

SHE IS NOT A CRIMINAL

THE IMPACT OF IRELAND'S ABORTION LAW

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CONTENTS

1. Executive summary	6
2. Methodology.....	11
3. In context: Abortion in Ireland.....	13
International human rights obligations to address gender stereotypes.....	13
3.1 The Irish state and religious institutions enforce harmful gender stereotypes and have institutionalised violence against women and girls.....	14
3.2 A climate of stigma and intimidation	17
4. Ireland’s legal and policy framework governing abortion	19
Criminal offences relating to abortion in Ireland	19
4.1 Constitutional framework and the X case	20
4.2 The Protection of Life During Pregnancy Act (PLDPA) and accompanying guidance ..	21
4.3 The PLDPA does not protect women and girls	22
Ireland’s burdensome legal requirements contravene human rights standards and World Health Organization guidance on safe abortion services.....	25
4.4 The Department of Health’s <i>Guidance Document</i> for health professionals on the implementation of the PLDPA	27
4.4.1 “Suicidal intent”	27
4.4.2 “Early delivery”	28
The Human Rights Committee’s Concluding Observations on Ireland (2014)	28
4.5 Health care providers regard the PLDPA and accompanying guidance as retrogressive and dangerous for women	29
5. Restricted access to legal, life-saving abortion.....	31
5.1 When does risk to health become risk to life? Physical health grounds.....	31
International human rights standards on abortion reflect the link between risks to life and health.....	31
Savita Halappanavar’s case	32
5.2 Risk to life but not to health: An impossible legal fiction	35
5.3 The impact of Savita Halappanavar’s death on women in Ireland	37
Lupe’s experience	38
5.4 A risk to life: The suicide exception	39
Ms. Y’s case: Denied a lawful abortion.....	40
6. Impact of the Constitution’s Eighth Amendment protection for the foetus on the quality of health care pregnant women receive	44
6.1 The impact of the Eighth Amendment on abortion-related care.....	45

6.2 The impact of the Eighth Amendment on non-abortion-related maternal health care.	46
Rebecca H.'s story	46
6.2.1 Eighth Amendment denies a pregnant woman dignity in death.....	48
Right to life protections do not apply before birth.....	49
7. Criminalization of abortion in cases of fatal and severe foetal impairment.....	51
Nicola's story	51
International human rights standards: Abortion on grounds of severe and fatal foetal impairment	52
7.1 The impact of carrying a fatal foetal impairment pregnancy to term	53
7.2 Forced to travel: Cast out from the Irish health care system after a diagnosis of fatal foetal impairment.....	55
7.2.1 No support upon return	57
7.2.2 Choices around severe foetal impairment.....	58
Laoise's mother's experience	58
8. Criminalization of abortion in cases of rape	60
8.1 Abortion ban is another layer of trauma for rape survivors	60
Asylum-seekers and sexual violence.....	61
8.2 Limited access to information for rape survivors	62
8.3 Travel: Compounding psychological trauma and complicating access to accountability	63
8.4 Rape as grounds for a lawful abortion	64
Denial of abortion on grounds of rape: Torture and other ill-treatment	64
9. Censorship and silence: Denial of information about abortion.....	66
9.1 The Regulation of Information Act.....	66
"Crisis pregnancy counselling" in Ireland	67
9.2 Restrictions on pregnancy counselling services and doctor-patient counselling under the Regulation of Information Act	67
9.3 Impact of restrictions on women, doctors, and the doctor-patient relationship	69
9.4 Denied critical health information and referrals due to Ireland's Regulation of Information Act.....	69
The denial and manipulation of pregnancy-related information violates fundamental human rights.....	72
9.5 Impact on the counsellor-client and doctor-patient relationship.....	72
9.5.1 Smear campaigns	73
UN Special Rapporteur on human rights defenders calls for protection of women, pregnancy counsellors and health care providers in Ireland	75
9.6 Restrictions on the provision of information about abortion services abroad to the general public.....	76

International bodies condemn Ireland’s information restrictions	76
10. Ireland “exporting” its human rights obligations: Women left to find their own alternatives outside Ireland’s health system	78
10.1 Forced to travel abroad for health care services	79
10.1.1 The logistical challenges of travelling abroad	80
10.2 Lack of referrals and support from doctors and the impact on access to services	81
10.3 Financial barriers to travel	82
10.4 The impact of travel on treatment options and on post abortion care	84
10.5 The stigma of travelling	86
10.6 Marginalized girls and women face additional barriers to accessing abortion services abroad	87
10.6.1 Asylum-seekers	88
10.6.2 Migrant women	90
10.6.3 Traveller women	91
10.7 Unable to travel: Suicide versus unsafe abortion	92
A.F.’s story	93
10.8 Forced to resort to home remedies or physical harm to induce an abortion	93
10.9 Undertaking an illegal medication abortion in Ireland	94
Sandra’s story	94
Áine’s story.....	96
11. Conclusion	98
12. Recommendations	99
ANNEX: International human rights standards.....	103
I. International human rights law and standards require the decriminalization of abortion and that states ensure access to abortion when a woman’s life and physical and mental health is in danger, in cases of rape and incest and in cases of severe and fatal foetal impairment	104
Ireland has an obligation to decriminalize abortion.....	104
Restrictive abortion laws violate fundamental human rights	105
International human rights standards require access to abortion when a woman or girl’s life or physical or mental health are at risk	106
Abortion on grounds of pregnancy as a result of rape or incest.....	107
Abortion on grounds of foetal impairment.....	108
II. Censorship and denial of abortion-related information is a violation of fundamental human rights.....	109

1. EXECUTIVE SUMMARY

Every day, between 10 and 12 women and girls living in Ireland travel to England¹ for an abortion. The majority of the women are aged between 20 and 34. Their reasons for terminating their pregnancies vary; however, their reason for travelling is the same. They cannot access safe and legal abortion services in Ireland, as procuring an abortion there is a criminal offence except where the pregnancy poses a “real and substantial” risk to their life.

Human rights bodies have repeatedly held that restrictive abortion laws, including those that exist in Ireland, violate women's and girls' rights to life, health, privacy, non-discrimination and freedom from torture and other ill-treatment. The withholding and denial of abortion-related information to women, as Ireland's Regulation of Information Act requires, also violates fundamental human rights, including the rights to information and freedom of expression. The findings of this report reveal violations of these human rights and demonstrate that Ireland is not implementing its international obligations to respect, protect and fulfil these rights.

Human rights obligations require the decriminalization of abortion² and that states ensure access to abortion, at a minimum, when a woman's life and physical and mental health is in danger, in cases of rape or incest and in cases of severe and fatal foetal impairment. International human rights laws and standards are clear that women should not face criminal penalties for undergoing abortions. Health care providers should also not be criminally sanctioned for providing safe abortion services to women. Again, Ireland's abortion law fails to comply with these human rights obligations.

Ireland's abortion law must be understood in context. The long history of the criminalization of abortion in Ireland is part of a broader social and political environment in which women and girls have been subject to strict, punitive social controls around their sexuality, in law, policy and practice. This history of institutionalized violence has produced a strong sense of stigma surrounding abortion in Ireland.

Ireland has long had one of the world's most restrictive abortion laws. For over 20 years, Ireland refused to engage in abortion law reform, despite repeated criticisms and calls for action from international and regional human rights bodies. Instead, the government has relied on the “safety valve” of women travelling to England and other jurisdictions, abdicating its responsibility to address the issue. “Out of sight, out of mind,” is how one woman

¹ These statistics, based on data collected by the UK Department of Health Statistics, refer to women resident in Ireland who travelled to both England and Wales to access safe abortion services. These numbers are underestimates, however, as they do not include women who travel to Scotland or to other countries in Europe. They also fail to include women who do not provide their Irish address to clinics or hospitals in England and Wales, often in order to protect their confidentiality.

² Decriminalization means that abortion is no longer regulated by criminal legislation, and is not a criminal offence in itself.

described the Irish government's approach. Recently, however, the Irish legislature was finally forced to act in order to comply with a decision by the European Court of Human Rights and to respond to the shocking, preventable and highly publicized death of Savita Halappanavar, a woman who was denied a medically-indicated abortion in an Irish hospital following a miscarriage.

Yet, this recent reform has left Ireland's legal framework on abortion largely unchanged. The Protection of Life During Pregnancy Act 2013 (PLDPA) criminalizes abortion on all but one ground. A woman may only obtain a legal abortion in Ireland if her life is at risk, including through suicide.

Although ostensibly an effort to clarify Ireland's legal framework and ensure access to abortion under the law, the PLDPA and its accompanying guidance are instead unclear, highly restrictive and provide little meaningful guidance. They offer little clarity into the circumstances in which women and girls may lawfully access an abortion, failing to define what constitutes a risk to life, as opposed to health. At the same time, the law and guidance introduce numerous barriers that must be overcome before a woman or girl may hope to qualify for a legal abortion. Women, health care providers and anyone who assists them face up to 14 years in prison for violating the PLDPA.

The on-going lack of clarity in the law, and the threat of professional sanction and criminal prosecution for health care providers and any one else assisting them, means that pregnant women and girls in need of an abortion for medical reasons are essentially forced to wait until their condition deteriorates sufficiently in order to justify a medical intervention. The narrow construction of Ireland's life exception means that longer-term risks to the life of a pregnant girl or woman, such as cancer or heart disease, are entirely disregarded.

Further, the PLDPA and its accompanying guidance appear to have been designed to severely limit access to abortion services under the exception for cases of risk to life from suicide. In the first publicly documented case of the denial of a lawful abortion under the PLDPA, health care providers coerced a young, suicidal woman, pregnant as a result of rape, who qualified for a lawful abortion on suicide grounds, to continue with her pregnancy to viability and then deliver by caesarean section. The concern for the protection of the foetus trumped any consideration of the woman's mental health and the consequent risk to her life.

As this case also illustrates, the role of Ireland's Eighth Amendment to the Constitution, which protects the foetus' right to life on an equal footing with a woman's, in shaping the health care that pregnant women receive cannot be underestimated. Deeply rooted in religious doctrine, the Eighth Amendment has resulted in a concern for foetal life taking precedence over the potential risks to the woman's life and health. This reality is inconsistent with international human rights law, which does not recognize a foetal right to life and is clear that human rights apply after birth.

Not only has the Eighth Amendment's protection for a prenatal right to life fundamentally shaped the restrictive scope and content of Ireland's abortion law, it has also had a negative impact on the quality of care that all pregnant women in Ireland receive, in the context of childbirth and even end-of-life care. Women that Amnesty International interviewed repeatedly expressed their distrust of the Irish maternity care system for this reason, and one

noted that “I would fear for my life to have another child in Ireland.”

Ireland's abortion law continues to criminalize abortion in cases of rape, incest and fatal or severe foetal impairment, perpetuating the suffering of survivors of sexual violence and of women and their partners already grappling with a devastating loss. Amnesty International spoke with many women, health care professionals and advocates who expressed their frustration and anger that abortion services were not legally available on these grounds and more broadly.

In addition to criminalizing access to abortion services in Ireland, the Irish state also heavily restricts information about abortion services abroad, criminalizing the provision of information by health care providers and pregnancy counsellors that “advocates or promotes” the option of abortion. The underlying rationale for this censorship, as with Ireland's abortion law, is the Eighth Amendment; the law aims to protect the foetus' life by limiting women's access to information on abortion. The combined chilling effect of Ireland's Regulation of Information Act (1995), which prohibits ‘advocacy or promotion’ of abortion, and the criminalization of abortion means that even basic information about abortion and the abortion procedure might not be provided to women, either by her doctor or in a counselling session. The impact of these information restrictions is far-reaching: in the context of the interview process for this report, Amnesty International noted that interviewees were cautious about how they expressed themselves, citing the restrictions of the Regulation of Information Act, including when they expressed views on changes needed to improve the law.

Despite these informational barriers, and other considerable financial and logistical challenges to travelling abroad for abortion, every year approximately 4,000 women and girls from Ireland travel to the UK and other countries in Europe for this medical service. These women and girls travel for a host of reasons: they may be carrying a foetus with fatal or severe impairment, they may be rape survivors, have health conditions or be struggling with economic or social challenges that mean parenting is not an option for them, or they may have chosen not to continue with a pregnancy for other personal reasons. What they share is the sense of exclusion from their health care system, the stigma of travelling, and the burden of secrecy and fear that comes with knowing they are doing something that is a criminal offence in Ireland. Some women interviewed by Amnesty International noted the harmful implications that travel had for their continuity of care and their physical and mental health. Forcing women to travel abroad for abortion care is not only discriminatory, it can also be an extremely traumatic experience, violating their right to health and, in some contexts, the right to be free from torture and other ill-treatment.

Not all women and girls are able to exercise the freedom to travel. Marginalized women and girls, such as asylum-seekers, migrants and those living in poverty, may be trapped in Ireland, without access to necessary health care. Unable to afford the significant financial burden of travelling, or prohibited from travelling due to their immigration or dependent status, or simply too ill to travel, these women and girls are forced to carry their pregnancies to term, or to resort to dangerous or clandestine measures to terminate their pregnancies. This may result in violations of a number of their human rights, including their rights to life, health and in some cases, the right to be free from torture and other ill-treatment.

Those who can't travel become desperate. Some consider suicide or potentially life-

threatening methods of self-induced unsafe abortion to be their only options. Other women and girls illegally purchase mifepristone or misoprostol, pills they use to unlawfully self-induce a medication abortion. Attempts to import these drugs through the mail will result in seizure by the Irish customs authorities; women must instead find ways to smuggle them into the country if they wish to use them for abortion. Medication abortion is a safe and internationally recommended option for terminating a pregnancy in the first trimester; however, the criminalization of abortion in Ireland means that women and girls may be taking these pills without effective medical supervision, potentially resulting in serious health complications.

Across the many testimonies from women, health care providers and civil society organizations about the impact of Ireland's restrictive abortion regime, there are significant recurrent themes that bear emphasizing. First, regardless of the law, women living in Ireland have – and will continue to have – abortions. World Health Organization estimates confirm that restrictive abortion laws do not reduce the number of induced abortions, as women will undergo abortions regardless of its legal status and lawful availability.³ Restricting access to safe and legal abortion in Ireland instead invariably leads to rights violations and disproportionately impacts those who are already marginalized or vulnerable, compounding the rights violations they experience. Without exception, every woman that Amnesty International spoke with, whether she travelled abroad for abortion care or remained in Ireland, experienced a violation of her right to physical and/or mental health.

Further, in speaking of their choices to travel or to procure an illegal medication abortion in Ireland, women made repeated reference to the death of Savita Halappanavar and the impact it had on them, some fearing for their lives should they need to undergo a lawful abortion in Ireland. Women also consistently emphasized that having to travel abroad for an abortion made them feel like a criminal; many underscored that they hoped for increased access to lawful abortion in Ireland in their lifetime, so that their daughters would not have to suffer the same trauma of travelling abroad for abortion care. Most health care providers and counsellors similarly expressed frustration over Ireland's restrictive abortion-related laws and emphasized how these laws severely hampered their ability to provide quality, ethical care and support to their patients and clients. Many called for Ireland's Eighth Amendment and abortion-related laws to be repealed and for a constitutional and legal framework that upholds women's and girls' human rights.

Amnesty International calls on the Irish authorities to take immediate steps to comply with their human rights obligations concerning abortion, including by:

- Repealing Article 40.3.3 (the Eighth Amendment) of Bunreacht na hÉireann, the Irish Constitution, to enable the provision of a human rights-compliant framework for abortion and information, in law and in practice;
- Decriminalizing abortion;

³ World Health Organization, *Unsafe abortion incidence and mortality: Global and regional levels in 2008, and trends during 1995–2008*, 2011.

10 She is not a criminal
The impact of Ireland's abortion law

- Repealing the PLDPA and replacing it with a legislative framework that ensures access to abortion both in law and in practice, at a minimum, in cases where the pregnancy poses a risk to the life or to the physical or mental health of a pregnant woman or girl, in cases of severe and fatal foetal impairment, and in cases where the pregnancy is the result of rape or incest; and
- Repealing the Regulation of Information Act.

2. METHODOLOGY

This report is part of Amnesty International's "My Body My Rights" global campaign.⁴ It is the result of research and interviews carried out by staff from Amnesty International's International Secretariat and Amnesty International Ireland between September 2014 and April 2015, in Ireland and England.

Amnesty International conducted a total of 60 interviews. Amnesty International researchers spoke with 26 women⁵ and six of their partners, as well as the mother of a teenage girl, about their first-hand experience of Ireland's restrictive abortion regime. Amnesty International also spoke with the lawyer for the woman identified as Ms. Y about the details of her case.⁶ Although a new abortion law came into effect in Ireland in 2014, the law remains equally restrictive and abortion continues to be criminalized on all the same grounds. The same barriers to access to abortion in Ireland therefore persist; in fact, additional problems have arisen with the introduction of burdensome administrative requirements and restrictive guidelines interpreting the law. While the majority of women's testimonies refer to experiences prior to the passage of Ireland's new law, Amnesty International believes their experiences reflect the on-going reality of Ireland's continuing restrictive abortion regime today.

In addition, Amnesty International interviewed 11 members of the health care profession, including doctors and health care counsellors, as well as representatives from three sexual and reproductive health care organizations, 13 civil society organizations and two statutory entities: the Crisis Pregnancy Programme and the Irish Medical Council. Although Amnesty International repeatedly requested interviews with the Department of Health and the Department of Justice and Equality, they declined to be interviewed for this report.⁷

Due to the pervasive stigma around abortion, fear of potential harassment and concerns about the legal consequences, it was difficult to identify health care providers and women who were willing to speak on the record to Amnesty International about their experiences. Of those women who did speak with Amnesty International, many declined to be identified by their real names in this report. Others, however, expressed a desire to use their real names or

⁴ See Amnesty International, *My life, my health, my education, my choice, my future, my body my rights*, (Index: ACT 35/001/2014), available at amnesty.org/en/library/info/ACT35/001/2014/en

⁵ Throughout this report, Amnesty International refers to "women" and "girls" in discussing the impact of Ireland's restrictive abortion law. Although the majority of personal experiences with abortion do relate to cisgender women and girls-- who were born female and identify as female, transgender men and people who identify as neither men nor women may have the reproductive capacity to become pregnant and so may need and have abortions. Amnesty International did not in the course of this research interview individuals with these gender identities, and as a result this report does not reflect any experience they may have had with Ireland's abortion law.

⁶ Ms. Y is a woman who was denied a lawful abortion in Ireland in 2014 in a very high profile case. For a full account of her experience, see the section below on Restricted access to legal, life-saving abortion in Ireland.

⁷ The Irish Department of Justice and Equality declined Amnesty International's request to be interviewed for this report, stating that access to abortion is not within its remit. Such a position would seem at odds with the Department's mandate, which includes criminal justice issues (including potential enforcement of criminal penalties) and equality (including discrimination against women).

initials, to help break the stigma and silence surrounding this issue. Where a woman's name has been changed at her request, this is indicated in a footnote.

Amnesty International is grateful to all those who agreed to be interviewed or provided information during this research. Amnesty International especially appreciates the time and effort that women took to share their personal stories. It has not been possible to include here all the testimonies of those who shared their experiences, but all the stories told, without exception, played an important role in the preparation of this report. The testimonies given by these women show the strength they have, despite the challenges and human rights violations they have experienced.

3. IN CONTEXT: ABORTION IN IRELAND

The Irish state has a long history of failing to address access to abortion as a human rights issue. For 20 years, despite repeated condemnation from human rights bodies and the Irish courts, the Irish government refused to legislate on abortion. Now that it has, the Protection of Life During Pregnancy Act 2013 (PLDPA) and accompanying guidance continue to be extremely restrictive and unclear. Although human rights bodies have repeatedly expressed concerns about Ireland's restrictive abortion law⁸ and called on Ireland to undertake the necessary legislative and constitutional reform to comply with its human rights obligations,⁹ Ireland continues to fail to do so.

The long history of the criminalization of abortion in Ireland is part of a broader social and political context in which the state and religious institutions have subjected women and girls to strict, punitive social controls around their sexuality. This history has produced a strong sense of stigma surrounding abortion in Ireland. Anti-choice groups and individuals, building on this fact and the restrictive legal framework, have further created a climate of intimidation, using aggressive tactics against those speaking out in favour of access to abortion to persecute them into silence. It is under these conditions that the Eighth Amendment (1983), Article 40.3.3 of the Irish Constitution, *Bunreacht na hÉireann*, and the subsequent PLDPA were developed and adopted.

As a result of these social pressures, as well as the state's clear refusal to meaningfully address access to abortion, many health care providers, women, government officials and journalists feel reluctant to speak out on this issue. Nonetheless, despite these significant challenges, organizations and individuals have been fighting for decades to address the draconian legal regime in Ireland.

INTERNATIONAL HUMAN RIGHTS OBLIGATIONS TO ADDRESS GENDER STEREOTYPES

The UN Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights, has long acknowledged the critical role that culture, and other social structures such as gender, has had on women's full enjoyment of their rights under the Covenant. In its General Comment No. 28, the Human Rights Committee elaborated: "Inequality in the enjoyment of rights by women throughout the

⁸ These human rights bodies include the Committee on the Elimination of all forms of Discrimination against Women (CEDAW Committee), Human Rights Committee, Committee against Torture, UN Special Rapporteur on human rights defenders, and the Council of Europe Commissioner for Human Rights. Most recently, Human Rights Committee Chairman Nigel Rodley characterized Ireland's abortion law as treating survivors of sexual violence as "a vessel and nothing more". See Padraic Halpin, *UN rights body criticizes Ireland on abortion, church homes*, Reuters, 24 July 2014.

⁹ See, for example, HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

world is deeply embedded in tradition, history and culture, including religious attitudes... States parties should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's... equal enjoyment of all Covenant rights."¹⁰ In *L.C. v. Peru* (2009), the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee), which monitors state compliance with the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), described Peru's abortion restrictions, which allows abortion only on grounds of health and life, as "based on a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right."¹¹

3.1 THE IRISH STATE AND RELIGIOUS INSTITUTIONS ENFORCE HARMFUL GENDER STEREOTYPES AND HAVE INSTITUTIONALISED VIOLENCE AGAINST WOMEN AND GIRLS

**"The [Irish] Constitution fosters stereotypical notions of motherhood as the natural and principal role of women and of women who choose to end a pregnancy as unfeminine, unnatural and deviant."
- Maeve Taylor, IFPA¹²**

Many of the specific human rights violations highlighted in this report are rooted in discriminatory and harmful stereotypes about women and girls. The existence of such stereotypes has led to a situation where laws, policies and practices have institutionalized violence against women and girls.

Harmful gender stereotypes concerning women's roles are enshrined in the Irish Constitution, which reinforces a deeply gendered state ideology around the traditional, patriarchal family and the idealized role of women as "mothers" within it.¹³ The Catholic Church, historically closely intertwined with the independent Irish state and granted a "special position" in Ireland's 1937 Constitution,¹⁴ played a significant role in nurturing this ideology.¹⁵ In 2005,

¹⁰ Human Rights Committee, *General Comment No. 28, Equality of rights between men and women (article 3)*, 2000, (U.N. Doc. CCPR/C/21/Rev.1/Add.10), para. 5.

¹¹ *L.C. v. Peru*, 2011, (CEDAW/C/50/D/22/2009), para. 7.7.

¹² Interview with Maeve Taylor, Senior Policy and Advocacy Adviser, Irish Family Planning Association, 3 October 2014.

¹³ See Article 41 of the Irish Constitution, which reads: "The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law." Further, Article 41.2 explicitly refers to women's "life within the home" and states that "mothers" should not be forced to work, for financial reasons, "to the neglect of their duties in the home."

¹⁴ The provision recognizing the Catholic Church's "special position" was repealed in 1972, 35 years after its original inclusion.

¹⁵ See Lisa Smyth, *Abortion and the Nation: The Politics of Reproduction in Contemporary Ireland*, 2005, pp. 39-40, 42. (At p. 42: "...official adoption of the principles of Catholic social teaching included a constitutional recognition of the patriarchal family as the 'primary unit' of Irish society."). See also Maria Luddy, 'Unmarried Mothers in Ireland', 1880-1973, in *Women's History Review*, Vol. 20, No.1, Feb. 2011, p. 112. ("With the establishment of the Irish Free State in 1922 the Catholic Church became particularly concerned with sexual immorality; they were especially anxious, as was the government, about the unmarried mother. Both the state and the Church emphatically presented women's place as being in the home and the ideal role of the Irish woman was as mother.")

the CEDAW Committee expressed its concern over Ireland's Constitution and "the persistence of traditional stereotypical views of the social roles and responsibilities of women and men in the family and in society at large".¹⁶

The Irish Constitution's Eighth Amendment,¹⁷ discussed in detail throughout this report and which bestows a constitutional right to life on the foetus equal to that of the pregnant woman, must be understood in this context. Intended to prohibit abortion, the Eighth Amendment feeds into the Irish Constitution's broader narrative of conscripted motherhood.

The notion of women as child-bearing vessels, rather than as autonomous, rights-holding individuals, is underscored in Ireland's recent inquiry into the use of forced symphysiotomy, a surgical procedure used during childbirth that "severs one of the main pelvic joints and unhinges the pelvis".¹⁸ Up until the 1980s, long after the rest of Europe and North America had turned to caesarean sections and discontinued the practice of symphysiotomy, its use continued in Ireland. Its use was, in part, "championed by some Irish doctors...[because] it facilitated future vaginal deliveries," enabling "women to have an unlimited number of children," as opposed to caesarean sections which were believed by some to limit the number of children a woman could subsequently have.¹⁹

The use of this traumatic and invasive procedure, primarily in private Catholic hospitals, not only left some women with life-long disabilities, it was also done without women's knowledge or consent.²⁰ In 2014, the Human Rights Committee criticized Ireland for failing to promptly investigate, prosecute and punish the perpetrators and provide remedies to the survivors of symphysiotomy, recognizing that this coercive practice implicated the right to be free from torture or other ill-treatment.²¹

Stereotypes about women's roles in society and their sexual conduct outside of marriage were also violently enforced by the state and religious institutions through the "Magdalene laundries". Throughout the 19th and 20th centuries, until the 1960s, unwed pregnant women and girls, along with other women and girls that did not conform to the social mores of the time, were confined in "asylums" run by Roman Catholic religious orders for months, years and sometimes decades. In Ireland's "Magdalene laundries", many women and girls experienced a range of abuses at the hands of the nuns who ran the laundries, including inhuman and degrading treatment, arbitrary deprivation of liberty and forced labour.²² Many

¹⁶ CEDAW Concluding Observations: Ireland, UN Doc. CEDAW/C/IRL/CO/4-5 (2005) para. 24.

¹⁷ The text of the Eighth Amendment is located in Article 40.3.3 of the Irish Constitution.

¹⁸ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 11.

¹⁹ Professor Irene Anne Jillson, *Symphysiotomy in Ireland: A Qualitative Study*, 2012, p. 3, available at www.patientfocus.ie/site/images/uploads/SYMPHYSIOTOMY_IN_IRELAND_By_Irene_Jillson_PhD.pdf According to Survivors of Symphysiotomy Ireland, some symphysiotomies "were not performed in an emergency or out of medical necessity, but as a matter of policy, out of personal choice. Some obstetricians and gynaecologists disliked Caesarean section because it capped family size. In place came symphysiotomy, a more dangerous procedure that enabled women to have an unlimited number of children." See <http://symphysiotomyireland.com/>

²⁰ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 11.

²¹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 11.

²² See for example Justice for Magdalenes, "Principal Submission to the Inter-departmental Committee to establish the facts of state involvement with the Magdalene Laundries," 16 February 2013, available at www.magdalenelaundries.com/State_Involvement_in_the_Magdalene_Laundries_public.pdf.

women and girls were forced to give up their children, either to be informally adopted²³ or sent to vocational training schools for children who had been neglected, orphaned or abandoned.²⁴ Women and girls that were sent to the laundries were shunned, stigmatized and exiled from mainstream society, silently and invisibly “atoning” for social wrongs committed.

The state was complicit in these laundries and has officially acknowledged its role;²⁵ however, it has not ensured accountability for these abuses.²⁶ The religious orders that ran the laundries have refused to formally apologize for their role in the abuse²⁷ and to contribute to a compensation fund for survivors.²⁸ The Committee against Torture, which monitors state compliance with the Convention against Torture, and the Human Rights Committee have both expressed concern about the human rights abuses committed in the Magdalene laundries and Ireland's failure to ensure accountability for these violations.²⁹

In publicly apologizing to the survivors of these laundries on behalf of the Irish state in 2013, the Taoiseach (Prime Minister) stated:

“I believe I speak for millions of Irish people all over the world when I say we put away these women because for too many years we put away our conscience... We lived with the damaging idea that what was desirable and acceptable in the eyes of the church and the State was the same and interchangeable... We can ask ourselves for a State, least of all for a republic... what is the “value” of the tacit and unchallenged decree that saw society humiliate and degrade these girls and women?... We can ask ourselves as the families we were then what was worthy, what was good about that great euphemism of “putting away” our daughters, our sisters, our aunties?”³⁰

This approach of stigmatizing and rendering invisible women and girls who are faced with unwanted or unplanned pregnancies continues today. As Ailbhe Smyth, a feminist academic

Complaints of these types of abuse in the Magdalene laundries were also described in the 2009 report of the Commission to Inquire into Child Abuse (the Ryan Report). See Amnesty International, *Ireland: Submission to the United Nations Human Rights Committee*, (Index: EUR 29/001/2014), available at www.ccprcentre.org/doc/2014/06/INT_CCPR_CSS_IRL_17502_E.pdf.

²³ Adoption was not legalized in Ireland until 1952.

²⁴ Maria Luddy, ‘Unmarried Mothers in Ireland, 1880-1973’, in *Women's History Review*, Vol. 20, No.1, Feb. 2011, p. 118.

²⁵ The state conducted referrals from the criminal justice system and the health and social services sector and engaged in financial interactions with the laundries. The Taoiseach (Prime Minister) of Ireland made a formal apology on behalf of the government to all the women who had been in the Magdalene laundries. Amnesty International, *Ireland: Submission to the United Nations Human Rights Committee*, (Index: EUR 29/001/2014).

²⁶ In 2014, the Human Rights Committee criticized Ireland for failing to promptly investigate, prosecute and punish the perpetrators and provide remedies to the survivors of the Magdalene laundries. HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 10; Amnesty International, *Ireland: Submission to the United Nations Human Rights Committee*, (Index: EUR 29/001/2014).

²⁷ ‘Making amends to Magdalene women’, *The Irish Times*, 29 June 2013, available at www.irishtimes.com/news/social-affairs/making-amends-to-magdalene-women-1.1446791

²⁸ Harry McGee, ‘Nuns say they will not pay Magdalene compensation’, *The Irish Times*, 16 July 2013, available at www.irishtimes.com/news/politics/nuns-say-they-will-not-pay-magdalene-compensation-1.1464737

²⁹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 10. See also CAT Concluding Observations: Ireland, UN Doc. CAT/C/IRL/CO/1 (2011) para. 21.

³⁰ Houses of the Oireachtas, Magdalene Laundries Report: Statements, The Taoiseach, 19 February 2013.

and activist, has written, by forcing women in Ireland to travel abroad for abortion: "Britain, ironically, has become a vast laundry for the human 'dirty linen' that Irish morality refuses to handle."³¹

3.2 A CLIMATE OF STIGMA AND INTIMIDATION

"I would love to see women being upheld as human beings who have rights and choices which are always legally, medically or religiously appropriate to the government. It feels like you can't just be a woman with free will. You have to be a suicidal woman and we will look after you."

- Linda Wilson Long, Head of Counselling at Dublin Well Woman, a reproductive health service provider and counselling centre³²

This history of harmful gender stereotyping and the resulting institutionalized violence against women has played a large role in enforcing the strong stigma associated with abortion in Ireland. The criminalization of abortion further reflects and exacerbates the stigma surrounding this medical procedure. Many of the women and their partners that Amnesty International interviewed mentioned the stigma they were made to feel when considering abortion travelling to another country to access services, and obtaining post-abortion care in Ireland.

This stigma is reinforced by the state, in its refusal to ensure human rights-compliant abortion legislation and policy, the Roman Catholic Church hierarchy, and highly vocal, anti-choice groups in Ireland. Anti-choice organizations and individuals have used aggressive strategies of public intimidation, including smear campaigns against pregnancy counsellors (see section below on Censorship and silence) and similar bullying tactics against journalists³³ and individual women,³⁴ which build on this stigma and create a climate of intimidation.

Roisin,³⁵ who spoke to Amnesty International about her first-hand experiences with miscarriage and abortion in Ireland, explains:

"[T]he pro-life movement in Ireland... are so vocal and so outspoken... a lot of women or even people who would speak out for abortion would be intimidated because they're so aggressively pro-life and they kick down anyone who expresses any other opinion. I see it all the time on Twitter and social media. It's very hard to take a stance against

³¹ 'A Sadistic Farce: Women and Abortion in the Republic of Ireland', in Ailbhe Smyth, Ed., *The Abortion Papers Ireland*, 1992, p. 21.

³² Interview with Linda Wilson Long, Head of Counselling, Dublin Well Woman, 2 October 2014. See also interview with Niall Behan, CEO, IFPA, 3 October 2014.

³³ Angela Nagle, *Why American Pro-Life Dollars Are Pouring Into Ireland*, 9 January 2013, available at www.theatlantic.com/sexes/archive/2013/01/why-american-pro-life-dollars-are-pouring-into-ireland/266981/; Interview with Roisin, 5 February 2015.

³⁴ 'Billboard company discontinues Youth Defence campaign after Rape Crisis Centre incident', in *thejournal.ie*, 27 June 2013, available at www.thejournal.ie/admobile-company-drops-youth-defence-after-rape-crisis-incident-969637-Jun2013/; Interview with Cathleen, 11 March 2015; Interview with Roisin, 5 February 2015.

³⁵ Not her real name.

that, if I suppose you're not a strong outspoken person, you would of course inevitably feel intimidated by the kind of language and rhetoric... I'm sure that's why a lot of people would choose anonymity in a study like yours [this report], you know, because you feel they might kind of start trolling you or something on social media. I feel on Twitter they are very, very nasty some of them. I would feel quite vulnerable in that way I suppose if my name was out there.”³⁶

Other women also expressed concerns about being singled out or ‘outed’ for having had an abortion by anti-choice health care professionals or local clergy.³⁷

Mary-Lou McDonald, a Member of Parliament representing Sinn Fein, notes that abortion is a volatile issue, saying “sometimes reactions can be outright abusive”.³⁸ Enda Kenny, the Taoiseach (Prime Minister), in the legislative debates on the PLDPA, similarly underscored:

*“[T]his is a sensitive issue. I am now being branded by personnel around the country as being a murderer, and that I am going to have on my soul the death of 20 million babies. I am getting medals, scapulars, plastic fetuses, letters written in blood, telephone calls all over the system”.*³⁹

Few are willing to accept the potential backlash that accompanies speaking out on abortion in public. Even seeking accountability for the denial of a lawful abortion can be risky.

