

**Observations by the Irish Human  
Rights and Equality Commission on  
the *General Scheme of a Bill Entitled  
Health (Regulation of Termination of  
Pregnancy) Bill 2018***

*September 2018*



**Coimisiún na hÉireann um Chearta  
an Duine agus Comhionannas**  
Irish Human Rights and Equality Commission

# **Observations by the Irish Human Rights and Equality Commission on the *General Scheme of a Bill Entitled Health (Regulation of Termination of Pregnancy) Bill 2018***

September 2018

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## Introduction

1. The Irish Human Rights and Equality Commission ('the Commission') is both the national human rights institution and the national equality body for Ireland, established under the Irish Human Rights and Equality Commission Act 2014. The Commission has a statutory mandate to keep under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights and equality, and to make recommendations to the Government to strengthen, protect and uphold human rights and equality in the State.
2. The Commission published a policy paper<sup>1</sup> in October 2017 setting out some of the principles that may best inform a reformed legal and regulatory framework governing access to abortion in Ireland in order to ensure it meets the State's international human rights obligations, including the obligation to guarantee women's right to the highest attainable standard of physical and mental health. The paper was published in the context of the establishment of a Joint Oireachtas Committee on the Eighth Amendment of the Constitution<sup>2</sup> and the Government's confirmed intention to hold 'a referendum on the eighth amendment in 2018'<sup>3</sup>.

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<sup>1</sup> Irish Human Rights and Equality Commission (2017), *Human rights and equality considerations in the development of a new legislative and regulatory framework on abortion*. Available at <https://www.ihrec.ie/app/uploads/2017/10/Human-rights-and-equality-considerations-in-the-development-of-a-new-legislative-and-regulatory-framework-on-abortion.pdf>. Hereafter cited as 'IHREC policy paper 2017'. The Commission also made a detailed submission to the Citizens' Assembly in December 2016 in the context of the Assembly's deliberations on the Eighth Amendment to the Constitution. The Commission's submission focused on the applicable regional and international human rights and equality standards which apply to women's access to reproductive health services, including abortion, and outlined in detail the human rights and equality shortcomings in Ireland's legal and regulatory framework on abortion as articulated to date by international human rights bodies. Irish Human Rights and Equality Commission (2016) *Submission to the Citizens' Assembly in its consideration of Article 40.3.3*<sup>o</sup>. Available at <https://www.ihrec.ie/documents/ihrec-submission-citizens-assembly-consideration-article-40-3-3-irish-constitution/> (hereafter 'IHREC Citizens' Assembly submission 2016').

<sup>2</sup> The Committee was established on 4 April 2017 and dissolved on 20 December 2017. See <https://www.oireachtas.ie/en/committees/32/eighth-amendment-constitution/>.

<sup>3</sup> Taoiseach Leo Varadkar TD speaking in Dáil Éireann on 14 July 2017. Available at <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2017061400030?opendocument>.

3. The Commission was invited by the Chair of the Joint Oireachtas Committee to address it on 4 October 2017<sup>4</sup>. In its policy paper, and in its engagement with the Joint Committee, the Commission stated the view that the constitutional framework:
  - puts in place barriers to women’s right to bodily autonomy and the highest attainable standard of health, as enshrined in international human rights law;<sup>5</sup> and
  - disproportionately impacts on particular groups of women in the state, contributing to their unequal treatment depending on their socio-economic, health, immigration, disability or other status.<sup>6</sup>
4. The Commission recommended that a referendum be carried out to put to the People the deletion of Article 40.3.3° of the Constitution in order to permit the development of a framework governing access to abortion in Ireland that has a basis in primary legislation and regulation.<sup>7</sup>
5. The policy paper also drew attention to a number of over-arching considerations in the formulation of a new framework governing access to abortion. This included:

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<sup>4</sup> Transcript available at

[https://www.oireachtas.ie/en/debates/debate/joint\\_committee\\_on\\_the\\_eighth\\_amendment\\_of\\_the\\_constitution/2017-10-04/2/](https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-10-04/2/)

