Universal Periodic Review Ireland

Submission for the 39th Session of the UPR Working Group

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Submitting Stakeholder

The Irish Family Planning Association (IFPA) is Ireland's leading sexual health charity. We promote the right of all people to sexual and reproductive health information and dedicated, confidential and affordable healthcare services. The IFPA offers a comprehensive range of services which promote sexual health and support reproductive choice on a not-for-profit basis from our clinics in Dublin city centre and Tallaght, and specialist pregnancy counselling services at ten centres nationwide. 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. The IFPA works with partner organisations and civil society to raise awareness of the importance of sexual and reproductive health and rights at home and all over the world. Our mission is to enable people to make informed choices about their sexual and reproductive health and to understand their rights.

Introduction

The aim of this submission is to follow up on recommendations regarding sexual and reproductive health and rights from Ireland's first and second UPR and raise new issues arising since 2018.

Sixteen states made recommendations regarding Ireland's abortion laws during the second UPR cycle in 2016: Ireland did not accept recommendations relating to removing restrictive legislation on abortion.[1] [2] Following a referendum to remove the effective constitutional ban on termination of pregnancy, abortion care in defined circumstances, including on a woman's own indication up to 12 weeks of pregnancy, became lawful and available without charge to women in January 2019.

A number of the 16 recommendations have therefore been addressed since 2018. Reform of the law has brought about a significant improvement in women's and girls' access to reproductive healthcare and in the enjoyment of the right to health.

However, Ireland's abortion laws are not yet fully compliant with international human rights law. Abortion has not been fully decriminalised. Access to abortion on the ground of severe fatal anomaly remains criminalised. These provisions have significant impacts on women and girls whose pregnancies fall outside the legal entitlement to abortion care provided for by the 2018 At. Women and girls are still forced to leave Ireland to access care in some circumstances. Furthermore, barriers to access in law and practice exist.

The women most likely to be affected by these denials of care are women who are otherwise vulnerable: minors, women living in domestic violence refuges, homeless women, and women living in direct provision centres (institutional accommodation provided by the State to those seeking asylum).[34]

1. Background

Until 2018, the Eighth Amendment (Article 40.3.3) of the Constitution prevented termination of pregnancy except where a pregnant woman's life was at risk. Following the reports of a Citizens'

Assembly in June 2017[5] and a Joint Committee of the Oireachtas (Parliament) in December 2017[6], the Government held a referendum on 25 May 2018 to delete Article 40.3.3 and substitute it with wording confirming that the Oireachtas may make laws for the regulation of termination of pregnancy. The referendum passed by a 66.4% majority. The Thirty-sixth Amendment of the Constitution Act was signed into law on 18 September 2018.[7]

2. Current legal framework

The Health (Regulation of Termination of Pregnancy) Act, signed into law in December 2018, provides the legislative framework for the provision of abortion care in defined circumstances.

The Act repealed the Protection of Life During Pregnancy Act 2013 and the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995. The Health (Regulation of Termination of Pregnancy) Act 2018 was enacted in December 2018. It repealed the Protection of Life During Pregnancy Act 2013. The Act permits termination of pregnancy without restriction up to 12 weeks of pregnancy, subject to a mandatory three-day waiting period; where there is a risk to the life, or of serious harm to the health of the pregnant woman; and where there is a condition that is likely to lead to the death of the foetus. The Act includes provisions for cases of emergency and for objection to participation in a termination on grounds of conscience. A woman may seek a review of a decision that she is not legally entitled to terminate a pregnancy. While it is an offence to intentionally end a pregnancy save in accordance with the legislation, these provisions do not apply to a woman in respect of her own pregnancy. The Act requires the Minister to carry out a review of its operation not later than 3 years after its commencement.[8]

3. Areas of non-compliance with international human rights law

3.1 Inclusion of criminal provisions in the 2018 Act

The Committee for the Elimination of Discrimination against Women (CEDAW) has made it clear that Ireland should remove all barriers interfering with access to health services, education and information, including "criminalisation of abortion or restrictive abortion laws".[9] The WHO also refers to "international, regional and national human rights bodies and courts [which] increasingly recommend decriminalization of abortion".[10]