³⁶ Interview conducted on 5 February 2015.

³⁷ See for example interview with Cathleen, 11 March 2015.

³⁸ Interview with Mary-Lou McDonald, TD (Sinn Fein), 30 January 2015.

³⁹ Enda Kenny, *Parliamentary Debates, Dáil Éireann, Vol. 806, No.2, 12th June 2013*, p. 655, available at

[http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/WebAttachments.nsf/\(\\$vLookupByConstructedKey\)/dail~20130612/\\$File/Daily%20Book%20Unrevised.pdf?openelement](http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/WebAttachments.nsf/($vLookupByConstructedKey)/dail~20130612/$File/Daily%20Book%20Unrevised.pdf?openelement)

4. IRELAND'S LEGAL AND POLICY FRAMEWORK GOVERNING ABORTION

Ireland's restrictive abortion laws have a long history. Until recently, the 1861 Offences Against the Person Act, which contained a criminal ban on abortion with lifetime imprisonment for anyone violating the law, was the governing legislation in Ireland. In 2013 – over 150 years later – Ireland had the opportunity to bring its law in line with international human rights standards, as countries around the globe have done in recent decades. Instead, Ireland chose to remain an outlier in Europe, criminalizing abortion on all but one ground – when a woman's life is at risk. Only Andorra, Malta and San Marino have more restrictive laws, prohibiting abortion in all cases. Poland also has a very restrictive law compared to the remaining 42 member states of the Council of Europe who allow abortion on request or on broad social and economic grounds.⁴⁰ Northern Ireland (part of the UK) permits abortion to save a woman's life or where there is a risk of real or serious long-term or permanent damage to the physical or mental health of the pregnant woman.⁴¹

Ireland's new abortion law was enacted in 2013 and came into effect in 2014.⁴² In addition to failing to meet human rights standards (see box below), it offers little clarity on the circumstances in which women and girls may lawfully access an abortion in cases where there is a risk to their life. At the same time, it introduces numerous administrative barriers that must be overcome before a woman or girl may hope to qualify for a legal abortion. Women, health care providers and anyone who assists them face up to 14 years in prison for violating the law.⁴³ As such, not only are women denied abortions in circumstances where it is their right under international human rights law, they would also be committing a crime if they exercised this right in Ireland.

CRIMINAL OFFENCES RELATING TO ABORTION IN IRELAND

The following are criminal acts in Ireland:

Obtaining, providing or assisting someone in obtaining or providing an abortion where the pregnancy does not pose a "real or substantial risk" to the pregnant woman's life, including through risk of suicide. Those who

⁴⁰ Center for Reproductive Rights, 'The World's Abortion Laws 2014', available at www.reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap2014.PDF. See also, Council of Europe, *Parliamentary Assembly Resolution 1607 (2008): Access to safe and legal abortion in Europe*, available at <http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta08/eres1607.htm> (inviting member states of the Council of Europe to, among other things, "decriminalise abortion within reasonable gestational limits, if they have not already done so" and "guarantee women's effective exercise of their right of access to a safe and legal abortion.")

⁴¹ Center for Reproductive Rights, 'The World's Abortion Laws 2014'. See also, Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services*, (Index: EUR 45/1057/2015), available at amnesty.org/en/documents/eur45/1057/2015/en/

⁴² The 2013 Act was the first legislation adopted on abortion by Ireland as an independent state. The 1861 Offences Against the Persons Act was legislation inherited from Britain

⁴³ Protection of Life During Pregnancy Act 2013, Number 35 of 2013 [hereinafter PLDPA], §22(2); Criminal Law Act 1997, §7 (introduces the offences of aiding, abetting, counselling or procuring an indictable offence in which the person who commits such acts is liable to be punished as a principal offender).

violate this law face up to 14 years in prison. (PLDPA, §22(2)).

- The provision of information that constitutes “advocacy or promotion” of abortion.
 - Specifically, pregnancy counsellors and doctors may not:
 - Provide a woman with information about abortion services abroad without her first requesting this information and without providing information on “all the courses of action that are open to her”.
 - Make “an appointment or any other arrangement” on a woman’s behalf with an abortion provider abroad.
 - Make a referral to an abortion provider abroad.
 - In addition, no person or institution may make information deemed to “advocate or promote” abortion publicly available. Information about abortion services abroad may not be publicly advertised or made available in unsolicited publications.
- Those who violate this law face a criminal conviction and a fine of up to €4,000 (Regulation of Information Act, §10(1)), Fines Act 2010).

4.1 CONSTITUTIONAL FRAMEWORK AND THE X CASE

In 1983, following abortion law reforms across Western Europe, Canada and the USA, Ireland held a national referendum on a constitutional amendment designed to prevent such liberalization. Article 40.3.3 (hereinafter the Eighth Amendment) reads:

“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.”⁴⁴

Ireland’s Constitution is the only one in Europe that grants the right to life prenatally, never mind on an equal basis with a woman.⁴⁵

The Eighth Amendment created a lack of clarity about access to abortion in Ireland. Its proponents believed that the Amendment would prohibit abortion under all circumstances; however, this did not prove to be the case. In 1992, the Supreme Court of Ireland had its first opportunity to interpret the Eighth Amendment in the context of abortion, in *X v. Attorney General and Others*. The case concerned the state’s attempt to prevent a 14-year-old girl, pregnant after being raped by her father’s friend, from obtaining an abortion abroad. The state argued that to permit the girl to travel abroad for an abortion would be unconstitutional under the Eighth Amendment, as it would violate the foetus’ right to life. The girl’s right to life was also at issue: a clinical psychologist had assessed her to be at risk of suicide if the pregnancy was not terminated.⁴⁶

The Supreme Court held that the Eighth Amendment, and Ireland’s criminal law provisions on abortion, permitted abortion in cases where there was a “real and substantial risk” to the life – “as distinct from the health” – of the pregnant woman, including through suicide. The

⁴⁴ Irish Constitution, Art. 40.3.3 (Eighth Amendment).

⁴⁵ The Czech, Hungarian and Slovak Constitutions have language recognizing prenatal life, but this only states that human life is “worthy of protection” before birth (Czech Republic and Slovakia) or at the moment of conception (Hungary) and does not grant the foetus a right to life, rights on an equal footing to a woman’s right to life. All three countries have liberal abortion laws, allowing abortion on request during the first trimester.

⁴⁶ *X v. Attorney General and Others* (1992) ILRM 401.

Court further regarded the government's failure to enact legislation clarifying the Eighth Amendment after nearly a decade, as "no longer just unfortunate: it is inexcusable".⁴⁷

Following the X case, in 1992, two related constitutional amendments were passed. These amendments protected "freedom to travel" from Ireland to another state to obtain abortion services (see section below on Ireland "exporting" its human rights obligations) and the "freedom to obtain or make available" in Ireland "information relating to services lawfully available in another state."⁴⁸ (See section on Censorship and silence).

4.2 THE PROTECTION OF LIFE DURING PREGNANCY ACT (PLDPA) AND ACCOMPANYING GUIDANCE

Several government-issued reports consistently noted the lack of clarity surrounding Ireland's abortion law and recognized the need for implementing legislation in the decade after the X judgment.⁴⁹ Nonetheless, it took more than 20 years after the X case – and 30 years after the passage of the Eighth Amendment – for the Oireachtas (Ireland's legislature) to pass legislation on abortion.

The impetus for the government to legislate on abortion ultimately came from two sources. In December 2010, the European Court of Human Rights issued a judgment in *A, B and C v. Ireland*. The case concerned three women, resident in Ireland, who were forced to travel abroad to seek abortion services. In its judgment, the European Court underscored the uncertainty created by the absence of a clear legal framework on abortion in Ireland.⁵⁰ The result, the Court concluded, was a "striking discordance between the theoretical right to lawful abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation."⁵¹

The Court also found that the continued criminalization of abortion in Ireland "constitute[d] a significant chilling factor for both women and doctors in the medical consultation process, regardless of whether or not prosecutions have in fact been pursued."⁵² Ultimately, the Court

⁴⁷ *X v. Attorney General and Others* (1992) ILRM 401. "The people, when enacting the Eighth Amendment were entitled to believe that legislation would be introduced to regulate the manner in which the right to life of the unborn and the right to life of the mother could be reconciled... In the context of the eight years that have passed since the Eighth Amendment was adopted the failure by the legislature to enact the appropriate legislation is no longer just unfortunate: it is inexcusable." This comment built upon the Chief Justice's observation in the 1988 *Open Door* case that it was "unfortunate that the [Parliament] has not enacted any legislation at all in respect of this constitutionally guaranteed right". Similar observations were made by the Supreme Court in *SPUC (Ireland) v. Grogan and Others*, decided in 1989.

⁴⁸ Thirteenth Amendment of the Constitution Act, 1992; Fourteenth Amendment of the Constitution Act, 1992.

⁴⁹ Reports were issued by the Constitution Review Group in 1996, a cabinet committee in 1999 and the Oireachtas committee on the Constitution in 2000. *A, B and C v. Ireland* (2010) ECHR 2032, Application no 25579/05, para. 265.

⁵⁰ Judgment in *A, B and C v. Ireland*, para. 253 (noting that following the X case "no criteria or procedures have been subsequently laid down in Irish law, whether in legislation, case law or otherwise, by which [the risk to a pregnant woman's life] is to be measured or determined, leading to uncertainty as to its precise application".)

⁵¹ Judgment in *A, B and C v. Ireland*, para. 264.

⁵² Judgment in *A, B and C v. Ireland*, para. 254.

held that “the absence of any implementing legislative or regulatory regime providing an accessible and effective procedure” by which the applicant could establish whether she qualified for a lawful abortion was in violation of the right to private life under the European Convention on Human Rights.⁵³

UN and regional human rights bodies, including the Human Rights Committee and the Committee against Torture, have also strongly criticized Ireland for its restrictive abortion regime and for not legislating on women's rights to access abortion.⁵⁴

Two years later, in October 2012, the reality of Ireland's restrictive and unclear laws – and the need for clear legislative and regulatory guidance for doctors – became painfully evident with the preventable death of Savita Halappanavar. Savita Halappanavar died from septic shock after being denied a medically-indicated abortion following a miscarriage, a practice that women interviewed by Amnesty International for this report had also experienced since Savita Halappanavar's death. Savita Halappanavar's doctors refused to terminate her pregnancy, citing Ireland's law on abortion and maintaining that her life was not at risk. They came to this conclusion, in part, on the basis of poor monitoring and evaluation of her condition. [See following section and the case of Savita Halappanavar].

In response to the mass outcry over Savita Halappanavar's death, and to comply with the European Court's judgment in *A, B and C v. Ireland*, the Protection of Life During Pregnancy Act 2013 (PLDPA) was introduced in 2013 and entered into force on 1 January 2014.⁵⁵ The Department of Health issued accompanying guidance for health care professionals in September 2014.⁵⁶

4.3 THE PLDPA DOES NOT PROTECT WOMEN AND GIRLS

“...access to abortion is a core aspect of women's right to health and of women's reproductive rights... The Protection of Life During Pregnancy Act, the first piece of legislation on abortion in Ireland, fails to properly protect women's lives and further criminalises women who access abortion services.”
- Orla O'Connor, Director, National Women's Council of Ireland⁵⁷

The PLDPA created a legal mechanism for approving abortions in life-threatening situations.

⁵³ Judgment in *A, B and C v. Ireland*, para. 267.

⁵⁴ See for example CAT Concluding Observations: Ireland, UN Doc. CAT/C/IRL/CO/1 (2011) para. 26; Concluding Observations of the Human Rights Committee: Ireland, 30 July 2008, UN Doc. CCPR/C/IRL/CO/3, para. 13; Concluding Observations of the Human Rights Committee: Ireland, 19 August 2014, UN Doc. CCPR/C/IRL/CO/4, para. 11; Council of Europe Commissioner for Human Rights, *Report by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe, following his visit to Ireland from 1 to 2 June 2011*, 15 September 2011, available at <https://wcd.coe.int/ViewDoc.jsp?id=1831077>

⁵⁵ Protection of Life During Pregnancy Act (PLDPA) 2013, Number 35 of 2013.

⁵⁶ Department of Health, *Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* (2014) [hereinafter Guidance Document]; Amnesty International, *Ireland's new abortion guidelines endanger the lives and rights of women and girls*, (News story), 19 September 2014, available at amnesty.org/en/articles/news/2014/09/ireland-s-new-abortion-guidelines-endanger-lives-and-rights-women-and-girls/

⁵⁷ Interview with Orla O'Connor, Director, National Women's Council of Ireland, 20 April 2015.

It specifies three circumstances where the risk to life may arise: a “real and substantial risk” of loss of life from physical illness; an “immediate risk” of loss of life from physical illness in an emergency; and a “real and substantial risk” of loss of life from suicide. Reflecting the language in the Eighth Amendment of Ireland’s Constitution, the Act consistently refers to “the need to preserve unborn human life as far as practicable” when evaluating each of these circumstances.⁵⁸

Regrettably, the PLDPA did little to create a clear legal framework to make lawful abortion accessible to women and instead erected multiple barriers to accessing abortion under the law. No new exceptions to criminalization – whether for cases of rape, incest, severe and fatal foetal anomaly, or a threat to the woman’s health – were created. A woman or girl may still only undergo an abortion in Ireland where there is a ‘real and substantial risk’ to her life. She and anyone assisting her in undergoing an abortion, including a health care provider, are liable to 14 years’ imprisonment if they violate the law.⁵⁹

However, the lack of clarity concerning the meaning, in practice, of a “real and substantial risk” to the woman’s life persists. The PLDPA repeats verbatim the “real and substantial risk” wording of the X case decision and provides little clinical guidance to health care professionals as to how to assess whether something is life-threatening for the purpose of ensuring access to lawful abortion.⁶⁰ In addition, the artificial legal distinction between a risk to life, versus health, remains intact, ignoring the lived reality of medical care in which health-threatening risks can quickly become life-threatening.⁶¹ This distinction also ignores the longer-term life-limiting effects of continuing a pregnancy, focusing instead on the shorter-term risks posed to a woman’s life.

As Dr Mark Murphy, a general practitioner (GP) and member of Doctors for Choice explains, “you cannot legislate for real and substantial risk... it is too grey a line, it’s too risky, and we have seen this happen in several high profile cases already... Will a woman who is unwell with heart disease or cancer... still have to travel [abroad for abortion services]? Is that a real and substantial risk to her life? No. She will still have to travel.”⁶²

Rather than creating an enabling framework for access to lawful abortion, the PLDPA sets forth a number of intrusive and burdensome consultation requirements, involving multiple

⁵⁸ PLDPA, §§7-9. The government which adopted the 2013 legislation argued that further liberalization of Irish abortion law was not possible given the constitutional position.

⁵⁹ PLDPA, §22(2).

⁶⁰ Little guidance is provided to health care professionals on making these distinctions other than a footnote noting that in cases of “real and substantial risk” the “risk does not need to be immediate or inevitable”, Guidance Document, p. 11. The doctor must also apply the other two parts of the three-part test – that the risk “can only be averted by the termination of the pregnancy” and “the doctor has, in good faith, had regard to the need to preserve unborn human life as far as practicable”.

⁶¹ See, for example, National Women’s Council of Ireland, *NWCI Policy Position Paper on Abortion* (March 2013), http://www.nwci.ie/download/pdf/nwci_policy_position_paper_on_abortion_final.pdf, pp 13-14; Doctors for Choice, *Submission to the United Nations Human Rights Committee for Ireland’s Review under the International Covenant of Civil and Political Rights* (May 2014), https://doctorsforchoiceireland.files.wordpress.com/2013/04/dfc_submission_unhrc_iccpr_final_june2014.pdf; and Health Service Executive, *Final Report: Investigation of Incident 50278 from time of patient’s self referral to hospital on the 21st of October 2012 to the patient’s death on the 28th of October, 2012* (June 2013).

⁶² Interview with Dr. Mark Murphy, General Practitioner, Doctors for Choice, 2 October 2014.

specialist doctors, which obstruct access to services under the law.

For example, in cases of a “real and substantial” risk to a pregnant woman’s life, a gynaecologist/obstetrician and a doctor with a specialty relevant to the woman’s illness must both agree that an abortion is necessary to save the woman’s or girl’s life.⁶³ In cases of a “real and substantial” risk of suicide, access to abortion requires the approval of two psychiatrists and an obstetrician.⁶⁴ Only in cases of “immediate risk” of loss of life from a physical illness in an emergency may a medical practitioner, without multiple approvals, perform the abortion;⁶⁵ there is no such emergency exception permitting a medical practitioner to perform an abortion in cases of immediate risk of suicide.

These requirements are logistically challenging and unnecessarily burdensome. For example, one of the psychiatrists must have experience in providing mental health services related to pregnancy; however, as Dr. Sam Coulter-Smith, Master of Rotunda Hospital, notes, there are only “three psychiatrists who specialize in mental health in pregnancy in the country.”⁶⁶ Training promised by the Health Service Executive (HSE) in June 2014 to provide the necessary resources for psychiatrists in “women’s health and obstetrics issues” in order to implement the PLDPA, is still not in place.⁶⁷

In addition, there is no medical basis for this more intrusive scrutiny of women at risk of suicide.⁶⁸ It is stigmatizing and distressing for women who are potentially suicidal to be subjected to two separate assessments by psychiatrists, who must both agree that she qualifies for an abortion under the PLDPA.⁶⁹ No emergency exception to permit a doctor to perform an abortion without these consultations exists for cases of immediate risk of loss of life from suicide.

The role of the obstetrician in a mental health evaluation, as required by the PLDPA, is not clear. As Dr. Sam Coulter-Smith states: “If a psychiatrist were to say ‘This is my assessment’ then it is not for an obstetrician to say ‘I don’t believe that the pregnancy should be terminated’.”⁷⁰

Having to consult with multiple specialists can be particularly burdensome for already marginalized women and girls, such as those living in rural areas, those living in poverty,

⁶³ PLDPA, §7.

⁶⁴ PLDPA, §9.

⁶⁵ PLDPA, §8.

⁶⁶ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

⁶⁷ Catherine Reilly, ‘Opening new chapters in Ireland’s abortion saga’, in *The Medical Independent* (5 Mar 2015).

⁶⁸ Houses of the Oireachtas, Joint Committee on Health and Children, Report on Protection of Life during Pregnancy Bill 2013, Volume 1, p. 228, (testimony of Dr. Peadar O’Grady) available at www.oireachtas.ie/parliament/media/committees/healthandchildren/Volume1.pdf

⁶⁹ Doctors for Choice, *Statement on PLDPA (2013) Implementation Guidelines*, available at <http://doctorsforchoiceireland.com/press-releases/> and Doctors for Choice, *Submission to the United Nations Human Rights Committee for Ireland’s Review under the International Covenant of Civil and Political Rights* (May 2014), https://doctorsforchoiceireland.files.wordpress.com/2013/04/dfc_submission_unhrc_iccpr_final_june2014.pdf

⁷⁰ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

minorities, asylum-seekers, migrants and children.

Under the PLDPA, in all cases, only an obstetrician – or, in a physical health emergency, another medical practitioner – can perform the abortion, even though GPs and mid-level health care providers can be just as qualified, in some circumstances, to offer early-term abortion services.⁷¹ The PLDPA requires the procedure to be performed in a select list of hospitals, without taking into account that early-term procedures can safely be made available in lower level facilities,⁷² which may be easier for women to access. The law also permits doctors, nurses and midwives to decline to provide services based on conscientious objection;⁷³ however, the PLDPA does not provide for any oversight mechanism to regulate this practice to ensure that it does not inhibit access to lawful services, as required under human rights laws and standards.⁷⁴

The situation is exacerbated for women who want to formally contest the denial of certification for a lawful abortion. A denial does not trigger an automatic formal review; a woman or girl in the midst of a health crisis (or a person acting on her behalf) must submit a written application. She must then be examined again by two additional doctors in cases of physical illness or three additional doctors in cases of risk of suicide.⁷⁵

The cumbersome and intrusive scrutiny required by the PLDPA interferes with, and can potentially violate, the pregnant woman's rights to life, health and private life, among other rights.⁷⁶ A woman seeking an abortion in case of physical illness could be forced to see up to six or seven health professionals: the referring health professional, the obstetrician and specialist, two second opinions, and a two-doctor review panel. Where feasible, women who can travel to England or elsewhere may opt to do so rather than subject themselves to such an intrusive, lengthy, complicated and uncertain process, not least given the time-sensitive nature of pregnancy and abortion.

IRELAND'S BURDENSOME LEGAL REQUIREMENTS CONTRAVENE HUMAN RIGHTS STANDARDS AND WORLD HEALTH ORGANIZATION GUIDANCE ON SAFE ABORTION SERVICES

In 2007, in a case concerning a woman who had been denied effective access to lawful abortion services in

⁷¹ The World Health Organization has made clear that mid-level providers can safely and beneficially provide first-trimester abortion services. See Marge Berer, 'Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives', *Bulletin of the World Health Organization*, (2009: 87), p. 58-63; <http://www.who.int/bulletin/volumes/87/1/07-050138/en/>; see also World Health Organization (WHO), *Safe abortion: technical and policy guidance for health systems* (2012), pp. 95-96 http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/ [hereinafter WHO, *Safe Abortion*].

⁷² WHO, *Safe Abortion*, p. 96.

⁷³ PLDPA, §17.

⁷⁴ See *RR v. Poland*, No. 27617/04 ECHR (2011) para. 206; *P. and S. v. Poland*, No. 57375/08 ECHR (2008) para. 107. See Annex of this report for additional information on human rights standards.

⁷⁵ Health professionals involved in earlier assessments of the pregnant woman or girl are not eligible to serve on the review panel.

⁷⁶ Concluding Observations of the Human Rights Committee: Ireland, 19 August 2014, UN Doc CCPR/C/IRL/CO/4, para 11.

Poland, the European Court of Human Rights stated: "Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it."⁷⁷ The World Health Organization (WHO), in its technical and policy guidance for countries on "evidence-based best practices for providing safe abortion care in order to protect the health of women," has stated that "[t]hird-party authorization should not be required for women to obtain abortion services," noting that "[a]ccess to care may... be unduly delayed by burdensome procedures of medical authorization, especially where required specialists or hospital committees are inaccessible." The WHO has emphasized that these "procedures disproportionately burden poor women, adolescents, those with little education, and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access."⁷⁸

Similarly, the UN Special Rapporteur on the right to health has stated that "requirements that abortions be approved by more than one health care provider... make safe abortions... unavailable, especially to poor, displaced and young women. Such restrictive regimes, which are not replicated in other areas of sexual and reproductive health care, serve to reinforce the stigma that abortion is an objectionable practice."⁷⁹

The WHO has also underscored that restrictions on the range of providers and facilities that may legally offer abortion services – requirements which they note are often not evidence-based and instead may be "over-medicalized, arbitrary or otherwise unreasonable" – limit equitable access to services, raises costs and delay access to care.⁸⁰

In addition, international and regional human rights standards require that states regulate the practice of conscientious objection so as to ensure it does not limit the right to access lawful abortion services.⁸¹ The European Court of Human Rights, for example, has held that the Convention does not protect every act motivated or inspired by religion: "States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation."⁸²

No other country in Europe has such burdensome requirements for obtaining an abortion, not least when a woman's or girl's life is at risk.

⁷⁷ *Tysi c v. Poland*, no. 5410/03, 45 ECHR (2007), para. 116. See also Amnesty International, 'Submission to the Council of Europe Committee of Ministers: *A. B. and C. v. Ireland*', Application No 25579/05 (17 February 2012).

⁷⁸ WHO, Safe Abortion, p. 95.

⁷⁹ *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. A/66/254 (2011), para. 24.

⁸⁰ WHO, Safe Abortion, pp. 95-96.

⁸¹ CEDAW Committee, *General Recommendation No. 24: Article 12 (women and health)*, 1999, para. 11; HRC Concluding Observations: Poland, UN Doc. CCPR/C/POL/CO/6 (2010) para. 12; CESCR Concluding Observations: Poland, UN Doc. E/C.12/POL/CO/5 (2009) para. 28; CEDAW Concluding Observations: Slovakia, UN Doc. A/63/38 (2008) para. 43; Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim report*, UN Doc. A/66/254 (2011).

⁸² *RR v Poland*, 2011, para. 206; *P and S v Poland*, 2012, para. 106.

4.4 THE DEPARTMENT OF HEALTH'S *GUIDANCE DOCUMENT* FOR HEALTH PROFESSIONALS ON THE IMPLEMENTATION OF THE PLDPA

The Department of Health's (DOH) guidance on the PLDPA issued to health care professionals creates additional barriers to accessing safe and lawful abortion services, and introduces further restrictions not in the PLDPA itself. Among these are the requirement to demonstrate suicidal "intent" (rather than risk). The guidance also allows for the possibility of an early delivery, rather than a medical or surgical abortion, at the doctor's discretion.

4.4.1 "SUICIDAL INTENT"

Nowhere in the PLDPA is reference made to "suicidal intent." Yet, the DOH's *Guidance Document* goes beyond the requirements of the PLDPA by stating that for a woman to qualify for an abortion there must be a "risk to life from suicide intent."⁸³ Dr. Peadar O'Grady, a Consultant Child and Adolescent Psychiatrist, explains:

*"From a medical perspective, mixing up 'risk of suicide' with 'suicide intent' is technically incompetent, full stop. One can only suppose that the reason to include 'intent' [in the Guidance] is not medical and is there only to restrict access to lawful abortions."*⁸⁴

Requiring a demonstration of intent appears to mean that psychiatrists must wait until a woman or girl is actively suicidal or suicide seems imminent, which is not only dangerous for women's health and lives but contravenes medical ethics and duties towards a patient. Professor Veronica O'Keane, a Consultant Psychiatrist and Professor of Psychiatry at Trinity College Dublin, explains in a news interview:

*"The terms of reference [of suicidal intent in the Guidance Document] are too narrow and dangerous, and we in Ireland have very high rates of suicide and even a government drive to reduce suicide numbers. In these guidelines, what we are actually doing is saying to Irish women 'You have to actually tell us that you're going to kill yourself or you won't get that abortion.' It is completely contrary to good psychiatric practice."*⁸⁵

Dr. Peadar O'Grady elaborates on risk of suicide existing along a spectrum:

"[C]atching that process early and intervening before it reaches the level of imminent risk or completed suicide is important. Delays in certifying suicide puts the person at risk. It is obvious that delays are unsafe. Why would you want to wait to find out? The

⁸³ *Guidance Document*, para. 3.3.

⁸⁴ Interview with Dr. Peadar O'Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

⁸⁵ Henry McDonald, 'Pregnant women face abortion ban in Ireland even if they're a suicide risk', *The Guardian*, 7 August 2014, available at www.theguardian.com/world/2014/aug/07/pregnant-women-ireland-abortion-ban-suicide?view=classic

precautionary and preventative principle means that if you think that the risk of suicide is elevated due to restricted access to abortion, then you should act to reduce that risk of suicide.”⁸⁶

4.4.2 “EARLY DELIVERY”

Even when a woman qualifies for a legal abortion, the guidance permits “clinicians... to use their clinical judgment... in cognisance of the constitutional protection afforded to the unborn” to determine whether “termination or an early delivery by induction or Caesarean section” is most appropriate for the pregnant woman.⁸⁷ The guidance does not state the role of the woman in this decision-making process. In discussing consent more broadly, the guidance notes that “general principles of informed consent apply to procedures carried out under this Act”; however, it then underscores that the HSE’s National Consent Policy, which allows for health care providers to seek the intervention of the High Court if there is disagreement between them and the pregnant woman on the best course of treatment, applies “to all health and social care services carried out by or on behalf of the HSE.”⁸⁸

A recent case, in which doctors reportedly coerced a woman who qualified for an abortion to continue with her pregnancy until viability and deliver, illustrates the potential dangers of such a vaguely worded provision. (See the following section for the case of Ms. Y).

THE HUMAN RIGHTS COMMITTEE’S CONCLUDING OBSERVATIONS ON IRELAND (2014)

In 2014, the UN Human Rights Committee strongly criticized Ireland’s “highly restrictive” abortion law – and its further “strict interpretation” of that law – during its periodic review of Ireland’s human rights record. The Committee expressed concern at the PLDPA’s criminalization of abortion in all but the most limited of circumstances. The Committee also highlighted the following issues as deeply problematic: “the lack of legal and procedural clarity concerning what constitutes ‘real and substantive risk’ [sic] to the life, as opposed to the health, of the pregnant woman; the requirement of excessive degree of scrutiny by medical professionals for pregnant and suicidal women leading to further mental distress... and the severe mental suffering caused by the denial of abortion services to women seeking abortions due to rape, incest, fatal foetal abnormality or

⁸⁶ Interview with Dr. Peadar O’Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

⁸⁷ *Guidance Document*, para. 6.4. (“The clinicians responsible for her care will need to use their clinical judgment as to the most appropriate procedure to be carried out, in cognisance of the constitutional protection afforded to the unborn, i.e. a medical or surgical termination or an early delivery by induction or Caesarean section.”)

⁸⁸ *Guidance Document*, para. 9.1. See also Health Service Executive, *National Consent Policy*, May 2013, pp.41-42. (“The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the “unborn”, there is significant legal uncertainty regarding the extent of a pregnant woman’s right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.”). Available at www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/National%20Consent%20PolicyMay14.pdf

serious risks to health.” The Committee recommended that Ireland “[r]evise 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.”⁸⁹

4.5 HEALTH CARE PROVIDERS REGARD THE PLDPA AND ACCOMPANYING GUIDANCE AS RETROGRESSIVE AND DANGEROUS FOR WOMEN

Health care providers interviewed by Amnesty International consistently underscored their lack of faith in the workability of the law and accompanying *Guidance Document*, and their concerns with its burdensome requirements. Ultimately, as health care providers and counsellors in Ireland point out, neither the PLDPA nor the guidance are crafted with the goal of providing safe, evidence-based health care to women. As Dr Mark Murphy, a GP and member of Doctors for Choice, clearly states:

“I have huge concerns. [The current framework] is not excellent practice, it is dangerous for women, there is criminalization of 14 years if we get it wrong... And then you have all these other restrictions. Guidelines are meant to facilitate and expedite evidence-based care. These guidelines are doublespeak. They are not guidelines; they are anti-guidelines. And it is the same with the PLDPA, it does not protect women. It actively harms them and puts their lives in danger... It is like an Orwellian nightmare at the moment in Ireland.”⁹⁰

Alison Begas, Chief Executive of Dublin Well Woman, expresses her concerns with the law:

“The restatement of criminal sanctions and the 14-year imprisonment of women and health care professionals; I cannot see how that fits into a civilized framework of human rights and health care. That is definitely a retrograde step. I think also that the very narrow framework of where [the pregnant woman’s] life is at risk... [is like saying] ‘to hell with her health, to hell with her if she is carrying a pregnancy resulting from rape or with a fatal foetal abnormality.’... I think that they had a chance to do something that was civilized and a bit more progressive and they did the bare, bare, bare minimum... That is my frustration and anger with it.”⁹¹

Dr. Peadar O’Grady explains:

“[T]he lack of provision of abortion services demonstrates that it is not workable. The government did not make an effort to make available the standard of abortion recommended by the guidelines of the WHO for safe abortion services. The WHO guidelines are recognised as international best practice – they are best practice in Ireland. It is like legislating for bus services but providing no buses.”⁹²

⁸⁹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

⁹⁰ Interview with Dr. Mark Murphy, General Practitioner, Doctors for Choice, 2 October 2014.

⁹¹ Interview with Alison Begas, Chief Executive, Dublin Well Woman, 2 October 2014.

⁹² Interview with Dr. Peadar O’Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

Senior clinicians that Amnesty International spoke with noted that the situation has not changed much since the introduction of the PLDPA. Dr. Rhona Mahony, Master of the National Maternity Hospital, says that little has changed with the new law, except that now there is a process, albeit “cumbersome”, whereby women can seek access to termination of pregnancy in the very restrictive circumstance of substantial risk to life.⁹³ Similarly, Dr. Sam Coulter-Smith, Master of Rotunda Hospital, says: “It hasn't changed the reality; it put some formality around it... We just fill in new forms.”⁹⁴

⁹³ Interview with Dr. Rhona Mahony, Master of the National Maternity Hospital, 30 January 2015.

⁹⁴ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

5. RESTRICTED ACCESS TO LEGAL, LIFE-SAVING ABORTION IN IRELAND

The extremely restricted access to abortion in Ireland – both before and under the PDLPA – stems, in part, from a general uncertainty as to what constitutes a “real and substantial risk” to a woman’s life. The threat of criminal prosecution and professional sanction⁹⁵ should health care providers “get it wrong,” as GP Dr. Mark Murphy put it, means that patients are essentially forced to wait until their condition deteriorates sufficiently in order for doctors to justify a medical intervention. This can have devastating consequences for women’s health and lives.

Further, the role of the Eighth Amendment, which protects the foetus’ right to life on an equal basis with a woman’s right to life, cannot be underestimated. In all of the cases discussed below, concern for foetal life – even where foetal demise was certain – took precedence over the potential risks to the woman’s life and health.

5.1 WHEN DOES RISK TO HEALTH BECOME RISK TO LIFE? PHYSICAL HEALTH GROUNDS

Permitting abortion only in life-threatening situations, and criminalizing abortion in health-threatening contexts, is dangerous and inconsistent with human rights obligations. Practical distinctions between life and health protection cannot be meaningfully drawn in the clinical context. A threat to health can transform into a threat to life. Death may or may not be a foreseeable outcome, depending on the individual woman and the constraints of the health system, of a health-related risk.