<sup>5</sup> In international human rights law, a clear linkage has been made between access to abortion for reasons of health and the right to the highest attainable standard of physical and mental health, as guaranteed by Article 12 of the UN International Covenant on Economic, Social and Cultural Rights. In its 2000 General Comment on Article 12, the Committee on Economic, Social and Cultural Rights (CESCR) states that the right to health encompasses: ‘the right to control one’s health and body, including sexual and reproductive freedom’ (at para. 8). With respect to the health needs of women, the Committee makes clear that: ‘The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health’ (at para. 21). See also UN Committee on Economic, Social and Cultural Rights (CESCR) (2016), *General Comment No. 22: the right to sexual and reproductive health, (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, E/C.12/GC/22/, Available at

[http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en). See Para 34: ‘States parties are under immediate obligation to eliminate discrimination against individuals and groups and to guarantee their equal right to sexual and reproductive health. This requires States to repeal or reform laws and policies that nullify or impair the ability of certain individuals and groups to realize their right to sexual and reproductive health. There exists a wide range of laws, policies and practices that undermine autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example criminalization of abortion or restrictive abortion laws.’

<sup>6</sup> IHREC policy paper 2017, p.24.

<sup>7</sup> IHREC policy paper 2017, p.25.

- the need for the state to approach legislation for and regulation of access to abortion services in Ireland primarily as a matter of healthcare policy;<sup>8</sup>
  - the decriminalization of abortion in all circumstances;<sup>9</sup>
  - the need to avoid onerous certification and assessment procedures;<sup>10</sup>
  - the need to avoid replication of conditions that have led to human rights violations, and to avoid the creation of new processes where vulnerable women and girls may be subject to trauma, re-victimization, delays in treatment or other harms.<sup>11</sup>
6. The Commission recommended that a reformed framework for access to abortion services in Ireland should encompass circumstances that reflect the wider reproductive health needs of women in Ireland, including: risk to life, health or wellbeing; socio-economic or family circumstances; pregnancy due to rape or incest; and fatal foetal abnormality. The Commission recommended that these circumstances be incorporated into a framework for access to abortion services in Ireland that places the decision-making process primarily in the hands of the pregnant person in consultation with their physician, and that avoids to the greatest extent possible onerous grounds-based certification procedures.<sup>12</sup>
7. On foot of the May 2018 referendum outcome,<sup>13</sup> repealing the Eighth Amendment, the Minister for Health has indicated that Government will enact legislation on regulation of termination of pregnancy as a matter of priority. A draft general scheme of proposed legislation was published in March 2018 in advance of the referendum campaign, and an updated version of this scheme was approved by Government and published on 10 July 2018.<sup>14</sup>

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<sup>8</sup> IHREC policy paper 2017, p.10.

<sup>9</sup> IHREC policy paper 2017, p.11.

<sup>10</sup> IHREC policy paper 2017, p.17.

<sup>11</sup> IHREC policy paper 2017, p.25.

<sup>12</sup> IHREC policy paper 2017, pp. 25-26.

<sup>13</sup> There was a 64.13% turnout at the referendum; 66.4% voted Yes to repeal the Eighth Amendment and 33.6% voted No. Of the total valid poll of 2 153 613, 1 429 981 voted Yes and 723 632 voted No.

<sup>14</sup> Department of Health (10 July 2018), Press Release, 'Minister Harris gets Government approval for legislation which will provide for the Regulation of Termination of Pregnancy in Ireland'. At <https://health.gov.ie/blog/press-release/minister-harris-gets-government-approval-for-legislation-which-will-provide-for-the-regulation-of-termination-of-pregnancy-in-ireland/>

8. The Commission notes, in particular, the approach taken in Head 7, allowing for access to termination in early pregnancy without a grounds-based certification procedure, but subject to a three-day waiting period.
9. The Commission also notes provisions in the scheme at Heads 4-5 for access to termination of pregnancy for reasons of risk to life or health, and the provision at Head 6 for termination of pregnancy where there is present a condition affecting the foetus that is likely to lead to the early death of the foetus.
10. The Commission recalls its concerns regarding the possible harmful effects of onerous certification and assessment procedures and delays in treatment.<sup>15</sup> In fulfilment of its statutory functions<sup>16</sup> the Commission will continue to track the detail of legislative proposals and related regulations, to assess the degree to which procedures envisaged under these Heads, and the review procedures envisaged under Heads 8-12, safeguard the right to bodily autonomy and the highest attainable standard of health.
11. The Commission notes that in the absence of new legislation and regulation, the legal and regulatory environment remains unchanged, and barriers to women's right to bodily autonomy and the highest attainable standard of health persist.
12. In this paper, the Commission would like to focus on two specific themes that arise in the context of this scheme of the Bill:
  - conscientious objection; and
  - equality of access to services

The Commission may provide further commentary on this scheme of Bill, or on subsequent draft legislation or regulations, in due course.

