SUBMISSION

Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018

Irish Human Rights and Equality Commission

November 2022

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

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The Irish Human Rights and Equality Commission was established under statute on 1 November 2014 to protect and promote human rights and equality in Ireland, to promote a culture of respect for human rights, equality and intercultural understanding, to promote understanding and awareness of the importance of human rights and equality, and to work towards the elimination of human rights abuses and discrimination.

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Contents

Recommendations

The Commission makes the following recommendations on the General Scheme.

Economic and Logistical Considerations

The Commission recommends that the Act be equality proofed to guarantee the universality and equality of access to abortion services for all women and girls, especially for victims of domestic violence, rural women, women living in poverty, disabled women, asylum seekers, women from ethnic or religious minorities, migrants, undocumented individuals, and temporary residents such as international students or women from Northern Ireland.

The Commission recommends that the current gaps in the provision of abortion care services are identified and addressed.

The Commission recommends the provision of support to women who incur additional costs accessing abortion, to ensure that abortion care is free to all at the point of access.

Data

The Commission recommends the design, development and resourcing of a robust national data framework and indicator set on abortion services, integrating continuous review.

The Commission recommends the development of a resourced research programme to build the evidence base around the operation of the Act and the experiences of service users and service providers.

Provision of Information

The Commission recommends that comprehensive, accessible and reliable health information is available to all sections of the public on abortion services, with targeted measures for structurally vulnerable groups.

Travelling Abroad

The Commission recommends the implementation of necessary measures to address the reasons why women and girls continue to travel abroad to seek abortion services upon being denied or not being able to access abortion services.

Section 11: Fatal Foetal Abnormality Criteria

The Commission recommends the reform of Section 11 so that there are legal avenues for abortion in all cases where fatal foetal anomalies are diagnosed.

Section 12: Mandatory Waiting Period

The Commission recommends that the mandatory waiting period set out in Section 12 of the Act be removed.

Section 22: Conscientious Objection

The Commission recommends measures to ensure that Section 22 and the current provision for conscientious objection does not erect barriers to access to abortion care.

The Commission recommends the establishment of an official register of conscientious objectors.

The Commission recommends research to examine the presence and operation of 'conscientious obstruction' and any impacts that this has on the provision of care.

The Commission recommends statutory guidance to medical practitioners reminding them of their legal and ethical obligations to ensure the expeditious transfer of care of patients seeking termination of pregnancy services.

Section 23: Criminal Penalties

The Commission recommends that abortion be decriminalised in all circumstances, as a matter of urgency.

Introduction

The Irish Human Rights and Equality Commission ('the Commission') is both the national equality body and national human rights institution for Ireland, established under *the Irish Human Rights and Equality Commission Act 2014*. In accordance with our founding legislation, we are mandated 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.[1] In our Strategy Statement 2022-2024, we have prioritised the following areas within the context of our work: seeking greater economic equality; access to justice; respect and recognition, promoting the eradication of racism, ableism, ageism and sexism through public understanding and State action; futureproofing, responding to crises that threaten rights and equality; and encouraging, reporting on and enforcing the compliance of public bodies with the Public Sector Equality and Human Rights Duty.[2]

In December 2021, the Minister for Health commenced the Review of the *Health (Regulation of Termination of Pregnancy Act) 2018* ('the Act'), statutorily required to take place within three years of enactment.[3] We have consistently provided recommendations intended to inform a legal and regulatory framework governing access to abortion in Ireland guided by the principles of equality and universality of access, compliance with the State's international human rights obligations and the respect, protection, and fulfilment of the rights of service users and providers.[4] We submitted legislative observations on the General Scheme of the Health (Termination of Pregnancy Services (Safe Access Zones)) Bill 2022.[5]

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[1] Section 10(2)(c) of the Irish Human Rights and Equality Commission Act 2014.
[2] IHREC, Strategy Statement 2022-2024 (2022).
[3] Department of Health, Minister for Health commences Phase one of the Review of the Health (Regulation of Termination of Pregnancy) Act 2018 (press release, 8 December 2021).
[4] IHRC (2013) Legislative Observations on the Protection of Life during Pregnancy Act 2013; IHREC (2016) Submission to the Citizens' Assembly in its consideration of Article 40.3.3 of the Constitution; IHREC (2017) Human rights and equality considerations in the development of a new legislative and regulatory framework on abortion; IHREC (2018) Observations on the General Scheme of a Bill Entitled *Health (Regulation of Termination of Pregnancy) Bill 2018*; IHREC (2022) Ireland and the International Covenant on Civil and Political Rights; IHREC (2020) Submission to the UN Committee on the Elimination of Discrimination Against Women; IHREC (2019) Ireland and the Convention on the Elimination of Racial Discrimination.
[5] IHREC (2022) Observations on the General Scheme of the Health (Termination of Pregnancy Services (Safe Access Zones)) Bill 2022.

We welcome the recent comments on the provision of abortion care in the State by the UN Human Rights Committee ('HRC') in its Concluding Observations on the State's periodic report.[6]

We welcome the opportunity to give our views on the operation of the legislation and to what extent it has been appropriate and effective,[7] and are available to the Independent Review to further discuss the information presented.

[6] Human Rights Committee (27 July 2022) Concluding Observations on the fifth periodic report of Ireland CCPR/C/IRL/CO/5.
[7] Joint Committee on Health, Debate: Review of Scope and Structure of Health (Regulation of Termination of Pregnancy) Act: Engagement with Minister for Health (8 Dec 2021).