INTERNATIONAL HUMAN RIGHTS STANDARDS ON ABORTION REFLECT THE LINK BETWEEN RISKS TO LIFE AND HEALTH

International human rights standards reflect an understanding of life protection as practically indistinguishable from considerations of health protection in the abortion context. The Human Rights Committee consistently references health protection in consideration of women’s right to life as applied to

⁹⁵ See Medical Practitioners Act, 2007, Parts 7 -9 (concerning the making of complaints against registered medical practitioners and the imposition of professional sanctions where allegations are proved) and §57(1) (outlining the grounds for complaints against medical practitioners, including a criminal conviction); Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 2014, (outlining the “standards expected of doctors” and noting in §3.1 that a criminal conviction is grounds for investigation by the Medical Council).

safe abortion.⁹⁶ In Concluding Observations on Poland, the Committee reiterated concern about restrictive abortion laws, “which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health” under Article 6 of the International Covenant on Civil and Political Rights (the right to life).⁹⁷ In 2005, the Committee noted that the penal code in Mauritius “penalizes abortion even when the mother’s life is in danger, and thus may encourage women to resort to unreliable and illegal abortion, with inherent risks for their life and health (Covenant, art. 6).”⁹⁸

Yet, because of Ireland’s restrictive abortion law, including the risk of criminal or professional sanction, doctors in Ireland may wait until a serious health concern becomes a life-threatening situation before they intervene. This practice occurs at the expense of pregnant women’s lives. Savita Halappanavar was one such woman. Her preventable death was a consequence of the Eighth Amendment and Ireland’s restrictive abortion law. If Ireland allowed abortion on health grounds in compliance with its human rights obligations, Savita Halappanavar could be alive today. Although her death provided the impetus for law reform, the PDLPA failed to address the fundamental issues that led to this devastating situation, and the Eighth Amendment still stands.

SAVITA HALAPPANAVAR’S CASE

“For a doctor to say ‘you are not dying enough yet,’ like Savita Halappanavar was not dying enough, until she was and they couldn’t pull her back from brink because the infection had ravaged her body – it is barbaric.”

- Alison Begas, Chief Executive of Dublin Well Woman⁹⁹

Savita Halappanavar was 17 weeks pregnant with her first child when she arrived at Galway University Hospital on 21 October 2012 accompanied by her husband, Praveen. It was a Sunday morning, and she had been experiencing lower back pain consistently for the past 12 hours. She expressed concern that there was an issue with the pregnancy.¹⁰⁰

By late afternoon it was clear to the doctor who examined her that Savita Halappanavar was miscarrying.¹⁰¹ According to the final report of a formal Health Service Executive (HSE) inquiry, conducted after the events, she told the obstetrician that the pain at that point was “unbearable.”¹⁰² Multiple health care staff documented that Savita was “distressed,” “very upset” and “crying.”¹⁰³ The doctor explained to Savita Halappanavar and her husband that miscarriage was “inevitable/impending” within “a matter of hours” and

⁹⁶See also, HRC Concluding Observations: El Salvador, UN Doc. CCPR/CO/78/SLV (2003) para. 14; HRC Concluding Observations: Mali, UN Doc. CCPR/CO/77/MLI (2003) para. 14; HRC Concluding Observations: Poland, UN Doc. CCPR/CO/82/POL (2004) para. 8.

⁹⁷HRC Concluding Observations: Poland, UN Doc. CCPR/CO/82/POL (2004) para. 8.

⁹⁸HRC Concluding Observations: Mauritius, UN Doc. CCPR/CO/83/MUS (2005) para. 9.

⁹⁹ Interview with Alison Begas, Chief Executive, Dublin Well Woman, 2 October 2014.

¹⁰⁰ Patient history is derived from the official investigation and final report done carried out by the HSE and commissioned by the hospital. Health Service Executive, *Final Report: Investigation of Incident 50278 from time of patient’s self referral to hospital on the 21st of October 2012 to the patient’s death on the 28th of October, 2012*, June 2013, pp. 21 and 22-53 [hereinafter HSE, Final Report 2013].

¹⁰¹ HSE, Final Report 2013, p. 26.

¹⁰² HSE, Final Report 2013, p. 25.

¹⁰³ HSE, Final Report 2013, pp. 25, 27.

that the proposed course of treatment was simply to “wait and see what would happen naturally.” No other options were discussed.¹⁰⁴

Overnight, Savita Halappanavar’s membranes (amniotic sac) ruptured, increasing the possibility of maternal infection.¹⁰⁵ According to the HSE inquiry report, it also meant that “foetal death... was certain.”¹⁰⁶ Nonetheless, the “documented plan of treatment... was that the patient was to have an ultrasound scan carried out to check for the presence of a foetal heart [beat] and to ‘await events.’”¹⁰⁷

By Tuesday, when a spontaneous miscarriage had still not occurred, Savita and her husband questioned whether there might not be other options. In the later HSE inquiry, an obstetrician testified that they “enquired about the possibility of using medication to induce miscarriage as they indicated that they did not want a protracted waiting time when the outcome, of miscarriage, was inevitable.” Instead, Savita and her husband were advised by the doctor that, “Under Irish law, if there’s no evidence of risk to the life of the mother, our hands are tied so long as there’s a foetal heart[beat].” Medical staff at the hospital continued to monitor the foetal heart rate, with the plan being to continue to “await events” and then to “induce labour when the foetal heart stopped.”¹⁰⁸

That same day, Savita Halappanavar developed a high fever, as a result of intrauterine infection.¹⁰⁹ As the later inquiry report explicitly stated, it is unquestionably known that “women with maternal infection can deteriorate rapidly to sepsis, severe sepsis and septic shock. Hence vigilance in observation is required”.¹¹⁰ Sepsis commonly leads to death, particularly maternal death, and septic shock is associated with extremely high rates of mortality.¹¹¹ By Wednesday, Savita Halappanavar had been diagnosed with sepsis¹¹² and her condition was rapidly deteriorating.

Her doctors, becoming increasingly concerned, discussed among themselves the possibility of a termination of pregnancy if Savita’s condition didn’t improve,¹¹³ but did not act to end the pregnancy. The HSE inquiry later concluded that, at this stage, foetal demise was certain and that “international best practice” made clear that the appropriate treatment was a termination of pregnancy “because of the risk to the [pregnant woman] if the pregnancy is allowed to continue.”¹¹⁴

The report further concluded that the lack of clarity in Ireland’s abortion law as to “what constitutes a potential major hazard or threat to [the pregnant woman’s] life” prevented doctors from intervening appropriately. Upon being interviewed for the inquiry, a doctor involved in Savita Halappanavar’s treatment

¹⁰⁴ HSE, Final Report 2013, p. 26.

¹⁰⁵ HSE, Final Report 2013, p. 60.

¹⁰⁶ HSE, Final Report 2013, pp. 60, 70.

¹⁰⁷ HSE, Final Report 2013, p. 30.

¹⁰⁸ HSE, Final Report 2013, p. 77.

¹⁰⁹ HSE, Final Report 2013, p. 77.

¹¹⁰ HSE, Final Report 2013, p. 64.

¹¹¹ The HSE report notes that there is a “high mortality rate (up to 60%)” associated with rapid deterioration of the patient from sepsis to severe sepsis to septic shock. HSE, Final Report 2013, p. 16. The report further states: “Expediting delivery (either medically or surgically as appropriate or feasible, and within the law) at the earliest signs of infection in the uterus is a critical part of management to reduce the risk of progression to sepsis, severe sepsis and septic shock and maternal morbidity and death.” HSE, Final Report 2013, p. 71.

¹¹² HSE, Final Report 2013, p. 76.

¹¹³ HSE, Final Report 2013, pp. 41-42.

¹¹⁴ HSE, Final Report 2013, p. 71.

“indicated that the law is such that: ‘If there is a threat to the mothers’ life you can terminate. If there is a potential major hazard to the mothers’ life the law is not clear’”.¹¹⁵

On Wednesday afternoon, in the midst of her rapid decline, Savita Halappanavar had a spontaneous miscarriage. Her condition continued to deteriorate. In the early hours of Thursday morning, she was transferred to the intensive care unit. She remained critically ill, with “severe sepsis” and then multiple organ failure through Saturday. At 12:45am on Sunday, just under one week since first presenting at the hospital, Savita Halappanavar suffered a cardiac arrest while in septic shock and was pronounced dead shortly afterwards.

Savita Halappanavar’s death sparked outrage in Ireland. Protestors from Ireland and around the world took to the streets, issuing calls for accountability and abortion law reform. The government, under intense public scrutiny, undertook multiple inquiries in the wake of Savita Halappanavar’s death, both to determine what happened and to prevent such an incident from ever happening again.¹¹⁶

In the HSE inquiry’s final report, the investigation team stated that a termination of pregnancy was medically indicated in Savita Halappanavar’s case and would have been performed in “other jurisdictions.”¹¹⁷ The investigation team was further “satisfied that concern about the law, whether clear or not, impacted on the exercise of clinical professional judgement.”¹¹⁸ The report concluded that there “was an apparent over-emphasis on the need not to intervene until the foetal heart stopped together with an under-emphasis on the need to focus appropriate attention on monitoring for and managing the risk of infection and sepsis in the mother.”¹¹⁹

The investigation team recommended, among other things, that “[t]here is immediate and urgent requirement for a clear statement of the legal context in which clinical professional judgement can be exercised in the best medical welfare interests of patients.” They also called for national clinical guidelines to assist health care providers in such circumstances, recognizing that “the guidance so urged may require legal change.”¹²⁰

¹¹⁵ HSE, Final Report 2013, p. 72.

¹¹⁶ In addition to the HSE inquiry, discussed below, the Health Information and Quality Authority (HIQA) – an independent body tasked with monitoring the safety and quality of health services in Ireland – decided to undertake a broader investigation into the standards of services provided to patients, including pregnant patients, at risk of clinical deterioration. The HIQA inquiry similarly concluded that Savita Halappanavar’s death was preventable, identifying 13 missed opportunities in which an intervention would have potentially resulted in a very different outcome for Savita Halappanavar. See HIQA, *Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar*, 7 October 2013.

¹¹⁷ HSE, Final Report 2013, p. 59 (“clinical practice in other jurisdictions would have led to an early termination of pregnancy in equivalent clinical circumstances”). According to the report, “the intrauterine infection necessitated termination of pregnancy to reduce the maternal risks”. HSE, Final Report 2013, p. 77.

¹¹⁸ HSE, Final Report 2013, p. 76.

¹¹⁹ HSE, Final Report 2013, p. 73.

¹²⁰ HSE, Final Report 2013, p. 17 (Recommendation 4b).

5.2 RISK TO LIFE BUT NOT TO HEALTH: AN IMPOSSIBLE LEGAL FICTION

“Under the PLDPA we must wait until women become sick enough before we can intervene. How close to death do you have to be? There is no answer to that. What needs to be done is to legislate to allow abortion when there is a serious threat to a mother’s health, as opposed to life, and the law [must] take into account a woman’s position and what risks she is willing to accept; that depends on the woman. The law does not make any allowance for input from the woman as to what a risk is.”¹²¹

- Dr. Peter Boylan, obstetrician/gynaecologist, former Master and Clinical Director of the National Maternity Hospital, Ireland

Although a new law and accompanying guidelines were, in fact, issued after Savita Halappanavar’s death, this framework retains the same narrow life exception and therefore does little to address the concerns that led to her death. Dr. Rhona Mahony, Master of Ireland’s National Maternity Hospital, explains:

“[The] new law has not changed much of the practice. When women get sick, we can’t intervene until her life is at risk, and then we have to hope we save her in time. The classic illustration of this concept is [in cases of] chorioamnionitis [infections of the amniotic sac and fluid], at gestations prior to foetal viability.

“[O]bstetricians are under the spotlight since the Savita [Halappanavar] case. It was a media storm and many staff fear their patient or themselves being part of the next media sensation. However, the discussions arising from the Halappanavar case, the clinical focus on sepsis and on other causes of maternal death, combined with a process guiding termination of pregnancy in the case of substantial risk to life, have given doctors some comfort.”¹²²

Doctors are forced into the position of either being viewed as breaking the law or being viewed as providing potentially unethical – and dangerous – care to their patients. As Doctors for Choice stated in their recent submission to the Human Rights Committee on Ireland’s abortion law:

“In clinical practice there is a spectrum of risk, not a legally definable line to be crossed. Many different factors can combine to produce risk in different ways. Clinical judgment should be permitted to evaluate these factors in particular concrete circumstances... there is no one clear, exact moment in time when all doctors will agree that a threshold has been crossed and a termination is necessary. Being legally required to make sharp distinctions between life and health is unwelcome from a clinical perspective as the two are intimately connected. A risk to life has to be evaluated using health indicators.”¹²³

¹²¹ Interview with Dr. Peter Boylan, obstetrician/gynaecologist former Master and Clinical Director at the National Maternity Hospital, 2 March 2014.

¹²² Interview with Dr. Rhona Mahony, Master of the National Maternity Hospital, 30 January 2015.

¹²³ Doctors for Choice Ireland, *Submission to the United Nations Human Rights Committee for Ireland’s Review under the International Covenant on Civil and Political Rights*, 12 June 2014, pp. 5-6, available

Dr. Sam Coulter-Smith, Master of Rotunda Hospital, underscores: "There has to be a broad enough interpretation of the legislation to allow clinicians to act."¹²⁴ Under Ireland's law, however, patients are essentially forced to wait until their condition deteriorates sufficiently in order to justify a medical intervention.

Dr. Peter Dunkin, a retired Consultant Anaesthetist, explains further:

"A woman who has to wait until she is in danger of death before having her surgery and anaesthetic is at significantly greater danger of dying during that surgery, or shortly afterwards, than if she had the operation before she became critically ill and in danger of death. This stipulation – that she has to wait until her life is in danger – almost guarantees that a mother's life is at significantly greater risk when she has surgery and anaesthesia."¹²⁵

The narrow construction of Ireland's life exception also means that longer-term risks to the life of a pregnant girl or woman are disregarded. As Ireland's Health Minister, Leo Varadkar, recently stated in remarks on abortion:

"Speaking today as Minister for Health and as a medical doctor, and knowing all that I do now, it is my considered view that the eighth amendment is too restrictive. While it protects the right to life of the mother [pregnant woman], it has no regard for her long-term health. If a stroke, heart attack, epileptic seizure happens [to a pregnant woman], perhaps resulting in permanent disability as a result, then that is acceptable under our laws. I do not think that is right."¹²⁶

Donagh Stenson, Associate Director of Marketing at the British Pregnancy Advisory Service (BPAS) Merseyside Clinic in Liverpool, England, which provides abortion services, recalls one such case that made a particular impression on her: "a woman who contacted me herself had cancer and she was in the last throes of her treatment. She found out she was eight weeks pregnant and they wouldn't end the pregnancy for her and they wouldn't continue the treatment either."¹²⁷ Once pregnant, and in the midst of a serious health crisis, this woman no longer had any decision-making power over whether she received life-saving medical care. Her long-term health, and the potential risk to her life of discontinuing her cancer treatment, was of no consequence as long as she remained pregnant.

at

https://doctorsforchoiceireland.files.wordpress.com/2013/04/dfc_submission_unhrc_iccpr_final_june2014.pdf

¹²⁴ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

¹²⁵ Dr. Peter Dunkin continues: "The exact quantity of this greater risk will vary from case to case and will depend on a number of factors, such as just how sick she is, any other underlying illnesses she may have, the exact nature of the surgery, among others. So to quantify the risk in an individual case is difficult. What is certain is that the risk is increased to a significant degree." Interview with Dr. Peter Dunkin, FFARCSI, Consultant Anaesthetist Retired, 12 April 2015.

¹²⁶ Houses of the Oireachtas, Thirty-fourth Amendment of the Constitution (Right to Personal Autonomy and Bodily Integrity) Bill 2014: Second Stage [Private Members], 16 December 2014, available at <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2014121600056?opendocument>. The highly restrictive nature of the law is a product of the Irish Constitution's protection for the right to life of the "unborn" in the Eighth Amendment. The law's directive to medical practitioners to have "regard to the need to preserve unborn human life as far as practicable" and to ensure that the risk to life "can only be averted by carrying out the medical procedure" are products of the Eighth Amendment's protection for the right to life of the "unborn" or foetus.

¹²⁷ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

5.3 THE IMPACT OF SAVITA HALAPPANAVAR'S DEATH ON WOMEN IN IRELAND

**"I wouldn't be inclined to trust services for women in this country at the moment."
- Roisin, who was forced to carry a dead foetus for weeks because
doctors wanted to be absolutely sure there was no foetal heartbeat**

Savita Halappanavar's death had a particularly strong impact on many of the women interviewed for this report. Her case was mentioned repeatedly in interviews, a reminder to women and their partners of the potential consequences of the abortion ban and of being unable to travel to another country when in need of abortion services.

Ava, and her husband Ciaran, who travelled abroad for an abortion after receiving a fatal foetal anomaly diagnosis, underscored this fear. Ava said, "my mam was very worried with everything with Savita going on; think what if the same thing happened to my daughter? This baby wasn't going to survive and what if I went through something similar?" Ciaran continued, "They say that Savita was the exception and it is not the exception. The way the staff treated her and postponed all the procedures; that's the way they do it here. That is the system".¹²⁸

Roisin's experience of a miscarriage occurred seven years before the death of Savita Halappanavar—but it was only because of the media attention around Savita Halappanavar's death that she realized quite how dangerous her situation had been. In 2003, Roisin was six weeks pregnant with her third child when she began to experience complications and bleeding. She was referred to the hospital by her doctor for a scan. Told she was probably having a miscarriage, the hospital doctors told her: "we can't really see a heartbeat but there is a lot of blood." She thought they would then give her a dilation and curettage (D&C)¹²⁹ – a surgical abortion – but instead they gave her a leaflet about miscarriage and told her that she would need to come back in two weeks for another scan.

When she returned two weeks later, Roisin asked for a D&C. However, she was told she needed to wait nearly a month longer, until she was 11 or 12 weeks pregnant, so that they could absolutely confirm there was no heartbeat.

*"I suppose that it was the first time it dawned on me that they don't do what the woman wants. They are not there to treat the woman, I didn't want to be pregnant. I was terrified there was something wrong with it and I really didn't feel good about it... [In the end,] I had gone from six weeks to 11 weeks carrying what I thought was probably a dead baby, although my body had all the symptoms of being pregnant. It was horrible."*¹³⁰

By the time Roisin's doctors had definitively confirmed that there was no foetal heartbeat,

¹²⁸ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

¹²⁹ Dilatation and curettage (D&C), is a surgical abortion procedure and is often used to remove the contents of the uterus after a first trimester miscarriage.

¹³⁰ Interview with Roisin [her name has been changed], 5 February 2015.

the abortion procedure was more invasive than an earlier term abortion would have been.

For Lupe, Savita Halappanavar's experience also hit very close to home, as she experienced a similar situation at the same hospital, a mere three months after Savita Halappanavar's death.

LUPE'S EXPERIENCE

Lupe, originally from Spain, moved to Ireland in 2011 with her husband. About a year later, she found out she was pregnant. Eleven weeks into her pregnancy, she experienced some bleeding and became concerned. When she went to the hospital they told her everything seemed fine and booked her for a scan in two weeks.

Worried that something more serious was wrong, a week later Lupe paid €100 for a scan at a private facility, which revealed that there was no heartbeat. Lupe was devastated. The doctor referred her for follow-up care at the University Hospital Galway, where another week later they did a detailed scan and determined that the embryo, only 3mm in size, had likely died four to five weeks into Lupe's pregnancy. At this point, she had been carrying the foetus for 14 weeks – "it had been dead for two months inside my womb," says Lupe.

"This is the saddest thing in my whole life... After two months with a dead embryo in my womb – you can have an infection or something and only three months before this, this was the hospital where Savita had died. You know Savita Halappanavar – they just let her die with septicaemia – she was having a miscarriage. So I was worried and afraid and wanted to put an end to this. So when the doctor asked me what I would like to do I told her that I wanted to put an end to the pregnancy, obviously. She told me they couldn't help me, that the only thing they could do for me was to book another scan in a week... It was absolutely clear – they had the private scan with no heartbeat and the vaginal scan, from a week later, with no heartbeat and I was 14 weeks pregnant with a 3mm embryo. There was no doubt [that the foetus had died]. The doctor herself told me she was sorry for my loss. She told me they only could book me for another scan in a week just to make sure the embryo was not growing. How could it be growing if it was dead?"

Lupe and her husband waited to speak to another doctor. She remembers, "During that time I was feeling really scared since it had become clear to me that, if any complication raised, these people would let me die, just as they did with Savita . . ."

Two more doctors came to talk to her and they all said the "same stupid thing." That they couldn't do anything for her other than book another scan. "At this moment, I understood what happened to Savita." Lupe went home and called her private doctor in Spain, who had taken care of her during her first pregnancy. She explained the situation and the doctor told her to come immediately and they would do a surgical abortion, as it was obvious she was having a retained miscarriage.

Lupe booked tickets home. She started bleeding heavily before she left but didn't want to stay in Ireland. "I didn't feel safe at all," she said. After 16 hours of travel, bleeding the whole way, she arrived home and went directly to the emergency room. "They took care of me," says Lupe.¹³¹

As Lupe's experience illustrates, pregnant women whose lives and health are at risk, who can afford to seek care outside of Ireland and are well enough to travel, may choose not to remain

¹³¹ Interview with Lupe, 1 December 2014.

in Ireland. Although doctors in Ireland have indicated, publicly and in Amnesty International's interviews, that a limited number of abortions are performed each year in Ireland when a woman's life is at risk, a pregnant woman cannot be certain that she will receive these services when needed. In addition, should a woman stay in Ireland for medical care, and obtain a medically necessary abortion, the lack of clarity in the PLDPA means she may risk being held criminally liable and receiving a penalty of up to 14 years' imprisonment.¹³²

Dr. Peadar O'Grady is clear: "In the past if a woman found herself in a situation like Savita Halappanavar they could either call a lawyer, call the media or get on a plane. The only available solution was to get out of the country [Ireland]. The women who are actively bleeding, who have to get on a plane to travel for an abortion, they are like Savita. There is always risk of infection when there is bleeding, that is what happened to Savita."¹³³

Ciaran and Ava, the couple who travelled to England for a therapeutic abortion, stated: "We have a daughter at home, why would we risk for Ava to be on her death bed before anything is going to happen? That is a no-brainer."¹³⁴ Unfortunately, not all women and girls are able to travel to avoid the risks posed by the Irish legal system.

5.4 A RISK TO LIFE: THE SUICIDE EXCEPTION

"Of the thousands who travel, there was a concern that a cohort would [use the PLDPA's suicide exception to] seek terminations in already overrun services but that thankfully hasn't happened; we haven't seen a traffic jam to Dublin."

- Dr. Sam Coulter-Smith, Master of the Rotunda Hospital¹³⁵

Access to abortion for women who are at risk of suicide is equally elusive in Ireland, despite being permitted since the 1992 X case. The irony of this exception is that the risk of suicide in pregnancy is increased where the pregnancy is unwanted and abortion services are criminalized and inaccessible.¹³⁶ In Ireland, this means that the risk of suicide in pregnancy is higher for those women who cannot travel abroad for services.¹³⁷ The denial of lawful

¹³² Houses of the Oireachtas, Joint Committee on Health and Children, *Report on Protection of Life during Pregnancy Bill 2013*, Volume 1, 2013, pp. 149-150 (Dr. Peter Boylan's submission to the Oireachtas on the proposed PLDPA).

¹³³ Interview with Dr. Peadar O'Grady, Consultant Child and Adolescent Psychiatrist, 5 March 2015.

¹³⁴ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

¹³⁵ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

¹³⁶ Dr. Peadar O'Grady, Opening Statement to the Joint Oireachtas Committee on Health & Children Public

Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013, pp. 228, available at <http://www.oireachtas.ie/parliament/media/committees/healthandchildren/Volume1.pdf> ("The opinion of many psychiatrists and other doctors internationally is that the risk of suicide is increased by having access to abortion restricted. The internationally renowned psychiatrist Prof Robert Kendell, summed it up well in his 1991 review in the British Medical Journal: Suicide in pregnancy... much rarer now thanks to contraception, legal abortion and less punitive attitudes."); Interview with Dr. Peadar O'Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

¹³⁷ Interview with Dr. Peadar O'Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

abortion services to these pregnant women contemplating suicide may thus exacerbate their suicidal state.

As discussed in the previous section, the PLDPA appears to have been deliberately designed to severely limit access to abortion services under the suicide exception. A particularly egregious case of the failure to ensure access to lawful abortion on suicide grounds is that of Ms. Y. Her case, occurring in the first few months of the PLDPA, is the first publicly known instance of a denial of a lawful abortion under Ireland's new abortion law. It is also the first documented case of a forced pregnancy and coerced caesarean section, in lieu of providing an abortion, since the law's passage.

MS. Y'S CASE: DENIED A LAWFUL ABORTION

The following account of Ms. Y's experience was relayed to Amnesty International by her lawyer, Caoimhe Haughey, C.M. Haughey Solicitors, Dublin. All the quotations in this testimony are from Ms. Y's lawyer.¹³⁸

Ms. Y is a young woman who travelled to Ireland seeking asylum after brutal persecution and violence in her country of origin. In February 2014, prior to arriving in Ireland, Ms. Y was kidnapped, held against her will, beaten and raped repeatedly by the head of a paramilitary organization. Her lawyer noted: "I understand he kept her for himself and raped her repeatedly. She was violently beaten and still bears the scars of those beatings, which are quite significant scars... not to mention the psychological trauma."

Eventually, she managed to escape. She was able to flee the country with a family member and arrived in Ireland at the end of March 2014. She and her family member were transferred to a Direct Provision Centre for accommodating asylum-seekers.

Within days of arriving in Ireland, Ms. Y felt unwell. A nurse who saw her determined that she was pregnant. Ms. Y "was devastated and became very distressed upon hearing this news," says her lawyer. She made it clear to the nurse and other officials who dealt with her that the pregnancy was as a result of rape, was unwanted and that she was feeling suicidal as a result. Giving her account of her ordeals was extremely difficult and traumatizing for Ms. Y. Her reporting of feeling suicidal continued and escalated.

Ms. Y was told she would have to travel to the UK or Europe for an abortion – but that the obstacles to travelling abroad for such a purpose were many. Ms. Y was told she would need to complete complicated forms to obtain a visa and a temporary travel permit. The paperwork was extensive and in English, a language which Ms. Y does not speak. In addition, Ms. Y was told she would need at least €1,300 for the travel documents, flights and abortion costs. At the time, she was in receipt of €19.10 per week as an asylum-seeker. Ms. Y was left feeling overwhelmed and abandoned.

In June 2014, Ms. Y was referred to SPIRASI, a voluntary agency that works with asylum-seekers, refugees and survivors of torture and persecution. Ms. Y was sent for a medical assessment as part of her asylum

¹³⁸ Ms. Y's name and country of origin have not been disclosed to protect her confidentiality and ensure her safety. All the information in this account about Ms. Y's case is from an interview with her lawyer, Caoimhe Haughey, who narrated Ms. Y's experience based on what Ms. Y told her and numerous written medical records, custody records and other documentation that she has obtained as part of her representation of Ms. Y. Interview with Caoimhe Haughey, Solicitor for Ms. Y, 28 January 2015.

application. The doctor who examined and assessed Ms. Y prepared a detailed medical report, which was submitted to the Reception and Integration Agency and other officials dealing with Ms. Y's case at that time. The medical report submitted states Ms. Y was suffering from post-traumatic stress disorder; it states that Ms. Y expressed the desire to end her own life if the pregnancy continued. Ms. Y was noted to have a "strong death wish." Further assessment and counselling was recommended; however, there was no follow up at all. Ms. Y was not referred for psychological or psychiatric support, intervention or treatment. Nor was she referred for ante-natal maternity care at this juncture.

"The clock was ticking... she had no one to turn to," her lawyer relates. "There were so many agencies involved and she was passed from pillar to post. They all knew of her pregnancy... they knew she was highly distressed and that she was seeking a termination. Nobody was listening to her and there was no intervention." Communicating with those around her was very challenging, necessitating a translator to be available and physically present at all times.

In July 2014, Ms. Y made a desperate, unsuccessful attempt to seek an abortion in the UK. A clinic was identified and arrangements were made. Upon arrival in the UK, Ms. Y was arrested and detained for up to eight hours. Her meagre personal belongings were taken from her, as were her clothes. The Custody Records note that she was deemed a risk to herself and that she was given a safety gown to wear. Ms. Y was monitored closely and medically assessed. The medical records state "suicidal since being pregnant as a result of rape." Ms. Y was later returned to Ireland, as she was not legally permitted to enter the UK.

A few weeks later, Ms. Y met with a general practitioner (GP). This GP's medical notes record concern about Ms. Y being suicidal. She was referred to a psychiatric unit. It took a number of days before she was eventually admitted to a maternity hospital.

Ultimately, Ms. Y was kept in hospital for several weeks during which time involuntary detention was mooted. Her medical records indicate that Ms. Y spoke of suicide on an almost daily basis, with increasing intensity. Her lawyer related that Ms. Y told her health care providers "I will kill myself if I cannot get rid of this baby... I don't want it inside me. I don't want to discuss it. I don't want to know about it. I want it out. I cannot continue with this pregnancy." Ms. Y repeatedly threatened self-harm. Nonetheless, Ms. Y was not advised of her rights under the Protection of Life During Pregnancy Act. Her medical records reflect that she was instead told: "you cannot get an abortion in this country."

There was "huge emotional pressure inflicted upon this very young, vulnerable woman by health care providers to get her to continue with her pregnancy, even though she expressed the intention of 'I am going to throw myself off the top of this building' and 'I am going to tie a rope around my neck,'" explains Ms. Y's lawyer. Ms. Y had made an earlier suicide attempt, which was interrupted.

As a desperate measure, Ms. Y went on a hunger strike, refusing all food and drink. Told by doctors that they would "terminate" her pregnancy, she resumed drinking and eating. However, "the termination" (as it was described) was postponed and postponed again amidst legal wrangling, resulting in an emergency application to the High Court. In early August 2014, the HSE obtained an order from the High Court to effectively force feed and hydrate Ms. Y; an order which was later abandoned. A number of days later, Ms. Y delivered Baby Y by caesarean section. This was the only option determined by the two psychiatrists and obstetrician, who certified

this procedure as meeting the requirements for a lawful abortion on suicide grounds under the PLDPA.¹³⁹

“In my opinion,” says her lawyer, Caoimhe Haughey, “Ms. Y was given no choice. I believe that she did not fully understand what was going on. How could she? I believe that she was unduly influenced into accepting the planned caesarean section, otherwise she would be kept in hospital in order to continue with the pregnancy, which was a life or death decision for my client. From what I have read, viability considerations and other legal implications were first and foremost in the minds of those involved.”

After Ms. Y recovered from the surgery, she was discharged from the hospital and left to pick up the pieces of her life. She was granted refugee status and returned to her accommodation in the Direct Provision Centre. Her lawyer believes her after-care medical treatment and support was less than satisfactory in terms of follow-up. She stopped eating and lost a considerable amount of weight. She remained very vulnerable and fragile. Ms. Y bears many scars from her ordeals, physical and mental. Her caesarean section scar is a permanent reminder of being raped and her unwanted pregnancy. With the help of her legal team, Ms. Y now has a multi-disciplinary medical team in place to support her.

Ms. Y's experiences at the hands of the HSE, health care providers and other state officials are the subject of two separate inquiries commissioned by the HSE, one of which is currently being challenged in the courts by Ms. Y's legal team.¹⁴⁰ Separately, Ms. Y's legal team has initiated legal action on her behalf against the HSE and various other entities, including the Irish State and the Attorney General and the Minister for Justice and Equality, by way of a civil claim for damages.¹⁴¹

Greg Straton, Interim Director of SPIRASI, an organization with a long history of working with survivors of torture, has characterized Ms. Y's forced pregnancy and forced caesarean surgery as a “continuation of the torture” she experienced as a result of her kidnap, gang rape, sexual slavery and being subject to physical violence at the hands of her captors.¹⁴² Certainly, her treatment by Irish authorities has compounded the trauma of her persecution at home and being forced to seek refuge abroad.

Ms. Y's case demonstrates the impact of Ireland's abortion law on already vulnerable and marginalized women. Without support systems and unable to travel, they can be denied access to lawful abortion care.

Not only was Ms. Y denied access to a lawful abortion when she was entitled to one, she was

¹³⁹ The certification of Ms. Y's caesarean section under the PLDPA's suicide grounds was also documented in the government's own draft inquiry report into these events, which was leaked to the press but has not been completed or officially published. The report team had not interviewed Ms. Y as part of their investigation at the time of the leak. See Health Service Executive, *First Draft Report concerning the care provided to a woman (Ms Y) who had her pregnancy terminated pursuant to the Protection of Life During Pregnancy Act (2013)*, September 2014. See also Kitty Holland and Ruadhán Mac Cormaic, 'Woman in abortion case tells of suicide attempt', *Irish Times*, 19 August 2014, available at www.irishtimes.com/news/health/woman-in-abortion-case-tells-of-suicide-attempt-1.1901256. Other interviewees for this report, familiar with Ms. Y's case, also affirmed that this procedure was certified under the PLDPA's suicide grounds.

¹⁴⁰ Interview with Caoimhe Haughey, Solicitor for Ms. Y, 28 January 2015.

¹⁴¹ Mark Tighe, 'Ms Y issues nine abortion lawsuits', *The Sunday Times*, 12 April 2015.

¹⁴² Interview with Greg Straton, Interim Director, SPIRASI, 29 September 2014.

further forced to undergo a major surgical procedure and early delivery against her will. In addition, although two psychiatrists ultimately certified that Ms. Y qualified for a termination of pregnancy under the PLDPA, deeming her suicidal, she was never provided the necessary psychiatric care and counselling she needed during or after her pregnancy, until her legal team's intervention after her delivery. The concern for the protection of the foetus trumped any consideration of Ms. Y's mental and physical health and the consequent risk to her life. In addition to illustrating the unworkability of the PDLPA and its impact on particularly marginalized individuals, this case also illustrates the harmful role played by Ireland's constitutional protection for the foetus in shaping the treatment and medical care that pregnant women receive in Ireland.

6. IMPACT OF THE CONSTITUTION'S EIGHTH AMENDMENT PROTECTION FOR THE FOETUS ON THE QUALITY OF HEALTH CARE PREGNANT WOMEN RECEIVE

"The Eighth Amendment continues to exert a chilling effect on doctors. Difficult decisions that should be made by women and their doctors, a couple or the next-of-kin where there is no capacity, and on the basis of best clinical practice, are now made on foot of legal advice."

**Leo Varadkar, Ireland's Minister for Health, during a debate
on a proposed bill to reform the Eighth Amendment¹⁴³**

"For 32 years, the Eighth Amendment has blighted the lives of many women with crisis pregnancy. Over that time, we have seen 150,000 women travel to Britain for abortion. It is time for legislators and politicians to face this issue and put a referendum to the people on repeal of the Eighth Amendment."