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<sup>15</sup> IHREC policy paper 2017, p.17, 25-26.

<sup>16</sup> Under Section 10(2)(b) of the Irish Human Rights and Equality Commission Act 2014, the Commission has a statutory function 'to keep under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights and equality'.

## Conscientious objection

13. Article 44 of the Constitution broadly guarantees freedom of religion and of conscience to all citizens, 'subject to public order and morality'.<sup>17</sup> The State has an obligation under the European Convention on Human Rights to vindicate the right of everyone to freedom of thought, conscience and religion, 'subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others'.<sup>18</sup> The State has similar obligations under the UN International Covenant on Civil and Political Rights (ICCPR).<sup>19</sup>

14. It is possible to effectively guarantee the freedom of religion and of conscience of medical practitioners while also safeguarding the right of women and girls to bodily autonomy and the highest attainable standard of health. Provision for conscientious objection is a regular feature of the legal frameworks for access to abortion services in many jurisdictions.<sup>20</sup> In its October 2017 policy paper, the Commission recommended that a reformed framework for access to abortion services in Ireland should put appropriate provisions in place to safeguard the right of medical practitioners to conscientious objection where there is no immediate danger to the patient's life or health.<sup>21</sup>

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<sup>17</sup> Article 44.2.1° of the Constitution of Ireland: 'Freedom of conscience and the free profession and practice of religion are, subject to public order and morality, guaranteed to every citizen'.

<sup>18</sup> Article 9, European Convention on Human Rights (ECHR). The European Convention on Human Rights Act 2003 (ECHR Act) incorporates the standards set out in the ECHR in Irish law, allowing them to be considered before the Irish Courts.

<sup>19</sup> Article 18(3) of the ICCPR reads: 'Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.'

<sup>20</sup> For a comparative analysis of the regulation of conscientious objection to abortion in the UK, Norway, Portugal and Italy, see Wendy Chavkin *et al*, 'Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study', *Health and Human Rights Journal*, Volume 19, No 1, June 2017, p. 55.

<sup>21</sup> IHREC policy paper 2017, p.28.



15. Under the current legal framework, Section 17 of the Protection of Life During Pregnancy Act 2013 permits conscientious objection by medical practitioners in the context of procedures provided for in that Act.<sup>22</sup> Medical procedures undertaken due to the risk of loss of life in an emergency are explicitly excluded from the purview of this section.<sup>23</sup> The section further obliges the objecting medical practitioner to transfer the care of the patient to enable the procedure to be carried out.<sup>24</sup>
16. Head 15 of the general scheme appears to be closely modelled on Section 17 of the Protection of Life During Pregnancy Act 2013. Head 15 (1) of the scheme provides that nothing in the bill will oblige a *medical practitioner, nurse or midwife* carry out, or to participate in carrying out, a termination of pregnancy under Head 4 (Risk to life or health), Head 6 (Condition likely to lead to death of foetus), or Head 7 (Early pregnancy). Termination of pregnancy due to risk to life or health in emergency (Head 5) is explicitly excluded from the purview of Head 15 in subhead 15(2).<sup>25</sup>
17. Subhead 15(3) provides that ‘A person who has a conscientious objection referred to in *subhead (1)* shall, as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the termination of pregnancy concerned’.
18. The Commission notes that Head 15 (1) does not refer to the wider health and social care professions with whom a pregnant person may come into contact, and to whom considerations of conscientious objection may also apply. The Commission is of the view that legislation should also ensure appropriate referral mechanisms for transfer of care by the wider cohort of health and social care professionals in the event of conscientious objection.

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<sup>22</sup> Section 17(1): ‘Subject to subsections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, any medical procedure referred to in section 7(1) or 9(1) to which he or she has a conscientious objection.’

<sup>23</sup> Section 17 (2): ‘Subsection (1) shall not be construed to affect any duty to participate in any medical procedure referred to in section 8(1)’.

