



Submission to Department of Health on the Updated General Scheme of a Bill to Regulate Termination of Pregnancy

10 September 2018

Amnesty International Ireland welcomes the Minister for Health’s intention, once the Thirty-sixth Amendment of the Constitution Bill is signed into law, to enact legislation to provide for expanded access to abortion services for women and girls.¹ We note that a Bill is expected to be published very shortly. In a submission dated 4 July 2018, we commented on the Draft General Scheme of a Bill to Regulate Termination of Pregnancy. This new submission provides observations on the contents of the Updated General Scheme of the Health (Regulation of Termination of Pregnancy) Bill subsequently published on 10 July. We will make additional commentary after the Bill is published.

We encourage the Department of Health to keep in mind while crafting this legislation, the World Health Organisation’s (WHO) recommendation that “laws and policies on abortion should protect women’s health and their human rights”, and “regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed”.² We urge that the focus of this law be on ensuring safe and timely access to abortion services in practice, in a manner respectful of women’s human rights to health, bodily integrity, autonomy, privacy, equality and dignity.

In this submission, we are conscious that the government and Department intends to adhere closely to what the Joint Oireachtas Committee on the Eighth Amendment proposed in its December 2017 report, and what the Department set out in the initial General Scheme. In this light, we urge that maximum respect for women’s rights be achieved within the parameters set politically for this upcoming Bill; and that, once enacted, this legislation is thereafter kept under routine periodic review so that its provisions can be strengthened to address existing gaps, and also better align with developing international human rights standards, medical evidence and practice.

This submission provides guidance, based on what is outlined in the Updated Scheme, on how to ensure that each head complies with international human rights law and standards. Some references to relevant international human rights standards, technical guidance on how to deliver abortion services in accordance with international best practice, and peer-reviewed research are provided throughout.

¹ Throughout this submission, Amnesty Ireland refers to ‘women and girls’ and sometimes to “pregnant people”. We recognise that whilst the majority of personal experiences with abortion relate to cisgender women and girls, it also holds true that intersex people, transgender men and boys, and people with other gender identities or who are gender non-conforming may have the reproductive capacity to become pregnant and may need abortions.

² See World Health Organisation, 2012. Safe abortion: technical and policy guidance for health systems, second edition, Geneva: WHO, 9.

Key principles of legislation to facilitate and regulate access to abortion

In recent years, UN human rights bodies and experts have provided advice to the Irish government on how to bring Irish law on abortion into compliance with its human rights obligations. Over almost a two-year period, members of the Citizens' Assembly and members of both Houses of the Oireachtas engaged in a process of democratic discussion and debate, aimed at realising access to abortion in Ireland for all those who need it.

This legislation should reflect a determination to guarantee access to abortion services, and finally to end the indignity and harm resulting from Ireland's restrictive abortion laws, by realising women's and girls' human rights. To achieve this, the Bill, perhaps in an explanatory memorandum, should set out key principles to guide the implementation of the legislation. Below are nine key principles to clarify the aims that must underpin this legislation: the realisation of women's health and human rights.

It should be recalled that under Article 12 of the International Covenant on Economic, Social and Cultural Rights, the government is obliged to achieve the full realisation of the right to the highest attainable standard of health for all, including reproductive health. This obligation requires the government not only to respect this right by refraining from interfering with its enjoyment; it must also to protect the right by taking measures to prevent third parties from interfering with its enjoyment, and fulfil the right by adopting legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right.

In addition, the right to health when applied to the delivery of health services has four essential and interrelated elements:

- Availability - achieved by integrating health services into the existing health system
- Accessibility - includes economic accessibility but also guarantees of non-discrimination
- Acceptability - requires respect for medical ethics, as well as requirements that services must be delivered in a manner that is respectful of culture and gender-sensitive
- Quality - indicates that services should be delivered to the highest quality that available resources can facilitate

Key principles for Bill

1. Protection of human rights

The legislation must be grounded in international human rights law and principles, and uphold the human rights of women, girls and people who can become pregnant.

2. Rights-holders at the centre

All legal, policy and other regulatory measures on abortion should respect, protect and fulfil the human rights of pregnant persons, not force them to undertake unsafe abortions or prevent them from obtaining a safe abortion. The legislation must affirm pregnant people's reproductive autonomy, which is the right of all people who can become pregnant to make decisions related to their pregnancies.

3. Non-discrimination and equality

No one's status as a rights holder may be suspended, diminished or mandatorily set aside because of pregnancy.