However, section 23 of the 2018 Act makes it an offence to "intentionally end the life of a foetus" or to assist in the termination of a pregnancy, "otherwise than in accordance with the provisions of this Act". The section does not apply to a pregnant woman in respect of her own pregnancy. The penalty on conviction is a fine and or imprisonment for up to 14 years. The inclusion of the criminal offence retains stigma regarding abortion in the law and frames abortion as a harm in itself. The provision operates a chilling effect on healthcare providers, who fear prosecution for making an incorrect decision about eligibility for access to abortion care. Fetal medicine specialists have described feelings of intense pressure and vulnerability to media scrutiny and prosecution.[11]

3.2 Exclusion and criminalisation of non-fatal foetal anomaly

The 2018 Act draws an artificial bright line between cases where death can be expected within 28 days and all other cases of foetal anomaly after 12 weeks of pregnancy, which are criminal offences. Health care providers have reported frustration and difficulty with cases that are "not quite fatal enough, but clearly not going to survive." The distinction in the law between fatal and nonfatal anomaly results in women whose pregnancies do not meet the strict eligibility criteria being "ostracised" and having to seek termination services outside the state.[12] Medical practitioners providing abortion in cases of fatal fetal anomaly have highlighted the challenges of working under 'ambiguous' and 'restrictive' legislation that contains the threat of criminal sanctions. Fetal medicine specialists report their difficulties in making decisions about whether a given condition or combination of conditions fall within the Act: "'there is never any certainty' when death will occur" and "there will always be an outlier (i.e. a baby that will live longer than expected)".[13]

3.3 High threshold for risk to health

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In its 2012 safe abortion guidance, the WHO makes clear that policies on abortion should aim to promote and protect the health of women, in line with this definition. The 2018 Act does not adopt this definition of health, instead imposing a high threshold for abortion access under this ground, specifying that the risk must be "to the life, or of serious harm to the health, of the pregnant woman".[14]

In the first year of service provision, out of a total of 6,666 abortions provided under the new law, only 21 women accessed abortion under the risk to life/health ground.[15] Furthermore, while Sections 13 to 18 of the 2018 Act provide for a review process for women who are refused termination of pregnancy under this ground and the fatal foetal anomaly ground, not a single review took place in the first year of service provision.

3.4 12-week gestational limit

The 12-week gestational limit is strictly interpreted as 12 weeks + 0 days by the Department of Health, rather than 12 weeks + 6 days, which is standard in pregnancy care. Healthcare providers have no discretion to waive the limit, regardless of a woman's circumstances. Three cohorts of women are negatively impacted by this aspect of the regulatory framework:

(1) Those who exceed the gestational limit. This includes women who are over 12 weeks but less than 13 weeks who are precluded from accessing care, even if their first engagement with services was before 12 weeks of pregnancy. This potentially excludes some pregnancies that result from rape and incest.

(2) Those who experience a failed medical abortion, but the ongoing pregnancy is not discovered until after the 12-week limit. These women are ineligible for further care under the current regulatory framework and must either travel abroad to access further abortion care or continue the pregnancy. The Abortion Support Network, a UK charity which provides financial assistance to women who have to travel abroad for abortion care, reports it has assisted at least 25 Irish residents to travel to England for abortion care following a failed medical abortion in Ireland.[16]

(3) Those who access medical abortion within the gestational limit but have a positive low-sensitivity pregnancy test post-abortion. These women may be referred to hospital by community providers due to real concerns that they would not be eligible for care if any continuing pregnancy was discovered after the 12-week limit. Therefore, rather than following up such cases at community-level with a repeat pregnancy test, the inflexibility of the legal gestational limit creates a burden of medically unnecessary hospital referral and investigation for women, healthcare providers and the health service.

