information and counselling on "all the options available to the woman in her particular circumstances". The law does not regulate the existence of "rogue" counselling agencies established to manipulate women's choices and withhold information about abortion.

The regulation of women's right to information on abortion is an unwarranted interference with their right to make autonomous decisions about their own healthcare. It also impacts on doctors' ability to act in their patients' best interests. In her 2013 report on the situation of human rights defenders in Ireland, the UN Special Rapporteur Margaret Sekaggya highlighted that the provisions of the Information Act can pose significant barriers for counsellors and potentially restrict women's access to information on sexual and reproductive rights: *"Moreover, the provision can restrict the ability of defenders to make contact with some women who may not be able to attend a face-to-face counselling session, including women who live in isolated or rural areas, young women, women in State care and/or migrant women. The inability of counsellors to make appointments on behalf of their clients further restricts the support they can offer to women seeking this type of service abroad."*[22]

In the context of strict regulation of information, the emergence of 'rogue agencies'—unregulated groups that actively provide misleading or inaccurate information about abortion and abortion services in order to prevent women from accessing abortion is of concern. These 'rogue agencies' masquerade as legitimate crisis pregnancy centres that provide impartial information on options for women who have an unintended pregnancy.[23] In practice, however, these groups misinform, intimidate and manipulate women with the aim of preventing them from having abortions.[24] Despite calls by advocacy groups and politicians, no regulation of these agencies has taken place. In November 2016, the Minister for Health announced that his department would conduct a review of the 1995 Act, however no further information has been provided as to the nature or timeline of this review.

1.4 The impact of the law on women asylum seekers

The requirement to travel abroad to access safe and legal abortion services has a disproportionate impact on vulnerable or disadvantaged women and girls. This includes women in poverty or living on low income, asylum-seeking and undocumented women who cannot travel freely to other states, women with disabilities and minors.

IFPA pregnancy counsellors have supported women who are pregnant, have made a decision that they cannot continue the pregnancy, but who are unable in spite of their best efforts to access abortion services outside the State. We know of women who have

attempted to gain entry to another state without a visa and who have been refused entry, women who resort to illegal and potentially unsafe methods to end the pregnancy, and women who are forced to parent against their will.

Women who cannot exercise the constitutionally guaranteed right to travel for an abortion constitute an increasing cohort of the IFPA's clients. The IFPA has repeatedly raised concerns about the impact of Ireland's abortion laws on women who already experience disadvantage. Indeed the IFPA first raised the specific needs of women asylum seekers with an unplanned or crisis pregnancy in 2002. But little has changed since then. While the Constitution guarantees the right to travel for abortion, many women cannot exercise this right due to an array of legal, social and economic barriers.

Costs can be an insurmountable barrier for some women, particularly when poverty intersects with other forms of disadvantage, such as a woman's legal status. Women without access to credit or savings must engage in a humiliating and degrading process of repeated disclosure of a situation that is private and personal to multiple agencies, officials, and at times money lenders and charities in order to obtain the necessary finance. Their dignity is violated at every turn.

When questioned about these issues by the UN Human Rights Committee during its 2014 examination of Ireland's implementation of the International Covenant on Civil and Political Rights, a representative of the Department of Health stated that there was "no solution" to this.[25]

Not all women can travel freely between states

The requirement to travel for abortion has discriminatory impacts on women living in poverty or on low incomes, migrant women, minors, women and girls in the care of the state, women asylum seekers, and undocumented women. Lack of access to safe abortion services therefore particularly affects women who are already burdened by inequality. Many women need two travel visas – a re-entry visa to leave and return to Ireland and another visa to enter the country where the abortion provider is located. If a woman is undocumented and without a passport, she must apply for a temporary travel document before applying for a re-entry visa.