Relevant Human Rights and Equality Standards

The stated objective of the Act; to govern access to termination of pregnancy services; engages a number of the State's obligations under international human rights law. In 2022, the World Health Organisation ('WHO') published its Abortion Care Guidelines ('WHO Guidelines'), which set out recommendations designed to deliver the highest possible quality of abortion care: care that is effective, efficient, accessible, acceptable/patient centred, equitable, and safe.[8] According to these guidelines the core rights and principles engaged by a legal and regulatory framework for abortion are the:

- right to the highest attainable standard of physical and mental health, including sexual and reproductive health and rights;[9]
- right to non-discrimination and equality;[10]
- right to life;[11]
- right to privacy;[12]
- right to be free from torture, cruel, inhuman and degrading treatment and punishment including the right to physical and mental integrity;[13]

[8] WHO (2022) Abortion care guideline.
[9] International Covenant on Economic, Social and Cultural Rights, Article 12; Universal Declaration of Human Rights, Article 15; Convention on the Elimination of All Forms of Racial Discrimination, Article 5; Convention on the Elimination of Discrimination Against Women, Articles 11, 12, 14; Convention on the Rights of Child, Article 24; Convention on the Rights of Persons with Disabilities, Article 25;
[10] Universal Declaration of Human Rights, Article 2; International Covenant on Civil and Political Rights, Articles 3, 26; International Covenant on Economic, Social and Cultural Rights, Article 2; Convention on the Elimination of All Forms of Racial Discrimination, Article 1; Convention on the Elimination of Discrimination Against Women, Articles 1, 2; Convention on the Rights of Child, Article 2; Convention on the Rights of Persons with Disabilities, Article 5.
[11] International Covenant on Civil and Political Rights, Article 6; Convention on the Rights of Child, Article 6; Universal Declaration of Human Rights, Article 3; Convention on the Rights of Persons with Disabilities, Article 10.
[12] International Covenant on Civil and Political Rights, Article 17; Universal Declaration of Human Rights, Article 12; Convention on the Rights of Child, Article 16; Convention on the Rights of Persons with Disabilities, Article 22.
[13] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; International Covenant on Civil and Political Rights, Article 7; Universal Declaration of Human Rights, Article 5; Convention on the Rights of Persons with Disabilities, Article 15; Convention on the Rights of Child, Article 37.

- right to decide freely and responsibly on the number, spacing and timing of children and to have the information and means to do so;[14]

- right to information and education, including on sexual and reproductive health;[15] and

- right to benefit from scientific progress and its realisation.[16]

State parties are required under the Convention on the Rights of Persons with Disabilities ('CRPD') to take measures to ensure the full and equal enjoyment by disabled women and girls of all human rights and fundamental freedoms, recognising that they are subject to multiple discriminations.[17] CRPD also requires that disabled persons are provided with the same standard of healthcare and programmes as provided to other persons, and that health services are provided as close as possible to people's own communities, including in rural areas.[18] [19]

[14] Convention on the Elimination of Discrimination Against Women, Article 16(1).
[15] International Covenant on Civil and Political Rights, Article 19; Universal Declaration of Human Rights, Article 19; Convention on the Elimination of Discrimination Against Women, Article 10, 14, 16; Convention on the Rights of Persons with Disabilities, Article 21; Convention on the Rights of Child, Article 13, 17.
[16] International Covenant on Economic, Social and Cultural Rights, Article 15.
[17] Convention on the Rights of Persons with Disabilities, Article 6.
[18] Convention on the Rights of Persons with Disabilities, Article 25.
[19] See IHREC (2022) Submission on the General Scheme of the Health (Termination of Pregnancy Services (Safe Access Zones)) Bill 2022, p6. The Commission is the designate Independent Monitoring Mechanism for the Convention on the Rights of Persons with Disabilities.

General Observations

Economic and Logistical Considerations

We reiterate the importance of ensuring that a legal framework for access to abortion avoids creating or replicating barriers to access, including barriers to access based on socio-economic status.[20] We previously recommended that regional gaps in services must be identified and remedied, because unequal distribution risks disproportionally impacting on structurally vulnerable groups in the State.[21]

Universality and equality of access is contingent on the availability of services across the State, so that individuals whose geographic location intersects with structural vulnerabilities may access termination of pregnancy services. The most recent available information shows that the number of GPs who provide abortion services is approximately 16% of the total population of practitioners.[22] However, only a smaller number of this cohort are listed on MyOptions, the rest only seeing existing patients, bringing the real proportion closer to 7%.[23] This has resulted in an unequal geographic distribution of service provision with some areas of the country such as the northwest particularly underserved. Data provided by the HSE shows that only four counties have a well-developed network of providing practitioners.[24] This is compounded by the fact that only 11 of 19 maternity units provide the full range of abortion services.[25] This translates into significantly longer travel times than

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[20] IHREC (2018) Observations on the General Scheme of a Bill Entitled *Health (Regulation of Termination of Pregnancy) Bill 2018*, pg. 12.

[21] IHREC (2018) Observations on the General Scheme of a Bill Entitled *Health (Regulation of Termination of Pregnancy) Bill 2018*, pg. 15; For the purpose of this parallel report, we define a structurally vulnerable person as someone who is particularly vulnerable to violations of their civil and political rights due to political, economic, social and cultural structures. Instead of focusing on the personal characteristics of individuals and groups and viewing them as lacking agency, 'structural vulnerability' refers to the structures in place which render certain sectors of the population particularly vulnerable to human rights abuses.