- Professor Ivana Bacik, Senator, Labour Party¹⁴⁴

The Eighth Amendment to Ireland's Constitution 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." In addition to severely restricting the provision of abortion-related care in Ireland, the Eighth Amendment has a significant and harmful impact on the quality of non-abortion maternal health care that pregnant women in Ireland receive.

According to Amnesty International's research, the Eighth Amendment's protection for the "unborn" has created a situation in which health care providers have: withheld medically indicated treatment, including abortion, and waited for a pregnant woman's health to seriously deteriorate; refrained from providing a suicidal woman with critical mental health care and instead contributed to her mental suffering by denying a lawful abortion; forced

¹⁴³ Houses of the Oireachtas, Thirty-fourth Amendment of the Constitution (Right to Personal Autonomy and Bodily Integrity) Bill 2014: Second Stage [Private Members], 16 December 2014, available at <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2014121600056?opendocument>.

¹⁴⁴ Interview with Ivana Bacik, Senator, member of The Labour Party, Rapporteur to the Labour Women Commission on Repeal of the Eighth Amendment to the Constitution, Reid Professor of Criminal Law, Criminology and Penology at Trinity College, Dublin, 20 April 2015.

medical care upon pregnant women without their consent, with the threat of a court order; and kept a clinically dead pregnant woman on life support, denying her the ability to die with dignity.

6.1 THE IMPACT OF THE EIGHTH AMENDMENT ON ABORTION-RELATED CARE

The Eighth Amendment has fundamentally shaped the restrictive scope and content of the PLDPA – the “need to preserve unborn human life as far as practicable” is referenced repeatedly throughout the PLDPA. In 2014, the Human Rights Committee reiterated “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 [the Eighth Amendment] of the Constitution and its strict interpretation by the State party.” The Committee recommended that Ireland “revise its legislation on abortion, including its Constitution” to provide for increased access to abortion.¹⁴⁵

Savita Halappanavar, Lupe, Roisin and Ms. Y,¹⁴⁶ women whose stories are discussed in this report, were all denied medically indicated abortions, at great risk to their health and lives, on the basis of the constitutional protection for the right to life of the foetus. Fearful of legal repercussions, some health care providers have interpreted the Eighth Amendment as requiring them to privilege the right to life of the foetus over that of the pregnant woman or girl.

Roisin, who was forced to carry a dead foetus for weeks against her wishes because doctors wanted to be sure there was no foetal heartbeat, says:

“[C]onstitutionally [doctors] feel obliged to, they have to make sure they are covered, you know, that they are not going to get sued or the government isn't going to come down on them and they seem to tend to... take care more of the foetus or the possible life of the foetus rather than the women. It's like the medical service isn't there for the woman.”¹⁴⁷

The Eighth Amendment undeniably discriminates against women. Ailbhe Smyth, Convenor of the Coalition to Repeal the Eighth Amendment,¹⁴⁸ explains that “its presence in the Constitution is indicative of a highly controlling State. It is highly controlling specifically of women because men are not subject to equivalent controls in any area of their lives.”¹⁴⁹ As

¹⁴⁵ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

¹⁴⁶ The government formally sanctioned the approach taken in Ms. Y's case in the PLDPA's accompanying guidelines, issued a month after Ms. Y's forced delivery. The guidance refers to the “constitutional protection afforded to the unborn” in permitting clinicians to decide whether to provide an abortion or undertake “early delivery by induction or Caesarean section.” See *Guidance Document*, para. 6.4.

¹⁴⁷ Interview with Roisin [her name has been changed], 5 February 2015.

¹⁴⁸ The Coalition to Repeal the Eighth Amendment is a coalition of over 20 organizations and groups formed in 2013 and campaigning to improve access to legal abortion in Ireland. See www.facebook.com/repeal8/info?tab=page_info

¹⁴⁹ Interview with Ailbhe Smyth, Convenor, Coalition to Repeal the Eighth Amendment, 1 October 2014.

Alan Shatter, the former Minister for Justice and Equality in Ireland, stated in the Irish legislature's debates leading up to the enactment of the PLDPA:

"There is no impediment to men seeking and obtaining any required medical intervention to protect not only their lives but also their health and quality of life. I do not merely have ministerial responsibility for justice... I am also responsible for equality. It can truly be said that the right of pregnant women to have their health protected is, under our constitutional framework, a qualified right... This is a republic in which we proclaim the equality of all our citizens but the reality is that some citizens are more equal than others."¹⁵⁰

6.2 THE IMPACT OF THE EIGHTH AMENDMENT ON NON-ABORTION-RELATED MATERNAL HEALTH CARE

The impact of the Eighth Amendment is felt far beyond the context of abortion, in the provision of health care services to all pregnant women. Rebecca H.'s experience of illness during a difficult pregnancy and delivery illustrates how the constitutional protection of the foetus results in the poor treatment of pregnant women, implicating their human rights.

REBECCA H.'S STORY

"It was always what was best for the baby, not what was best for both of us equally. His safety and well-being was of the utmost importance to me but I needed the pregnancy to end, if the hyperemesis gravidarum [severe sickness] wasn't cured by delivery I would jump in front of a train. I wanted him to be okay but I couldn't go on another day. I felt like an incubator. I didn't feel like a human being anymore."
— Rebecca H.

Rebecca H. suffered from hyperemesis gravidarum throughout her pregnancy. This condition is characterized by a permanent feeling of nausea, severe vomiting – sometimes up to 50 times a day, and dehydration. She recalls: "the nausea was incredibly debilitating and even the motion of taking a few steps would cause me to vomit." She struggled with "frequent hospital admissions for dehydration and becoming depressed."

At 14 weeks, she could no longer care for herself and moved in with family. She says she asked for mental health support to help her cope but was never provided with any counselling. "The longer my pregnancy went on the more despondent I became." She "began losing hope" and was finally admitted to the hospital in order to manage her condition. She recalls, "I truly believed I was dying and I wanted to... I couldn't live another day in this hell... At 36 weeks... I spent most days lying in my hospital bed with my fists clenched and my eyes shut tight begging for the world to stop spinning, the nausea was so crippling it was worse than the constant vomiting... I could barely walk to the end of the hall most days."

¹⁵⁰ Alan Shatter, *Parliamentary Debates, Dáil Éireann, Vol. 784, No.2, 27th November, 2012*, p. 313, available at [http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/WebAttachments.nsf/\(\\$vLookupByConstruct edKey\)/dail~20121127/\\$File/Daily%20Book%20Unrevised.pdf?openelement](http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/WebAttachments.nsf/($vLookupByConstruct edKey)/dail~20121127/$File/Daily%20Book%20Unrevised.pdf?openelement)

Although her health care team told her that she could have an early delivery, it was repeatedly denied to her. "They would lie to me about when [delivery] would be, first it would be next Tuesday and then it would be next Thursday, then it would be comments about 'well you say you love your baby, but you can't love your baby if you want to deliver him early... You are putting your baby's life at risk...' all these sort of things. It was completely insane. They said they would induce at 35 weeks then it was 36 and then 37 and then 38... it was just always next week."

Finally, "I said to them just let me go home, if you can't help me I will find another way. And then they said 'well that's it you can't go anywhere.' They said 'it's our job to look after the baby, the baby comes first.' I told them that his safety was the utmost priority to me but at the same time, this is torture. Absolute torture." The hospital staff denied her request to be discharged and go home.

Eventually, the doctors agreed to induce Rebecca at 38 weeks. However, they "then started pressuring me to have a natural birth. I was so weak and despondent and I asked them for a [caesarean] section and they said 'absolutely not, you would be putting the life of your baby in danger.'" Rebecca expressed that she didn't feel physically capable of labour and natural delivery, but the doctors refused her request for a planned caesarean section. Instead, Rebecca was induced and forced to labour for over 36 hours. Ultimately, Rebecca received an emergency caesarean section as the baby was having a stress response to labour. Her son spent his first few days recovering in the neo-natal unit.

Rebecca concludes: "The Eighth amendment is currently being abused. It is being used to treat women as objects and not as human beings anymore. I would fear for my life to have another child in Ireland."¹⁵¹

The Association for Improvements in the Maternity Services Ireland (AIMS Ireland)¹⁵² has documented numerous cases of rights abuses in the provision of maternal health care that are a product of the Eighth Amendment. In a recent statement they noted:

*"[T]he Eighth Amendment is repeatedly used in the context of maternity rights to deny women the right to bodily autonomy in terms of decision making in pregnancy, in labour, in birth and in the postpartum period. Women have reported being forced into caesarean births, forced into invasive procedures during labour, threatened with social services and in some cases threatened with the Gardaí [police] and mental health services for trying to assert their right to bodily autonomy."*¹⁵³

Krysia Lynch, Co-Chair and Spokesperson for AIMS Ireland, characterized the situation as the "quashing of choice from the minute you're pregnant."¹⁵⁴

The HSE's National Consent Policy further sanctions these aggressive measures. Invoking the Eighth Amendment, the policy allows for health care providers to seek the intervention of the High Court if there is disagreement between them and the pregnant woman on the best

¹⁵¹ Interview with Rebecca H., 28 October 2014.

¹⁵² AIMS Ireland is an organization that advocates for women's human rights in the context of childbirth.

¹⁵³ *AIMS Ireland Statement on the Removal of Somatic Support to a Woman with an Unviable Foetus of 18 Weeks Gestation*, 31 December 2014, available at <http://aimsireland.ie/aims-ireland-statement-on-the-removal-of-somatic-support-to-a-woman-with-an-unviable-foetus-of-18-weeks-gestation/>

¹⁵⁴ Interview with Krysia Lynch, Co-Chair and Spokesperson, AIMS Ireland, 28 September 2014.

course of treatment.¹⁵⁵

The need to navigate the court system and obtain legal counsel to challenge the threat of a court order, for example, is extremely intimidating, and for marginalized women it is even more challenging.

6.2.1 EIGHTH AMENDMENT DENIES A PREGNANT WOMAN DIGNITY IN DEATH

The influence of the Eighth Amendment on pregnant women's health care had a particularly tragic manifestation in December 2014, when health care providers invoked it to keep a clinically dead pregnant woman on life support, against her family's wishes. Unsure of what was required of them under the Eighth Amendment, and "in the absence of medico-legal guidelines," the medical staff at the hospital told the woman's father "that, for legal reasons, they felt constrained to put his daughter on life support because her unborn child still had a heart beat." Their stated intent was to continue this treatment until the 15-week foetus had reached the point of viability.¹⁵⁶

The woman's father, partner and aunt all felt that she should be taken off life support.¹⁵⁷ Her father found the situation "very stressful" and "wanted her to have a dignified death and be put to rest." Ultimately, her father was forced to bring a case before the High Court and argue that these "measures are unreasonable and should be discontinued."¹⁵⁸

Expert doctors who testified during the court hearings stated that "continuing the somatic support [to keep her body functioning] was not appropriate and amounted to 'experimental medicine'"¹⁵⁹ and that, given the woman's physical state, "continuance of the treatment would 'be going from the extraordinary to the grotesque.'"¹⁶⁰

The court ultimately ordered the withdrawal of life support, on the grounds that the foetus had no chance of survival and therefore the maintenance of life support was "a futile exercise," which "would deprive [the pregnant woman] of dignity in death and subject her father, her partner and her young children to unimaginable distress."¹⁶¹

Dr. Peter Boylan, who testified in this case, told Amnesty International that what happened to this woman and her family "is outrageous". He continued: "They should have been able to discontinue life support. It's a very upsetting case." He also notes that the court's judgment

¹⁵⁵ HSE, *National Consent Policy*, May 2013, pp. 41-42. ("The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the 'unborn', there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.")

¹⁵⁶ *PP v. HSE* [2014] IEHC 622, 26 December 2014. All descriptions and facts concerning this case are taken from this published court decision.

¹⁵⁷ *PP v. HSE*.

¹⁵⁸ *PP v. HSE*.

¹⁵⁹ *PP v. HSE*. (Testimony of Dr. Frances Colreavy, taken from court's decision).

¹⁶⁰ *PP v. HSE*. (Testimony of Dr. Peter McKenna, taken from court's decision).

¹⁶¹ *PP v. HSE*.

was based on the “evidence that the foetus had no chance of survival [given the woman’s critical state]. If there was evidence that she could have kept going, they would have kept her going.”¹⁶²

RIGHT TO LIFE PROTECTIONS DO NOT APPLY BEFORE BIRTH

Opponents of abortion claim that right to life protections set forth in international and regional human rights treaties are accorded before birth, thereby prohibiting states from allowing abortions. The history of the development of UN human rights treaties, including the Convention on the Rights of the Child, and the subsequent interpretation of their right to life provisions by their official interpretative bodies, shows that the right to life treaty provisions only apply after birth.¹⁶³ In fact, no human rights body has ever found allowing termination of pregnancy to be incompatible with human rights. UN bodies, however, have recognized that prenatal interests can be protected through promoting the health and well-being of pregnant women.¹⁶⁴ Moreover, international human rights bodies have found restrictions on access to abortion in law or in practice to be a violation of state obligations¹⁶⁵ (for details see Annex: International human rights standards), including obligations to protect pregnant women’s and girls’ rights to life and health.¹⁶⁶

The CEDAW Committee, in a case against Peru regarding the denial of an abortion to a suicidal young girl who had been raped, recommended that the state take measures to ensure access to abortion in cases of rape and

¹⁶² Interview with Dr. Peter Boylan, obstetrician/gynaecologist, former Master and Clinical Director at the National Maternity Hospital, 2 March 2014.

¹⁶³ Rhonda Copelon *et. al.* ‘Human Rights Begin at Birth: International Law and the Claim of Fetal Rights’, in *Reproductive Health Matters* Vol. 13, No. 26, November 2005, pp. 120-129. An argument to the contrary is erroneously built upon Paragraph 9 of the UN Convention on the Rights of the Child Preamble, which provides: “Bearing in mind that, as indicated in the Declaration of the Rights of the Child, ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.’ The history of negotiations by states on the treaty clarify that these safeguards “before birth,” must not affect a woman’s choice to terminate an unwanted pregnancy. As originally drafted, the Preamble did not contain the reference to protection “before as well as after birth,” although this language had been used in the earlier Declaration on the Rights of the Child. The Holy See led a proposal to add this phrase, at the same time as it “stated that the purpose of the amendment was not to preclude the possibility of an abortion” (UN Commission on Human Rights, *Question of a Convention on the Rights of a Child: Report of the Working Group*, 36th Session, UN Doc. E/CN.4/L/1542 (1980)). Although the words “before or after birth” were accepted, their limited purpose was reinforced by the statement that “the Working Group does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States Parties.” UN Commission on Human Rights, *Report of the Working Group on a Draft Convention on the Rights of the Child*, 45th Session, UN Doc. E/CN.4/1989/48 (1989), p. 10.

¹⁶⁴ See for example, CEDAW Article 12; CEDAW General Recommendation 24 on Women and Health, UN Doc. A/54/38/Rev.1 (1999), para. 31(c).

¹⁶⁵ See for example, *L.C. v. Peru*, CEDAW Committee, 2011; *KL v Peru*, Human Rights Committee, 2005; *LMR v Argentina*, Human Rights Committee, 2007. See also, Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, 33rd Session, UN Doc. CRC/GC/2003/4 (2003), para. 31.

¹⁶⁶ See for example, the Committee on the Rights of the Child (CRC), which monitors compliance with the Convention on the Rights of the Child and has explicitly called for states to decriminalize abortion and recommended that a state “review its legislation on abortion and provide for additional exceptions in cases of pregnancy resulting from rape or incest, when the pregnancy poses a risk to the health of the adolescents and when abortion is in the best interests of the pregnant adolescent so as to prevent her from resorting to unsafe abortion. The state party should ensure in law and in practice that the views of the child always be heard and respected in abortion decisions.” CRC Concluding Observations: Venezuela, UN Doc. CRC/C/VEN/CO/3-5 (2014) para. 57; CRC Concluding Observations: Morocco, UN Doc. CRC/C/MAR/CO/3-4 (2014) paras. 56-57.

that the life and health of a pregnant woman or girl are prioritized over protection of the foetus.¹⁶⁷ In addition, the Human Rights Committee, in its most recent review of Ireland's compliance with the ICCPR has recognized the role that the Eighth Amendment of the Constitution has had on access to abortion in Ireland and recommended that the Constitution be revised in order to ensure that abortion be accessible in line with human rights obligations.¹⁶⁸

The European Court of Human Rights, in its most recent case on this subject, *A, B, and C v. Ireland*, left the issue of when life begins for the purposes of abortion for states to determine, invoking their margin of appreciation doctrine.¹⁶⁹ Although the Court declined to address the explicit question of the extent to which Convention protection applies prenatally for the purposes of abortion, the Court has consistently found state failure to implement existing abortion laws, and barriers to accessing abortion, to be violations of the Convention, including in the case of *A, B, and C v. Ireland*.¹⁷⁰

¹⁶⁷ *L.C. v. Peru*, CEDAW Committee, 2011, para. 8.15; CEDAW Concluding Observations on Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013) para. 30.

¹⁶⁸ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014).

¹⁶⁹ The margin of appreciation doctrine refers to the degree of discretion that a state has in fulfilling its obligations under the European Convention on Human Rights.

¹⁷⁰ *Tysi c v. Poland*, no. 5410/03, 45 ECHR (2007); *R.R. v Poland* (App. No. 27617/04)(2011); *P. and S. v. Poland* (App. No. 5735/08) (2012); *A.B.C. v. Ireland*, E.C.H.R. 2032 (2010).

7. CRIMINALIZATION OF ABORTION IN CASES OF FATAL AND SEVERE FOETAL IMPAIRMENT

“We are women and men who have all made the heartbreaking choice to terminate much wanted pregnancies due to fatal foetal abnormalities. Due to the restrictive laws in Ireland, we were all forced to travel to the UK in order to do this. We have all been traumatised, shocked and appalled that at our greatest time of need, our country turned its back on us and made us feel like criminals.”
- Campaign to Make Termination for Medical Reasons Available in Ireland¹⁷¹

Testimony gathered by Amnesty International and leading studies reflect that women's experiences of a diagnosis of fatal or severe foetal impairment differ, depending on a number of factors and circumstances.¹⁷² Nevertheless they generally have one thing in common: women and their partners experience a traumatic and devastating loss. And Ireland's criminal prohibition perpetuates their suffering.

NICOLA'S STORY

“You're alone from the diagnosis until the baby's heart stops. Between that, there's just a void.” – Nicola

In 2009, Nicola was 19 weeks into her second pregnancy when a routine scan revealed a problem with the foetus. After a more detailed follow-up scan medical staff told her that the impairment was fatal and there was no chance of survival. Nicola told Amnesty International: “I thought straight away that they would induce me but the nurse explained they couldn't do that because it's classed as a termination and wasn't allowed in this country.” She remembers thinking:

“You just can't leave me carrying the baby when the baby's going to die. I can't do it, I can't do it. I just couldn't comprehend, I just thought I was going to pass out... I think I cracked when I asked them when they

¹⁷¹ See Termination for Medical Reasons: www.terminationformedicalreasons.com/about-us/

¹⁷² See for example, N. Asplin *et al.* 'Pregnancy termination due to fetal anomaly: Women's reactions, satisfaction and experiences of care' in *Midwifery* Vol. 30 Issue 6 (May 2014) pp. 620-627; Glauca R.G. Benute *et al.* 'Feelings of women regarding end-of-life decision making after ultrasound diagnosis of a lethal fetal malformation', *Midwifery* Vol. 28 Issue 4 (August 2012) pp. 472-475; D. Côté-Arsenault and E. Denney-Koelsch "'My Baby is a Person": Parents' Experiences with Life Threatening Fetal Diagnosis', *Journal of Palliative Medicine* Vol.14 Issue 12 (December 2011) pp. 1302-1308; J. Lalor, C.M. Begley and E. Galavan, 'Recasting Hope: A process of adaptation following fetal anomaly diagnosis', *Social Science and Medicine* Vol.68 Issue 3, pp. 462-472; V. Mirllesse, 'Women's experience of termination of pregnancy for fetal anomaly: Effects of socio-political evolutions in France', *Prenatal Diagnosis* Vol.31 Issue 11, pp. 1021-1028; M. Sandelowski and J. Barroso, 'The Travesty of Choosing After Positive Prenatal Diagnosis', *Journal of Obstetric Gynecologic and Neonatal Nursing* Vol.34 Issue 3, pp. 307-318.

would induce me. I was just so naïve. I just thought automatically that they'd induce me if the baby was that sick."

Unable to afford the cost of travelling outside of Ireland in order to procure an abortion, and unwilling to "put myself and my family under the [financial] pressure" in order to do so, Nicola says she was forced to remain in Ireland and to continue with her pregnancy.

"I was conforming to what they do in Ireland. So a woman makes that decision, surely then there should be support for her once she's made the decision to carry her baby – not to have a termination as they call it. There was nothing, no support for me whatsoever, nothing."

Nicola went to the hospital every week for a scan. "Most women are getting scans to make sure their baby is alive. I was getting a scan to see if my baby had died," recalls Nicola. After five weeks the medical staff confirmed that the foetus had died. "Straight away the doctor came in, we can take you in tomorrow, this evening, now to induce you." Following her induction and delivery, Nicola developed an infection due to a retained placenta, which required further hospitalization and care.

"If I had been offered the induction from the start, I could have been saved this whole trauma, I strongly believe. I would have been saved the trauma of our friends offering us money, feeling under pressure to make this decision, facing the trauma of all these infections and having to spend time in the hospital, reliving my story every night because people were coming in. When I think about it, I just feel nothingness, there was no care."¹⁷³

INTERNATIONAL HUMAN RIGHTS STANDARDS: ABORTION ON GROUNDS OF SEVERE AND FATAL FOETAL IMPAIRMENT

International human rights bodies have repeatedly made clear that the denial of access to abortion in cases of severe and fatal foetal impairment is a violation of a woman's fundamental human rights, including her rights to privacy, health and freedom from torture and other ill-treatment.¹⁷⁴

In *K.L. v. Peru*, a case decided by the UN Human Rights Committee (HRC), a young woman pregnant with an anencephalic foetus – a fatal condition which medical science has well-established would not allow it to survive more than a few hours or days beyond birth – was denied a therapeutic abortion. Forced to carry the pregnancy to term, and contend with the baby's inevitable death four days after birth, she became severely depressed. The HRC explicitly held that the denial of a therapeutic abortion caused K.L. substantial and foreseeable "mental suffering" and amounted to a violation of article 7, the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment.¹⁷⁵

The HRC also found that the state's failure to provide K.L. with a therapeutic abortion interfered arbitrarily

¹⁷³ Interview with Nicola, 22 October 2014.

¹⁷⁴ See for example, *K.L. v. Peru*, HRC, UN Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter *K.L. v. Peru*]; HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9; CEDAW Concluding Observations: Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012) para. 34.

¹⁷⁵ *K.L. v. Peru*, para. 6.3.

with her private life. In finding the right to privacy violated, the HRC recognized that the existing provision of the law allowing for abortion in cases of risk to the health of the pregnant woman (there is no explicit foetal impairment ground in Peru's law) entitled her to a lawful abortion.¹⁷⁶

The UN treaty bodies have not limited their calls for access to abortion to cases in which foetal impairments are such that stillbirth or death immediately after birth is a virtual certainty. UN treaty bodies have also made general calls for access to "therapeutic abortions," meaning abortions that are indicated for medical reasons, without specifying what those medical reasons might be.¹⁷⁷ The CEDAW Committee has called for access to abortion in cases of "severe" foetal impairment in recent concluding observations.¹⁷⁸

In 2014, the HRC expressed concern about Ireland's criminalization of abortion in cases of fatal foetal impairment and "the severe mental suffering caused by the denial of abortion services to women seeking abortions" in this context. The HRC recommended that Ireland amend its abortion law to provide for an exception to criminalization in cases of fatal foetal impairment.¹⁷⁹

7.1 THE IMPACT OF CARRYING A FATAL FOETAL IMPAIRMENT PREGNANCY TO TERM

"[Ireland's legal framework relating to abortion] forces couples to bring to term a child that has no chance of survival for long outside the womb, if at all. Forcing them, against their own judgment, to explain for weeks and months to all enquirers that their baby is dead... I do not believe anything is served by requiring women or couples to continue with such pregnancies should they not wish to do so when there is no chance of the baby surviving for long."

- Leo Varadkar, Ireland's Health Minister, in a speech before the lower house of Parliament regarding a proposed bill to replace the Eighth Amendment of the Irish Constitution with a provision acknowledging the right to personal autonomy and bodily integrity, 16 December 2014¹⁸⁰

Women and their partners who have dealt with the news of a fatal foetal impairment describe the psychological impact of this uncompromising prognosis – and of the prospect of continuing with such a pregnancy.

Grainne told Amnesty International how she felt after being told that she was carrying an anencephalic pregnancy, a fatal condition where a significant portion of the foetus' brain and

¹⁷⁶ *K.L. v. Peru*, para. 6.4.

¹⁷⁷ CAT Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009) para. 16.

¹⁷⁸ In its July 2014 concluding observations on Peru, for example, the CEDAW Committee recommended that the state "[e]xtend the grounds for legalization of abortion to cases of rape, incest and severe foetal impairment." CEDAW Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014) para. 36(a); CEDAW Concluding Observations: Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012) para. 34; CEDAW Concluding Observations: United Kingdom (regarding Northern Ireland), UN Doc. CEDAW/C/GBR/CO/7 (2013), para. 51.

¹⁷⁹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

¹⁸⁰ Houses of the Oireachtas, Thirty-fourth Amendment of the Constitution (Right to Personal Autonomy and Bodily Integrity) Bill 2014: Second Stage [Private Members] (16 December 2014), available at <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2014121600056?opendocument>.

skull fails to develop:

*"How cruel would it be to make me go through this. My baby could live nine months; it could be born and live for a couple of minutes. That would put me through a full pregnancy, I would have the breast milk, I would have everybody asking me how long are you gone?... How could they think that would not affect someone mentally? I could never have gone through that, I just couldn't."*¹⁸¹

Eoghan recounts his and his wife's experience and their reasons for deciding to travel for an abortion:

*"No one knows what you go through. It is kind of unbelievable; we were carrying this baby that wasn't going to survive. My wife was beginning to show only at 13 weeks and if we had gone to 20-22 weeks then I don't know how we would have coped, I don't think that she would have ever recovered from having to carry a baby that long that we knew we were going to lose. We had told our parents but we were a couple of days away from telling our friends and family and then having to tell them that we were having this baby that wasn't going to survive, we weren't mentally strong enough for it. We weren't willing to take that on."*¹⁸²

Continuing to go to work can be particularly difficult during this time. Ava was given the foetal diagnosis of Edward's Syndrome at 15 weeks.¹⁸³ Her doctors in Ireland told her that, at best, she would carry the pregnancy to 24 weeks and that if she went into labour the baby would be stillborn. Her job required a steady stream of social interaction.

*"A huge factor for me was in work having to go in and out of people's homes, it was not as though I could hide behind a desk and scurry in and out of work I had to be out and [visibly pregnant]... I felt who the hell are they to say that I am mentally strong enough to carry this baby to full term and then not have it at the end?... I was so angry that was my choice in this country – to carry on and get bigger and then there wouldn't even be any support at the end of that either."*¹⁸⁴

Gerry explained the emotions that he and his wife felt after receiving a diagnosis of foetal anencephaly at 20 weeks gestation and the pressure this put on their daily interactions:

"Gaye just couldn't face going to work, at this stage total strangers were putting their hands on the bump, and saying you must be so excited... to pretend would be wrong, but we couldn't tell someone that the baby isn't going to live, wouldn't, couldn't put

¹⁸¹ Interview with Grainne, 21 October 2014.

¹⁸² Interview with Eoghan, 17 October 2014.

¹⁸³ Edward's Syndrome is a chromosomal abnormality that results in a number of life-threatening medical conditions. According to the UK's National Health Service, "a significant proportion of fetuses with Edwards syndrome miscarry or are stillborn... About 50% of infants [that are delivered] die within the first two weeks after birth... Median life expectancy is 14 days." See www.geneticseducation.nhs.uk/genetic-conditions-54/651-edwards-syndrome-new

¹⁸⁴ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

people in that position, making them feel awkward."¹⁸⁵

Gaye continues: "One thing that I remember very clearly and at a very visceral level... I didn't leave the house in the two weeks between diagnosis and termination... what were people going to say to me?... The isolation was very pervasive because we were made to feel that we were an extraordinary exception."¹⁸⁶

Cerys also worried about the impact on her other children of carrying her pregnancy to term, and explains how that influenced her decision-making. She recalls:

*"[O]n the Thursday evening we got the results which said that it was Edwards Syndrome. I have two boys at home and I had to make a decision, I thought 'this isn't going to work'. Our eldest boy was aware that I was pregnant and he was over-excited and totally in awe of everything. I could not put him through a delivery and have this child where we could have anything between three hours and three days with this baby that would be born crying in pain... So the way we looked at it, I acted like a mum; we had two other boys who were going to be left with a funeral. I don't think that I was selfish in any way, I didn't act on a whim."*¹⁸⁷

7.2 FORCED TO TRAVEL: CAST OUT FROM THE IRISH HEALTH CARE SYSTEM AFTER A DIAGNOSIS OF FATAL FOETAL IMPAIRMENT

"We deserved to have support within the Irish health care system, to get us through that... They export the problem and they forget all about you."

- Emma Kitson¹⁸⁸

Many of the individuals that Amnesty International spoke with who had received a diagnosis of fatal foetal impairment expressed a profound sense of abandonment and anger that they could not receive the services and support they needed within their own country at such a difficult time. They also spoke of the impact this had on their ability to mourn their loss. Ava explains, "I felt let down by everyone and particularly let down by this country." She continues:

"For me it is mental health and how people cope afterwards, do they realise what they are putting people through? I know you will never forget going through that but it was made worse by having this big, dirty secret. I made the best decision for myself, for my daughter, we made the best decision because what we were going to get was a baby that wasn't going to be here, all we would have been doing was delaying the grieving process just to make a government feel better that they don't have abortion in

¹⁸⁵ Interview with Gerry and Gaye Edwards, 27 September 2014.

¹⁸⁶ Interview with Gerry and Gaye Edwards, 27 September 2014.

¹⁸⁷ Interview with Cerys [her name has been changed], 1 October 2014.

¹⁸⁸ Interview with Emma Kitson, 8 December 2014.

*Ireland, well done you.*¹⁸⁹

Historically, many women go to Liverpool Women's Hospital in England, as it is known to provide specialist services for women with fatal foetal impairments and has "informal links" with maternity hospitals in Ireland.¹⁹⁰

In 2014, news reports indicated that Liverpool Women's Hospital was nearing full capacity – turning Irish patients away or making them wait two to three weeks before they could obtain an appointment.¹⁹¹ Amanda, Administrative Co-ordinator and Counsellor at BPAS' clinic in Liverpool explains:

*"[A] while ago [Liverpool Women's Hospital] decided they couldn't really cope with the numbers that were coming from Ireland so we've seen an increase of the foetal anomalies coming here [to the clinic]... those cases are really heartbreaking. They are very much wanted pregnancies and sometimes, well, the woman's life can be in danger to continue with that pregnancy."*¹⁹²

Women and their families who make the decision to terminate their pregnancy are faced with a host of challenges, including meeting the substantial costs of travelling and grappling with the sudden upheaval in their medical care. Women and their families describe feeling abandoned, anxious and panicked about making the necessary logistical and financial arrangements. Ava, who travelled to England for an abortion after receiving a diagnosis of fatal foetal impairment, recalls:

*"It took a couple of days. I rang on the Friday and they said they would come back with an appointment; they rang on the Monday and said can you come on Thursday. And then in the midst of all this pain and grief you have to scramble around to get money and flights and childcare and organize yourself, whereas it should be a simple trip down to the hospital. That is worst point, when you are in so much pain, is trying to organize it, and you have to organize it yourself, you know the hospital won't do it for you."*¹⁹³

Women and their partners who spoke to Amnesty International expressed the feeling that being forced to travel affected their ability to fully grieve and to come to terms with their diagnosis. For example, Emma Kitson remembers her experience of having to travel at such an emotional time:

"[I]f you were going to hospital in Ireland to have a termination, you could cry your eyes out in the car on the way there, you could deal with all of your emotions. While I

¹⁸⁹ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

¹⁹⁰ Kitty Holland, 'Concern voiced over UK hospital restrictions', *The Irish Times*, 17 April 2014, available at www.irishtimes.com/news/social-affairs/concern-voiced-over-uk-hospital-restrictions-1.1764419?mode=print&ot=example.AjaxPageLayout.ot; Interview with Dr. Rhona Mahony, Master of the National Maternity Hospital, 30 January 2015.

¹⁹¹ Kitty Holland, 'Concern voiced over UK hospital restrictions', *The Irish Times*, 17 April 2014.

¹⁹² Interview with Amanda, Administrative Co-ordinator and Counsellor, Merseyside Clinic, BPAS, 14 October 2014.

¹⁹³ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

was sitting on a plane full with people, and I was in an airport full of people, I couldn't really cry my eyes out and deal with the emotions I was feeling because I felt like I shouldn't... be crying and people would be looking at me."¹⁹⁴

7.2.1 NO SUPPORT UPON RETURN

The need to travel abroad for medical care means that women and their partners do not have the support systems around them that they would normally have. Grainne remembers waiting for her flight back to Ireland after the procedure:

*"As we had nowhere else to go, we sat in a Costa coffee drinking a coffee and eating a Panini after losing our baby. When all I wanted to be was at home in my own bed, with my mum giving me a hug, with my family around me and there I was sitting in another country looking like a wreck".*¹⁹⁵

Many women also spoke of the impact of travel on their continuity of care, creating a gap in their medical record at home and implications for their ability to receive appropriate post-abortion care. Women and their partners also underscored how travel abroad impacts their ability to grieve and be supported in mourning their loss.