Some individuals and groups tend to be differently or disproportionately affected by restrictive abortion legislation, policies, guidelines and practices due to the discrimination they face in society. These include young people and adolescents, people living with disabilities, lesbian, gay, bisexual and intersex people, gender non-conforming individuals, those living in rural areas, those living in poverty, members of the Travelling community, and racial and ethnic minorities, among others. The legislation and those implementing it must take into account the experience of marginalised groups and individuals, and the impact of intersectional discrimination on abortion access, and remove the specific barriers such groups may face in accessing abortion services.

4. Evidence-based

The legislation must be grounded in evidence and informed by international best practice. It must be underpinned by impartiality and independence from any political ideology or religion.

5. A comprehensive package of services and information

The legislation should acknowledge that abortion is just one part of the full package of sexual and reproductive health information and services that the state has an obligation to provide throughout a person's lifetime. The full realisation of sexual and reproductive rights requires a range of sexual and reproductive health services and goods, including access to modern methods of contraception, information and comprehensive sexuality education.

6. Ensuring free, informed autonomous decision-making

The legislation must be acknowledge that the state has an obligation to ensure people have access to full information and are empowered to make their own choices about whether to carry their pregnancy to term. No one should ever be compelled to seek recourse to abortion due to denial of their economic and social rights.

7. Opposing biased and discriminatory practices

The legislation must reject gender stereotyping, abortion-related stigma, and attacks on scientific evidence.

8. Evolving with international human rights law

In order to keep pace with the evolving nature of international human rights law, the legislation should be guided by the fundamental principles on which international human rights law is founded, including bodily integrity, autonomy, privacy, equality, dignity, social and gender justice, participation and accountability.

Issues for Consideration in the Bill

a. Head 1

i. Definition of medical practitioner

The Updated General Scheme defines a ‘medical practitioner’ as “a medical practitioner who is for the time being registered in the register”. As the Irish Medical Council’s register includes only doctors, this definition places unnecessary limits on who can provide abortion services. This is out of step with international best practice. The WHO Safe Abortion Guidelines advise that “abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers.”³ The guidelines clarify that “midlevel providers” include “midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors and others who are trained to provide basic clinical procedures related to reproductive health.”⁴ We recommend that the definition of who can provide abortion services be expanded in line with international best practice; we also recommend that this not be included in the legislation but instead within the medical guidelines, as lawmakers need not designate who can provide abortion in the law.⁵

ii. Definition of “termination of pregnancy”

It is important to affirm that the legal protection of human rights under international human rights law, commences at birth. This includes the right to life. To avoid creating a foetal right to life, which does not have a basis in international human rights law and is problematic in the context of the Eighth Amendment having been repealed, the legislation should avoid referring to “intentionally ending the life of a foetus” under any head. A more appropriate definition would be “intentionally ending a pregnancy.”

iii. Definition of woman

The Updated General Scheme defines a ‘woman’ as “a female person of any age”. While the majority of personal experiences with abortion relate to cisgender women and girls, it also holds true that intersex people, transgender men and boys, and people with other gender identities or who are gender non-conforming may have the reproductive capacity to get pregnant. Therefore we recommend that the definition be broadened to “a pregnant person of any age”.

b. Head 4(1)(a)

i. Respecting autonomous decision-making

Head 4(1) requires that two medical practitioners must certify that there is a “risk of serious harm to the health of the pregnant woman”. This provision does not clarify the role the woman or girl’s own decision-making plays in determining the degree of risk she is willing to accept in respect of her own health or life. International human rights law and medical ethics are predicated on the principles of dignity and autonomy, meaning that individuals have a right to informed consent, to avail of and refuse medical treatment, and to participate in making healthcare decisions. Head 4(1) must ensure the participation of the woman or girl or pregnant

³Ibid, 65.

⁴ Ibid.

⁵ IPAS, Who can provide abortion care? Considerations for law and policy makers. 2015, 1.

person in abortion decision making where there is any degree of risk in relation to their health or life, in order to realise their right to informed consent.

Additionally, the requirement that two medical practitioners must certify a risk to health runs counter to international human rights law and standards, as well as best medical practice. In its concluding observations to New Zealand, the UN Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee) called on New Zealand to simplify its abortion laws and ensure women's autonomy.⁶ In New Zealand, women are required to get certification from two doctors before an abortion can be performed, which the committee described as "nullifying their autonomy."⁷ Furthermore, in its concluding observations to Timor-Leste, the CEDAW Committee expressed concern about the requirement for multiple medical authorisations before an abortion can be carried out, such as permission from a panel of doctors.⁸

In order to respect the autonomous decision-making of the patient as required by international human rights law, Head 4(1)(a) must reduce the number of certifying doctors from two to one, and clarify the central role of the patient in the decision-making process, particularly regarding the level of risk to health or life that the patient is willing to accept.

ii. Attaching qualifiers to 'risk to health'

- *Risk of 'serious harm'*

The risk to health ground outlined in the Updated General Scheme includes a qualifier that the risk must be of "serious harm to the health" of the pregnant woman before a termination of pregnancy can be provided. This is a worryingly high threshold of harm required and should be reduced.