[22] Data reported as being accurate as of December 2021 see: Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 34

[23] Note: Information was provided to the NWCI by the HSE and published in - Abortion Working Group (AWG) (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018

[24] Note: Information was provided to the NWCI by the HSE and published in - Abortion Working Group (AWG) (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018

[25] The HSE website lists the hospitals providing abortion services as; the National Maternity Hospital, Coombe Women & Infants University Hospital, Midland Regional Hospital Mullingar, Rotunda Hospital, Our Lad of Lourdes Hospital Drogheda, University Hospital Galway, Mayo University Hospital, University Maternity Hospital Limerick, Cork University Maternity Hospital, University Hospital Waterford, Sligo University Hospital.

other forms of healthcare.[26] HSE-published research reports that this uneven geographical distribution runs the risk of abortion care not being available in practice, and has concluded that there is a need to increase GP provision in these sparse areas.[27]

The clinical guidance requirement that any pregnant woman who is post nine weeks gestation must be referred to a hospital exacerbates logistical access barriers by requiring service users to attend at least two appointments in one of 11 maternity units in the State, three of which are located on the east coast of Dublin.[28]

The State has obligations to ensure termination of pregnancy services are affordable.[29] In addition, the State has obligations to ensure termination of pregnancy services are available and physically accessible.[30] We welcome the recent practice of telemedicine as a measure to ameliorate the access issues posed by the uneven distribution of services.[31] [32]

International research has indicated that travel and the logistics involved, such as organising time off work, arranging childcare and paying for the travel itself can serve to delay access to abortion care.[33] Travel creates logistical and economic barriers for structurally vulnerable groups who do not have the mobility or resources to navigate the law easily, such as women living in abusive circumstances, or disabled women who require accessible transport and supports, including Irish Sign Language interpretation.[34]

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[26] Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg.44 – 57% of respondents reported having to travel further to access abortion care than they typically would for other forms of medical care and 30% reported travelling between 4-6 hours.
[27] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 34-35, 85.
[28] HSE (2018) Draft Model of Care for the Termination of Pregnancy Service.
[29] UN Committee on Economic, Social and Cultural Rights (2016) General comment No. 22 on the right to sexual and reproductive health, E/C.12/GC/22, para 17.
[30] UN Committee on Economic, Social and Cultural Rights (2016) General comment No. 22 on the right to sexual and reproductive health, E/C.12/GC/22, paras. 11-21.
[31] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 78; Irish Family Planning Association (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, pg. 11.
[32] WHO (2022) Abortion Care Guideline, pg. 12.
[33] Laura O'Shea et al (2020) Access to and sustainability of abortion services: a systematic review and meta-analysis for the National Institute of Health and Care Excellence – new clinical guidelines for England, Human Reproduction Update, 26(6), pg. 896.
[34] For more information on the particular problems facing Traveller women, disabled women, minority ethnic women, migrant women and others see: National Women's Council of Ireland (NWCI) (2021) Accessing Abortion in Ireland: Meeting the Needs of Every Woman, pg. 42-47

The current framework provides abortion care free at the point of access to individuals with either a Personal Public Service Number ('PPSN') or an Irish address. This creates potential barriers to access for groups, who may not have a PPSN, including: asylum-seekers, migrants, and undocumented individuals, temporary residents such as international students or women from Northern Ireland. We are concerned by reports of women incurring costs and being denied care as a consequence of the framework's requirements.[35]

Research conducted since the introduction of the Act has found that women living in rural settings face particular barriers to access including locating providing GPs and the time, cost and logistics involved in organising travel to appointments especially where they do not own a vehicle or their area has poor, inaccessible public transport links.[36] This includes refugees in isolated Direct Provision Centres, who experience the location of services as significant obstacles.[37]

The UN Committee on Economic, Social and Cultural Rights has drawn a clear link between social inequality and barriers to accessing reproductive health services.[38] The HRC, in its Concluding Observations, expressed its concern at the challenges faced by women and girls to access safe and legal abortion, due to the alleged low percentage of general practitioners providing abortion services, disproportionately affecting women and girls in vulnerable situations and rural communities.[39]

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[35] Irish Family Planning Association (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, pg. 22: The IFPA reports that the Primary Care Reimbursement Scheme is no longer reimbursing women who only provide an Irish address, that some providers have declined care to women who do not possess these details and that the IFPA has had to bear the costs for a number of women to access abortion care.

[36] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 75, 80-81; Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg. 22, 39, 41, 44

[37] Joanna Mishtal, Karli Reeves, Dyuti Chakravarty, Lorraine Grimes, Bianca Stifani, Wendy Chavkin et al (2022) Abortion policy implementation in Ireland: Lessons from the community model of care, PLoS ONCE 17(5) pg. 16-17.

[38] UN Committee on Economic, Social and Cultural Rights (2016) General comment No. 22 on the right to sexual and reproductive health, E/C.12/GC/22, para. 8.

[39] The HRC recommended that the State implement the necessary measures to guarantee the universality and equal access to abortion services for all women and girls, especially for rural women, women living in poverty, disabled women, asylum seekers, victims of domestic violence, and women from ethnic or religious minorities. See Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.