<sup>24</sup> Section 17(3): ‘A person who has a conscientious objection referred to in subsection (1) shall make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the medical procedure concerned.’

<sup>25</sup> Head 15(2): *Subhead (1)* shall not be construed to affect any duty to participate in a termination of pregnancy in accordance with Head 5(1).

19. **The Commission welcomes the provision outlined in Head 15 (3).<sup>26</sup> The obligation for expeditious transfer of care is in line with international best practice,<sup>27</sup> and essential to ensure that conscientious objection does not pose a barrier to safe and timely access to care under the legislation.**
20. **The Commission recommends that the provisions of Head 15 be made to apply more broadly than currently outlined in Head 15(1), to provide for the possibility of conscientious objection by the broader range of health and social care profession with whom a pregnant woman or girl may come into contact.**
21. **The Commission recommends that in addition to the provision in legislation, clear procedures for expeditious transfer of care are provided through regulation and guidelines.**

### **Accommodating conscientious objection: institutional and organisational challenges**

22. The accommodation of conscientious objection has the potential to pose organisational and institutional challenges for healthcare institutions, and to the State, in their allocation and deployment of staff and resources within the healthcare system.
23. The European Committee of Social Rights has heard a number of recent collective complaints against Italy under the Revised European Social Charter<sup>28</sup> concerning the

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<sup>26</sup> This is the majority view of the Irish Human Rights and Equality Commission. One member of the Commission did not support this view.

<sup>27</sup> International Federation of Gynecology and Obstetrics (FIGO), *Resolution on 'Conscientious Objection (Kuala Lumpur, 2006)*: 'FIGO affirms that to behave ethically, practitioners shall: [...] 2. Refer patients who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services'. See also World Health Organization (WHO) (2012), *Safe abortion: technical and policy guidance for health systems, Second edition* at p. 69: 'Health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible healthcare facility, in accordance with national law.'

<sup>28</sup> The Revised European Social Charter (the Revised Charter) was adopted by the Council of Europe in 1996 and sets out those human rights which are described as 'economic and social' rights. The Revised European Social Charter comprises the European Social Charter (adopted by the Council of Europe in 1961) together with its additional Protocol and other amendments. Ireland ratified the Revised Charter in 2000. Social partners and

accessing of abortion services where a high number of medical practitioners were exercising the right to conscientiously object to carrying out the termination of pregnancies.<sup>29</sup> It decided that: ‘the provision of abortion services must be organised so as to ensure that the needs of patients wishing to access services are met’<sup>30</sup> and that the availability of healthcare ‘applies with particular force to time-sensitive procedures such as abortion’.<sup>31</sup> The unavailability of non-objecting practitioners, particularly in certain areas, resulted in a violation of the right to protection of health (Article 11)<sup>32</sup> and in conjunction with that right, found that the treatment involved multiple discrimination (Article E).<sup>33</sup> Additionally, the Committee found discriminatory treatment in relation to the treatment of the non-objecting medical practitioners who were found to have suffered cumulative disadvantages at work.<sup>34</sup>

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non-governmental organisations can lodge collective complaints regarding violations by states who are party to the Revised Charter. Complaints are examined by the European Committee of Social Rights, following which it adopts a decision on the merits of the complaint. The Committee of Ministers subsequently adopts a resolution and may recommend that the State concerned take specific measures to bring the situation into line with the Charter.

<sup>29</sup> In this way, lawful abortion services were not available in practice, particularly in certain regions of Italy. See *International Planned Parenthood Federation – European Network (IPPR EN) v Italy* (Complaint No. 87/2012), available at: <http://hudoc.esc.coe.int/eng/?i=cc-87-2012-dmerits-en> and *Confederazione Generale Italiana del Lavoro (CGIL) v Italy* (Complaint No. 91/2013), available at: <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168063ecd7>.

<sup>30</sup> Para. 163 of *International Planned Parenthood Federation – European Network (IPPR EN) v Italy* (Complaint No. 87/2012), available at: <http://hudoc.esc.coe.int/eng/?i=cc-87-2012-dmerits-en>.

<sup>31</sup> Para. 164 of *International Planned Parenthood Federation – European Network (IPPR EN) v Italy* (Complaint No. 87/2012), available at: <http://hudoc.esc.coe.int/eng/?i=cc-87-2012-dmerits-en>.