The lack of a complete medical record at home requires women to relive the trauma of their experience, even as they may be trying to obtain the psychological support they need. Lily explains,

"A week after I came home I was in touch with the IFPA [Irish Family Planning Association] and went to see one of their counsellors who was amazing. I said, 'last week we lost our little boy' and I was sobbing and I had to give her the back story... there was no continuity of care, if I had it all [confirmation of the diagnosis of fatal foetal impairment and the termination] in Ireland she could have had my file but I had to tell her my story from the start."¹⁹⁶

Women and their partners emphasized the lack of counselling and support upon their return. Claire explains, "It's very much left up to you to find what you need. Nobody's going to come and say to you 'are you OK, do you need help?' Unfortunately the tendency here is to just bury it. Government just washes its hands and you're left to pick up the pieces of your life."¹⁹⁷ Keith recalls the period following his and his wife's return to Ireland after the abortion and the difficulty in resuming regular social interactions: "No one tells you what to say. There is nothing to say. I didn't answer my phone for three or four weeks, I couldn't. It is stressful."¹⁹⁸

Ava told of how she had to find a support group on her own as she received no information or referrals from her hospital in Ireland. In contrast, when Ava had a subsequent miscarriage,

¹⁹⁴ Interview with Emma Kitson, 8 December 2014.

¹⁹⁵ Interview with Grainne, 21 October 2014.

¹⁹⁶ Interview with Lily [her name has been changed], 2 October 2014.

¹⁹⁷ Interview with Claire, 16 October 2014.

¹⁹⁸ Interview with Keith and Rebecca Coady, 28 September 2014.

the hospital “gave me a book on miscarriage and that was fine, but they knew that the bigger deal was [the fatal foetal impairment pregnancy and subsequent abortion] and that was more upsetting and they still didn't offer any support or tell me about the support group because it isn't spoken about.”¹⁹⁹

Travelling abroad for an abortion also denies women and their families the ability to mourn their loss, in a way that is meaningful to them. Families appear to be given varying information about whether it is possible to bring the remains back to Ireland. Some are told they cannot; others are given the option of having the ashes couriered to them in Ireland.

Gerry told Amnesty International:

“Joshua's remains arrived during the day; the estate was empty as people were at work. It was a big jiffy envelope and didn't dawn on me what it was. Gaye could see the delivery van and had figured it out and Gaye broke down and I was trying to be normal for the delivery man. I just held the envelope that contained our son's remains... that was our funeral... a fucking envelope handed over the door... If we had continued in our hospital, we could have been under the same care, our families could have seen him, we could have had a wake for him, he could have had a funeral. We felt alone. There was no one to talk to, no one understood.”²⁰⁰

7.2.2 CHOICES AROUND SEVERE FOETAL IMPAIRMENT

Reforming the PLDPA to narrowly address fatal foetal impairment, however, results in the law interfering with clinical and personal decisions that are not always so black and white. Determining what is best for a woman, her family and her pregnancy is a personal decision, which only a pregnant woman can make. Dr. Sam Coulter-Smith, Master of Rotunda Hospital, underscores: “As a clinician, you have look at the best interests of the woman and respect her choices.”²⁰¹

LAOISE'S MOTHER'S EXPERIENCE²⁰²

“In February 2015 I wrote in *The Irish Times* regarding my experience of terminating a much wanted pregnancy due to a severe foetal abnormality. The following is a brief account of that experience.

Our baby, Laoise, due to a genetic mutation, had a number of very serious abnormalities. There was a

¹⁹⁹ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

²⁰⁰ Interview with Gerry and Gaye Edwards, 27 September 2014.

²⁰¹ Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

²⁰² This experience of undergoing an abortion was relayed to us by Laoise's mother in an interview on 19 November 2014 and also sent to us, afterwards, in writing. This testimony is a verbatim copy of her written testimony, as submitted to Amnesty International. Her full story can be found in this article, published in *The Irish Times*: ‘Severe foetal abnormality: “Her short life was a burst of sunshine”’, *The Irish Times* (27 February 2015), available at www.irishtimes.com/life-and-style/people/severe-foetal-abnormality-her-short-life-was-a-burst-of-sunshine-1.2113963

possibility that these abnormalities, though severe, were not necessarily fatal. We felt however that due to the severity and combination of her health issues that she would have an extremely poor quality of life if she lived. We did not want her to have to endure a prolonged death and we struggled to see how her life could be a happy one if she survived. In addition we knew that the medical intervention that would have been needed to keep her alive would have caused her substantial physical pain over a long period.

We travelled to France (my husband being French) to seek a further diagnosis once our baby's health problems were detected in Ireland. We desperately wanted our baby to live and we desperately wanted to care for her. However, following a more complete diagnosis in France, we reached a realization that letting our baby go gently and peacefully was the most loving thing we could do for her. After our baby died we learned that had she been born alive we would have been strongly advised to consider declining life-saving surgeries (this would have been the case in both Ireland and France).

The doctors overseeing our baby's care (in a maternity and paediatric hospital) unanimously supported our decision. The staff who accompanied us through our baby's death and birth in that hospital made the experience very dignified and serene. Our daughter fell asleep in the comfort of my womb and died peacefully.

In our grief in France we were supported by sympathetic, understanding staff. On our return to Ireland the maternity staff here gave us tremendous support that we valued enormously. This contrasted with the varied support and inconsistent information we received prior to travelling abroad with one obstetrician advising that late term abortion was not possible in any country.

The process of obtaining and considering a diagnosis in France, our baby's death and birth, and our baby's funeral necessitated being away from home and from our two other children for over two and a half weeks. Over a two day period, before I left Ireland, I had to break the news to my four- and six-year-old that their baby sister was very sick, I had to prepare them for the possibility that she might die, and then, when they most needed our support, I had to leave them with their grandparents without even being able to tell them when I would be home.

Our baby was beautiful. She weighed 5lbs. and she had lots of dark chestnut hair. She bore a strong resemblance to both of her siblings. Our baby was loved and very much wanted from the moment I was aware of her existence. Now we cherish happy memories of when we were planning for her arrival. We will always love her."

8. CRIMINALIZATION OF ABORTION IN CASES OF RAPE

8.1 ABORTION BAN IS ANOTHER LAYER OF TRAUMA FOR RAPE SURVIVORS

“[T]here is something rather unique about the nature of rape that differentiates it in some important respects from other types of trauma. Evidently, the experience of being treated as less than a human being, being denied one’s subjectivity, crushes the rape victim’s sense of self and protective capacities in an unmatched manner.”

- Excerpts from an HSE report²⁰³

In the midst of coming to terms with the traumatic experience of rape, the HSE’s national rape guidelines note that girls and women must “make many, often overwhelming, decisions. These include how the experience is named, whether and how to tell family or friends, whether to report the crime and whether to allow for the collection of forensic evidence from their own bodies.”²⁰⁴

Those who become pregnant as a result of rape face another layer of overwhelming decision-making and planning. As Fiona Neary, the former Executive Director of the Rape Crisis Network Ireland (RCNI),²⁰⁵ noted: “Women respond in different ways to rape. Many girls and women respond by going numb, and almost pretend it never happened. Pregnancy is a physical reality that does not allow that retreat.”²⁰⁶

Clíona Saidléar, Acting Executive Director of the RCNI, relates: “The prohibition [on abortion] in Ireland makes it difficult, because there is no choice, and adds to the trauma. It shows a lack of compassion to survivors of rape.”²⁰⁷ Not all women will choose to have an abortion after becoming pregnant from rape; however, for those that decide this is the best option for them, the process of choosing to terminate a pregnancy from rape can be “an empowering experience, after an experience of complete disempowerment,” explains Fiona Neary.²⁰⁸

In 2002, a national government-funded study on sexual violence in Ireland, conducted by the Royal College of Surgeons in Ireland, found that 7.6% of girls and 7.4% of women in Ireland

²⁰³ Health Service Executive, *Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland*, 3rd Edition (2014) p. 115. [Hereinafter National Rape Guidelines].

²⁰⁴ National Rape Guidelines, p. 115.

²⁰⁵ RCNI is a network of 14 country-wide rape crisis centres that provide free advice, counselling and support for survivors of sexual violence in Ireland.

²⁰⁶ Fiona Neary, former Executive Director of the Rape Crisis Network of Ireland, ‘When rape results in pregnancy’, *Irish Examiner*, 12 January 2013, available at www.irishexaminer.com/ireland/when-rape-results-in-pregnancy-219386.html

²⁰⁷ Interview with Clíona Saidléar, Acting Executive Director, Rape Crisis Network Ireland, 10 March 2015.

²⁰⁸ Fiona Neary, former Executive Director of the Rape Crisis Network of Ireland, ‘When rape results in pregnancy’, *Irish Examiner*, 12 January 2013.

reported experiencing rape or attempted rape.²⁰⁹ In 2014, a Europe-wide survey on violence against women found that 5% of Irish women had experienced sexual violence by a non-partner since the age of 15, and 6% of Irish women had experienced sexual violence by an intimate partner since the age of 15.²¹⁰ These statistics are underestimates, as only a minority of those who experience sexual violence will report this fact to any authority.²¹¹ This reality also prevented Amnesty International from identifying survivors of sexual violence who were willing to speak about their experiences of pregnancy from rape and, in cases where they chose to terminate that pregnancy, of travelling abroad for an abortion.

Although not all survivors of sexual violence who become pregnant will choose to terminate their pregnancies, already disadvantaged women and girls are less likely to be in a position to make a choice. For example, Clóna Saidléar of the RCNI observed the following from clients who were pregnant from rape:

“Young people are more likely to become pregnant after rape because they are not likely to be on contraceptives already, they don't have the wherewithal or knowledge to get emergency contraception, nor the capacity and finances, and economic freedom to make an independent decision; there is the expensive cost of going to travel to have an abortion.”²¹²

In general, marginalized populations of women and girls are at greater risk of sexual violence. This includes minors,²¹³ women with disabilities,²¹⁴ Traveller women and other minorities²¹⁵ and asylum-seekers. These women and girls are also least likely to be able to terminate an unwanted pregnancy. (See section on Ireland “exporting” its human rights obligations for more on the challenges facing marginalized groups in this regard).

ASYLUM-SEEKERS AND SEXUAL VIOLENCE

A 2014 report by the RCNI revealed that 14% of the incidents of rape perpetrated against female refugees and

²⁰⁹ Royal College of Surgeons in Ireland, *The SAVI report: Sexual abuse and violence in Ireland* (2002) xxxv, available at <http://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1009&context=psycholrep>

²¹⁰ European Union Agency for Fundamental Rights, Survey data explorer: Violence against women survey, Ireland, available at <http://fra.europa.eu/DVS/DVT/vaw.php>; Violence against women: an EU-wide survey, Main results report, March 2014, available at <http://fra.europa.eu/en/publication/2014/vaw-survey-main-results>.

²¹¹ RCNI's 2013 statistics reveal that 64% of those who experienced sexual violence did *not* report the incident(s) to a formal authority (such as the HSE, Redress Board, education authority, church authority or asylum application process) or the police. See RCNI, *RCNI National Rape Crisis Statistics 2013*, (November 2014) p. 21, available at www.rcni.ie/wp-content/uploads/RCNI-National-Statistics-2013.pdf [hereinafter *RCNI National Rape Crisis Statistics 2013*].

²¹² Interview with Clóna Saidléar, Acting Executive Director, Rape Crisis Network Ireland, 10 March 2015.

²¹³ RCNI's 2013 statistics, for example, reveal that 62% per cent of female survivors were under the age of 18 at the time of the sexual violence. See *RCNI National Rape Crisis Statistics 2013*, p. 26. Of the girls who were aged 13-17 at the time of the violence, 65% had been raped. See *RCNI National Rape Crisis Statistics 2013* p. 14.

²¹⁴ RCNI, *Rape & Justice in Ireland: Handbook* (2010) p. 10, available at www.rcni.ie/wp-content/uploads/RAJHandbook.pdf; See also, RCNI, *Sexual Violence Against People with Disabilities* (2011) p. 9-10, available at www.rcni.ie/wp-content/uploads/SexualViolenceAgainstPeopleWithDisabilities2011.pdf

²¹⁵ National Rape Guidelines, p. 169.

asylum-seekers (whether before or after their arrival in Ireland) and disclosed to their rape crisis centres (RCCs) resulted in pregnancy.²¹⁶ The majority of these asylum-seekers attending RCCs had experienced rape, often accompanied by high levels of other violence, in their home countries.²¹⁷ However, some had experienced sexual violence since arriving in Ireland. RCNI's report makes clear that "the process of migration, asylum and refuge also increases vulnerability to sexual violence both in transit and in the destination state, suggesting that asylum-seekers may be survivors of sexual violence in their home country, in transit, in their host country or all three."²¹⁸

In Ireland, the government's system of Direct Provision accommodation, in which asylum-seekers are housed while awaiting a decision on their asylum application, are mixed gender and often overcrowded, with men and women living together in close quarters. Some centres have a significant gender imbalance, with women consisting of a very small minority. These circumstances can lead to instances of rape or sexual violence.²¹⁹

Women may be forced to endure this trauma and vulnerability for years: although Direct Provision accommodation centres were only intended to house individuals for a maximum of six months, 8.8% of asylum-seekers in 2012 had spent more than seven years in Direct Provision, and 59.3% more than three years.²²⁰ Ultimately, this system "suspends recovery" for traumatized asylum-seekers and reflects the state's failure to protect asylum-seekers from sexual violence.²²¹ UN and national human rights bodies and advocates have roundly criticized Ireland's Direct Provision system.²²²

8.2 LIMITED ACCESS TO INFORMATION FOR RAPE SURVIVORS

Women and girls who are pregnant from rape and seek pregnancy counselling may have information on abortion and abortion services abroad lawfully withheld from them. In addition, under the Regulation of Information Act, they may be subject to biased and

²¹⁶ RCNI, *Asylum-seekers and refugees surviving on hold: Sexual violence disclosed to Rape Crisis Centres* at 11 (2014), <http://www.rcni.ie/wp-content/uploads/RCNI-Asylum-Seekers-and-Refugees-Surviving-on-Hold.pdf> [hereinafter *Asylum-seekers and refugees surviving on hold*].

²¹⁷ RCNI *National Rape Crisis Statistics 2013* at 25, 27; *Asylum-seekers and refugees surviving on hold* at 18-19, 26.

²¹⁸ *Asylum-seekers and refugees surviving on hold* at 18, 26. See also UNHCR, *Sexual Violence against Refugees: Guidelines on Prevention and Response*, Geneva 1995, pgs. 5-6, <http://www.refworld.org/pdfid/3ae6b33e0.pdf>.

²¹⁹ As the RCNI explains in their 2014 report, "The mixing of people from different cultural and linguistic backgrounds, lack of personal space and privacy, experience of trauma, high levels of stress, economic vulnerability, lack of knowledge of laws and reporting procedures, fear of authorities and making personal disclosures to authority figures, create conditions in which asylum-seekers are vulnerable to sexual exploitation and assaults." *Asylum-seekers and refugees surviving on hold* at 23.

²²⁰ Reception and Integration Agency, *Annual Report 2012* (2012) at p. 12, <http://www.ria.gov.ie/en/RIA/RIA%20Annual%20Report%20%28A3%292012.pdf/Files/RIA%20Annual%20Report%20%28A3%292012.pdf>.

²²¹ *Asylum-seekers and refugees surviving on hold* at 24.

²²² *Id.* at 23 ("The Direct Provision System has been highly criticised by a number of sources including the Ombudsman (O'Reilly, 2013), the United Nations Committee on the Elimination of Racial Discrimination (CERD, 2011), human rights groups, and national organisations such as AkiDwa (2012) – the migrant women's organisation."); CERD Concluding Observations: Ireland, UN Doc. CERD/C/IRL/CO/3-4 (2011) para. 20; Geoffrey Shannon, Department of Children and Youth Affairs, Fifth Report of the Special Rapporteur on Child Protection (2012), <http://www.dcy.gov.ie/documents/publications/5RapporteurRepChildProtection.pdf>.

coercive counselling, further contributing to the trauma of their experience. (See section on Censorship and Silence).

Some women who become pregnant from rape may continue with their pregnancies. However, if a woman decides to terminate her pregnancy, and seeks out counselling services that offer information on her options for having an abortion abroad, she must first endure legally-mandated counselling on parenting and adoption. As Greg Straton of SPIRASI, an organization that supports survivors of torture, observed: "You've been brutally raped and someone's talking to you about parenting."²²³

8.3 TRAVEL: COMPOUNDING PSYCHOLOGICAL TRAUMA AND COMPLICATING ACCESS TO ACCOUNTABILITY

Forcing women who have been raped to travel abroad for abortion services compounds their experience of stress, secrecy and stigma. Fiona Neary elaborates on this trauma:

*"[T]he process of organising it, in secret and with all the added difficulty of going abroad, prolongs the trauma of the rape,[and is] a further humiliation, a further violence, a further taking over of the body, a further experience of having no control... Every experience of sexual violence is an experience of isolation. Being forced to travel abroad to access an abortion, sometimes alone, can deeply add to the feelings of isolation. Now you have two secrets to keep from everyone."*²²⁴

Forcing women who have been raped and are pregnant to travel abroad for abortion services also has serious repercussions for ensuring accountability of the perpetrator. The HSE's national guidelines on rape acknowledge that under-reporting of sexual crimes is of significant concern and that delays in reporting may make the collection of forensic evidence and DNA challenging.²²⁵ Donagh Stenson and Amanda of BPAS' Merseyside Clinic in Liverpool, England, have witnessed cases of forensic evidence collection. Amanda, counsellor at BPAS, explains: "We have had... a couple of rape victims come and the police have come with them from Ireland [in order to] take the products of conception back for DNA testing for the court case."²²⁶ However, this does not appear to be a systemized procedure, and it is not clear how many women in Ireland are subject to it. For those who do not, this is a significant lost opportunity to ensure accountability for this violent crime.

²²³ Interview with Greg Straton, Interim Director, SPIRASI, 29 September 2014.

²²⁴ Fiona Neary, former Executive Director of RCNI, 'When rape results in pregnancy', *Irish Examiner*, 12 January 2013.

²²⁵ National Rape Guidelines, p. 37.

²²⁶ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, and Amanda, Administrative Co-ordinator and Counsellor, BPAS, 14 October 2014.

8.4 RAPE AS GROUNDS FOR A LAWFUL ABORTION

Recent polls suggest that a clear majority of the Irish public is in favour of law reform to permit access to safe and legal abortion in Ireland for women who have been raped.²²⁷ However, a debate persists among the public as to how to determine whether a woman would qualify on those grounds and whether a formal reporting requirement, to prove the rape, would need to first be met.

Dr. Peter Boylan, a leading obstetrician/gynaecologist in Ireland, says “there is a discussion about how to believe women if we allow it on grounds of rape. There is a huge lack of trust of women. We believe patients when they come and tell us most things, why not believe her in the case of rape?”²²⁸

Cliona Saidléar of the RCNI notes that the entire debate on the conditions for accessing abortion on rape grounds is a reflection of an extremely restrictive legal framework. She says: “We should not be adding another layer of potential judgement and cross-examination on a survivor. The ideal situation is if women did not have to be re-traumatized in seeking abortion. And they could have their privacy respected. The violence should be decoupled from ensuring access to abortion.”²²⁹

DENIAL OF ABORTION ON GROUNDS OF RAPE: TORTURE AND OTHER ILL-TREATMENT

The UN Committee against Torture (CAT Committee) interprets and ensures compliance with the UN Convention against Torture, to which Ireland is a state party. The CAT Committee has recognized that where abortion is criminalized in cases of rape or incest, and women and girls who wish to terminate their pregnancies are denied access to the procedure, “the women concerned are constantly reminded of the violation committed against them, which causes serious traumatic stress and carries a risk of long-lasting psychological problems.”²³⁰ It results in “constant exposure to the violation ... and [carries] a risk of long-lasting psychological problems such as anxiety and depression.”²³¹

The CAT Committee, along with the UN Human Rights Committee, has recognized that denying a woman or girl access to an abortion when a pregnancy is a result of rape can be a form of torture or other ill-treatment.²³²

²²⁷ ‘Majority of voters want abortion law liberalised’, *The Irish Times*, 13 October 2014, available at www.irishtimes.com/news/social-affairs/majority-of-voters-want-abortion-law-liberalised-1.1961142 (68% wanted a national referendum on abortion to liberalize the law to permit abortion in cases of rape and fatal foetal impairment); MillwardBrown, *National Opinion Poll: September 2014*, published in the *Sunday Independent*, www.millwardbrown.com/docs/default-source/ireland-downloads/opinion-polls/sunday-independent-september-2014-poll.pdf?sfvrsn=2 (69% responded that abortion was acceptable in cases of rape).

²²⁸ Interview with Dr. Peter Boylan, obstetrician/gynaecologist, former Master and Clinical Director at the National Maternity Hospital, 2 March 2014.

²²⁹ Interview with Cliona Saidléar, Acting Executive Director, RCNI, 10 March 2015.

²³⁰ CAT Concluding Observations: Paraguay, UN Doc. CAT/C/PRY/CO/4-6 (2011) para. 22.

²³¹ CAT Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009) para. 16.

²³² See for example CAT: Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009); Concluding Observations: Paraguay, UN Doc. CAT/C/PRY/CO/4-6 (2011); *LMR v Argentina*, Human Rights Committee, 2007.

These Committees, as well as the UN CEDAW Committee and UN Committee on the Rights of the Child (which monitors state compliance with the Convention on the Rights of the Child), and the Committee on Economic, Social and Cultural Rights (which monitors state compliance with the Convention by the same name) have all called for access to safe abortion for women and girls who are pregnant as a result of rape.²³³ The Human Rights Committee has specifically expressed concern that Ireland's PLDPA criminalizes abortion in cases of rape and incest, underscoring the "severe mental suffering caused by the denial of abortion services to women" in these circumstances.²³⁴ Similarly, the Irish Human Rights Commission, citing to a number of international human rights decisions, has urged the Irish government to include a rape exception in its abortion law to ensure compliance with its human rights obligations.²³⁵

²³³ Human Rights Committee, *General Comment 28: Equality of rights between men and women*, para. 11 (2000); *L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011; See for example, CRC Concluding Observations: Argentina, UN Doc. CRC/C/ARG/CO/3-4 (2010) para. 59; CESCR Concluding Observations: Peru, UN Doc. E/C.12/PER/CO/2-4 (2012) para. 21; CESCR Concluding Observations: Kenya, UN Doc. E/C.12/KEN/CO/1 (2008) para. 33; HRC Concluding Observations: Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012) para. 20.

²³⁴ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

²³⁵ Irish Human Rights Commission, Observations on the Protection of Life During Pregnancy Bill 2013, para. 116, available at www.ihrec.ie/download/pdf/ihrc_observations_protection_of_life_in_pregnancy_bill_2013.pdf.

9. CENSORSHIP AND SILENCE: DENIAL OF INFORMATION ABOUT ABORTION

9.1 THE REGULATION OF INFORMATION ACT

Not only does the Irish state criminalize access to abortion services in Ireland and force women to travel abroad for a safe and legal abortion in most circumstances, it also heavily restricts information about abortion services abroad and bans information that constitutes “advocacy or promotion” of abortion. The underlying rationale for this censorship is the Eighth Amendment of the Constitution.

In a 1988 case, the Irish Supreme Court held that the provision of information by pregnancy counselling agencies about abortion services abroad was unconstitutional, as it violated the foetus' right to life under the Eighth Amendment.²³⁶ The case was brought by the counselling agencies to the European Court of Human Rights, which found that this prohibition on abortion information constituted a violation of the right to freedom of expression.²³⁷ Shortly after this decision, in 1992, a clear majority of the Irish public voted in favour of a constitutional amendment to protect the freedom to obtain or make available information about abortion services abroad.

Following this constitutional change, and in order to comply with the European Court's decision, Ireland's legislature passed the 1995 Regulation of Information Act. However, the law continues to strictly regulate the provision of information “likely to be required for a woman for the purpose of availing herself of services provided outside the State for the termination of pregnancies.”²³⁸ The Act limits the information that can be given in one-to-one counselling and made available to the general public. Violations of the Act's provisions can result in prosecution under the criminal law.

The combined effect of the Regulation of Information Act and the criminalization of abortion means that even basic information about abortion and the abortion procedure may not be provided to a woman either by her doctor or in a counselling session. As discussed above, women with foetal impairment pregnancies reported that their doctors failed to provide them with critical information on the status of their health and the health of their pregnancy, including by not providing a medical opinion on a diagnosis or prognosis and evaluation of

²³⁶ *Society for the Protection of Unborn Children (Ireland) Ltd v. Open Door Counselling Ltd and Dublin Well Woman Centre Ltd* (1988) Irish Reports 618.

²³⁷ *Open Door and Dublin Well Woman v. Ireland* (App. No. 14234/88; 14235/88) ECHR 68 (1992).

²³⁸ Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995, §2(a) (hereinafter Regulation of Information Act).

treatment options, or on where and how to obtain treatment. For women who chose to have an abortion, some reported that they were not provided full information on what to expect when undergoing the procedure. This is in direct conflict with legal and ethical principles that are fundamental to the doctor-patient relationship.

“CRISIS PREGNANCY COUNSELLING” IN IRELAND

In Ireland, the term “crisis pregnancy” is used by the state to refer to “a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her. This includes women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances.”²³⁹ According to national statistics from 2010 published by the government’s Crisis Pregnancy Programme, 35% of women who have been pregnant reported experiencing a “crisis pregnancy.” The mean age at which the “crisis pregnancy” occurred for women was 23.²⁴⁰

Pregnancy counselling services in Ireland operate under the auspices of the Crisis Pregnancy Programme (formerly Agency), or CPP. The CPP was established by the Irish government in 2001 to create and implement a national strategy to reduce the number of “crisis pregnancies” in Ireland – specifically, to reduce the number of women “who opt for abortion by offering services and supports which make other options more attractive.”²⁴¹ The CPP is housed within the HSE, the state’s health service administrative body, and provides funding, training and information resources to medical, counselling and pregnancy support services, including the Irish Family Planning Association (IFPA) and The Well Woman Centre.

9.2 RESTRICTIONS ON PREGNANCY COUNSELLING SERVICES AND DOCTOR-PATIENT COUNSELLING UNDER THE REGULATION OF INFORMATION ACT

Under the Regulation of Information Act, doctors, pregnancy counsellors, and pregnancy-related advice centres and agencies are prohibited from giving a pregnant woman any information that may “advocate or promote” abortion.²⁴² The Act does not define what constitutes “advocacy or promotion” of abortion, leading to confusion among doctors and counsellors as to what information they can provide and in what form. However, under the Act, they are permitted to advocate *against* abortion.

In addition, any information given to a woman on abortion services abroad – such as the contact information for a clinic abroad that provides abortions – may only be provided where a woman first requests it and it must be accompanied by information on “all the courses of action that are open to her.”²⁴³ This would require discussions around adoption and parenting, even in situations where this may be inappropriate, such as fatal foetal

²³⁹ See www.positiveoptions.ie/unplanned-pregnancy/what-is-a-crisis-pregnancy/. See also, Crisis Pregnancy Programme Report No. 24, *Irish Contraception and Crisis Pregnancy Study 2010* (2012) p. 23.

²⁴⁰ Crisis Pregnancy Programme Report No. 24, *Irish Contraception and Crisis Pregnancy Study 2010* (2012) p. 90.

²⁴¹ HSE *Crisis Pregnancy Programme 2013: Annual report*, p. 5, available at www.crisispregnancy.ie/wp-content/uploads/2014/10/Annual-Report-2013.pdf

²⁴² Regulation of Information Act, §5.

²⁴³ Regulation of Information Act, §5.

impairments.²⁴⁴

In passing this legislation, the government understood it as constitutionally necessary in light of the Eighth Amendment's requirement to defend, "as far as practicable," the foetus' right to life. As such, it did not hide the fact that the Act's goal is to privilege anti-abortion counselling. As the Minister of Health explained in his presentation of the Bill before Parliament, prior to its enactment into law:

*"The Bill does not preclude a doctor or agency, in the context of giving Act information and information on the other available options, from encouraging the woman concerned not to have an abortion. Thus, while the Bill permits 'non-directive' counselling, it does not impose an obligation on doctors or agencies to provide this; they are free to provide counselling either in a non-directive manner or in a manner which is directive away from, but not towards, the option of abortion."*²⁴⁵

Further, when providing abortion information, counsellors and doctors must be "truthful and objective" and "fully inform the woman" of all her options without "any advocacy or promotion of" abortion.²⁴⁶ Notably, doctors or counsellors that do not provide any information on abortion are not subject to the law's conditions to provide "truthful and objective" information that will "fully inform" a woman of all of her options.²⁴⁷

If a woman chooses to travel for an abortion, health care providers and counsellors are prohibited from making "an appointment or any other arrangement" on her behalf with an abortion provider abroad.²⁴⁸ This means, among other things, that they cannot make a referral. This can have serious implications for women's health; the World Health Organization is clear that "well-functioning referral systems are essential for the provision of safe abortion care. Timely referrals to appropriate facilities reduce delays in seeking care, enhance safety, and can mitigate the severity of abortion complications."²⁴⁹ Under the Regulation of Information Act, doctors and counsellors are only permitted to give a woman the names and addresses of abortion services abroad, and then, only if she asks for this information, and to provide her with her medical records.²⁵⁰

If a health care provider or counsellor violates any of the Act's provisions, they face a criminal

²⁴⁴ See Amnesty International interviews with health care providers in Ireland; Submission by Doctors for Choice, Ireland to the Human Rights Committee for Ireland's review under the ICCPR, (12 June 2014).

²⁴⁵ Transcript from the Regulation of Information (Services Outside the State for Termination of Pregnancies) Bill, 1995: Second Stage reading before the Oireachtas, available at <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/seanad1995031300015?opendocument>.

²⁴⁶ Regulation of Information Act, §5(b)(iii).

²⁴⁷ Transcript from the Regulation of Information (Services Outside the State for Termination of Pregnancies) Bill, 1995: Second Stage reading before the Oireachtas. (Minister of Health, in presenting the Bill, states: "pregnancy counselling which does not include Act information is not restricted by the Bill.") See also Citizens Information board, *Abortion information – the law*, available at www.citizensinformation.ie/en/health/women_s_health/abortion_information_the_law.html#rules

²⁴⁸ Regulation of Information Act, §8(1).

²⁴⁹ WHO, *Safe abortion*, p. 67.

²⁵⁰ Regulation of Information Act, §8.

conviction and a fine of up to €4,000.²⁵¹ A judge may issue a warrant to police authorizing the search of counselling or health care premises if violations of the Act are suspected.²⁵²

9.3 IMPACT OF RESTRICTIONS ON WOMEN, DOCTORS, AND THE DOCTOR-PATIENT RELATIONSHIP

“The [Regulation of] Information Act is double speak. I can talk through options but I can't advocate? We are barred from providing full disclosure on all the available information on the procedure. I can't think of another regulation that limits providing information on a medical procedure or banning referral.”

- Dr. Mark Murphy, GP²⁵³

The Regulation of Information Act is a complex, unclear and confusing piece of legislation. The terms used are vague and undefined; there is no clear distinction made between information provision that is criminalized versus what is legal. Doctors and counsellors are understandably unsure of what they are permitted to say to patients, frustrating their ability to provide comprehensive, quality care to women and threatening the doctor-patient relationship. Women with whom Amnesty International spoke are angered by the numerous barriers they face to obtaining information about their health and about abortion services abroad. There is no other medical procedure in Ireland that Amnesty International is aware of where information about the service and how to obtain care is restricted in this way by criminal law.

9.4 DENIED CRITICAL HEALTH INFORMATION AND REFERRALS DUE TO IRELAND'S REGULATION OF INFORMATION ACT

Women consistently relayed to Amnesty International their frustrations with the lack of information about their health and pregnancy, particularly in the foetal impairment context. Grainne recalls being given limited information on the diagnosis of foetal impairment, and no information on the implications that her pregnancy might therefore have for her own health:

“I felt we got no support. It was assumed we understood what a fatal foetal anomaly was. It was assumed we understood what anencephaly was. ... I just felt that there was nothing there for [me]. Washing your hands, ‘bye now’, and the door is closed. And I remember walking out of the hospital holding my husband's hand, thinking, ‘is this it?’ We've just been told ‘your baby's going to die whatever circumstances that it may be, and we can't help you here if you want to get medical treatment. And there's the name of the clinic. See you later.’ That's basically what they do to you here.”²⁵⁴

Grainne ultimately terminated her pregnancy in England, rather than continuing with the

²⁵¹ Regulation of Information Act, §10; Fines Act 2010.

²⁵² Regulation of Information Act, §9.

²⁵³ Interview with Dr. Mark Murphy, General Practitioner, Doctors for Choice, 25 February 2015.

²⁵⁴ Interview with Grainne, 21 October 2014.

pregnancy and delivering in Ireland. It was only upon Grainne's return to her doctor in Ireland for a follow-up visit that the doctor explained the possible health complications of carrying an anencephalic foetus to viability and delivering – and told her she thought Grainne had done the right thing for her health by terminating the pregnancy.²⁵⁵ Grainne told Amnesty International:

"I was scared to think that... she can't say anything that would be seen to influence [my] decision... Medical professionals, most of them that I encountered in Ireland, they feel their hands are tied... to even to tell you if this is the medically correct thing to do."²⁵⁶

Ava had a similar experience, after being told that the chances of her baby surviving were "non-existent". She said her doctor "was very clear that there was nothing that could be done in Ireland but that there are other options. We told him that we were looking into them and he didn't obviously come out and say it but you could tell he thought that it was the safer, better option." In contrast, Ava said: "When we did get over to [the hospital in] England it was a complete shock... their system was completely the opposite way. They were very outspoken by saying this is by far the best thing medically for you, that it is ridiculous in Ireland that you don't have the option".²⁵⁷

Ava's husband, Ciaran, continued: "[E]veryone knew medically what the best thing to do was, but there is some stupid obstacle of the government in the way of doing what is right." After the initial diagnosis, they went home and looked at the law but "Ava would have to be on her death bed before anything would be done" said Ciaran.²⁵⁸

Doctors' silence on abortion services appears to extend to even to the provision of information on support groups. For example, Irish women whose pregnancies had fatal or severe foetal impairment told Amnesty International that they were not given information on Leanbh Mo Chroí, an Irish support group for women who have faced this situation. One such woman, who found out about Leanbh Mo Chroí "through Google, just by chance", suggested that this might be because of the law's restrictions on advocacy or promotion of abortion. She explains: "Leanbh Mo Chroí is run by TFMR [Terminations for Medical Reasons Ireland], a campaign group which seeks legislative change to allow termination for medical reasons, and maybe that stops health care professionals from making people aware of them, which I think is a pity."²⁵⁹

By favouring directing women away from the option of abortion, the Regulation of Information

²⁵⁵ A US Medical Task Force on Anencephaly concluded that "[p]regnancy with a fetus with anencephaly carries an increased risk for the [pregnant woman]... Labor and delivery are commonly associated with an unstable fetal lie, dysfunctional labor... and postpartum hemorrhage." See The Medical Task Force on Anencephaly, 'The infant with anencephaly', *New England Journal of Medicine* Vol.322 Issue 10 (1990) pp. 669-674. In addition, in *K.L. v. Peru*, a case decided by the Human Rights Committee and discussed above, the Committee noted that K.L.'s anencephalic pregnancy "exposed her to a life-threatening risk" and that the denial of an abortion in these circumstances "may have endangered [K.L.'s] life." See *KL v. Peru*, para. 6.2.