A re-entry visa must be applied from the Irish Naturalisation and Immigration Service office. A temporary travel document must be obtained from the Department of Justice and Equality. The twelve page application form must be stamped by a Garda. The form requires personal identifying details, immigration history, a letter confirming attendance at a counselling service, and biometric passport photographs. If the documents are issued, the second, and more complex, stage begins of applying for an entry visa for the country where the abortion clinic is located. To apply for an entry visa to the Netherlands, a woman must submit at least twelve pieces of documentation in person at the Dutch embassy. This includes an application form, a copy of a registration card of the Garda National Immigration Bureau, a current bank statement showing adequate funds, and a copy of medical travel insurance. Confirmation of a clinic appointment, accommodation and flight tickets are also required – all which can only be booked with a credit card. In total it can take more than eight weeks to organise travel documentation. Such delay has a significant impact on a woman's physical and mental health, particularly where a woman has an underlying health condition.

Adult asylum seekers receive a weekly allowance of €19.10 from the State. Yet in order to access abortion lawfully, a woman must pay many multiples of this amount for travel document application fees, transport to and from embassy and government offices, flights, abortion provider fees, accommodation and indirect costs, such as childcare. A re-entry visa and a temporary travel document cost €60 and €80 respectively and must be paid with a bank draft or postal order.[26] An entry visa to the Netherlands costs €60, a UK visa costs £85. An abortion procedure can cost €420 to €1,550, depending on the clinic and the stage of gestation.

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

1.5 The Citizens' Assembly

In 2016, the government convened a Citizens' Assembly, comprised of 99 citizens, and chaired by a Justice of the Supreme Court, to make recommendations to Parliament about constitutional change to Article 40.3.3. The Assembly met over five weekends between November 2016 and April 2017. The final weekend was given over to voting on (1) constitutional options for reform and (2) the substantive reforms to the law.

The Assembly voted by 87% to 13% that Article 40.3.3 should not be retained in full and in subsequent ballots showed very strong support for progressive regulation of abortion. Notably, the participants of the Citizens' Assembly rejected an initial limited ballot paper and insisted on the inclusion of options more closely aligned to legal frameworks in other European countries, to international human rights law and to best international healthcare practice.

While the convening of a deliberative process is, of itself, insufficient to meet the State's obligations under international human rights law, the state has repeatedly highlighted the Citizens' Assembly process as central to its response to criticisms by UN expert treaty monitoring bodies and, in the IFPA's view, must treat its recommendations with due regard. An Oireachtas (parliamentary) Committee has now been convened to consider the recommendations. The recommendations, if taken as guidance for change in Ireland's abortion laws, would deliver healthcare policy that respects women's reproductive health rights, their dignity, autonomy and equality and bring an end to many of the harms that the IFPA highlights in this submission.

2. Migrant women's and girls' sexual and reproductive health

Migrant women in Ireland experience a number of barriers in accessing sexual and reproductive healthcare. Research indicates that a woman's legal status has strong bearing on her access to and use of health services.[27] Additional access barriers include lack of

knowledge about sexual and reproductive health services, cost, and language difficulties. Migrant women also report a need for greater awareness and expression of cultural sensitivity amongst healthcare professionals and a need to pay more attention to language and communication difficulties that patients from migrant backgrounds might experience.[28]

2. 1 Female genital mutilation (FGM)

It is estimated that at least 5,277 women and girls in Ireland have experienced FGM.[29] A 2015 study on FGM risk within the European Union calculated that between 1 and 11% of the 14,577 girls aged 0-18 in Ireland whose parents originate from FGM-practicing countries may be at risk of having the procedure done to them.[30]

While FGM is prohibited by the Criminal Justice (Female Genital Mutilation) Act 2012, legislation alone is insufficient to ensure the abandonment of the practice. To date, there have been no prosecutions under the 2012 Act. In September 2016, media reports indicated a man was arrested by police investigating an alleged case of FGM involving a two-year old girl.[31] In the absence of media reports, it is unclear whether additional cases of FGM have been reported to An Garda Síochaná (Irish police force) since the enactment of the 2012 Act because there is no Irish Crime Classification System (ICCS) code for FGM.