The WHO Guidelines cite a lack of available services as constituting particular barriers to access for rural dwellers and those facing financial hardship.

The Commission recommends that the Act be equality proofed to guarantee the universality and equality of access to abortion services for all women and girls, especially for victims of domestic violence, rural women, women living in poverty, disabled women, asylum seekers, women from ethnic or religious minorities, migrants, undocumented individuals, and temporary residents such as international students or women from Northern Ireland.

The Commission recommends that the current gaps in the provision of abortion care services are identified and addressed.

The Commission recommends the provision of support to women who incur additional costs accessing abortion, to ensure that abortion care is free to all at the point of access.

Data

Publicly available data on Ireland's abortion services is limited, currently covering only the number of terminations, the grounds under which the termination was provided, the county or place of residence,[40] and the Medical Council registration number of the provider.[41]

The WHO Guidelines highlight the need for improved data infrastructure and is currently developing a set of abortion care indicators, in addition to a quality abortion care monitoring and evaluation framework. [42] The Unplanned Pregnancy and Abortion Care study recommended that an appropriate data infrastructure, in the Irish context would comprise mandated data collection by hospital and primary care providers[43]. At a national level, the Abortion Working Group has also called for a national abortion database.[44]

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[40] National Women's Council, Abortion Working Group Joint Submission to the Public Consultation: Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, 2018
[41] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, p.225
[42] WHO, Abortion Care Guidelines, 2022, p.18
[43] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, p225.
[44] National Women's Council, Abortion Working Group Joint Submission to the Public Consultation: Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, 2018

Our view is that characteristics of a national data framework should include: [45]

- Health system input monitoring, including governance, financing, workforce, and learning and development data;

- Service delivery monitoring, including availability of services, wait times, abortions, conscientious objection, and any related referral information;[46]

- Individual care monitoring, including age of service user, gestation data, previous history, method of abortion, ultrasound referral, complications and contraceptive service uptake post-abortion;[47]

- Population outcome monitoring, including population data on access to services, and population knowledge of knowledge of access to quality, affordable abortion care;[48]

- Impact measurement, including abortion related mortality and morbidity, and the incorporation of abortion service-delivery monitoring data into other administrative data collection mechanisms, including population-based surveys;[49] and

- Appropriate disaggregation indicators, including geographic information, age, socio-economic status, and ethnicity.

A robust data framework on abortion services at a national level is critical to legislative, policy and practice development and reform. This would allow for the monitoring and measuring of service provision, enhancing transparency of process, and supporting policy implementation and governance.[50] In addition, such enhanced data could potentially identify gaps in care provision, mitigating risks and barriers to service users.

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[45] The Framework includes domains, indicator areas, data sources, and categories for inequality disaggregation.
[46] National Women's Council, Abortion Working Group Joint Submission to the Public Consultation: Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, 2018
[47] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, p.225
[48] WHO, Abortion Care Guidelines, 2022, p.19
[49] WHO, Abortion Care Guidelines, 2022, p.19
[50] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, p.225

Such a framework requires reviewing the adequacy of existing data infrastructure, identifying gaps in the existing data and infrastructure, and considering modalities of data collection, having regard to existing studies and to the WHO Guidelines[51] for best practice in termination of pregnancy services data infrastructure, and to the EU Equality Data Resources for best practice in equality data infrastructure.[52] Approaches to data collection should be continuously and consistently reviewed, towards a systematic evidence-base for abortion services.

We note that while a robust data framework has the potential to capture high-quality and timely data, it is limited to services overseen by clinicians. Such a framework forms part of a broader research agenda to capture evidence and data on self-managed abortion, women who have travelled outside the jurisdiction for services, and the qualitative experiences of women accessing services within the Irish legislative framework.

The Commission recommends the design, development and resourcing of a robust national data framework and indicator set on abortion services, integrating continuous review.

The Commission recommends the development of a resourced research programme to build the evidence base around the operation of the Act and the experiences of service users and service providers.

Provision of information

We have repeatedly emphasised the importance of ensuring that comprehensive, accessible and reliable health information is available to the public on abortion services.[53] A 2019 survey found that: approximately one third of respondents reported not knowing where to find information on abortion, half did not know where the point of entry for abortion care

[51] WHO, Abortion Care Guidelines, 2022

[52] These resources include: The European Handbook on Equality Data, Guidelines on the collection and use of equality data (2018), Guidance note on the collection and use of equality data on racial and ethnic origin (2021), Forthcoming Guidance note on the collection and use of Sexual Orientation, Gender Identity and Expression, and Sex Characteristics (SOGIESC) data (2023). Equality data collection | European Commission (europa.eu)

[53] IHREC (2020) Submission to the UN Committee on the Elimination of Discrimination Against Women on the follow-up procedure to Ireland's combined sixth and seventh periodic report, pg. 11-14; IHREC (2022) Ireland and the International Covenant on Civil and Political Rights, pg. 48-50

was, and two-thirds knew that care was free before accessing it.[54] While HSE information campaigns have successfully raised public awareness, significant information flow barriers remain outside of urban areas, where promotional campaigns are less visible.[55]

The unique information flow barriers experienced by rural dwellers and migrants highlight the importance of universally accessible public health information.[56] Further, public information must be accessible to disabled people across all impairment groups.[57]

The Commission recommends that comprehensive, accessible and reliable health information is available to all sections of the public on abortion services, with targeted measures for structurally vulnerable groups.