<sup>32</sup> Article 11 of the Revised European Social Charter provides as follows:

‘With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.’

<sup>33</sup> Article E of the Revised Charter provides as follows: ‘The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status.’

<sup>34</sup> The Committee decided that there had been a violation of Article 1(2) of the Revised Charter in *Confederazione Generale Italiana del Lavoro (CGIL) v Italy* (Complaint No. 91/2013), available at: <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168063ecd7>

24. Therefore, there is a risk that provision for conscientious objection could place undue barriers in the path of women seeking abortion services. To avoid this, conscientious objection must operate within a legislative and regulatory framework that ensures the necessary systems, personnel and resources to guarantee that women are provided safe and timely access to medical procedures.

25. The European Court of Human Rights has pointed to this obligation under the ECHR:

‘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’.<sup>35</sup>

The Council of Europe has placed an emphasis on the ability of the healthcare system to foresee and plan for conscientious objection, recommending that States should:

‘establish clear procedures within healthcare facilities for medical personnel to report in advance their refusal to provide certain services, including the establishment of a register of objecting providers, and should clearly establish the duties of objecting healthcare providers.’<sup>36</sup>

**26. Government should take every necessary measure to ensure that healthcare institutions have the means to plan for and accommodate conscientious objection in a way that does not adversely affect women’s and girls’ access to services.**

**27. The Commission considers that provision for advance declaration and registration of conscientious objection by medical practitioners may assist medical institutions to effectively plan for and accommodate conscientious objection, and identify gaps in effective access to services.**

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<sup>35</sup> *R.R. v Poland* (App. 27617/04), 28 November 2011, para 206.

<sup>36</sup> McCafferty, Christine (Rapporteur), Council of Europe Parliamentary Assembly Social, Health and Family Affairs Committee, *Women’s access to lawful medical care: the problem of unregulated use of conscientious objection*, Doc 12347, 20 July 2010, para.19.

## Equality and universality of access to services

### Socio-economic considerations

28. The UN Committee on Economic, Social and Cultural Rights and the World Health Organisation have highlighted clear links between barriers to accessing reproductive health services and social inequality.<sup>37</sup>
29. General Comment 22 of the Committee on Economic, Social and Cultural rights underlines the importance of States providing reproductive health services that are affordable for all,<sup>38</sup> and ensuring:
- ‘universal access without discrimination for all individuals, including those from disadvantaged and marginalized groups, to a full range of quality sexual and reproductive health care, including maternal health care; contraceptive information and services; safe abortion care’.<sup>39</sup>
30. The Commission has outlined its concern that the current legal framework on abortion disproportionately impacts on certain groups of women, in particular those

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<sup>37</sup> CESCR GC 22, para. 8: ‘the right to sexual and reproductive health is also deeply affected by: “social determinants of health”, as defined by WHO. In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distribution of power based on gender, ethnic origin, age, disability and other factors. Poverty, income inequality, systemic discrimination and marginalization based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well. The nature of these social determinants, which are often expressed in laws and policies, limits the choices that individuals can exercise with respect to their sexual and reproductive health. Therefore, to realize the right to sexual and reproductive health, States parties must address the social determinants as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health.’

<sup>38</sup> CESCR GC 22, para. 17.

<sup>39</sup> CESCR GC 22, para. 45. See also United Nations General Assembly (2011), *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/66/254: ‘laws prohibiting public funding of abortion care ... make safe abortions and post-abortion care unavailable, especially to poor, displaced and young women’. Para. 24.

who cannot access abortion services abroad due to their socio-economic circumstances.<sup>40</sup>

31. Further, the Commission has stressed the importance of ensuring that a reformed legal framework for access to abortion avoids creating or replicating barriers to access.<sup>41</sup> This includes any barriers to access based on socio-economic status.
32. While the question of universal access to services is outside the scope of the current Scheme of Bill, the Minister for Health has recently confirmed that Government has approved the inclusion in legislation of provision that: ‘services for the termination of pregnancy will be provided on a universal basis – so that cost is not a barrier for women to access these services’.<sup>42</sup>
33. **Recalling its 2017 recommendation<sup>43</sup> that services available under the new framework should be incorporated into the existing public health and social welfare system, and made available to all, without discrimination, the Commission welcomes confirmation that services for the termination of pregnancy will be provided on a universal basis.**