The right to the enjoyment of the highest attainable standard of physical and mental health in international human rights law is not qualified in any way by reference to the potential harm to the health of rights-holder. The right to health applies to health in the most holistic sense, and not simply the absence of serious harm to health. To this end, the qualifier 'serious' must be removed. Furthermore, the reference to 'harm' should also be removed for practical reasons: doctors assess risk, not harm which is the result of non-intervention. "Serious harm" is not an internationally accepted threshold and should be removed for clarity.

In understanding international best practice around what a risk to health ground should holistically encompass, the WHO defines this in the following way:

The fulfilment of human rights requires that women can access safe abortion when it is indicated to protect their health. Physical health is widely understood to include conditions that aggravate pregnancy and those aggravated by pregnancy. The scope of mental health includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe fetal impairment. A woman's social circumstances are also taken into account to assess health risk.⁹

⁶ UN Doc. CEDAW-C-NZL-CO-7 (2012), paras. 33-34.

⁷ Ibid.

⁸ UN Doc. CEDAW/-C-TLS-CO-2-3 (2015) para 31(a).

⁹ WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2012, second edition, 92.

We therefore recommend that this provision be amended to refer to “a risk to the health” of the pregnant woman, without attempting to qualify this in terms of the level of harm, as this aligns with international human rights standards and best international medical practice.

- *Qualifying level of risk*

Should it be decided to qualify the level of risk to a women’s health, we caution that this runs counter to international human rights standards and best medical practice. Decisions around the level of risk the woman is willing to accept in continuing a pregnancy should be left to her, based on medical advice and her own personal circumstance. This is also in keeping with all advice provided to the Joint Oireachtas Committee around best practice when legislating for a health ground. During the Joint Oireachtas Committee hearings, experts agreed that doctors are hindered from intervening to protect a woman’s health or life when legislation governing the procedure requires them to wait until the risk is “real and substantial” or “serious”.

The following is a summary of advice experts gave to the Committee in warning against qualifying a risk to health ground:

- It is not common practice; in most European countries, abortion legislation includes an explicit health ground that is unqualified¹⁰
- Risk can escalate very quickly, therefore it is dangerous to categorise risk as not ‘serious’¹¹
- Doctors require flexibility in order to take into account all implications on health during pregnancy¹²
- Doctors feel it is unethical to allow a woman or girl’s health to decline to any extent when this is entirely avoidable¹³
- Doctors expressed a lack of clarity on what a ‘serious’ risk to health means¹⁴
- We have a history of the term “real and substantial” operating as a barrier to timely access to services; experts advised that the term ‘serious’ would result in similar obstruction¹⁵
- The term used in international human rights law is simply “risk”¹⁶
- The term used by the World Health Organisation is simply “risk” or “health risk”¹⁷
- It is only after the event of a detrimental health outcome that risk can be categorised as ‘serious’¹⁸
- Risk to health cannot be defined as it depends on individual cases¹⁹
- Assessing a woman or girl’s mental health in terms of gradations is not possible for clinicians²⁰
- Qualifying terms such as ‘serious’ negate the right of the woman or girl to decide the degree of risk she is willing to accept; it removes her from the decision-making process around her own health²¹
- In a clinical context, defining a risk to be ‘serious’ or not is arbitrary²²
- Risk cannot be gauged rigidly, it cannot be fixed²³

¹⁰ Ms Leah Hctor, presentation to the Joint Oireachtas Committee on the Eighth Amendment, 8 November 2017.

¹¹ Dr Peter Boylan, 18 October 2017.

¹² Dr Rhona Mahony, 11 October 2017.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Dr Ruth Fletcher, 8 November 2017.

¹⁶ Professor Siobhan Mullally, 4 October 2017.

¹⁷ Dr Ronald Johnson, 11 October 2017.

¹⁸ Dr Bela Gantra, 11 October 2017.

¹⁹ Ms Christina Zampas, 4 October 2017.

²⁰ Dr Anthony McCarthy, 8 November 2017.

²¹ Professor Sabaratnam Arulkumaran, 18 October 2017.

²² Dr Maeve Ni Bhuiinneain, 11 October 2017.

²³ Professor Veronica O’Keane, 25 October 2017.