Travelling Abroad

UK Government statistics report that since the Act was introduced, over 700 Irish residents have travelled to the UK to access terminations of pregnancy.[58] During this same time, over 17,000 women and girls accessed abortion care within the State.[59]

Of concern are reports that the application of Section 11 has caused both uncertainty for service users and delays to their treatment which have resulted in pregnant women travelling abroad to jurisdictions with less restrictive grounds for access to terminations (see discussion below in 'Section 11: Fatal Foetal Abnormality Criteria').[60]

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[54] Abortion Rights Campaign (2019) Too Many Barriers, pg. 28; This also accords with the experience of the IFPA see: Irish Family Planning Association (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, pg. 22.

[55] Deirdre Duffy et al (2022) Information flows as reproductive governance. Patient journey analysis of information barriers and facilitators to abortion care in the republic of Ireland, SSM Population Health, 19, pg. 4-5.

[56] Deirdre Duffy et al (2022) Information flows as reproductive governance. Patient journey analysis of information barriers and facilitators to abortion care in the republic of Ireland, SSM Population Health, 19, pg. 6-7.

[57] CRPD Article 9: Accessibility

[58] Figures compiled from: Office of Health Improvement and Disparities, Abortion statistics, England Wales: 2021 (25 August 2022); Abortion statistics, England and Wales: 2020 (4 May 2022); Abortion statistics, England and Wales: 2019 (11 June 2020).

[59] Figure compiled from: Department of Health, Notifications in accordance with section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018: Annual Report 2019, 2020 and 2021.

[60] See Section: Fatal Foetal Abnormality Criteria; See also: Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 165 – It has been reported that the protracted nature of the FFA assessment period and the uncertainty of outcome has led to pregnant women travelling to the UK to access abortion without beginning or completing the

UK Government statistics report that just 3.2% of those who travelled to the UK for an abortion in 2021 were under ten weeks gestation.[61] The Abortion Support Network reports it has assisted 342 individuals who were over 12 weeks gestation.[62] This data would appear to suggest the gestational age limit of 12 weeks is potentially acting as a barrier to accessing care, resulting in travel abroad. Further, we note that in the Citizens' Assembly report upon which the choice of 12 weeks was made, support for 22 weeks was only marginally lower.[63]

The HRC, in its Concluding Observations expressed concern at the reports that women and girls are continuing to travel abroad to seek abortion services upon being denied, or not being able to access abortion services in Ireland.[64]

The Commission recommends the implementation of necessary measures to address the reasons why women and girls continue to travel abroad to seek abortion services upon being denied or not being able to access abortion services.

assessment process due to the certainty of access the UK legislation provides them with; Stacey Power, Sara Meaney & Keelin O'Donoghue (2021) Fetal Medicine Specialists' experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: A qualitative study, pg. 4-5 Abortion Support Network (2021) Report of the Trustees and Financial Statements for the year ended 31st December 2020 for the Abortion Support Network, pg. 7 – The Abortion Support Network has reported being contacted by large numbers of women with 'catastrophic' foetal anomalies who were denied care due to a diagnosis of 'not fatal enough'.

[61] Office of Health Improvement and Disparities, Abortion statistics, England Wales: 2021 (25 August 2022)

[62] Statistics provided to ARC by the ASN: ARC (2022) Submission for the Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018, pg. 19.

[63] The Citizens' Assembly (2017) First Report and Recommendations of the Citizens' Assembly: The Eighth Amendment of the Constitution pg. 4: 48% recommended a 12 week gestational age limit whereas 44% recommended 22 weeks.

[64] Human Rights Committee (2022) Concluding Observations on the fifth periodic report of Ireland (27 July) CCPR/C/IRL/CO/5.

Specific Observations

Section 11: Fatal Foetal Abnormality Criteria

Section 11 of the Act provides that an abortion in the case of foetal abnormality will only be legally permissible if two medical practitioners form a reasonable opinion that the foetus will likely die before or within 28 days of birth. According to official figures, in 2021, 53 terminations were carried out under Section 11, constituting slightly over 1% of terminations carried out in Ireland that year.[65] Of the 206 Irish residents who travelled to the UK to access abortion in 2021, 103 sought a termination under Ground E of the UK Abortion Act 1967,[66] constituting approximately half of all those who travelled.[67]

This data raises concerns that Section 11 may be limiting access to termination for pregnant women who receive fatal foetal abnormality diagnoses, but who are required to travel to access healthcare.[68]

HSE-published research has recommended a review of Section 11 and how it is interpreted, and whether it has the effect of refusing care and negative consequences for the physical and mental health of the woman.[69]

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[65] Department of Health (2022) Notifications in accordance with Section 20 of the Health (Regulation of Termination of Pregnancy) Act 2018: Annual Report 2021.

[66] Office of Health Improvement and Disparities, Abortion statistics, England Wales: 2021 (25 August 2022); See also: Ground E is defined as there being a substantial risk that the child, if born, would suffer serious mental or physical abnormalities. See: UK Abortion Act 1967, Section 1

[67] Official statistics show that Ground E has consistently increased as a proportion of the total number of terminations sought in the UK by Irish residents since the Act's introduction. In 2018 Ground E was claimed 84 times and constituted 2.9% of all terminations sought by Irish residents in the UK. In 2019 Ground E was claimed 64 times, 17% of the total. In 2020 Ground E was claimed 62 times, 32% of the total. In 2021 Ground E was claimed 103 times, 50% of the total. See: Office for Health Improvement and Disparities and Department of Health and Social Care, Collection: Abortion statistics in England and Wales (21 June 2022).