²⁵⁶ Interview with Grainne, 21 October 2014.

²⁵⁷ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

²⁵⁸ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

²⁵⁹ Interview with Laoise's mother, 19 November 2014.

Act leads to women receiving inconsistent and sometimes misleading information about their options. One woman, grappling with the devastating diagnosis of a severe foetal impairment, remembers: "We were given misinformation about the possibility of having a termination in another country and incorrectly told [by a doctor] that I was too far along in my pregnancy for an abortion. We were shocked that we were given false information. The legal system in Ireland, I feel, allows for personal opinions to wrongly influence or limit advice given to patients."²⁶⁰

Orla, whose 15-year-old daughter was faced with an unwanted pregnancy in 2015, was given no information about her options, and misinformation about Ireland's abortion law. She remembers:

"The GP's attitude was 'I am so sorry, did you not know she was sexually active? I've seen this before.' That was it. My daughter was crying. It was all 'there, there, there'; they provided no information. He did not offer crisis pregnancy counselling... I took it upon myself to call the IFPA."

Orla was concerned that her daughter, already bullied at school, might be at risk of suicide if she did not obtain an abortion. She asked her daughter's GP for a letter stating that she qualified for an abortion under the PLDPA, which had been in effect for over a year. "He said no, that legislation is not brought in yet. I told him that the new law was in place. He said that he cannot help me with that."²⁶¹

Pregnancy counsellors also spoke of women's reactions to the restrictions on information provision. Evelyn Geraghty, Director of Counselling at the IFPA, explains that when women call their helpline for pregnancy support, they are often taken aback by the fact that they need to make an in-person appointment to receive services.²⁶² "What we hear is disbelief. 'What do you mean? I don't understand that.' It's anger and frustration."²⁶³

Helen Nela, Clinical Nurse Manager at the BPAS Merseyside Clinic in England, hears similar stories from women who have travelled and are upset by the lack of support and withholding of information. Where their GP is anti-choice, for example, women do not know where to turn for support. Helen Nela explains: "[T]hey say my GP doesn't want to know, is not interested and that's frustrating for them because they think the GP is there to help them. Where do they go if the GP isn't going to help them?... [GP's] have a duty really to provide her with the information to go elsewhere if they don't believe in that particular scenario [abortion] and that's what frustrates me a lot talking to the girls." Instead, Helen Nela explains, these women and girls obtain information through word-of-mouth.²⁶⁴

²⁶⁰ Interview with Laoise's mother, 19 November 2014.

²⁶¹ Interview with Orla [her name has been changed], 10 March 2015.

²⁶² Although pregnancy counsellors and women made reference to the fact that information on abortion services abroad must be provided in the context of a face-to-face, in-person counselling session, this is not explicitly stated in the Regulation of Information Act. The Crisis Pregnancy Programme, when asked about this by Amnesty International, was unable to identify the source of this practice, which is perceived by many as a legal requirement.

²⁶³ Interview with Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

²⁶⁴ Interview with Helen Nela, Clinical Nurse Manager, Merseyside Clinic, BPAS, 14 October 2014.

THE DENIAL AND MANIPULATION OF PREGNANCY-RELATED INFORMATION VIOLATES FUNDAMENTAL HUMAN RIGHTS

The European Court of Human Rights has recognized in two cases, *R.R. v. Poland* and *P. and S. v. Poland*, that deliberate withholding of abortion-related information amounted to a violation of the right to freedom from inhuman and degrading treatment (Article 3 of the European Convention on Human Rights). In making these determinations, the Court took into account the implications that the intentional denial and manipulation of information had on the applicants' dignity and the level of suffering resulting from such conduct.

In *R.R. v. Poland*, a woman was repeatedly denied access to a genetic prenatal examination after her doctor discovered foetal irregularities during a sonogram.²⁶⁵ In finding a violation of Article 3, the Court noted that "for weeks she was made to believe that she would undergo the necessary tests" and that doctors deliberately delayed access to these tests by sending her to "various doctors, clinics and hospitals far from her home... for no clear clinical purpose."²⁶⁶

P. and S. v. Poland concerned information and other barriers faced by a minor seeking a lawful abortion on grounds of rape. The Court found that the girl and her mother were "given misleading and contradictory information" and "did not receive appropriate and objective medical counselling... [with] due regard to their own views and wishes."²⁶⁷ In finding a violation of the right to be free from inhuman and degrading treatment, the Court pointed to the "pressure... exerted on her by the chief doctor who tried to impose her own views," the fact that the girl was "obliged to talk to a priest without being asked whether she in fact wished to see one," and that "considerable pressure was put on her and on her mother" by state institutions.²⁶⁸

9.5 IMPACT ON THE COUNSELLOR-CLIENT AND DOCTOR-PATIENT RELATIONSHIP

Niall Behan, CEO of the IFPA, is clear that the counsellor-client relationship is severely compromised by the Regulation of Information Act:

*"[T]here is a right to information in the Constitution, but the Act isn't rights-based. It treats 'Act information' as toxic or hazardous, and treats women as if they are incapable of making their own decisions and [as being] so susceptible to influence that criminal provisions are required to regulate the way information is given. IFPA counsellors see the client who opts for abortion as a woman who has made a rational decision based on her own particular circumstances and give her non-judgemental, nondirective support and information."*²⁶⁹

Linda Wilson Long, Head of Counselling at Dublin Well Woman, explains that quality counselling "is about upholding the autonomy of the client; it is their world, it is their journey. The law doesn't take that into account. The law dismisses me in my work; it doesn't

²⁶⁵ *R.R. v Poland* (Application no. 27617/04) (2011) paras. 144-147.

²⁶⁶ *R.R. v Poland* (Application no. 27617/04) (2011), para. 153.

²⁶⁷ *P. and S. v. Poland* (App. No. 5735/08) (2012), para. 108.

²⁶⁸ *P. and S. v. Poland* (App. No. 5735/08) (2012), para. 163.

²⁶⁹ Interview with Niall Behan, CEO, IFPA, 3 October 2014.

matter if you are there for your client, you have to do it this way.”²⁷⁰

Doctors also feel the effects of the Regulation of Information Act on their ability to provide professional standards of quality, ethical care. Dr. Mark Murphy, a GP, says: “If I cannot provide full and complete information on the abortion procedure, it’s tantamount to professional misconduct. The Regulation of Information Act restricts the totality of what I can say and I should be able to refer women, but I can’t under the Act. This compromises the doctor-patient relationship.”²⁷¹

Doctors have also expressed their frustration with the impact of the Regulation of Information Act on their ability to provide appropriate care and referrals to women and girls with foetal impairment pregnancies. Referrals, which are supposed to connect patients with providers that best meet their needs and ensure some degree of continuity of care, are particularly important in cases of foetal impairment, which may require more complex, specialist care.

Dr. Sam Coulter-Smith, Master of Rotunda Hospital, notes: “We have links with hospitals in the UK. We can’t refer the women for a termination but can refer to foetal medicine clinics [abroad] for another test. It’s a crazy situation. It makes no sense to send people to another jurisdiction for more tests... The situation is very frustrating and care should be given here.”²⁷²

The Act’s severe restrictions on information provision, and its overt support for directive counselling against abortion, contributes to the overall stigma around abortion in Ireland. Evelyn Geraghty of the IFPA explains: “Health service providers tend to be very unsure about the requirements of the Regulation of Information Act, so if a woman mentions abortion, they don’t want to deal with it. And that is very stigmatizing to women. So in our services we’re very careful not to reinforce stigma, and to use language that challenges stigma.”²⁷³

9.5.1 SMEAR CAMPAIGNS

In 2012, a “team of women, some from the pro-life movement”²⁷⁴ in Ireland, conducted an undercover “operation”,²⁷⁵ in which women posed as clients with unwanted pregnancies and secretly recorded counselling sessions in 11 sites across the country. The women’s goal was to show that the pregnancy counselling agencies were failing to comply with the Regulation of Information Act. They provided the recordings to the Irish Independent, Ireland’s best-

²⁷⁰ Interview with Linda Wilson Long, Head of Counselling, Dublin Well Woman, 2 October 2014.

²⁷¹ Interview with Dr. Mark Murphy, General Practitioner, Doctors for Choice, 25 February 2015.

²⁷² Interview with Dr. Sam Coulter-Smith, Master of The Rotunda Hospital, 29 January 2015.

²⁷³ Interview with Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

²⁷⁴ Gemma O’Doherty, ‘Revealed: the abortion advice that could put lives at risk’, *The Irish Independent* (27 October 2012), available at www.independent.ie/irish-news/revealed-the-abortion-advice-that-could-put-lives-at-risk-28824188.html

²⁷⁵ Interview with Linda Wilson Long, Head of Counselling, and Alison Begas, Chief Executive, Dublin Well Woman, 2 October 2014; Interview with Niall Behan, CEO, Maeve Taylor, Senior Policy and Advocacy Adviser, Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014; Interview with Helen Deely, Head, HSE Crisis Pregnancy Programme, 29 January 2015; Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

selling daily newspaper, which published a piece alleging “malpractice” and “illegal” information provision.²⁷⁶ This smear campaign came at a time when the legislature seemed poised to implement the *A, B and C* decision of the European Court of Human Rights and enact abortion legislation.

In response to the news article, the HSE launched an investigation into all HSE-funded pregnancy counselling services in Ireland, with a particular focus on those against which the allegations were made.²⁷⁷ Dublin Well Woman and the IFPA were among the organizations subject to an “in-depth review” and audit by the HSE, to determine, in part, whether they were acting in “accordance with relevant legislation”, namely the Regulation of Information Act.²⁷⁸

During six months of investigations, counselling agencies were required, among other things, to submit to an audit of all their protocols, supply written responses to a number of questions about policies and practice, provide evidence demonstrating adherence to protocols, and undergo site visits by the investigating team, which included in-person interviews and on-site document reviews. After six months of investigations the HSE's audit uncovered no legal violations.²⁷⁹ In addition, a police investigation into “alleged malpractice” concluded with the Director of Public Prosecutions deciding “that there will be no prosecution arising from the case.”²⁸⁰ Niall Behan, CEO of the IFPA explained, “The Gardaí [police] confirmed to each pregnancy counselling agency and to the individual counsellors, that the investigation had found “no wrongdoing whatsoever” on the part of any counsellor.”²⁸¹

Although the counselling organizations were acting lawfully, the experience of being secretly recorded by anti-choice groups was deeply upsetting to pregnancy counsellors and had varying impacts on pregnancy counselling services. Already severely constrained by the dictates of the Regulation of Information Act and its strict limits on what counsellors can say, some pregnancy counsellors became guarded and inhibited, especially in the immediate aftermath of these events.

Linda Wilson Long of Dublin Well Woman, explains:

“Having been taped, that has created caution that wasn't there before; all of us became slightly more careful and lost our spontaneity... We say ‘I am not legally allowed to tell you’, we all work really tightly under those guidelines. We don't ring

²⁷⁶ Gemma O'Doherty, ‘Revealed: the abortion advice that could put lives at risk’, *The Irish Independent* (27 October 2012).

²⁷⁷ Health Service Executive, *Audit of crisis pregnancy counselling services provided by the HSE and HSE funded agencies following alleged breaches of crisis pregnancy counselling practice* (December 2014) pp. 10-13, available at www.hse.ie/eng/about/Who/healthwellbeing/Contact_Health_Promotion/cpc/cppauditreport.pdf [hereinafter *Audit of crisis pregnancy counselling services*].

²⁷⁸ *Audit of crisis pregnancy counselling services* pp. 23, 10-13. Interview with Linda Wilson Long, Head of Counselling, and Alison Begas, Chief Executive, Dublin Well Woman, 2 October 2014; Interview with Niall Behan, CEO, Maeve Taylor, Senior Policy and Advocacy Adviser, Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

²⁷⁹ *Audit of crisis pregnancy counselling services* pp. 6, 12-13.

²⁸⁰ *Audit of crisis pregnancy counselling services* p. 1.

²⁸¹ Interview with Niall Behan, CEO, IFPA, 3 October 2014.

[abortion services on behalf of women]... we don't have access to money [to help women travel]; we might be able to suggest a website if they want to read the information, but that is it. We stay very clearly within the right to travel... So in one way you are taking the client in and giving them the best you... can and in another breath you are pushing them away. That is what it is like."²⁸²

The nature of counselling services requires a degree of trust, intimacy and respect for confidentiality between a client and counsellor. This made the undercover operation particularly distressing for individual counsellors. Says Linda Wilson Long, "they have attacked the essence of what this particular kind of counselling is about."²⁸³

Niall Behan of the IFPA also spoke to Amnesty International of the impact of the HSE's decision to audit their services and protocols after the smear campaign. Although nothing was found to suggest that IFPA had violated the law, IFPA counsellors were concerned about further entrapment attempts. Niall Behan states:

"The IFPA had no problem complying with the investigations and providing all the documentation requested. Our counsellors operate within the law, and this has been confirmed by the HSE and the Gardaí. But it's absurd that their professional practice is subject in the first place to this offensive and misogynistic [Information] Act. It was a very distressing time for our counsellors. But these attacks strengthen our resolve and our commitment to women who need our services. In the end, I'd say what the smear campaign achieved was to highlight two things: the lengths that anti-choice groups will go to attempt to discredit health service providers that promote women's right to reproductive health services, and the need to repeal the [Regulation of] Information Act."²⁸⁴

UN SPECIAL RAPPORTEUR ON HUMAN RIGHTS DEFENDERS CALLS FOR PROTECTION OF WOMEN, PREGNANCY COUNSELLORS AND HEALTH CARE PROVIDERS IN IRELAND

During her November 2012 visit to Ireland, the UN Special Rapporteur on human rights defenders expressed concern "at reports and evidence received during her visit indicating the existence of a smear campaign and stigmatization of defenders and activists working on abortion issues." She stressed that "the stigmatization of defenders may lead to the selective enforcement of existing laws and regulations, reinforce existing stigma and culminate in the criminalization of their legitimate activities."²⁸⁵ She further recommended that the Irish government "[r]ecognize publically the work of defenders and practitioners who work for the enjoyment of the right to health of women, including sexual and reproductive rights, and protect them effectively from harassment or intimidation of all kinds, including smear campaigns".²⁸⁶

²⁸² Interview with Linda Wilson Long, Head of Counselling, Dublin Well Woman, 2 October 2014.

²⁸³ Interview with Linda Wilson Long, Head of Counselling, Dublin Well Woman, 2 October 2014.

²⁸⁴ Interview with Niall Behan, CEO, IFPA, 3 October 2014.

²⁸⁵ UN Special Rapporteur on human rights defenders, *Report of the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya*, UN Doc. A/HRC/22/47/Add.3 (2013) para. 87.

²⁸⁶ UN Special Rapporteur on human rights defenders, *Report of the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya*, UN Doc. A/HRC/22/47/Add.3 (2013) para. 111(n).

9.6 RESTRICTIONS ON THE PROVISION OF INFORMATION ABOUT ABORTION SERVICES ABROAD TO THE GENERAL PUBLIC

In addition to restricting the information provided directly to a pregnant woman, the Regulation of Information Act also heavily censors public access to information on abortion services outside of Ireland. For example, the law criminalizes making information about abortion services abroad publicly available – whether “orally” at a publicly-accessible meeting, “in a book, newspaper, journal, magazine, leaflet or pamphlet, or any other document,” in a film, by radio or television or any other publicly-accessible publication – unless that information relates to specific abortion services or providers abroad and “does not advocate or promote” abortion.²⁸⁷ Further, the public display of this information, through public notices, billboards or advertisements, and the distribution of unsolicited publications, films or recordings containing such information, is prohibited.²⁸⁸ Any violations of these restrictions carry a criminal penalty and a fine of up to €4,000.²⁸⁹

The Regulation of Information Act also has impacts that are felt beyond Ireland's borders. BPAS, the British Pregnancy Advisory Service, has an Irish website where women can access information on the services they offer. Says Donagh Stenson, Associate Director of Marketing at BPAS:

“We've had to be very careful [not to breach advertising laws]... we're not allowed to advertise services in Ireland and we have had certain people, anti-choice, threaten us because our website is so easy to access. I'm having to look at all sorts of ways... so that we're not breaching any laws... We still suffer with getting information into the hands of Irish women.”²⁹⁰

INTERNATIONAL BODIES CONDEMN IRELAND'S INFORMATION RESTRICTIONS

In its 2014 recommendations to Ireland, the Human Rights Committee expressed concern about the Regulation of Information Act's “strict restrictions on the channels via which information on crisis pregnancy options may be provided to women and the imposition of criminal sanctions on health care providers who refer women to abortion services outside the State”.²⁹¹ The Committee noted that these information restrictions raise issues under Article 19, the right to freedom of expression, which includes the “freedom to seek, receive and impart information and ideas of all kinds”.²⁹² The Committee recommended that Ireland “mak[e] more information on crisis pregnancy options available through a variety of channels, and ensure that health care providers who provide information on safe abortion services abroad are not subject to criminal sanctions.”²⁹³

²⁸⁷ Regulation of Information Act, §3.

²⁸⁸ Regulation of Information Act, §4.

²⁸⁹ Regulation of Information Act, §10; Fines Act 2010.

²⁹⁰ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

²⁹¹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

²⁹² HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9; ICCPR, art. 19.

²⁹³ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

In the report of her 2012 visit to Ireland, the UN Special Rapporteur on human rights defenders noted that the Regulation of Information Act “can pose significant barriers for counsellors and potentially restrict women’s access to information on sexual and reproductive rights, particularly on access to the health services available abroad. Moreover, [it] 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.” She recommend that Ireland “[c]onsider reviewing certain provisions of the... Act to remove obstacles faced by reproductive health providers.”²⁹⁴

²⁹⁴ UN Special Rapporteur on human rights defenders, *Report of the Special Rapporteur on the situation of human rights defenders, Margaret Sekagya*, UN Doc. A/HRC/22/47/Add.3 (2013) paras. 86 and 111(m).

10. IRELAND “EXPORTING” ITS HUMAN RIGHTS OBLIGATIONS: WOMEN LEFT TO FIND THEIR OWN ALTERNATIVES OUTSIDE IRELAND’S HEALTH SYSTEM

“Everyone has to make the best decision for them and their family, but let’s acknowledge that it is happening instead of exporting the problem and thinking that it’s okay as long as the British hospitals keep accepting us and then saying that there is no abortion in Ireland.”

- Lily, who travelled to England in 2012 to terminate her pregnancy following a diagnosis of a fatal foetal impairment²⁹⁵

Ireland has gone to great lengths to restrict access to abortion within its borders. It has passed a constitutional amendment, granting equal rights to the foetus as to the pregnant woman, and has ensured that abortion remains criminalized on all but the narrowest of grounds. At the same time, Ireland’s courts have repeatedly affirmed a woman’s or girl’s freedom to travel abroad for an abortion and the public has passed a constitutional amendment, guaranteeing this as a fundamental freedom. The courts, legislature and general public thereby recognize that women need abortions and will procure them, regardless of the procedure’s legal status in Ireland.²⁹⁶ Dr. Peter Boylan notes: “Our Constitution is profoundly hypocritical. It protects women to go abroad for something that is outlawed here.”²⁹⁷

Without the “safety valve” of travel, and the close proximity of countries where abortion is legal on broader grounds, Ireland would likely have been faced with the high rates of mortality and morbidity from unsafe abortion that plague other countries with highly restrictive abortion laws.²⁹⁸ When women and girls are unable to travel to seek abortions, the consequences can be grave. Some may resort to unsafe, illegal abortion or to suicide. For women and girls who cannot travel – typically those from the most vulnerable groups, such as

²⁹⁵ Interview with Lily [her name has been changed], 2 October 2014.

²⁹⁶ WHO global estimates also confirm this, see World Health Organization, *Unsafe abortion incidence and mortality, Global and regional levels in 2008, and trends during 1995–2008*, (2011).

²⁹⁷ Interview with Dr. Peter Boylan, Obstetrician/Gynaecologist, former Master and Clinical Director at the National Maternity Hospital, 2 March 2014.

²⁹⁸ Researchers have consistently noted that countries with restrictive abortion laws have higher rates of mortality and morbidity from unsafe abortion; conversely, countries with more liberal abortion laws have seen their maternal mortality rates drop dramatically. David A. Grimes *et al*, ‘Unsafe abortion: the preventable pandemic’, *The Lancet* Vol. 368 No. 9550 (November 2006) p. 1913; Gilda Sedgh *et al*, ‘Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008’, *The Lancet* Vol. 379 No. 9816 (2012) pp. 635, 631. See also WHO, Safe Abortion.

women living in poverty, asylum-seekers, migrants, and those with serious health problems – the constitutional freedom to travel has little practical value.

Those that can, travel abroad for an abortion. Every year approximately 4,000 women and girls from Ireland travel to the UK, the Netherlands, Belgium, France and Spain, among other countries, for this medical service.²⁹⁹ They travel for a host of reasons: they are faced with fatal or severe foetal impairment pregnancies, are rape survivors, have health conditions, are struggling with economic or social challenges that don't make parenting an option, or choose not to continue with a pregnancy for personal reasons. What they share is the sense of exclusion from their health care system, the stigma of travelling for an abortion, and the burden of secrecy that often comes with it.³⁰⁰

The fact that thousands of women quietly travel abroad for services each year has allowed the government to abdicate any responsibility towards them. As one woman who travelled puts it – “out of sight, out of mind.”³⁰¹ Ireland has effectively exported its human rights obligations regarding access to safe and legal abortion, relying on other countries to provide the services that women and girls in Ireland are entitled to under human rights law and standards.

10.1 FORCED TO TRAVEL ABROAD FOR HEALTH CARE SERVICES

“[A] flight to the UK [or] a ferry is not preventing people from having abortions, so deal with it in your own country, have the backbone to accept that this is happening for better or for worse. Look after your own people.”

– Sean, who travelled to England with his wife, Clara, for an abortion in 2013, after they received a diagnosis of a fatal foetal impairment

Every day, between 10 and 12 women and girls living in Ireland travel to England³⁰² for an abortion. The majority of the women are aged between 20 and 34.³⁰³ Their reasons for

²⁹⁹ UK Department of Health, *Abortion statistics, England and Wales*, available at www.gov.uk/government/collections/abortion-statistics-for-england-and-wales (for statistics from 2011 to 2013); The UK Government, National Archives, <http://webarchive.nationalarchives.gov.uk/20130123231223/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm> (for statistics from 1971-2010). Amnesty International's research and interviews have also documented cases of women traveling from Ireland to Spain, France, the Netherlands and Belgium for abortions.

³⁰⁰ See Crisis Pregnancy Programme Report No. 24, *Irish Contraception and Crisis Pregnancy Study 2010* (2012) p. 105 (“approximately 1 in 4 women experiencing a crisis pregnancy that ended in abortion did not tell their sexual partner... there appears to be an increasing trend in the proportion of women not disclosing that they have had an abortion to friends and family.”)

³⁰¹ Interview with Emma Kitson, 8 December 2014.

³⁰² These statistics, based on data collected by the UK Department of Health Statistics and requested by Amnesty International, refer to women resident in Ireland who travelled to both England and Wales to access safe abortion services. These numbers do not include women who travel to Scotland, although Amnesty International is cognizant of the fact that some women do travel there for safe abortion services.

³⁰³ UK Department of Health, *Abortion statistics, England and Wales*, available at www.gov.uk/government/collections/abortion-statistics-for-england-and-wales (for statistics from 2011 to 2013); The UK Government, National Archives, <http://webarchive.nationalarchives.gov.uk/20130123231223/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm>

terminating their pregnancies vary; however, their reason for travelling is the same. They cannot access safe and legal abortion services in Ireland.

Overall, approximately 4,000 women and girls make this journey from Ireland to England every year; over 177,000 girls and women have done so since 1971.³⁰⁴ These figures, kept by the UK authorities, do not capture all the women in Ireland who travel abroad to procure an abortion. They do not include the women who give false names and addresses to clinics in England due to stigma or fear should their real identities become known, nor do they include the women who travel elsewhere, such as the Netherlands and Belgium, for abortion services.

Under Irish law, women have a constitutionally protected freedom to travel abroad to obtain an abortion. Far from facilitating this freedom, the Irish government has set up obstructions in the form of the Regulation of Information Act to make travelling for an abortion all the more challenging. In addition, there are logistical and financial barriers to travelling. Although many women are able to circumnavigate these obstacles and travel for an abortion, many others face barriers that are too difficult to surmount.

10.1.1 THE LOGISTICAL CHALLENGES OF TRAVELLING ABROAD

The logistics of travelling to another country for an abortion are complex, time consuming and challenging. Women often travel in secret, due to the stigma associated with the procedure, and without assistance from the health care system (see section above on Censorship and silence for a discussion of the challenges in accessing information on abortion services abroad and the criminalization of abortion referrals under Irish law). Women are also trying to organize their travel within a specific, inflexible time frame. If they travel too early or too late, they may not be treated.

Women and girls in Ireland must first identify a reputable clinic or hospital abroad and then try to book an appointment on a date that they are able to travel, and that meets their medical and financial restrictions. Once an appointment is made, the woman may then need to arrange for her medical records to be sent to the clinic or hospital abroad. Employed women, and their travel partners, must arrange to take time off work – clinics typically operate only on weekdays. Women with children need to arrange childcare. In order to enter the UK or another EU country they must have identification that shows their nationality, ideally a passport. Flights or ferries must be booked and, for some, accommodation reservations made. Driving or taking the train across the border to Northern Ireland is typically not an option, as Northern Ireland's abortion law is also restrictive, permitting abortion only on grounds of a risk to life and narrow health grounds.³⁰⁵

All of these logistical challenges associated with travel for medical care are felt most acutely by marginalized women and girls (see below). However, the need to make these arrangements disproportionately burdens a range of women and girls. For example: those in rural areas

[atistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm](#) (for statistics from 1971-2010).

³⁰⁴ For the most recent statistics from 2013, see

www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics_England_and_Wales_2013.pdf

³⁰⁵ Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services*, (Index: EUR 45/1057/2015), available at www.amnesty.org/en/documents/eur45/1057/2015/en/

whose travel itinerary is necessarily longer and more complicated; those in violent relationships who may face obstacles to their freedom of movement; girls trying to navigate all this without parental support; those with mental or physical health concerns or who have only recently survived an experience of sexual violence; women and girls living on low incomes who cannot afford the costs.

10.2 LACK OF REFERRALS AND SUPPORT FROM DOCTORS AND THE IMPACT ON ACCESS TO SERVICES

Because some women and girls are unable to receive appropriate help or advice from their health care provider in Ireland, they may not realize that they cannot undergo an abortion until they arrive in the UK. In addition, women with serious health conditions may require “specialist placements”, making scheduling an appointment even more difficult.

Kally, the Unit Manager of the BPAS Merseyside Clinic in Liverpool, England recalls a woman who recently came to their clinic for an appointment but who could not receive a termination because she had travelled too early in her pregnancy and the clinic could not rule out the possibility of an ectopic pregnancy. Kally recounts:

“[Y]ou know to see someone so distressed, you know, and literally the tears were dropping off her face and... there is nothing you can do in that situation... She had done everything right. She'd accessed the service, she had booked it, you know, and arranged the flights and it's just the way she got here wasn't suitable. That frustrates me that she has to go all the way back to [Cork] and she is still pregnant, she's got no support and she was covert, she didn't tell anybody she was coming and so that makes me feel... quite angry and quite distraught.”³⁰⁶

Setting up an appointment is all the more challenging for women and girls with serious health conditions, as they have a narrower set of care options due to their more complex medical needs. The more accessible, independent clinics that offer abortion services cannot take on clients with serious health issues. Donagh Stenson, Associate Director of Marketing at BPAS in Liverpool, England, gives an example of a recent case: “We had to turn someone down last week who got some kind of neuro[logical] issue which meant she had seizures. We've got a rule... a lot of our clinics are not attached to hospitals and if [the woman has] had a seizure in the last 12 months we can't treat them safely.”³⁰⁷

In cases like these, the Liverpool clinic may try to refer the woman or girl to a public hospital in England, so she can receive the more specialist care that she needs. However, these types of “specialist placement” hospitals are “very few and far between,” says Donagh Stenson. They are typically harder to reach and require additional travel.³⁰⁸ In addition, many public facilities decline to take on private patients, which would rule out almost all women travelling

³⁰⁶ Interview with Kally, Unit Manager, Merseyside Clinic, BPAS, 14 October 2014.

³⁰⁷ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

³⁰⁸ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

from Ireland, because they are not covered by England's National Health Service.³⁰⁹ This makes a successful placement all the more difficult.³¹⁰

10.3 FINANCIAL BARRIERS TO TRAVEL

**"It's the human rights aspect, the fact that we all know that some women can afford this and we all know that some women can't and we're just happy to see some of our citizens live out a life of poverty... And that is not OK, that's not how modern democracy should operate."
- A.F., who travelled to the USA for an abortion**

The financial burden of travelling for an abortion is significant, costing between €1,000 and €1,500 on average.³¹¹ This amount can be prohibitive, particularly in recent years of austerity and unemployment in Ireland.³¹² Some women are reluctant to borrow from friends and family due, in part, to the stigma associated with abortion, leaving many to struggle on their own to raise this substantial sum.

Specifically, women and girls must pay for flights or the ferry, the procedure itself and sometimes a night or more in a hotel. Orla, who urgently needed to book an appointment for her teenage daughter, remembers:

"We had an appointment on 27-28 February 2015. Because there was a football match in Liverpool, the flights were astronomical, and no hotels. I tried ferries, trains, and literally could not afford it. They moved our dates to the 3-4 March, which made flights €250 compared to €550 on football match day, but they were concerned about the gestational time. The most I could borrow was €400 and with the flight and the hotel it would not be possible. I asked ASN [the Abortion Support Network] for support. My daughter was upset about the cost, she was aware of our financial situation. She was sorry about that... On top of everything else, she should not have to think about this. I was angry that a 15-year-old child would worry about how we are

³⁰⁹ The National Health Service (NHS) is a publicly-funded health service for legal residents of the UK. Health care services, including abortion services, are normally provided free of charge at point of service for those entitled to NHS coverage. However, those who travel to England for services, and are not resident there, generally have to pay for NHS treatment. See NHS Choices, *Am I entitled to NHS treatment when I visit England?*, available at www.nhs.uk/chq/pages/1086.aspx?categoryid=68

³¹⁰ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

³¹¹ Although experiences varied, depending on the clinic and the gestational age, women reported to Amnesty International that the abortion procedure cost anywhere from €320 for a first trimester abortion, to between €500 and €700 for an early second trimester abortion, and €1,850 to €2,300 for a later-term second trimester termination. Travel costs were typically anywhere from €90 to €500, depending on the destination, the timing of travel and the need to book accommodation. One woman, who procured a later term abortion, reported having to pay €5,000 for outpatient expenses, flights and hotel fees.

³¹² Maeve Taylor of the IFPA notes: "Since the economic collapse... access to credit is much more restricted. Access to disposable cash. [Ireland was] kind of in a spend cycle for a while... And the way that cuts to social welfare and cuts to various school based sort of services and the pressure and the choices and the increase in property taxes and water charges... all those things for people who are close to the margins and already in debt, all those things become a lot more difficult." Interview with Maeve Taylor, Senior Policy and Advocacy Adviser, IFPA, 3 October 2014.

going to pay for this."³¹³

Women and girls travelling from a rural area may have a complex travel route with fewer flight options and higher travel costs. For example, the airports of Knock and Shannon do not offer return flights to England on the same day. Therefore, "if you want an abortion you pretty much have to stay [in England] for three days for a five-minute medical procedure – or take the bus to Dublin and fly from there, which also makes a much longer journey," explains Mara Clarke, founder of Abortion Support Network (ASN), an organization that offers financial help and accommodation to women who travel from Ireland and Northern Ireland for abortions in England.³¹⁴

If they can afford to, many women prefer to travel with a family member or friend, adding to the cost. Otherwise they must travel alone, without support. Some families must also pay for childcare for their children while they are abroad.

Frances, who travelled to London for an abortion, struggled to pull together the funds she needed. She was married with two daughters, living in a rural area, when she found out she was pregnant. She told Amnesty International that as the family's sole breadwinner, she "would have been plunged into absolute poverty, misery and isolation living in the middle of nowhere with very little [if she had another child]... I had so little money but I had some savings – I did have enough to cover [the abortion], just about. I spent every penny I had at the time on that."³¹⁵

Mara Clarke of ASN notes that women try a multitude of strategies to obtain money to travel to end a pregnancy. "The milder cases are those of food and bill payment... 'I haven't eaten lunch in a month... I cut off the land line... We didn't get the brakes on the family car fixed... I skipped paying the rent and risked getting evicted... I didn't pay the power bill...' those sorts of things. There was one woman who went to six different charity shops to buy the school uniforms so she would have €60 extra towards the abortion."³¹⁶ Evelyn Geraghty, Director of Counselling at the IFPA also notes, "What we hear is that women are borrowing off family. That they go to the loan shark. Or they've gone to the pawn broker."³¹⁷

Aoife terminated an unplanned pregnancy in 2012 when she was in her mid-30s. She found the decision extremely difficult. The man she had gotten pregnant with lived abroad and did not want the baby. "That was hard to hear, but I heard it" she recalls. Aoife was also unable to afford to pay rent at the time and was living in a temporary house-sitting situation. "I work in the arts and it was the beginning of all the cutbacks and a lot of work had gone down the pipeline so I wasn't earning. So these were my considerations at the time. After the death [of a childhood friend] I was depressed and not working or earning and I just didn't feel strong enough to do it [raise a child] on my own."

³¹³ Interview with Orla [her name has been changed], 10 March 2015.

³¹⁴ Interview with Mara Clarke, Founder, Abortion Support Network, 11 November 2014. See Abortion Support Network, *About ASN*, available at www.abortionsupport.org.uk/about/

³¹⁵ Interview with Frances [her name has been changed], 2 December 2014.

³¹⁶ Interview with Mara Clarke, Founder, Abortion Support Network, 11 November 2014.