## Geographical considerations and rural women

34. The UN Convention on the Elimination of Discrimination against Women (CEDAW)<sup>44</sup> obliges the State to ‘take all appropriate measures to eliminate discrimination against women in rural areas’, including ensuring that such women have the right to

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<sup>40</sup> IHREC policy paper 2017, p.17; IHREC Citizens’ Assembly submission 2016, p.30. The UN Human Rights Committee’s decisions in both *Mellet* and *Whelan* pointed to the communicants’ differential treatment due to their socio-economic circumstances. See Human Rights Committee (2016) *Mellet* decision, para. 7.11: ‘The differential treatment to which the author was subjected in relation to other similarly situated women failed to adequately take into account her medical needs and socio-economic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy of purpose’. See also Human Rights Committee (2017) *Whelan* decision, para. 7.12.

<sup>41</sup> IHREC policy paper 2017, p.24.

<sup>42</sup> Department of Health (10 July 2018), Press Release, ‘Minister Harris gets Government approval for legislation which will provide for the Regulation of Termination of Pregnancy in Ireland’. At <https://health.gov.ie/blog/press-release/minister-harris-gets-government-approval-for-legislation-which-will-provide-for-the-regulation-of-termination-of-pregnancy-in-ireland/>.

<sup>43</sup> IHREC policy paper 2017, p.32.

<sup>44</sup> Ireland signed and ratified the CEDAW Convention in 1985.

‘access to adequate health care facilities, including information, counselling and services in family planning’.<sup>45</sup>

35. The CEDAW Committee has outlined the potential barriers faced by rural women, in particular older women and women with disabilities, in accessing reproductive healthcare. These barriers include ‘insufficient budget allocations to rural health services’, and ‘lack of infrastructure and trained personnel’.<sup>46</sup> The Committee has underlined the need for States Parties to ensure that ‘quality health care services and facilities are physically accessible and affordable for rural women’, including ‘family planning; access to contraception, including emergency contraception; and to safe abortion and quality post-abortion care’.<sup>47</sup>

36. The European Committee of Social Rights (ECSR) has also highlighted the relevance of geographical location to prompt and effective access to services, noting:

‘Women who are denied access to abortion facilities in their local region may in effect be deprived of any effective opportunity to avail of their legal entitlement to such services, as the tight time-scale at issue may prevent them from making alternative arrangements’.<sup>48</sup>

The ECSR has further commented on the potential limitations of publicly-funded abortion services where they are inadequately geographically distributed, noting: ‘if a service is not available in practice, it is irrelevant whether it is for free or has to be paid for’.<sup>49</sup>

37. Unavailability of regional access to services under the proposed legislation would risk disproportionately impacting particular groups of women in the state, contributing to

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<sup>45</sup> Article 14, CEDAW.

<sup>46</sup> UN Committee on the Elimination of all forms of Discrimination against Women (CEDAW) (2016), *General Recommendation No. 34 on the rights of rural women*, CEDAW/C/GC/34, para. 37.

<sup>47</sup> UN Committee on the Elimination of all forms of Discrimination against Women (CEDAW) (2016), *General Recommendation No. 34 on the rights of rural women*, CEDAW/C/GC/34, para. 39(a).

<sup>48</sup> *International Planned Parenthood Federation – European Network (IPPR EN) v Italy* (Complaint No. 87/2012), para. 193. Available at: <http://hudoc.esc.coe.int/eng/?i=cc-87-2012-dmerits-en>.

<sup>49</sup> *International Planned Parenthood Federation – European Network (IPPR EN) v Italy* (Complaint No. 87/2012), para. 193. Available at: <http://hudoc.esc.coe.int/eng/?i=cc-87-2012-dmerits-en>.

their unequal treatment, in particular where their geographic location intersects with their socio-economic, health, immigration, disability or other status. The Commission is of the view that universality and equality of access to services for the termination of pregnancy in Ireland will therefore be contingent on the availability of such services across the State, and not solely in specific urban areas.

- 38. The Commission recommends that the State ensure that all publicly funded healthcare institutions and services in the State fall within the scope of the legislation.**
- 39. The Commission recommends that where regional gaps in access to services are identified, appropriate remedial measures are taken to ensure safe and timely access to care under the legislation.**





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