No national guide for assessing risk of FGM exists and the IFPA is concerned that frontline service providers, including teachers and social workers, are not adequately informed about key protection issues in relation to FGM. This includes how to identify girls at risk of FGM and what actions should be taken in order to protect girls in such a situation.

There are no references to FGM in either the National Sexual Health Strategy 2015-2020 or the National Maternity Strategy 2016-2026. Although the National Maternity Health Care Record (NMHCR) includes FGM as a risk factor, it is unclear if this information is being used to develop management plans for pregnant women who have experienced FGM. The IFPA is aware of cases where pregnant women with Type 3 FGM have been discharged from maternity hospitals (having delivered by caesarean section) without being treated for FGM or even referred to the existing FGM Treatment Service in Dublin where deinfibulation could be arranged. Failure to provide deinfibulation can result in obstetric complications and is contrary to the World Health Organization guidelines on the management of health complications from FGM.[32] Furthermore, it is unclear if the NMHCR data on FGM is being collated and analysed for the purpose of assessing FGM prevalence across the country. Such data could be extremely useful for determining whether additional treatment services for FGM are required.

The Irish Family Planning Association operates an FGM Treatment Service, which provides free medical and psychological care to women and girls who have experienced FGM. Established in 2014, the clinic is funded by the Health Service Executive. Although the IFPA carries out outreach work to raise awareness about the service, particularly amongst asylum-seeking women, challenges remain in ensuring access to the service. This is because many affected women and girls who have applied for asylum are housed in rural areas and must travel significant distance to access the FGM clinic. This is particularly problematic in relation to counselling, as women may require multiple counselling sessions. In the IFPA's experience, asylum-seeking clients (who do not have the right to work in Ireland and rely on a government allowance of €19.10 per week) may also be unaware of

how to access state support for transport costs or face unreasonable barriers when they apply for such support.

The IFPA is of the view that a government-led interagency committee, with representation from key government departments and other state and non-governmental bodies, is required to effectively combat FGM. This committee should be tasked with responsibility for the development of a national action plan or strategy across the key areas of prevention, protection, provision (for women and girls who have experienced FGM) prosecution and promotion (of efforts to eradicate FGM). The development of a comprehensive plan to safeguard women and girls and support those who have experienced FGM is an urgent priority and, in its absence, there is no whole of government approach to combatting FGM.

FGM is part of a wider set of issues in healthcare provision for women from minority ethnic backgrounds, particularly asylum seekers. From the IFPA's engagement with women and girls in direct provision and with state agencies, the issue of access to FGM treatment cannot be separated from the larger structural and systemic problems of the barriers asylum-seeking women and girls experience in accessing sexual and reproductive health services more broadly.

2.2 Direct provision

The IFPA is deeply concerned about the harms caused by inadequate sexual and reproductive health services to the physical and mental health and well-being of women and girls who are living in direct provision, the system Ireland uses to provide for the welfare of asylum seekers as they await decisions on their asylum application.

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 knows from its services that some women and couples who wish to limit their family size, often in the interests of the well-being of their children, have been unable to do so. It is critical that women and girls living in direct provision have the information and means to protect themselves from sexually transmitted diseases (STIs) and to control their fertility and plan the number and spacing of their children.

A combination of factors, including the isolation of direct provision centres from the wider community, makes accessing services and information particularly difficult for these groups. This cohort of women experiences a range of barriers in accessing sexual and reproductive healthcare, including treatment for female genital mutilation. These obstacles include affordability, language barriers, access to information and the physical location of services.

The experience of IFPA counsellors is that women who attend counselling through the FGM clinic present with much broader emotional and psychological issues than those solely connected to their experiences of FGM. Some clients in direct provision reception centres need to first process the difficulties associated with their current living arrangements before they can go back further to deal with FGM-related trauma. These difficulties include the lack of privacy associated with living alongside strangers in cramped conditions, noise pollution, poor diet and nutrition, lack of control over their own lives, marginalisation from broader society, social isolation, and uncertainties relating to the asylum-seeking process (the latter

being a particular stressor). For some clients, the negative impacts of life in direct provision are so profound that it is impeding them from making progress in addressing past trauma.