3.5 Waiting period

Ireland's model of early abortion care requires two consultations with a medical practitioner separated by a three-day mandatory waiting period. It can only begin with a first consultation with a doctor, even when, as in most cases, a woman is clear in her decision and or has consulted a nurse, midwife or pregnancy counsellor.[17] The waiting period has been described by leading gynaecologist practitioners of abortion care as a "presumptive and patronizing insinuation that people are not certain in their decision." [18] This is contrary to best international practice as set out by standard-setting bodies such as the World Health Organization, which considers mandatory waiting periods to be access barriers, and the Royal College of Obstetricians and Gynaecologists, which recommends that abortion care be provided as soon as possible, ideally on the same day as the initial assessment.[19] Doctors have no discretion to waive the waiting period, regardless of the particular circumstances of the woman or girl's situation. The waiting period has resulted in women being unable to avail of care in Ireland and being forced to travel or avail of medications elsewhere.[20]

3.6 Failure to provide care

There is no official published data on the geographical spread of abortion providers in Ireland, although it is known that only half of the country's maternity units (10 out of 19) provide the full range of abortion services and there is one county with no community-level provider.[21] In one notable example, all four consultant obstetricians in one rural hospital announced that the hospital was unsuited to the provision of abortion care. The effect of this is to deny women in this part of the country reasonable access to democratically endorsed and legally recognised care.[22] Furthermore, the 2019 abortion statistics for England and Wales show that 375 women gave Irish addresses when accessing abortion services, including women who were legally eligible for care in Ireland. For women forced to leave the country to access abortion, travelling abroad has become even more complex and burdensome in the context of the global pandemic.[23]

3.7 Anti-abortion activists outside healthcare facilities

Anti-abortion activity outside healthcare facilities aims to deter individuals from accessing lawful, State-funded healthcare and doctors from providing it. The IFPA knows from our services that such activities can cause distress, exacerbate existing societal stigmas and pose a serious risk to a range of rights.[24] In the first year of service provision, IFPA patients and staff were subjected to multiple incidents of harassment. The nature of these activities has varied, but included the following: prayer groups or "vigils"; individuals approaching women with leaflets as they try to leave or enter clinics; attempts to engage women in "sidewalk counselling"; display of graphic or religious imagery; verbal harassment of service users and staff; solo and group protests.

The Government has committed to introducing "exclusion zones outside medical facilities", [25] but has not yet introduced legislation, leaving the safety and well-being of patients and staff at risk in these settings.

4. Recommendations

- Decriminalize abortion in all circumstances by amending the Health (Regulation of Termination of Pregnancy) Act to repeal s.23 (Offences).
- Expand access to abortion services to bring the law into line with the requirements of international human rights law.
- Take all necessary measures, legislative and otherwise, to remove the barriers to access to abortion encountered by women and girls, in particular migrant women, women with disabilities, women who live in counties that are underserved by providers.
- Ensure the review of the Health (Regulation of Termination of Pregnancy) Act 2018 is transparent, inclusive, evidence based; and that its terms of reference require a comprehensive examination of the implementation of the Act with regard to compliance with the principles of fulfilment of the right to the highest attainable standard of healthcare.

References

[1] UN Human Rights Council, Report *of the Working Group on the Universal Periodic Review: Ireland*, Addendum, 20 September 2016, A/HRC/33/17/Add.1. Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/207/53/PDF/G1620753.pdf?OpenElement.