³¹⁷ Interview with Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

Aoife borrowed money from her sister to pay for the abortion, which she paid back over the following year. She travelled to a clinic in Manchester that she had found online and which was the “easiest and cheapest to get to”. She thought that she was less than 12 weeks pregnant, but the clinic said she was more than 14 weeks pregnant, which made the procedure much more expensive. Overall, she estimates that she spent a total of €1,000; about €700 or €800 for the procedure, and another €200 for travel.³¹⁸

Sometimes, women find themselves unable to obtain an abortion because of the delay in finding the necessary funds. Kally, Unit Manager at a BPAS clinic in Liverpool, notes: “we have had women who have travelled and... they've been too late in their pregnancy so we couldn't treat them, because they were waiting to save up money to get the treatment.”³¹⁹

10.4 THE IMPACT OF TRAVEL ON TREATMENT OPTIONS AND ON POST ABORTION CARE

Travelling to another country for abortion services can limit women's options regarding the type of medical procedure they may safely undergo. This is because women are usually further along in their pregnancies, sometimes as a result of delays in arranging travel logistics and obtaining the significant sum of money needed to travel and pay for the procedure. From a health perspective, earlier abortions are always preferable as they generally require safer and less invasive procedures.³²⁰

In addition, Helen Nela, a Clinical Nurse Manager at the BPAS Merseyside Clinic in England, says that there are challenges for clients from Ireland of undergoing a medication abortion – a safe and non-invasive method of terminating a pregnancy using pills. This is because a medication abortion requires women to take two pills 24 to 48 hours apart, and the woman may not be able to stay in England for that length of time.³²¹

Travelling may also affect a woman's access to quality post-abortion care once she returns to Ireland. Post-abortion care is an important component of the medical care a woman receives when obtaining an abortion, and includes treatment for possible complications following an abortion, counselling on contraceptive options and linking women with community-based

³¹⁸ Interview with Aoife [her name has been changed], 18 December 2014.

³¹⁹ Interview with Kally, Unit Manager, Merseyside Clinic, BPAS, 14 October 2014. Amanda at BPAS also noted: “you get women who haven't realized about the abortion support networks and they've been saving up to come and when they do get here, they're too far along, we can't help them.” Interview with Amanda, Administrative Co-ordinator and Counsellor, Merseyside Clinic, BPAS, 14 October 2014.

³²⁰ WHO, *Safe Abortion*, p. 36 (“the advantage of abortion at earlier gestational ages in terms of their greater safety over abortion at later ages should be explained. Once the decision is made by the woman, abortion should be provided as soon as is possible to do so.”)

³²¹ WHO, *Safe Abortion*, p. 3. In many countries where abortion is legal, the combination of two drugs – misoprostol and mifepristone – has been approved also for use in inducing abortions. These medical methods for first trimester abortion have been demonstrated to be both safe and effective. Use of misoprostol alone is also effective, albeit less so. See World Health Organization Reproductive Health Medical Library, *Medical Methods for First Trimester Abortion*, available at <http://apps.who.int/rhl/fertility/abortion/dgcom/en/>

support services. However, the WHO explains, “[f]ollowing safe, induced abortion, post-abortion care may not require a follow-up visit if the woman has adequate information about when to seek care for complications and has received any needed supplies or information to meet her contraceptive needs.”³²²

For women and girls living in Ireland who travel abroad for safe abortion services, post-abortion care may be most relevant in the rare event of complications following the abortion procedure. The Committee against Torture has emphasized that states must ensure “immediate and unconditional treatment of persons seeking emergency medical care” after abortion, in line with WHO guidelines.³²³ Amnesty International did not document any cases where women were denied post-abortion care in Ireland; however, women did note that the quality of the care they received in Ireland was compromised by having to travel abroad for abortion services.

Emma Kitson experienced complications after travelling to England to terminate a fatal foetal impairment pregnancy. She recalls trying to get medical advice over the phone from the hospital in England:

“[I]t just added to the torture. The aftercare you know, wasn’t there... I was in agony for six days... if the hospital had been in Ireland, maybe I could have popped in and they could have checked me out and immediately found out what was wrong but instead I was dealing with them [the hospital in England] over the phone.”³²⁴

After eventually going to a public hospital in Ireland, Emma Kitson was diagnosed with an incomplete abortion³²⁵ and told that she had been in labour for the past week. As she recalls, the hospital wanted her to take medication for another six days “and hopefully I would expel the products of pregnancy naturally”. She then got in touch with her private doctor “who said ‘I can’t let you go through that, it’s too long, you’ve been through enough now, I’m taking you in tomorrow for another D&C’”. After the procedure, she was offered the option of staying in the hospital for another night, which she did: “I was worn out.” Her prolonged health complications could easily have been avoided if she had not been required to travel and had therefore received continuity of care with the same health care provider throughout.

For Frances, a mother of two and her family’s sole breadwinner, who spent all her savings to travel to England for an abortion, the stigma associated with abortion affected the quality of post-abortion care she received and deterred her from getting the care she needed. Shortly after returning to rural Ireland after having an abortion in London, Frances started bleeding. In shock and far from any health care services, she called a clinic in Dublin that offered post-abortion care. As she later told Amnesty International: “I just remember that the way the nurse or whoever it was treated me on the phone was absolutely awful. She was so dismissive and cruel. It made me feel terrible and I didn’t seek any more help after that. But I did get a

³²² WHO, Safe Abortion p. 52; Crisis Pregnancy Programme, *Abortion Aftercare Leaflet*, available at <http://crisispregnancy.ie/wp-content/uploads/2012/05/abortion-aftercare-leaflet.pdf>.

³²³ CAT Concluding Observations: Chile, UN Doc. CAT/C/CR/32/5 (2004) para. 7(m).

³²⁴ Interview with Emma Kitson, 8 December 2014.

³²⁵ An incomplete abortion occurs when parts of the products of conception are retained in the uterus following a miscarriage or induced abortion.

really bad uterine infection and I was on serious antibiotics for weeks and weeks afterwards.” She ultimately went to a consultant in Limerick after weeks of bleeding and explained that she had terminated a pregnancy. He prescribed antibiotics but was rude and dismissive, barely communicating with her. She said: “It made me feel terrible.” If abortion was not criminalized and Frances had not been required to travel, Frances says: “it would have been... so much less stressful and I would have been looked after properly”.³²⁶

Alison Begas of Dublin Well Woman underscores that some women needing post-abortion care may be afraid to seek it upon returning to Ireland because they fear being reported to the police by health care workers. This is despite the fact that travelling to obtain an abortion abroad is a constitutionally protected freedom and that post-abortion care in Ireland is provided legally:

“There was an instance about seven years ago, a woman came into one of our clinics who had had a termination in the UK... and she began to haemorrhage in the clinic. We called an ambulance to ensure she was taken to hospital. As she was being carried out of our clinic, her abiding concern was ‘please don’t report me to the Gardaí [police], don’t report me’. I think that people also fear going to the GP because someone they know might work as the GP’s receptionist and might see the file. There is this corrosive fear that is very damaging.”³²⁷

10.5 THE STIGMA OF TRAVELLING

“This has really made me feel like an outcast, that we’ve done something wrong [even though] we did the best we could in horrible circumstances for our daughter. The Church would hate me and the state shuns me.”

- Orla, who travelled to the UK with her 15-year-old daughter for an abortion

The fact that travel is often shrouded in secrecy and silence, due to the criminalization of abortion and the associated stigma, often leaves women feeling isolated and further distressed. As Ava, who travelled to England for an abortion after receiving a diagnosis of fatal foetal impairment, recalls: “We had to sneak away, in the middle of the night, we didn’t want people to know our business and my mam told people that I went into the hospital and had a miscarriage. We had to go over and come back that night because we had our daughter and she was asking questions and she was at that very sensitive age”.³²⁸

The knowledge that they are travelling abroad to do something that is illegal in Ireland and which carries a criminal penalty of 14 years’ imprisonment, weighs greatly on many women, adding to the stress of their experience. Cerys, who travelled to England for an abortion after receiving a diagnosis of fatal foetal impairment, voiced the feeling that many women have. She says that if women could obtain abortion services in Ireland, they would not feel as

³²⁶ Interview with Frances [her name has been changed], 2 December 2014.

³²⁷ Interview with Alison Begas, Chief Executive, Dublin Well Woman, 2 October 2014.

³²⁸ Interview with Ava and Ciaran [their names have been changed], 28 September 2014.

though they had “done something wrong”.

Cerys elaborates:

“At the moment it is like ‘mission impossible’. That is making light of it, but it is a covert operation, the flights, the times, who can you tell, who can you trust?... thinking about child care and the [cost] of flying... you feel like a criminal. I am a law-abiding citizen and I felt like I was committing a crime, like I was smuggling drugs across the border. That feeling was horrible.”³²⁹

10.6 MARGINALIZED GIRLS AND WOMEN FACE ADDITIONAL BARRIERS TO ACCESSING ABORTION SERVICES ABROAD

Asylum-seekers, migrants and women from Traveller communities are some of the marginalized groups who are particularly affected by the lack of access to safe abortion services in Ireland.³³⁰ These women and girls face barriers to travel due to their immigration status, dependency on the state, lack of access to counselling and health services and lack of financial resources, all of which make obtaining an abortion abroad especially difficult. The case of Ms. Y (discussed above in the section A risk to life: The suicide exception) underscores the grave potential consequences of Ireland's abortion regime for women and girls from marginalized groups.

Increasingly, according to the IFPA, it is these marginalized women that seek out pregnancy counselling. Most women can access information about abortion services online. The women who come to pregnancy counselling tend to be in complex, difficult situations: women whose pregnancy has become a crisis because of circumstances in her life, women who have received a diagnosis of foetal impairment, women who have particular difficulties in covering the costs of accessing abortion, or women who have difficulties in travelling out of Ireland. “Women and girls who are able to overcome these challenges and travel face significant extra delays in accessing abortion, resulting in more invasive and expensive medical procedures,” says Evelyn Geraghty, Director of Counselling at the IFPA.³³¹ For some, unsafe, illegal abortion in Ireland – whether through home remedies or safer medication abortion (see discussion below) – is their only option.

Evelyn Geraghty of the IFPA notes the resilience of women, in spite of all the obstacles they face:

“Some women with travel restrictions manage to travel. But the hardest part of a counsellor's job is to explain to a woman who already has so much stacked up against her just how complex the process is. We cannot disguise the difficulties. We work with

³²⁹ Interview with Cerys [her name has been changed], 1 October 2014.

³³⁰ Women and girls living in poverty and girls in state care are other examples of marginalized groups in Ireland that may face significant barriers to accessing abortion services abroad.

³³¹ Interview with Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

each client to give her all the information she needs and to support her through the process. But we do so knowing that ultimately she may have no option but to continue with the pregnancy and [become a] parent against her wishes.”³³²

10.6.1 ASYLUM-SEEKERS

Linda Wilson Long of Dublin Well Woman sums up the experience for asylum-seekers requiring an abortion:

“[Asylum-seekers] struggle in a very different way, never mind rape or incest but just poorness... they have no papers, they have no money. I dread to think what happens to some of them that I have seen, because I can't help them. [Asylum-seekers] might get out but they might not get back in. The visa might take months to get through. And it costs and you have to approve things like a bank account, and someone who is an asylum-seeker doesn't even have a passport, they don't have a bank account, they are living in a holding area... there is just not a chance.”³³³

An asylum-seeker in Ireland must deal with a number of significant obstacles if she is to obtain an abortion abroad.

Although all pregnant women and girls must contend with the restrictions of Ireland's Regulation of Information Act, an asylum-seeker is particularly poorly placed to obtain the information she needs. According to the IFPA, this “[l]ack of knowledge, information and support can result in delayed presentation to crisis pregnancy services, unsafe abortion and extreme stress and anxiety.”³³⁴

The IFPA's Sexual Health and Asylum Handbook underscores that even where asylum-seekers may be aware of their entitlement to counselling and their freedom to travel abroad for abortion, they may be afraid to seek assistance or support out of fear that this could negatively impact their asylum application.³³⁵ In addition, the strong stigma surrounding abortion, the small and close-knit nature of many refugee or migrant communities, and the lack of privacy and confidentiality for women living in accommodation centres for asylum-seekers, further deters or delays women from seeking abortion-related information and services.³³⁶

As a general rule, asylum-seekers cannot leave Ireland until their refugee or immigration status is determined, something which may take years to resolve. However, the state *may* make an exception for a woman to travel abroad for an abortion, assuming she can complete the complicated paperwork, pay the associated costs and has the time to wait for these

³³² Interview with Evelyn Geraghty, Director of Counselling, IFPA, 3 October 2014.

³³³ Interview with Linda Wilson Long, Head of Counselling, Dublin Well Woman, 2 October 2014.

³³⁴ IFPA, *Sexual Health & Asylum: Handbook for People Working with Women Seeking Asylum in Ireland* (2010) p. 23, available at www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf [hereinafter IFPA Sexual Health & Asylum Handbook].

³³⁵ IFPA Sexual Health & Asylum Handbook p. 13.

³³⁶ IFPA Sexual Health & Asylum Handbook pp. 12, 23.

stages to be completed. Even then, issuing the necessary travel documentation remains at the government's discretion.

In order to travel, an asylum-seeker typically needs a temporary travel document and two visas: one for the country she is going to and one for Ireland, for when she returns. This process can take more than two months and can cost between €200 and €240.³³⁷

The two closest and most common destinations for abortion, the UK and the Netherlands, require "at least 12 pieces of documentation" before a visa can be issued.³³⁸ The paperwork required for these entry and re-entry visa applications includes confirmation of an appointment with an abortion clinic abroad and of attendance at a pregnancy counselling service in Ireland.³³⁹

Says Amanda of BPAS: "We've had clients who haven't been able to get a visa [to the UK] out of Ireland so they've had to phone up to postpone their appointments."³⁴⁰ These delays mean higher costs and may ultimately result in women being too late in their pregnancies to access abortion services.

Asylum-seekers may also have the added burden of language barriers and the need for an interpreter. In addition, most accommodation centres for asylum-seekers are located in rural areas in Ireland; women must navigate public transportation on their own to reach Dublin and all the necessary embassies and government buildings.³⁴¹ The law does not permit pregnancy counsellors to accompany women to any government or embassy offices, nor can they make a clinic appointment on a woman's behalf.³⁴² Not only are all these arrangements a daunting prospect for a new arrival, they are also a financial burden.

Asylum-seekers in Ireland are provided with a weekly allowance of €19.10.³⁴³ They typically have no other income as they are not permitted to work in any paid employment³⁴⁴ and are not entitled to most social welfare benefits.³⁴⁵ To travel abroad for an abortion, the IFPA's 2013 Annual Report documents, an asylum-seeker's cost breakdown includes: a re-entry visa (€60), travel document (€80), entry visa (€60-€100, depending on the country) and clinic

³³⁷ IFPA, *Annual Report 2013: access, choice and advocacy* (2014) p. 12, available at www.ifpa.ie/sites/default/files/documents/annual-reports/ifpa_annual_report_2013.pdf [hereinafter IFPA Annual Report 2013]; IFPA Sexual Health & Asylum Handbook p. 23.

³³⁸ IFPA Annual Report 2013 p. 12; Niall Behan, *Opinion: Ireland's law on abortion is a shambles entirely of the State's creation* (27 September 2014), available at www.thejournal.ie/readme/abortion-laws-ireland-ms-y-1689733-Sep2014/

³³⁹ IFPA Sexual Health & Asylum Handbook p. 23; IFPA Annual Report 2013 p. 12.

³⁴⁰ Interview with Amanda, Administrative Co-ordinator and Counsellor, Merseyside Clinic, BPAS, 14 October 2014.

³⁴¹ Niall Behan, *Opinion: Ireland's law on abortion is a shambles entirely of the State's creation* (27 September 2014).

³⁴² See Censorship and silence section.

³⁴³ See Reception and Integration Agency, *Direct Provision*, available at www.ria.gov.ie/en/RIA/Pages/Direct_Provision_FAQs

³⁴⁴ Citizens Information Board, *Services and entitlements for people seeking asylum*, available at www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees/services_for_asylum_seekers_in_ireland/direct_provision.html

³⁴⁵ IFPA Sexual Health & Asylum Handbook, p. 13.

fees (€600–€2,000),³⁴⁶ depending on the clinic and the stage of their pregnancy.³⁴⁷ Flights and accommodation may also be needed. In total, Ms. Y, for example, needed to raise at least €1,300 within just a few months, with a weekly allowance of €19.10.³⁴⁸

Patricia, an ASN-affiliated host for women who travel abroad for an abortion, remembers a recent case of an asylum-seeker who stayed with her in England before her abortion procedure:

*"I think it was her just incredible vulnerability. She told me that she'd arrived in Ireland when she was only 13 as an unaccompanied child and she was now 22 and already had a child in the care system. I think she was 19 or 20 weeks [pregnant when she travelled]... ASN had got in touch at least eight weeks earlier... a couple of times about a date for her to come, and that date had fallen through because her paperwork hadn't come through... I saw her when she came, and for her the relief that she was able to come over, because you know she didn't know anybody, she hadn't been here before, [she was] very isolated."*³⁴⁹

Ultimately, these overwhelming obstacles to travelling abroad for an abortion mean that, in practice, asylum-seekers with unwanted pregnancies may be forced to resort to illegal and sometimes unsafe abortion methods in Ireland (see discussion of illegal and unsafe abortion, below), or to carry their pregnancies to term. Asylum-seekers who are forced to, or choose to, carry their pregnancies to term and become parents receive minimal financial support from the Irish state.³⁵⁰

10.6.2 MIGRANT WOMEN

Migrant women in Ireland may face many of the same barriers to travelling for abortion as asylum-seekers. Many must obtain the same travel documents³⁵¹ and contend with the same, often prohibitive, costs. Depending on their legal status, they may not be entitled to medical cards, leaving them "significantly less likely to use Irish health services", according to a

³⁴⁶ The costs for the abortion procedure are not necessarily fixed. BPAS clinics in England, for example, operate on a discounted, sliding scale for private clients from Ireland, waiving some or all of their fees in cases where women do not have the means to pay, potentially lowering the cost of the abortion procedure for some women travelling from Ireland. Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

³⁴⁷ Amnesty International, *Ireland: Submission to the United Nations Human Rights Committee*, (Index: EUR 29/001/2014), available at www.ccprcentre.org/doc/2014/06/INT_CCPR_CSS_IRL_17502_E.pdf

³⁴⁸ Interview with Caoimhe Haughey, Solicitor for Ms. Y, 28 January 2015.

³⁴⁹ Interview with Patricia, ASN host, 13 January 2015.

³⁵⁰ Irish Refugee Council, Summary of Report on Children in Direct Provision (2012), available at www.irishrefugeecouncil.ie/children-and-young-people/children-in-direct-provision-accommodation/two-page-report-summary (explaining there is "no child benefit for asylum seeker children. Parents routinely must buy school books etc. from their €19.10 allowance"); NASC, *Child Benefit Eligibility (Children of Asylum Seekers)* (2013), available at www.nascireland.org/campaign-for-change/social-protection/pq-child-benefit-eligibility-children-of-asylum-seekers/ (explaining that asylum-seekers are not eligible for payment of Child Benefit).

³⁵¹ IFPA Annual Report 2013 at 12.

recent study by the Crisis Pregnancy Programme.³⁵²

A 2014 study found that migrants had “low levels of engagement with Irish health services due to language issues, limited knowledge of services and unfamiliarity with how to access services.”³⁵³ The study further determined that migrant women who reported experiencing “a crisis pregnancy revealed a lack of knowledge about crisis pregnancy support services.”³⁵⁴

A migrant woman's experience of an unwanted pregnancy can compound the feelings of isolation and vulnerability that come from being in an unfamiliar country. Salome Mbugua, founder of AkiDwA, a national network of migrant women living in Ireland, explains:

“I facilitated a symposium with one specific group of women from Nigeria... they were all condemning the whole issue of abortion... So imagine if one woman from that community was going through an abortion how isolated she would be, and also condemned by the rest of the community. So it is very, very difficult and if something happens to a migrant woman here and she knows people here, it doesn't only end up here it goes back to her home country and family in particular. It leaves the woman in a very awkward position and it even makes her more vulnerable because she will end up in greater isolation.”³⁵⁵

Ultimately, migrant women may be forced to resort to unsafe abortion in order to end their pregnancy. Says Salome Mbugua, “if the €200 tablet does not work they may take something additional, like bleach. [If that does not work,] they go back to the woman that sold them the tablet and they get more tablets. So it would be as dangerous as that, if a woman is determined.”³⁵⁶

10.6.3 TRAVELLER WOMEN

The Traveller community is an indigenous minority ethnic group that has historically experienced discrimination, low social status and exclusion in Ireland.³⁵⁷ A 2010 study of Traveller health found that Travellers have a significantly “higher burden of ill-health,”³⁵⁸ higher rates of suicide and poor mental health, and higher rates of mortality when compared to the general population.³⁵⁹ Access to health care services for Travellers is limited, and their

³⁵² Crisis Pregnancy Programme, *Research with Young Migrant Women on Sex, Fertility and Motherhood Booklet* (2014) 4, available at <http://www.crisispregnancy.ie/wp-content/uploads/2014/05/Research-with-Young-Migrant-Women-2014-FINAL-WEB.pdf> [hereinafter *Research with Young Migrant Women*].

³⁵³ *Research with Young Migrant Women* at 4.

³⁵⁴ *Research with Young Migrant Women* at 4.

³⁵⁵ Interview with Salome Mbugua, Founder of AkiDwA, 14 October 2014.

³⁵⁶ Interview with Salome Mbugua, Founder of AkiDwA, 14 October 2014.

³⁵⁷ All Ireland Traveller Health Study Team, *All Ireland Traveller Health Study: Our Geels: Summary of Findings* (2010) p. 9, available at www.paveepoint.ie/tempsite3/wp-content/uploads/2013/10/AITHS-Summary-of-Findings.pdf [hereinafter *All Ireland Traveller Health Study*].

³⁵⁸ *All Ireland Traveller Health Study* p. 80.

³⁵⁹ Pavee Point, *Selected Key Findings and Recommendations from the All-Ireland Traveller Health Study – Our Geels 2010* (2012) p. 5, available at www.paveepoint.ie/tempsite3/wp-content/uploads/2013/10/AITHS-Booklet-Sep.12.pdf [hereinafter *Selected Key Findings and Recommendations from the All-Ireland Traveller Health Study*].

health care experiences are often shaped by discrimination.³⁶⁰ Travellers also have extremely high rates of unemployment, with many living in poverty.³⁶¹

As Ronnie Fay, Director of the Pavee Point Traveller and Roma Centre, a minority rights group, explains, in general “many [Travellers] might have difficulty in accessing a GP and even where they do get access to GP services they don't get good quality services”. In addition, Ronnie Fay continues, “there are huge levels of mistrust [in health care providers] and people feeling that... they are not welcome, that they're a nuisance... that they're blamed, so it's not a very welcoming environment in terms of Travellers going to mainstream health services and they are very judgemental, they don't understand Traveller ethnicity, respect their cultural identity, they don't understand the reality of people's lives.”³⁶²

Financial barriers, barriers to accessing information and counselling services, and the intense stigma associated with abortion, make travelling abroad for abortion difficult. The close-knit nature of family relationships in the Traveller community,³⁶³ and the expectation that a single woman or girl “is not supposed to go anywhere on her own until she gets married,”³⁶⁴ as one Pavee Point report explains, also mean that travelling for an abortion without other community members' knowledge is incredibly challenging.

Donagh Stenson from BPAS in England explains:

*“[W]hat tends to happen is that a Traveller woman who has any sort of difficulty, like not wanting people in her community to find out that she was pregnant or whatever... tend to come through the agencies [IFPA, Well Woman, One Family]... So they'll manage to find some support or information in Ireland but [then] this woman needs to be [in England] very quickly... I would say there seems to be many more time pressures”.*³⁶⁵

10.7 UNABLE TO TRAVEL: SUICIDE VERSUS UNSAFE ABORTION

For women or girls who are unable to travel abroad for an abortion, their options are incredibly limited and the constitutional freedom to travel is meaningless. The UN Human Rights Committee has expressed its concern to Ireland over the “discriminatory impact of the [PLDPA] on women who are unable to travel abroad to seek abortions”.³⁶⁶ As discussed above, marginalized women and girls are more likely to find themselves in this category. Faced with being forced to carry their pregnancies to term, these women resort to experimenting with “home remedies” or, increasingly, turn to clandestine medication

³⁶⁰ Selected Key Findings and Recommendations from the *All-Ireland Traveller Health Study*, pp. 12-13.

³⁶¹ Selected Key Findings and Recommendations from the *All-Ireland Traveller Health Study*, p. 10.

³⁶² Interview with Ronnie Fay, Director, Pavee Point Traveller and Roma Centre, 23 November 2014.

³⁶³ Pavee Point, Position Paper on Violence against Women (December 2011), available at www.paveepoint.ie/tempsite3/wp-content/uploads/2013/11/Pavee-Point-Position-Paper-Final.pdf 13.

³⁶⁴ Pavee Point, Position Paper on Violence against Women (December 2011), p. 14.

³⁶⁵ Interview with Donagh Stenson, Associate Director of Marketing, BPAS, 14 October 2014.

³⁶⁶ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

abortion.

Some women may consider suicide. Dr. Peadar O'Grady, a Consultant Psychiatrist, is clear that for women with unwanted pregnancies "restricting access to abortion raises the risk of suicide."³⁶⁷ The Human Rights Committee has also raised this as an issue, expressing concern about a restrictive abortion law in Ecuador and "the very high number of suicides of young females... which appear in part to be related to the prohibition of abortion."³⁶⁸

A.F.'S STORY

"I remember walking around thinking I'll just throw myself in front of a truck. That'll solve that problem." – A.F.

In late 1997, A.F. found herself with an unplanned pregnancy. She was working several part-time jobs and leading a "very hand-to-mouth existence". She told Amnesty International that she started thinking about suicide: "I was literally wandering around Galway, walking down a really busy street, past lots of traffic thinking if I just fell into this traffic I wouldn't have to worry or if I walked over a bridge – there's a bridge in Galway over a really busy part of the river – and if I just fell into that river, then I wouldn't have to worry... I didn't have money, I didn't feel I could tell my parents... I felt very alone."

Ultimately, A.F. received financial help from her sister to travel abroad and was able to terminate her pregnancy. She says, "There was no doubt in my mind that what I was doing was the right thing".

If her sister hadn't helped her, she told Amnesty International: "I don't doubt I would have tried something."³⁶⁹

10.8 FORCED TO RESORT TO HOME REMEDIES OR PHYSICAL HARM TO INDUCE AN ABORTION

"I read online about self-induced abortions, about some Chinese herbs. I was probably six or seven weeks along, apparently it needed to be earlier. I tried them and they didn't work, while I was still waiting for an appointment [with the clinic in England] because you try everything when you are desperate."

- Sandra, who tried home remedies to end her pregnancy before successfully ending the pregnancy through a medication abortion in Ireland³⁷⁰

Women without the option of travelling may resort to a host of methods to try to end the pregnancy, many of which can cause severe physical harm. Mara Clarke of ASN says that, for these women: "The next step is taking the morning after pill,³⁷¹ taking three morning after

³⁶⁷ Interview with Dr. Peadar O'Grady, Consultant Child and Adolescent Psychiatrist, 23 February 2015.

³⁶⁸ HRC Concluding Observations: Ecuador, UN Doc. A/53/40 (1998) para. 284.

³⁶⁹ Interview with A.F., 8 January 2015.

³⁷⁰ Interview with Sandra [her name has been changed], 17 October 2014.

³⁷¹ The morning after pill, or emergency contraception, is a form of contraception that can be taken up to

pills, going to several different chemists and taking several packs of birth control pills with a bottle of gin or a bottle of vodka. Overdosing on over-the-counter prescriptions. Scalding baths. One woman noted 'I have tried to do everything, I have been drinking excessively, and I have thrown myself down the stairs.' Then there was the woman who was trying to figure out how to crash the car to have a miscarriage but not permanently injure herself or die."³⁷²

10.9 UNDERTAKING AN ILLEGAL MEDICATION ABORTION IN IRELAND

The use of medication, typically the drug mifepristone followed by misoprostol within a 24 to 48 hour period, is a safe and internationally recommended option for terminating a pregnancy in the first trimester.³⁷³ The increasing accessibility of misoprostol and mifepristone globally has been cited as contributing to a decrease in the number of deaths and severe complications attributed to unsafe abortion worldwide.³⁷⁴

The criminalization of abortion in Ireland means that women and girls may be taking these pills without effective medical supervision, potentially resulting in serious health complications. Salome Mbugua, founder of AkiDwA, a national network of migrant women living in Ireland, relates: "We heard of a woman who sells a pill, I think it is €200 a pill to terminate the pregnancy. We have also heard that women have ended up in hospital in severe pain when the drug doesn't work."³⁷⁵

These pills may cost as little as €50 to €100 – far more affordable than the more than €1,000 it costs to travel to England for an abortion. Women on Web is one online abortion service that helps women in restrictive legal environments obtain the pills necessary for a medication abortion. They provide an online medical consultation with a licensed doctor and, if not contraindicated, the medication is delivered to the woman's chosen address.³⁷⁶

SANDRA'S STORY

Sandra is a young, single mother who told Amnesty International that she used medication obtained through Women on Web to end an unplanned and unwanted pregnancy in 2014. "Two children would be a catastrophe for me, I can't afford that. I have just finished school and I am getting my career going, I don't know how that

five days after intercourse and can prevent pregnancy. It is a form of contraception; it does not have an impact on an existing pregnancy.

³⁷² Interview with Mara Clarke, Founder, Abortion Support Network, 11 November 2014.

³⁷³ WHO, *Safe Abortion* p. 3. In many countries where abortion is legal, misoprostol combined with the drug mifepristone has been approved also for use in inducing abortions. These medical methods for first trimester abortion have been demonstrated to be both safe and effective. Use of misoprostol alone is also effective, albeit less so. See World Health Organization Reproductive Health Medical Library, *Medical Methods for First Trimester Abortion*, available at <http://apps.who.int/rhl/fertility/abortion/dgcom/en/>

³⁷⁴ World Health Organization, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, p. 14, available at http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf?ua=1

³⁷⁵ Interview with Salome Mbugua, Founder of AkiDwA, 14 October 2014.

³⁷⁶ Women on Web, *I need an abortion with pills*, available at www.womenonweb.org/en/i-need-an-abortion

would be possible with two kids.”³⁷⁷

Immediately after discovering she was pregnant, Sandra tried to schedule an appointment with a clinic in England but found it difficult and costly.³⁷⁸ She attempted to induce an abortion using high doses of vitamins and some “Chinese herbs” she had read about on the internet. She told her mother she was trying these methods because, “you don’t want something happening to you and people not knowing what happened to you. Just in case you collapse.”

Sandra’s mother had read about Women on Web in an *Irish Independent* article about women who were travelling to Belfast [in Northern Ireland] to collect the pills for medical abortion. Sandra made a €90 donation, set up a postal box in Belfast, and made a six-hour round trip to pick up the pills. “It was very easy; all they did was ask for my ID, they didn’t photocopy it or do anything. I took off the packaging that it was in, because when you are carrying something like that, you have this fear. I just took the pills and the instructions and hid them in my bra, because you never know. I was paranoid... I got home and I think that is when the fear starts, before I was just getting through but when you have to take it... I took the pills. The next day I took the second one and it was very bad, it was really painful. Then the following day it was done... You have this bleeding but it is done. I got my period again about a week and a half ago and I am very happy.”³⁷⁹

Although misoprostol is legal in Ireland, and is commonly used to treat ulcers, it is not labelled for use as an abortifacient [abortion-inducer].³⁸⁰ Mifepristone is effectively banned in Ireland. A woman who uses these drugs to induce an abortion would be liable to 14 years’ imprisonment under the PLDPA. Further, any attempts to import the drugs through the mail will result in seizure by the Irish customs authorities. Rebecca Gomperts, head of Women on Web, explains: “the medical abortion packages are not sent to Ireland anymore because they are always confiscated.”³⁸¹

In 2014, Irish customs and the Health Products Regulatory Authority (HPRA) seized 1,017 tablets of mifepristone and misoprostol that were sent through the mail. This was more than double the amount seized in 2013. According to the HPRA, the intended recipients of the pills are generally sent a form letter informing them that their package has been detained and giving them the opportunity to explain why the products should be released to them under Irish law.³⁸² However, prosecutions may also result. In 2009, a woman was prosecuted for importing mifepristone from China and selling it in a supermarket in Ireland. She was convicted, fined €5,000 and ordered to pay costs to the Irish Medicines Board (now the HPRA) of €5,550.³⁸³

To avoid seizure and prosecution, women order pills online and have them sent to an address in Northern Ireland, as Sandra did. They, or a friend, then travel north to pick up the pills

³⁷⁷ Interview with Sandra [her name has been changed], 17 October, 2014.

³⁷⁸ Interview with Sandra [her name has been changed], 17 October, 2014.

³⁷⁹ Interview with Sandra [her name has been changed], 17 October, 2014.

³⁸⁰ Health Products Regulatory Authority (HPRA), *Medicines: Misoprostol*, available at www.hpra.ie/homepage/medicines/medicines-information/find-a-medicine/results?query=MISOPROSTOL&field=ACTIVESUBSTANCES

³⁸¹ Interview with Rebecca Gomperts, Head, Women on Web, 24 October 2014.

³⁸² Email correspondence with the HPRA, 9 April 2015 (on file with Amnesty International).

³⁸³ Ailbhe Jordan, ‘Woman charged with selling illegal abortion tablets in supermarket’, *The Medical Independent*, 27 January 2011.

and smuggle them back across the border. This process may still be risky – if women are caught, they may potentially be subject to prosecution.

Northern Ireland's abortion law is also extremely restrictive³⁸⁴ and at times customs officials in Northern Ireland also crack down on the shipment of these packages. In the summer of 2013, customs officials in Northern Ireland seized at least seven packages and sent letters to several addressees warning of prison terms for those importing the drugs.³⁸⁵ Rebecca Gomperts of Women on Web recalls that women “were emailing that they got this letter and that they were worried sick. People really did think that they were going to jail with this letter.”³⁸⁶

ÁINE'S STORY

In 2014, Áine was pregnant six months after the birth of her second child.

She remembers feeling terrified: “I didn't think I'd be able to cope. I had too much on my hands. I had already in a way thrown away a degree I'd finished the previous year [when I had my second child].”