The 2015 Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers made a number of recommendations in relation to sexual and reproductive health (see Appendix). A progress report released by the Department of Justice in February 2017 on the implementation of the reforms stated that all of these recommendations have been implemented.[33] However, no information is given about specific initiatives or measures that have been introduced. The experience of IFPA staff in their outreach activities to direct provision centres is that significant gaps remain in terms of awareness about and access to sexual and reproductive healthcare amongst the asylum-seeking population. In our experience, women living in direct provision are frequently unaware of: free screening programmes such as CervicalCheck and BreastCheck; the availability of different methods of long-term contraception; and the legal position regarding abortion in Ireland.

2.3 National Intercultural Health Strategy

At present there is no state-wide health promotion policy to address the particular barriers to access to sexual and reproductive health information and services, including treatment for FGM, encountered by women living in direct provision centres and migrant women more generally.

To address these issues, it is important that sexual and reproductive health is included as a distinct theme within the National Intercultural Health Strategy that is currently being developed by the Health Service Executive (HSE). Among the areas that could be addressed under such a theme are FGM treatment and prevention; access to contraceptive information and services; access to free national cancer screening programmes; and referral pathways for women with unintended pregnancies.

3. Recommendations

The IFPA respectfully requests that the Committee make the following recommendations to Ireland:

- Decriminalise abortion in all circumstances.
- Repeal the *Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995* in order that women and girls can access information about abortion services in other states in a manner consistent with international human rights law and women's right to dignity in access to health services.
- Repeal the *Protection of Life During Pregnancy Act 2013* and replace it with a constitutional, legislative and policy framework that upholds the reproductive rights of women and girls and guarantees that abortion services are available and accessible in a manner that ensures their autonomy and decision-making is respected, in line with best international health practice.
- Ensure that conscience based refusals of abortion care do not jeopardise women and girls' access to abortion services.

- Prioritise the development and dissemination of a national guide for assessing FGM risk.
- Allocate resources for the establishment of a government-led interagency committee tasked with developing a government action plan to combat FGM.
- Increase its efforts to educate the public about the harms of FGM through awareness-raising activities.
- Take steps to ensure that all women and girls who have undergone FGM are aware of the free FGM Treatment Service and their entitlement to financial support in order to attend the service.
- Ensure that sexual and reproductive health is included as a distinct theme within the new National Intercultural Health Strategy.
- Eliminate specific access barriers to sexual and reproductive health information and services experienced by marginalised groups including migrant women and girls, asylum-seekers, undocumented migrants, young people in care, women or girls with limited financial means, women or girls with disabilities and members of the Traveller community.

Appendix

Report of the Working Group on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers – recommendations relating to sexual and reproductive health

Recommendations 5.100

The Working Group:

- Recommends that a health promotion initiative be targeted at residents of Direct Provision centres to inform them about access to breast screening, cervical checks, and bowel and diabetic screening services free of charge.

- Strongly urges that a review by the relevant organisations of services for persons in the system experiencing a crisis pregnancy be undertaken immediately with a view to a protocol being agreed to guide State agencies and NGOs supporting such persons. Particular attention should be paid to addressing the needs of the individual in the context of the legislative framework. Issues relating to travel documents, financial assistance, confidentiality, and access to information and support services should be addressed.

- Recommends that an initiative be put in train to facilitate access by persons in the system to information and services concerning sexual and reproductive health and family planning.

- Recommends that information leaflets, posters, talks and confidential contact details be provided in every centre and kept up to date to target vulnerable groups and promote dignity. Issues to be identified include e.g. FGM, torture, HIV, mental health, LGBT, disability, religion, domestic violence, human trafficking, exploitation, prostitution and older people's needs.

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