[2] 135.136 to Conduct consultations involving all stakeholders, including civil society organisations, in order to examine whether article 40.3.3 of the Constitution could be revised and the legal framework related to abortion broadened (Switzerland); 135.137 Make sure all women and young girls have easy access to information on crisis pregnancy options by health-providers (Sweden);136.15 Further strengthen women's rights and review Articles 40 and 41 of the Irish constitution with a view to abandon formulations that potentially promote gender discrimination and to bring Ireland's laws on abortion into compliance with international human rights standards in law and in practice (Germany);
136.16 Establish a Constitutional Convention on article 40.3.3 of the Constitution with the aim to remove all restrictive legislation on abortion (Netherlands);
136.17 Revise its legislation on abortion, including its Constitution, to provide for additional exceptions in cases of rape, incest or serious risks to the health of the mother, building on the recommendation from the Human Rights Committee (Norway);
136.18 Repeal legislation that criminalizes abortion and eliminate all punitive measures, in particular article 40.3.3 of the Irish Constitution (Iceland);
136.19 Take forward the democratic process of repealing the Eighth Amendment of the Irish Constitution with a clear timeline, and take all necessary steps to decriminalise abortion in all circumstances, in accordance with the recommendations of the Human Rights Committee, the Committee on Economic, Social and Cultural Rights and the Committee on the Rights of the Child (Denmark);
136.64 Ensure availability of safe abortions, at a minimum in cases where the pregnancy is the result of rape or incest and in cases of severe and fatal foetal impairment (Iceland);
136.65 Take all necessary steps to revise the Protection of Life During Pregnancy Act 2013 in line with International Human Rights standards (India);
136.66 Amend the Protection of Life During Pregnancy Act 2013 that the women interests and health are better protected, especially in instances where the pregnancy resulted from rape or incest, or in cases of severe foetal impairment (Lithuania);
136.67 Consider revising its relevant legislation on abortion in line with international human rights standards on sexual and reproductive health and rights (Republic of Korea);
136.68 Broaden through an inclusive public debate the access to abortion for pregnant women, in particular in cases of threat to health, rape and incest (Czech Republic);
136.69 Take the necessary steps aimed at revising the relevant legislation with a view to decriminalize abortion within reasonable gestational limits (the former Yugoslav Republic of Macedonia);
136.70 Ensure the full right for women to abortion and implement the decisions of the European Court of Human Rights regarding this right (Slovakia);
136.71 Take necessary steps to revise its legislation on abortion and provide for clear exceptions, in line with international human rights law and standards, so as to ensure the right to abortion in cases of rape and incest, as well as cases entailing serious risks to the health of the mother or fatal foetal abnormality (Sweden);
136.72 Decriminalize abortion in all circumstances and, as a minimum, ensure access to safe abortion also in cases of rape, incest, serious risks to the health of the mother and fatal foetal abnormality (Slovenia);
136.73 Review the law on abortion to expand the circumstances in which it can be carried out (Uruguay);
136.74 Adopt a comprehensive sexual and reproductive health policy for adolescents and ensure that sexual and reproductive health education is a part of the mandatory school curricula and targeted at adolescents (Lithuania);
136.75 Ensure that the new system of universal health care guarantees availability and access to services to boys and girls and contraception methods to adolescents, while allowing access to these services in general without discrimination on any grounds (Mexico);
136.76 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 (New Zealand);
136.77 Identify and address gaps in reproductive health legislation to ensure the protection of women's sexual and reproductive health and rights (United States of America);
136.78 Take all necessary measures to ensure the full respect of sexual and reproductive rights (France);
136.79 Protect and promote reproductive rights without any discrimination, recognising reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, as well as decide on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion (Canada).

[3] Donnelly M and Murray C. *Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision.* Ethical and Legal Issues in Reproductive Health. First published: 02 November 2019 https://doi.org/10.1002/ijgo.13025.

[4] Irish Family Planning Association. *Annual report 2019*. Page 8. Available at: IFPA_AR_2019_LR.pdf.

[5] Laffoy M. *First Report and Recommendations of the Citizens' Assembly – The Eighth Amendment of the Constitution*. 29 June 2017.

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[8] Health (Regulation of Termination of Pregnancy) Act 2018, section 7 ("The Minister shall, not later than 3 years after the commencement of this section, carry out a review of the operation of this Act").
[9] CESCR GC 14, para. 21.
[10] P.87.
[11] Power S, Meaney S, O'Donoghue K. *Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study.* BJOG 2020: page 3-4. Available at: https://doi.org/10.1111/1471-0528.16502.
[12] Ibid: page 4.
[13] Ibid. In a case covered in the media in March 2021, for example, a couple reported that while their baby was unlikely to survive labour, and would spend the minutes or hours after birth "struggling to breathe", they were denied access to a termination because there was a possibility of survival for more than 28 days. (*Our baby would not live, so we had to travel to London. Our hearts are broken.* Thejournal.ie. March 21 2021. Available at https://www.thejournal.ie/readme/maternity-care-5381970-Mar2021/?utm_source=story.
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