[68] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 191; Deirdre Duffy et al (2022) Information flows as reproductive governance. Patient journey analysis of information barriers and facilitators to abortion care in the republic of Ireland, SSM Population Health, 19, pg. 7;

[69]Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 224; See also: Respondents to the survey who were not eligible for care under Section 11 reported feelings of abandonment and shame at having to travel, pg. 141, 159, 170, 173-174

We also note the implications of travelling abroad for women who are denied care, and may not have the permission, clearance or means to travel, such as migrant women, international protection applicants, and disabled women.

The HRC in its Concluding Observations expressed concern at the restrictive specifications of Section 11 of the Act, requiring the opinion of two medical professionals that the foetus is not likely to survive beyond 28 days following birth, leaving many women forced to continue with pregnancies with foetal abnormalities. The HRC recommended that the State take the necessary steps to remove existing barriers and ensure women with foetal abnormality conditions have adequate access to abortion services.[70]

The WHO Guidelines recommend that the provision of abortion should not be dependent on grounds based limitations or restrictions such as those in the Act.[71]

The Commission recommends the reform of Section 11 so that there are legal avenues for abortion in all cases where fatal foetal anomalies are diagnosed.

Section 12: Mandatory Waiting Period

Section 12 of the Act prohibits a termination of pregnancy from being carried out unless no less than three days have passed since the initial consultation where it was verified that the gestational age of the pregnancy had not exceeded 12 weeks. There is no guarantee that the second appointment will be scheduled on the fourth day and those seeking terminations could experience delays, depending on the service provider's resources and capacity to provide timely appointments.[72]

We note that while some service users report seeing merit in the waiting period, and believe it could be of use to others; generally those who were required to observe it report

[70] Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.
[71] WHO (2022) Abortion Care Guidelines, pg. 26-27
[72] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 105: Several respondents reported that their three-day wait exceeded three days due to appointment scheduling; See also: Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg. 39 – 23% of respondents waiting more than the prescribed 3 days for their second appointment.

dissatisfaction.[73] Research with service users has found that the mandatory waiting period caused additional anxiety and stress[74] and increased the risk that service users would have to disclose their pregnancy against their wishes.[75]

Some women face particular barriers in attending a single appointment at their nearest provider. The imposition of a requirement to attend another appointment in the absence of any health rationale unnecessarily exacerbates these barriers.[76]

Medical professionals have expressed concerns that mandatory waiting periods can impact access to health care and completion of care, for example if the initial termination fails, particularly for women close to the 12 weeks' gestation limit. [77] Of concern are reports that women are timing out of eligibility for care as a direct result of the mandatory waiting period.[78]

International research has found that waiting periods can cause delays in accessing termination of pregnancy services. [79] Both the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination Against Women have criticised mandatory waiting periods as barriers to access and recommended their repeal.[80]

The HRC, in its Concluding Observations expressed its concern at provisions of the Act that subject women to a mandatory three-day waiting period prior to termination of pregnancy.

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[73] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 224.
[74] Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg. 41-42.
[75] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 101-105.
[76] See Section on: Logistical and Economic Considerations
[77] Joanna Mishtal, Karli Reeves, Dyuti Chakravarty, Lorraine Grimes, Bianca Stifani, Wendy Chavkin et al (2022) Abortion policy implementation in Ireland: Lessons from the community model of care, PLoS ONCE 17(5), pg.15.
[78] Abortion Support Network (2021) Report of the Trustees and Financial Statements for the year ended 31st December 2020 for the Abortion Support Network, pg. 7.
[79] See Laura O'Shea et al (2020) Access to and sustainability of abortion services: a systematic review and meta-analysis for the National Institute of Health and Care Excellence – new clinical guidelines for England, Human Reproduction Update, 26(6), pg. 896
[80] UN Committee on Economic, Social and Cultural Rights (2016) General comment No. 22 on the right to sexual and reproductive health, E/C.12/GC/22, para. 41; UN Committee on the Elimination of Discrimination Against Women (2016) General recommendation No. 34 on the rights of rural women, CEDAW/C/GC/34, para. 38-39.

The HRC recommended that the State review provisions of the Act that could create barriers to women seeking safe abortions, including mandatory waiting periods.[81]

The WHO Guidelines state that mandatory waiting periods pose logistical and economic challenges and are felt most strongly by women with fewer resources.[82]

The Commission recommends that the mandatory waiting period set out in Section 12 of the Act be removed.

Section 22: Conscientious Objection

Section 22 of the Act provides that no medical practitioner, nurse or midwife will be obliged to participate in the provision of a termination of pregnancy where they have a conscientious objection to the procedure. However, medical professionals who conscientiously object are required by Section 22 to, as soon as may be, make the necessary arrangements for the transfer of care of the pregnant women concerned to enable her to avail of the termination of pregnancy concerned.