Áine decided to procure a medication abortion at home. She explains why she chose to terminate her pregnancy in Ireland: “Well, obviously enough, the money. A friend of mine had an abortion in England and she had to go on her own and she said she was so ill afterwards, having to lie down in the airport. I couldn't afford to get me over there let alone bring my partner to look after me afterwards. It was my only option, really.”³⁸⁷

Obstetrician/gynaecologists noted that it is difficult to know whether an abortion was spontaneous or induced by medication. Dr. Peter Boylan explains: “We might have unwittingly [treated a patient who took these pills], women do not admit or declare it. We treat them, we are not going into asking what or why. It would not alter our care. We would not be able to tell if they took the pills, we would not know.”³⁸⁸

Mark Murphy, a GP with Doctors for Choice, believes that women who obtain post-abortion care following an illegal medication abortion are taking on “a real risk”. The “fear [of doctors reporting the woman to the police] is not unfounded”, he says.:

“I would never do that and I think that 99% of GPs wouldn't. But there are five cases in which a doctor can breach confidentiality, which is sanctioned through the Irish Medical Council in our [Ethics] Guidelines... and an illegal activity is one. And if, for example, a woman procured an abortifacient on Henry Street at seven weeks and let's say that the procedure was successful in terminating her pregnancy and she then went to the GP as a follow up check-up, theoretically a GP could breach confidentiality there... one in 10 doctors are anti-choice in any situation, [and] there is a potential risk that confidentiality could be breached. So that will only heighten the chilling

³⁸⁴ See Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services* (Index: EUR 45/1057/2015).

³⁸⁵ Copy of letter on file with Amnesty International.

³⁸⁶ Interview with Rebecca Gomperts, Head, Women on Web, 24 October 2014.

³⁸⁷ Interview with Áine, 20 October 2014.

³⁸⁸ Interview with Dr. Peter Boylan, obstetrician/gynaecologist, former Master and Clinical Director at the National Maternity Hospital, 2 March 2014.

factor".³⁸⁹

In sum, medication abortion is certainly a preferable and safer option for women where the alternative is resorting to dangerous methods of unsafe abortion. Nonetheless, being forced to procure tablets clandestinely, at risk of criminal prosecution and without medical supervision, is not a legitimate substitute for having access to a safe and legal abortion in one's country of residence.

³⁸⁹ Interview with Dr. Mark Murphy, general practitioner, Doctors for Choice, 2 October 2014.

11. CONCLUSION

Ireland's abortion regime violates the fundamental human rights of women and girls, including their rights to life, health, equality, non-discrimination, privacy, information and freedom from torture and other ill-treatment. In particular, the privileged position that the Irish Constitution's Eighth Amendment accords to the foetus comes at the unacceptable expense of the rights and lives of pregnant women and girls. This constitutional provision is inconsistent with international human rights law, which does not recognize a foetal right to life and is clear that human rights apply after birth.

Time and again, human rights bodies have called upon Ireland to undertake law reform to comply with its human rights obligations to ensure women's and girls' rights to safe and legal abortion. Finally forced to reckon with the devastating consequences of its restrictive and opaque abortion law in recent years, Ireland's new abortion law falls significantly short of its human rights obligations. By criminalizing abortion on all but one narrow ground, Ireland forces women who seek abortions to travel – in their thousands – to other countries to obtain a routine and essential medical procedure. Showing complete disregard for those who cannot travel, Ireland forces these women and girls to continue with an unwanted or dangerous pregnancy or resort to unsafe abortion. This reality has resulted in unnecessary suffering for thousands of women, girls and their families.

Women and their families repeatedly expressed their anger at this situation, and the discrimination they are made to endure. Abortion, they believe, should be a safe and legal medical service, available to them in their country of residence. One woman's statement embodies the sentiments of many interviewed for this report: "I'm hoping [access to safe and legal abortion in Ireland] will happen in my lifetime. So my daughter, when she is older and she needs to have an abortion, doesn't need to travel to the UK in secret, in silence."³⁹⁰

³⁹⁰ Interview with Roisin [her name has been changed], 5 February 2015.

12. RECOMMENDATIONS

Amnesty International calls on the Irish authorities to take immediate steps to comply with their human rights obligations concerning abortion, including by implementing the recommendations recently issued to them by the UN Human Rights Committee to (1) revise the Eighth Amendment of the Irish Constitution and the PLDPA to “provide for additional exceptions [to criminalization of abortion] in cases of rape, incest, serious risks to the health of the mother, or fatal foetal abnormality”; and (2) “ensure that health-care providers who supply information on safe abortion services abroad are not subject to criminal sanctions.”³⁹¹

Amnesty International recommends to the following authorities:

To the Irish Executive and Houses of Oireachtas (Irish Parliament):

- Repeal Article 40.3.3 (the Eighth Amendment) of Bunreacht na hÉireann, the Irish Constitution, to enable the provision of a human rights compliant framework for abortion and information, in law and in practice.
- Decriminalize abortion.
- Repeal the PLDPA and replace it with a legislative framework that ensures access to abortion both in law and in practice, at a minimum, in cases where the pregnancy poses a risk to the life or to the physical or mental health of a pregnant woman or girl, in cases of severe and fatal foetal impairment, and in cases where the pregnancy is the result of rape or incest.
- Legislation and policy should:
 - Ensure that decisions regarding a termination of pregnancy are made solely between the pregnant woman and her medical practitioner.
 - Ensure that the provision of abortion is not limited to obstetricians and gynaecologists, and that qualified mid-level providers can offer services in appropriate circumstances.
 - Not include unnecessary, non-evidence-based barriers to accessing abortion services, such as requirements that a provider consult with one or more other health care providers before performing an abortion or that abortions must always be performed in tertiary care facilities.³⁹²
 - Make clear that those who object to providing abortion services have a duty to make a timely referral to another health care provider who will offer the services, and to always

³⁹¹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

³⁹² WHO, Safe Abortion, pp. 95-96.

provide care, regardless of their personal beliefs or objections, in emergency circumstances or where a referral or continuity of care is not possible.

- In the interim, while working towards the decriminalization of abortion:
 - Comply with the call of the UN Special Rapporteur on the right to health to “consider, as an interim measure, the formulation of policies and protocols by responsible authorities imposing a moratorium on the application of criminal laws concerning abortion”.³⁹³
 - Ensure that PLDPA-mandated reporting data on abortion is made available to the public, and is disaggregated by life-threatening condition.
- Repeal the Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act and any related censorship laws limiting access to abortion information. Ensure that the provision of information relating to abortion abroad remains decriminalized and that such information is widely available and accessible.
- Comply with the UN Special Rapporteur on human rights defenders’ recommendation to “[r]ecognize publically the work of defenders and practitioners who work for the enjoyment of the right to health of women, including sexual and reproductive rights, and protect them effectively from harassment or intimidation of all kinds, including smear campaigns”.

To the Department of Health:

- Immediately ensure that women can practically access abortion where pregnancy poses a risk to life, with due regard to long-term health.
- Immediately revise the Implementation of the *Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* to, among other things:
 - Remove references to “suicidal intent”;
 - Make clear that, under no circumstances should a woman or girl be forced or coerced in any way to continue a pregnancy to viability when she has qualified for an abortion;
 - Provide clearer clinical guidance to health care professionals on how to assess whether a condition is life-threatening for the purpose of ensuring access to lawful abortion, making clear that risks to health can also be risks to life.
- Ensure that health care providers who fail to maintain professionalism (for example, by engaging in abusive or derogatory rhetoric and intentionally misleading patients about their

³⁹³ Anand Grover, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/66/254 (2011) para. 65(h)-(i).

treatment options and care) are held accountable.

- Ensure that transparent and accessible inquiry processes are in place for cases of maternal death or morbidity and for denials of lawful abortion, so that patients and their families are able to hold institutions and health care providers accountable.
- Make clear to all health care professionals, counsellors, the HSE and all private health care institutions that post-abortion treatment is a legal medical service and that women who obtain such services, regardless of the circumstances of their abortion, should be treated with dignity and respect and have the right to confidentiality.
- Revise the HSE's *National Consent Policy*, which currently allows for health care providers to seek the intervention of the High Court if there is disagreement between them and the pregnant woman on the best course of treatment. Ensure that pregnant women's autonomy and choices are respected and upheld.
- Ensure that marginalized populations – including asylum-seekers, migrants and Travellers – have access to sexual and reproductive health services, including pregnancy counselling.
- Develop and disseminate clinical practice guidance for health care providers on the provision of safe abortion and post-abortion care services, modelled on the World Health Organization's Safe Abortion Guidance.
- Develop guidance for health care providers on diagnostic and health information, and counselling, to be provided to women in cases of foetal impairment.
- Ensure appropriate training for medical professionals – including all general practitioners, obstetrician/gynaecologists and psychiatrists – on abortion provision and certification to ensure practical access to quality abortion services in Ireland.

To the Medical Council:

- Amend the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (2014) to:
 - Make clear that reporting women whom medical practitioners suspect of illegal abortion is a violation of patient confidentiality.
 - Make clear that if medical practitioners have a conscientious objection to providing treatment or information that they must disclose this to the patient and refer her to another health care provider in a timely manner.
- Ensure that medical practitioners who fail to maintain professionalism (for example, by engaging in abusive or derogatory rhetoric and intentionally misleading patients about their treatment options and care) are held accountable under the Council's professional code of conduct.

To the HSE Crisis Pregnancy Programme:

- Develop, disseminate and make publicly available clear guidelines for pregnancy counsellors and health care providers on the provision of abortion-related information. Make clear that providers and counsellors always can, and should, discuss the abortion procedure, explain the process for travelling abroad, and advise on what patients might need to bring with them and what they can expect.
- Ensure that women are aware that post-abortion care is a legal service in Ireland and that they will not be reported to the police or prosecuted for seeking or obtaining this care.
- Ensure that asylum-seekers, migrants, Travellers and other marginalized groups are aware of pregnancy counselling services and their health care options.

To the Department of Justice and Equality:

- Ensure that asylum-seekers and migrants who need time-sensitive access to travel documentation and re-entry visas are able to receive them without delay. Ensure that asylum-seekers who require emergency travel documentation are made aware that their reasons for travel will be kept confidential and that travel for abortion will not impact their asylum application.
- Ensure that asylum-seekers within the Direct Provision system are provided with the timely counselling and support, including translation services, they need to deal with an unwanted or unplanned pregnancy.
- Ensure that asylum-seekers are made aware of pregnancy counselling services and are facilitated to access these services when needed.

ANNEX: INTERNATIONAL HUMAN RIGHTS STANDARDS

International and regional human rights law sets out minimum obligations that states, including Ireland, are bound to respect, protect and fulfil. Through ratification of international and regional human rights treaties, Ireland has undertaken to put into place domestic measures and legislation compatible with its treaty obligations and duties. The implementation of international human rights treaties is monitored by UN treaty bodies. Treaty bodies also have a mandate to provide interpretative guidance to states on fulfilling their specific human rights obligations under each of the treaties they have ratified.

Ireland is party to all major UN and European human rights treaties relevant to the issues raised in this report, including:

- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- The International Covenant on Civil and Political Rights (ICCPR)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- The Convention on the Rights of the Child (CRC)
- The European Convention on Human Rights and Fundamental Freedoms (ECHR)

The findings of this report reveal violations of fundamental human rights. These rights include the right to life, the right to be free from torture and other ill-treatment, the right to privacy, the right to health, the right to determine the number and spacing of children, and the right to information, and the right to non-discrimination. The issues described in this report demonstrate that Ireland is not implementing its international obligations to respect, protect and fulfil these rights.

Many of the specific human rights violations highlighted in this report are rooted in discriminatory and harmful stereotypes of women and girls. The existence of such stereotypes has led to a situation where laws, policies and practices have institutionalized violence against women and girls in all forms, including when they are prohibited from accessing a therapeutic abortion. Article 5 of CEDAW requires Ireland to take measures to modify existing social and cultural patterns of conduct, which are based on stereotyped roles for men and women. The treaty body that monitors implementation of the Convention, the CEDAW Committee, has called on states to take all necessary action to improve the situation for women “including the dismantling of patriarchal barriers and entrenched gender

stereotypes".³⁹⁴

The information below addresses the specific human rights concerns presented in this report and highlights Ireland's obligation to address them. Other international human rights standards and specific recommendations to Ireland can be found throughout this report.

I. INTERNATIONAL HUMAN RIGHTS LAW AND STANDARDS REQUIRE THE DECRIMINALIZATION OF ABORTION AND THAT STATES ENSURE ACCESS TO ABORTION WHEN A WOMAN'S LIFE AND PHYSICAL AND MENTAL HEALTH IS IN DANGER, IN CASES OF RAPE AND INCEST AND IN CASES OF SEVERE AND FATAL FOETAL IMPAIRMENT

UN treaty bodies, including the Committee against Torture, the Human Rights Committee, the CEDAW Committee, CESCR Committee, and the Committee on the Rights of the Child, have consistently found that countries that criminalize abortion and do not allow abortion on such grounds in law and in practice violate numerous human rights, including the rights to life, health, privacy, freedom from discrimination and freedom from torture and other ill-treatment.

Governments have been held accountable for not ensuring that abortion is available in cases when the life or health of women and girls is in danger, in cases of foetal impairment and in cases of rape or incest.³⁹⁵ UN treaty bodies have also made general calls for access to "therapeutic abortions", meaning abortions that are indicated for medical reasons, without specifying what those medical reasons might be. For example, the Committee against Torture called on Nicaragua "to consider the possibility of providing for exceptions to the general prohibition of abortion for cases of therapeutic abortion and pregnancy resulting from rape or incest".³⁹⁶ The CEDAW Committee has called for "a broad interpretation of the right to physical, mental and social health" by all health staff in determining whether therapeutic abortion is indicated.³⁹⁷ States are responsible for women's deaths and disability, and for other violations of fundamental rights when women do not have access to safe and legal abortion on these grounds.

IRELAND HAS AN OBLIGATION TO DECRIMINALIZE ABORTION³⁹⁸

"Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor

³⁹⁴ CEDAW, Article 5.

³⁹⁵ *K.L. v Peru*, Human Rights Committee, 2005; *LC v Peru*, CEDAW Committee, 2011; *LMR v Argentina*, Human Rights Committee, 2007.

³⁹⁶ CAT Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009) para. 16.

³⁹⁷ *Id.* para. 36(g).

³⁹⁸ Decriminalization means that abortion is no longer regulated by criminal legislation, and is not a criminal offence in itself.

physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system. Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.”³⁹⁹

- UN Special Rapporteur on the right to health

Ireland's law, which allows for the punishment of women and girls undergoing abortion as well as the doctors providing abortions, is in violation of international human rights law, regardless of whether or not the law is applied.

The Human Rights Committee and the Committee on the Rights of the Child, along with other UN treaty bodies, have called for the removal of punitive measures for abortion, in Ireland and elsewhere.⁴⁰⁰ The Committee against Torture has also raised similar concerns to Ireland: “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.”⁴⁰¹

RESTRICTIVE ABORTION LAWS VIOLATE FUNDAMENTAL HUMAN RIGHTS

UN treaty bodies have consistently condemned countries that have total abortion bans or very restrictive laws. The Committee against Torture, for example, has criticized countries with very restrictive abortion laws and laws that criminalize women for undergoing an abortion. It has recognized that such restrictions result in serious harm to women, including death, and may violate Articles 2 and 16 of the Convention against Torture.⁴⁰² Article 2 places an obligation on states parties to “take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction” and provides that: “An order from a superior officer or a public authority may not be invoked as a justification of torture.”

The Committee on Economic, Social and Cultural Rights monitors state compliance with the ICESCR. In June 2014, it issued a recommendation to El Salvador to decriminalize abortion, noting the breadth of the harm resulting from the total ban on abortion, including “grave situations of distress and injustice”.⁴⁰³

The CEDAW Committee has explicitly addressed the issue of restrictive abortion laws as a

³⁹⁹ UN Special Rapporteur on the right to health, *Report to the UN General Assembly*, UN Doc. A/66/254 (2011) para. 21.

⁴⁰⁰ See HRC: Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9; Concluding Observations: El Salvador, UN Doc. CCPR/C/SLV/CO/6 (2009) para. 10; Concluding Observations: Costa Rica, UN Doc. CCPR/C/79/Add.107 (1999) para. 11; Concluding Observations: Morocco, UN Doc. CCPR/CO/82/MAR (2004) para. 29; CRC: Concluding Observations: Nicaragua, UN Doc. CRC/C/NIC/CO/4 (2010) para. 59(b); Concluding Observations: Morocco, UN Doc. CRC/C/MAR/CO/3-4 (2014) paras. 56-57.

⁴⁰¹ CAT Concluding Observations: Ireland, UN Doc. CAT/C/IRL/CO/1 (2011) para. 26.

⁴⁰² CAT: Concluding Observations: El Salvador, CAT/C/SLV/CO/2 (2009) para. 23; Concluding Observations: Poland, UN Doc. CAT/C/POL/CO/5-6 (2013) para. 23.

⁴⁰³ CESCR Concluding Observations: El Salvador, UN Doc. E/C.12/SLV/CO/3-5 (2014).

form of discrimination against women and noted that they implicate violence against women.⁴⁰⁴ It has stated more generally, in its general recommendation on women and health that, "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women." The CEDAW Committee notes:

*"The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals... For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."*⁴⁰⁵

It has also addressed this issue in its General Recommendation on Violence against Women:

*"States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control."*⁴⁰⁶

INTERNATIONAL HUMAN RIGHTS STANDARDS REQUIRE ACCESS TO ABORTION WHEN A WOMAN OR GIRL'S LIFE OR PHYSICAL OR MENTAL HEALTH ARE AT RISK

UN human rights treaty bodies interpret the rights to life, health, non-discrimination and freedom from torture and other ill-treatment as requiring state parties to ensure access to abortion in law and in practice, in order to protect a woman's life and her physical and mental health. These bodies have consistently advised state parties to amend national laws on abortion to ensure access on these grounds. In 2014, the Human Rights Committee recommended that Ireland amend its abortion law, which only has a life exception, to include a health exception, as well as exceptions for rape, incest and fatal foetal abnormality.⁴⁰⁷

A decision by the Human Rights Committee established that denying access to an abortion on health grounds violated a woman's most basic human rights. In *K.L. v. Peru*, the Committee reasoned that state failure to enable the applicant to benefit from a therapeutic abortion caused the depression and emotional distress she experienced, and thus constituted a violation of Article 7 of the ICCPR (the right not to be subject to torture or cruel, inhuman or degrading treatment or punishment).⁴⁰⁸ Article 7 therefore requires a state to guarantee access to lawful abortion where necessary to protect a woman's physical or mental health. The Human Rights Committee ordered the state (in this case, Peru) to provide the complainant with an effective remedy, including compensation, and to take steps to prevent

⁴⁰⁴ *LC v Peru* CEDAW Committee (2011).

⁴⁰⁵ CEDAW General Recommendation 24: Women and health, para. 14.

⁴⁰⁶ CEDAW General Recommendation 19: Violence Against Women (1992), para 24(m).

⁴⁰⁷ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

⁴⁰⁸ *K.L. v. Peru*, HRC.

the future occurrence of similar violations.⁴⁰⁹

ABORTION ON GROUNDS OF PREGNANCY AS A RESULT OF RAPE OR INCEST

UN treaty monitoring bodies widely agree that abortion should be legal when a pregnancy results from rape and have repeatedly urged countries to amend their laws to this effect.⁴¹⁰ They have also urged states to take measures to provide for implementation mechanisms to ensure availability and accessibility of abortion on rape and incest grounds and to adopt relevant medical standards to this end.⁴¹¹

In its 2011 review of Paraguay, the Committee against Torture, for example, expressed concern about the long-standing psychological consequences of banning abortion in cases of sexual violence, incest, or when the foetus is not viable. The Committee made similar findings in its review of Nicaragua in 2009, stating that laws that deny access to abortion in cases of sexual violence leads to “constant exposure to the violation... and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression”, recommending that the state liberalize its laws to allow for abortion in cases of sexual violence as a means of relieving such trauma.⁴¹²

Addressing a law which only permitted abortion in instances of rape when the woman is mentally disabled, the Human Rights Committee urged the state of Argentina to amend their abortion laws to permit abortion in *all* cases of rape.⁴¹³ In 2011, the CEDAW Committee decided the case of *L.C. v. Peru*, involving a young woman who, after becoming pregnant as a result of rape, was denied urgently needed spinal surgery because of the risk it would pose to her pregnancy. Under Peru's restrictive abortion laws, abortion is only legal when the pregnancy poses a risk to the life or health of the woman or girl, and there is not an exception when pregnancy results from rape. In its decision, the CEDAW Committee urged Peru to “review its legislation with a view to decriminalizing abortion when the pregnancy results

⁴⁰⁹ *K.L. v. Peru*, HRC.

⁴¹⁰ See for example: CRC Concluding Observations: Argentina, UN Doc. CRC/C/ARG/CO/3-4 (2010) para. 59 (“The Committee recommends that the State party... Take urgent measures to reduce maternal deaths related to abortions, in particular ensuring that the provision on non-punishable abortion, especially for girls and women victims of rape, is known and enforced by the medical profession without intervention by the courts and at their own request”); CESCR Concluding Observations: Peru, UN Doc. E/C.12/PER/CO/2-4 (2012) para. 21 (“it recommends that the criminal code be amended so that consensual sexual relations between adolescents are no longer considered as a criminal offence and that abortion in case of pregnancy as a result of rape is not penalized.”); CESCR Concluding Observations: Kenya, UN Doc. E/C.12/KEN/CO/1 (2008), para. 33 (“The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by... decriminalizing abortion in certain situations, including rape and incest.”); HRC Concluding Observations: Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20 (“The State party should, pursuant to article 3 of its Constitution, include additional exceptions to the prohibition of abortion so as to save women from having to resort to clandestine abortion services that endanger their lives or health in cases such as pregnancy resulting from rape or incest .”)

⁴¹¹ CEDAW Concluding Observations: Kuwait, UN Doc. CEDAW/C/KWT/CO/3-4 (2011) para. 43(d); CAT Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009).

⁴¹² CAT Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009); CAT Concluding Observations: Paraguay, UN Doc. CAT/C/PRY/CO/4-6 (2011).

⁴¹³ HRC Concluding Observations: Argentina, UN Doc. CCPR/CO/70/ARG (2000) para. 14.

from rape or sexual abuse".⁴¹⁴

ABORTION ON GROUNDS OF FOETAL IMPAIRMENT

International human rights bodies have repeatedly made clear that the denial of access to abortion in cases of severe and fatal foetal impairment is a violation of a woman's fundamental human rights, including her rights to privacy, health and freedom from torture and other ill-treatment.

In *K.L. v. Peru*, a case decided by the Human Rights Committee, a young woman pregnant with an anencephalic foetus – a fatal condition that medical science has well-established would not allow it to survive for more than a few hours or days beyond birth – was denied a therapeutic abortion. Instead, she was forced to carry the pregnancy to term until its inevitable death four days later. She became severely depressed as a result of this experience. The Committee explicitly held that the denial of a therapeutic abortion caused K.L. substantial and foreseeable "mental suffering" and amounted to a violation of Article 7, the prohibition against torture or to cruel, inhuman or degrading treatment or punishment.⁴¹⁵ The Committee also found that the state's failure to provide K.L. with a therapeutic abortion interfered arbitrarily with her private life.⁴¹⁶

In 2014, the Human Rights Committee expressed concern about Ireland's criminalization of abortion in cases of fatal foetal impairment and "the severe mental suffering caused by the denial of abortion services to women seeking abortions" in this context. The Committee recommended that Ireland amend its abortion law to provide for an exception to criminalization in cases of fatal foetal impairment.⁴¹⁷

The UN treaty bodies have not limited their calls for access to abortion to cases in which foetal impairments are such that stillbirth or death immediately after birth is a virtual certainty. The CEDAW Committee has called for access to abortion in cases of "severe" foetal impairment in recent concluding observations. In its July 2014 concluding observations on Peru, for example, the Committee recommended that the state "[e]xtend the grounds for legalization of abortion to cases of rape, incest and severe foetal impairment".⁴¹⁸ Similarly, the Committee noted in its 2012 concluding observations on Chile:

*"[T]he Committee deeply regrets that all the recent parliamentary initiatives aimed at decriminalizing abortion have failed in the State party, including those where the health or life of the mother are at risk, in cases of serious foetus malformation or rape."*⁴¹⁹

⁴¹⁴ *LC v. Peru*, CEDAW Committee, para. 9(b)(iii).

⁴¹⁵ *K.L. v. Peru*, HRC, para. 6.3.

⁴¹⁶ *K.L. v. Peru*, HRC, para. 6.4.

⁴¹⁷ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

⁴¹⁸ CEDAW Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014), para. 36(a).

⁴¹⁹ CEDAW Concluding Observations: Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012), para. 34.

II. CENSORSHIP AND DENIAL OF ABORTION-RELATED INFORMATION IS A VIOLATION OF FUNDAMENTAL HUMAN RIGHTS

Human rights standards require states to ensure that women have access to health information that is timely, complete, accessible, reliable and proactive on reproductive matters; this should include information about sexual and reproductive health services.⁴²⁰ Laws and practices that limit information from health care providers to a pregnant woman on the status of her health and the health of her pregnancy, including providing a comprehensive medical opinion on a diagnosis, prognosis and evaluation of treatment options and where and how to obtain them, conflict with legal and ethical principles in the provider-patient relationship. Such laws and practices are inconsistent with international and regional human rights standards. Moreover, the provision of comprehensive, non-biased information about abortion services abroad and support for women who seek such services is critical in a context where abortion is criminalized and stigma is pervasive.

A law that obstructs access to such information or supports the provision of inadequate or possibly erroneous information deprives women of the ability to make informed decisions on the basis of such information. The withholding of such information, whether prescribed by law or in practice, can result in serious and irreparable damage to women's mental and physical health, violating numerous human rights, including the right to information and potentially the right to be free from torture and other ill-treatment.

In its 2014 concluding observations and recommendation to Ireland, the Human Rights Committee raised concerns over the Regulation of Information Act regarding its restrictions on "information on crisis pregnancy options" and the "imposition of criminal sanctions on health care providers who refer women to abortion services outside the State". The Committee recommended that Ireland "mak[e] more information on crisis pregnancy options available through a variety of channels, and ensure that health care providers who provide information on safe abortion services abroad are not subject to criminal sanctions."⁴²¹

The UN Special Rapporteur on the right to health recognized that criminal laws and other legal restrictions interfere with respect for human dignity: "Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health."⁴²² In this context, the Special Rapporteur recommended that states decriminalize the provision of information relating to sexual and reproductive health.⁴²³ The UN Special Rapporteur on torture has affirmed that "access to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the right to health and to physical integrity".⁴²⁴

⁴²⁰ CEDAW, General Recommendation 24, Women and Health, UN Doc. A/54/38/Rev.1 (1999) chap. I; CESCR *General Comment 14, the right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4 (2000).

⁴²¹ HRC Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 9.

⁴²² UN Special Rapporteur on the Right to Health, *Interim report to the General Assembly*, UN Doc. A/66/150 (2011) para. 15.

⁴²³ UN Special Rapporteur on the Right to Health, *Interim report to the General Assembly*, para. 65 (e).

⁴²⁴ *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/22/53 (2013), para. 47.

The European Court of Human Rights recognized in two cases that deliberate withholding of abortion-related information amounted to a violation of Article 3, the right to be free from torture and inhuman and degrading treatment or punishment.⁴²⁵ In finding a violation of the prohibition of inhuman and degrading treatment, the Court took into account the implications that the intentional denial and manipulation of information had on the applicants' dignity and the level of suffering resulting from such conduct.

In the European Court of Human Rights case of *R.R. v Poland*, the applicant had repeatedly been denied a genetic prenatal examination after her doctor discovered foetal irregularities during a sonogram.⁴²⁶ The examination would have informed R.R.'s decision on whether or not to terminate her pregnancy, yet doctors, hospitals, and administrators denied R.R. information and diagnostic tests until abortion was no longer a legal option.⁴²⁷ The Court noted that the right of access to information is often crucial for the woman to exercise personal autonomy by making decisions, on the basis of that information, that affect her future quality of life.⁴²⁸ In the case of R.R., access to relevant health-related information was directly relevant for the exercise of personal autonomy, as the information R.R. sought to obtain was relevant to a decision concerning lawful termination of pregnancy.⁴²⁹

In finding a violation of Article 3, the European Court of Human Rights recognized the humiliation and suffering R.R. endured both before and after the results of her tests became known. This was due to her poor treatment by doctors, despite being in a position of vulnerability in carrying a pregnancy with a potentially severe foetal impairment and having a need for health care services. The Court recognized that her humiliation and suffering was aggravated by the fact of the availability of such services and her entitlement to them under the law.⁴³⁰ The Court noted R.R.'s access to genetic testing as being "marred by procrastination, confusion and lack of proper counselling and information" and that ultimately she only obtained admission to a hospital where the genetic tests were conducted "by means of subterfuge".⁴³¹ The Court recognized that:

*"[T]he applicant was in a situation of great vulnerability. Like any other pregnant woman in her situation, she was deeply distressed by information that the foetus could be affected with some malformation... As a result of the procrastination of the health professionals... she had to endure weeks of painful uncertainty concerning the health of the foetus, her own and her family's future... She suffered acute anguish through having to think about how she and her family would be able to ensure the child's welfare, happiness and appropriate long-term medical care."*⁴³²

⁴²⁵ European Court of Human Rights: *P. and S. v. Poland* (App. No. 5735/08) (2012); *R.R. v Poland* (App. No. 27617/04)(2011). In both cases the Court also found violations of Article 8, the right to private life.

⁴²⁶ *R.R. v Poland*, paras. 144-147.

⁴²⁷ *R.R. v Poland*, para. 115.

⁴²⁸ *R.R. v Poland*, para. 197.

⁴²⁹ *R.R. v Poland*, paras. 197-198. While Poland has one of the most restrictive abortion laws in Europe, the law does allow for abortion in cases of foetal abnormality and also entitles women to receive genetic prenatal examinations.

⁴³⁰ *R.R. v Poland*, paras. 159-160.

⁴³¹ *R.R. v Poland*, para. 153.

⁴³² *R.R. v Poland*, para. 159.

The Court, in finding a violation of the prohibition of inhuman and degrading treatment, characterized the provision of information and treatment of the patient by doctors in relation to access to information as “shabby and humiliating”.⁴³³ The Court essentially recognized that the quality of information received by R.R. was contrary to Polish law. Irish law appears to mandate and support a similar quality of information.

The case of *P. and S. v Poland* concerned a minor seeking a lawful abortion on grounds of rape. She was not provided with complete information about the abortion procedure nor any information on post-abortion care, was misinformed about the legal requirements to obtain an abortion and was not given “appropriate and objective medical counselling with due regard to [her] own views and wishes”.⁴³⁴ The Court found that the circumstances taken as a whole, including the “lack of proper and objective counselling and information” violated Article 3.⁴³⁵

Other international and regional human rights bodies have also urged states to refrain from censoring or withholding such information or preventing participation in health-related matters.⁴³⁶ The Committee on Economic, Social and Cultural Rights has specifically recognized states parties' obligation to respect the right to health by refraining from “deliberate[ly] withholding or misrepresent[ing] information vital to health protection or treatment”.⁴³⁷ International human rights standards set a high bar for withholding health information from a patient. For example, the European Convention on Human Rights and Biomedicine permits restrictions on the provision of information only where absolutely necessary, such as where disclosure of information would endanger the patient's life or health.⁴³⁸

In the case of *Open Door Counselling and Dublin Well Woman v. Ireland*, the European Court of Human Rights found that an injunction preventing two women's health clinics from disseminating information to women in Ireland on legal abortion services in England violated Article 10, the right to freedom of expression, of the European Convention on Human Rights.⁴³⁹ The Court recognized that the injunction “may have had more adverse effects on women who were not sufficiently resourceful or had not the necessary level of education to have access to alternative sources of information”.⁴⁴⁰ Similarly, the impact of Ireland's censorship of information and lack of referrals will fall most heavily on women who face literacy, language or other barriers to accessing abortion information and services, and for whom a health care provider's assistance in making arrangements for abortion may be critical to ensuring their health and well-being.

⁴³³ *R.R. v Poland*, para. 160.

⁴³⁴ *P. and S. v. Poland*, para. 108.

⁴³⁵ *P. and S. v. Poland*, paras. 167-169.

⁴³⁶ Committee on Economic, Social and Cultural Rights, *General Comment 14*, para. 34.

⁴³⁷ Committee on Economic, Social and Cultural Rights, *General Comment 14*, para. 50.

⁴³⁸ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine), (1997), Article 10 and its Explanatory Report.

⁴³⁹ *Open Door and Dublin Well Woman v. Ireland* (App. No. 14234/88; 14235/88) ECHR 68 (1992).

⁴⁴⁰ *Open Door and Dublin Well Woman v. Ireland*, para. 77.

WHETHER IN A HIGH-PROFILE CONFLICT OR A FORGOTTEN CORNER OF THE GLOBE, **AMNESTY INTERNATIONAL** CAMPAIGNS FOR JUSTICE, FREEDOM AND DIGNITY FOR ALL AND SEEKS TO GALVANIZE PUBLIC SUPPORT TO BUILD A BETTER WORLD

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I WANT TO HELP



SHE IS NOT A CRIMINAL

THE IMPACT OF IRELAND'S ABORTION LAW

Ireland's Constitution and abortion legislation result in violations of the fundamental human rights of women and girls, including their rights to life, health, equality, non-discrimination, privacy, information and freedom from torture and other ill-treatment.

Ireland has one of the world's most restrictive abortion laws. Women and girls cannot legally have an abortion in Ireland unless there is a risk to their life. And even where that is the case, access is difficult. Having an abortion under any other circumstances is a criminal offence, carrying a possible 14-year prison sentence both for the woman and the abortion provider. In addition, Ireland's restrictive Regulation of Information Act makes the provision of routine information by doctors, counsellors and nurses a crime as it bans "promoting or advocating" abortion.

The Republic of Ireland forces around 4,000 women and girls each year to travel abroad in order to obtain an abortion. Those who cannot travel are forced to continue with their pregnancy or resort to an illegal and unsafe abortion. This includes women and girls whose health is at risk, rape survivors, those faced with fatal or severe foetal impairment pregnancies, and women for whom parenting is not an option.

The barriers and stigma faced by women and girls in Ireland are documented in this report through personal testimonies that illustrate the devastating impact and stifling effect of Ireland's ongoing criminalization of abortion.

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