The Irish Medical Council's Guide to Professional Conduct and Ethics details a responsibility on practitioners to arrange and facilitate the transfer of care of a patient seeking an abortion in a safe, effective and timely manner.[83] Further, medical professionals are obliged to not impede or obstruct access to care.[84]

Provision for conscientious objection is a common feature in legal frameworks governing access to abortion, as a means of striking an appropriate balance between the freedom of religion and conscience of medical professionals, and the right of women and girls to bodily autonomy and the highest attainable standards of health.[85] It is also important that those

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[81] Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.
[82] WHO (2022) Abortion Care Guidelines, pg. 42.
[83] Irish Medical Council (2019) Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Amended), pg. 35.
[84] Irish Medical Council (2019) Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Amended), pg. 35.
[85] For a comparative analysis of the regulation of conscientious objection to abortion in the UK, Norway, Portugal and Italy, see Wendy Chavkin, Laurel Swerdlow & Jocelyn Fifield (2017) Regulation of Conscientious Objection to Abortion: An International Comparative Multiple – Case Study, Health and Human Rights 19(1), pg. 55.

seeking terminations can do so, free from fear of judgment or disapproval. The WHO Guidelines recommend that conscientious objection be provided for, only in a way that does not impede access to abortion care.[86]

We welcomed the obligation on conscientious objectors to refer patients seeking terminations in a timely manner. We noted the potential for the accommodation of conscientious objection to pose organisational and institutional challenges for healthcare institutions and the State in their allocation of staff and resources within the healthcare system. We called for clear procedures for expeditious transfer of care to be provided through regulation and guidelines. [87]

While the Medical Council Guidelines recommend that health staff communicate their objection to their colleagues and employer,[88] no official register of objectors is kept.

HSE-commissioned research found evidence that Medical Council Guidelines are being contravened in how conscientious objections are being applied.[89] Service users have reported being refused a referral from a non-providing doctor,[90] and problems with non-providers ranging from a failure to provide information to outright dissuasion.[91] This would appear to indicate that both professional and ethical guidelines and the statutory obligation to refer for care are being breached on a regular basis.

In addition to refusing to assist those seeking abortion care there have also been reports of medical professionals actively obstructing access at all junctions of the care pathway. The WHO received reports from service users that referrals by non-providing GPs were often unreliable, caused delays and involved unpleasant encounters.[92] Research on the

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[86] WHO (2022) Abortion Care Guideline, pg. 60-62.
[87] IHREC (2018) Observations on the General Scheme of a Bill Entitled *Health (Regulation of Termination of Pregnancy) Bill 2018*, pg. 7-9.
[88] Irish Medical Council (2019) Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Amended), pg. 35.
[89] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 84, pg. 213.
[90] Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg. 55.
[91] Duffy et al (2022) Information flow as reproductive governance. Patient journey analysis of information barriers and facilitators to abortion care in the republic of Ireland, SSM – Population Health 19, pg. 5.
[92] Joanna Mishtal, Karli Reeves, Dyuti Chakravarty, Lorraine Grimes, Bianca Stifani, Wendy Chavkin et al (2022) Abortion policy implementation in Ireland: Lessons from the community model of care, PLoS ONE 17(5), pg. 13.

experience of service providers, in particular fetal medical specialists, found that 'conscientious obstruction' from non-providing colleagues resulted in protracted diagnoses periods and delayed treatments.[93]

Furthermore, it has been argued that conscientious objection is playing a significant role in the poor level of service provision and uneven geographical distribution of providers.[94]

The current provision for conscientious objection is causing delays and in some cases preventing access to abortion care. Non-providing practitioners must be reminded of their legal and ethical responsibilities towards patients seeking abortion care and legal or disciplinary consequences should be introduced for those who refuse to comply. Procedures should be put in place to allow service users to report practitioners who obstruct and/or refuse to refer.

UN Treaty Monitoring Bodies have identified the regulation of conscientious objection as an important measure for the State's obligation to protect the rights to life,[95] non-discrimination[96] and to sexual and reproductive health.[97] Regulating conscientious objection is in keeping with the views the European Court of Human Rights,[98] the Council of Europe,[99] the European Social Committee,[100] and the International Federation of Gynaecology and

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[93] Stacey Power, Sara Meaney & Keelin O'Donoghue (2020) The incidence of fatal fetal anomalies associated with perinatal mortality in Ireland, Prenatal Diagnosis 40(5), pg. 4-5. The term 'conscientious obstruction' was used by research participants.

[94] Bianca Stifani et al (2022) Abortion policy implementation in Ireland: successes and challenges in the establishment of hospital-based services, pg. 8; Having conducted qualitative investigative discussions with staff at both providing and non-providing hospitals this report concludes that the primary reason why hospitals do not provide is conscientious objection among staff; See also: National Women's Council of Ireland (NWCI) (2021) Accessing Abortion in Ireland: Meeting the Needs of Every Woman, pg. 21; Gráinne Ní Aodha, Conscientious objection prevents full rollout of abortion services in several maternity hospitals, The Journal (16 July 2019); Abortion Working Group (AWG) (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018

[95] UN Human Rights Committee (2018) General Comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life, CCPR/C/GC/36, para 8

[96] UN Committee on the Elimination of Discrimination Against Women (1999) General Recommendation: Article 12 of the Convention (Women and Health), A/54/38/Rev.1.chap.1, para 11

[97] UN Committee on Economic, Social and Cultural Rights (2016) General comment No. 22 on the right to sexual and reproductive health, E/C.12/GC/22 para 43.

[98] R.R. v Poland (App. 27617/04), 28 November 2011, para 206

[99] 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.

[100] International Planned Parenthood Federation – European Network (IPPR EN) v Italy (Complaint No. 87/2012),

Obstetrics, who consider the regulation of conscientious objection of fundamental importance in the provision of safe, timely and effective access to abortion care.[101]

The HRC in its Concluding Observations recommended that the State review provisions of the Act that could create barriers to women seeking safe abortions including those caused as a result of the exercise of conscientious objection by individual medical providers.[102]

We reiterate our call for the legislative and regulatory framework to ensure that the accommodation of conscientious objection does not impede the provision of the necessary systems, personnel and resources to guarantee that women are provided safe and timely access to abortion.

The Commission recommends measures to ensure that Section 22 and the current provision for conscientious objection does not erect barriers to access to abortion care.

The Commission recommends the establishment of an official register of conscientious objectors.

The Commission recommends research to examine the presence and operation of 'conscientious obstruction' and any impacts that this has on the provision of care.

The Commission recommends statutory guidance to medical practitioners reminding them of their legal and ethical obligations to ensure the expeditious transfer of care of patients seeking termination of pregnancy services.

Section 23: Criminal Penalties

Section 23 of the Act provides for criminal offences in relation to performing or assisting a pregnant woman in obtaining an abortion, where it is not in accordance with the Acts, with a penalty of a fine or imprisonment of up to 14 years.

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[101] Christina Zampas (2013) Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings, International Journal of Gynaecology and Obstetrics 123.
[102] Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.

The criminalisation of abortion provision sets it apart from other forms of healthcare. It is unclear why professional and fitness to practice oversight, and general criminal and civil sanctions are insufficient for the regulation of practitioners in this area of healthcare.[103] Treating abortion care as distinct from other forms of healthcare and the creation of a specific criminal offence stigmatises its provision.[104] Throughout this submission we evidence the stigmatisation and trauma caused by the operation of certain provisions of the Act. We welcome the HRC's recommendation that the State strengthen efforts to prevent the stigmatisation and trauma of women and girls who seek abortion.[105]

HSE-commissioned research found that the Act's criminal penalties may be dissuading doctors from opting in as providers.[106] Service providers have expressed concern over the chilling effect criminalisation has on their practice.[107] Medical professionals working in prenatal diagnosis fear the potential media scrutiny and criminal prosecution that could follow an incorrect diagnosis;[108] and this can lead to conservative diagnoses and interpretations of the legislation.[109]

UN human rights treaty monitoring bodies have a consistent consensus position that abortion must be completely decriminalised.[110] The HRC, in its Concluding Observations

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[103] Mary Donnelly & Claire Murray (2019) Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision, International Journal of Gynecology & Obstetrics, 148(1) pg. 10
[104] Mary Donnelly & Claire Murray (2019) Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision, International Journal of Gynecology & Obstetrics, 148(1) pg. 10
[105] Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.
[106] Catherine Conlon, Kate Antosik-Parsons & Éadaoin Butler (2022) Unplanned Pregnancy and Abortion Care (UnPAC) Study, Health Service Executive, pg. 224.
[107] National Women's Council of Ireland (NWCI) (2021) Accessing Abortion in Ireland: Meeting the Needs of Every Woman, pg. 40.
[108] Stacey Power, Sara Meaney & Keelin O'Donoghue (2021) Fetal Medicine Specialists' experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: A qualitative study, pg. 6.
[109] See: Abortion Rights Campaign (ARC) & Lorraine Grimes (2021) Too Many Barriers: Experiences of Abortion in Ireland after Repeal, pg. 64-70; Irish Family Planning Association (2022) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018, pg. 15; ARC (2022) Submission to the Review, pg. 23-24; Stacey Power, Sara Meaney & Keelin O'Donoghue (2021) Fetal Medicine Specialists' experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: A qualitative study, pg. 6-7.
[110] Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women, Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities (29 August 2018); UN Committee on the Elimination of Discrimination Against Women (2017) Concluding observations, CEDAW/C/IRL/CO/6-7, para 43; UN Committee on the Rights of the Child (2016) Concluding observations, CRC/C/IRL/CO/3-4, paras 57-58; UN Committee on Economic, Social and Cultural Rights (2015) Concluding observations, E/C.12/IRL/CO/3, para 30;

expressed its regret that the State had decided to establish criminal liability in Section 23 of the Act. It recommended that the State consider taking action to remove criminal sanctions to medical service providers.[111]

The WHO Guidelines recommend that complete decriminalisation is of fundamental importance in delivering the highest possible quality of abortion care.[112]

We reiterate our previous position that abortion be decriminalised in all circumstances.[113]

The Commission recommends that abortion be decriminalised in all circumstances, as a matter of urgency.

UN Human Rights Committee (2022) Concluding observations, CCPR/C/IRL/CO/5, para 25; UN Committee Against Torture (2011) Concluding observations, CAT/C/IRL/CO/1, para 26.

[111] Human Rights Committee (27 July 2022) Concluding observations on the fifth periodic report of Ireland. Advance unedited version, para 25, p6.

[112] WHO (2022) Abortion Care Guideline, pg. 24-25.

[113] IHREC (2017) Human rights and equality considerations in the development of a new legislative and regulatory framework on abortion, pg. 11-12; See also the Commission's contribution in: Joint Committee on the Eighth Amendment of the Constitution, Eighth Amendment of the Constitution: Constitutional Issues Arising from the Citizens Assembly Recommendations (4 October 2017).

Coimisiún na hÉireann um Chearta an Duine agus Comhionannas
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