Indeed, the Joint Oireachtas Committee report, which forms the basis of the General Scheme and likely forthcoming Bill, specifically states:

The Committee notes that, in some European countries where a health exception permits a termination beyond the time limits for termination on request, the law does not define risk. Having regard to the expert evidence made available, the Committee accepts that risk depends to a large extent on individual circumstances. The Committee is therefore of the opinion that it is difficult to define in legislation the circumstances in which a risk to the health of the mother might arise.²⁴

The advice to the Committee is that the assessment of that risk is best considered in a clinical setting rather than being fixed in legislation. The Committee accepts this advice. The Committee also accepts that, in the case of women presenting with mental health issues, the grading of risk is particularly difficult.²⁵

- **Definition of health**

Head 1 in the Updated General Scheme defines “health” as “physical or mental health”. We very much welcome that it is proposed not to create an artificial and unhelpful distinction between physical and mental health in relation to the risk to health ground set out in Head 4. The more detailed provisions of the Bill too (or accompanying guidelines) must avoid creating an arbitrary and unjustifiable distinction between the two, as in the Protection of Life During Pregnancy Act.

In addition, it is important to recall that the internationally accepted definition of ‘health’ is outlined in the 1946 Constitution of the WHO: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” In its inclusion of social well-being, this definition acknowledges the importance of ensuring abortion services are delivered free from stigma, so that women and girls accessing these services are not made to feel isolated or unsupported. A recent study from the University of Limerick found that for women who feel stigmatised due to having an abortion experience increased psychological distress and physical health symptoms.²⁶

c. Head 4(1)(b)

i. Removing gestational limits from risk to health and life ground

The Updated General Scheme proposes that a termination of pregnancy may be performed to avert a risk to the life, or of serious harm to the health, of a pregnant woman’s health only if “the foetus has not reached viability”. International human rights standards require that women have a right to access abortion services for reasons of a risk to health or life at any stage of pregnancy, so it is absolutely necessary that this not be constrained by rigid gestational limits. While states are not prohibited in international human rights law from imposing reasonable restrictions on abortion services, such as gestational limits, such restrictions must not undermine women or girls’ human rights. There must be flexibility in regulations in order to ensure that women and girls’ human rights can be protected throughout pregnancy. In many

²⁴ Report of the Joint Committee, page 8, para 2.13.

²⁵ Report of the Joint Committee, page 8, para 2.13.

²⁶ Msetfi, Rachel, et al. "Restricted reproductive rights and risky sexual behaviour: How political disenfranchisement relates to women's sense of control, well-being and sexual health." *Journal of health psychology* (2017): 1359105317736784.

countries that provide access to safe and legal abortion, no gestational limits are imposed for abortions that avert a risk to health or life, in cases of severe or fatal foetal impairment, or where the pregnancy is the result of rape or incest.

Furthermore, guidance around gestational limits for any grounds for accessing abortion would be better outlined in medical guidelines, rather than law. These are healthcare decisions medical professionals and pregnant women should make without arbitrary statutory restrictions. This was underscored by experts presenting to the Joint Oireachtas Committee who highlighted that viability cannot be defined arbitrarily based on gestational age, there are complex factors involved in determining the prospect of health and survival.²⁷ Such provisions in law will inevitably lead to greater risk to women's health and life through delay or denial of their access to abortion services. It would also force medical professionals to deliver a foetus in circumstances potentially conflicting with their clinical judgement, and indeed with medical ethics and best practice. Furthermore, no woman or girl or pregnant person must ever be subjected to coerced early delivery where alternative methods of abortion can be performed safely. These concerns are exacerbated given the proposal that there must be a risk of "serious harm" to the woman's health for this ground to even be triggered.

Finally, in practical terms, when an abortion is carried out for health reasons after the point of viability, this is in almost all circumstances a very much wanted pregnancy, and abortion is being accessed as a last resort to preserve a woman's health and sometimes her life. There are exceptions to this, of course, including in cases of rape where, due to rape trauma²⁸ a woman or girl has not been able to present to services within the 12-week limit. This is no less of a health issue, and her access must be facilitated beyond the 12 weeks provided for. Access to abortion for rape survivors beyond 12 weeks is required by the international human rights framework.²⁹

d. Head 6

i. Providing for access to abortion in cases of severe and fatal foetal impairment

- *Removing specific timeframes for fatal foetal impairment*

The Updated General Scheme proposes access to abortion where the pregnancy involves "a condition affecting the foetus that is likely to lead to the death of the foetus either before or

²⁷ Dr Fergal Malone, 11 October 2017.

²⁸ See A W Burgess and L L Holmstrom, 'Rape Trauma Syndrome' [1974] American Journal of Psychiatry 981. Rape trauma syndrome is a form of post traumatic stress disorder: see American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th edn, Washington DC 2013).

²⁹ See for example: CRC Concluding Observations: Argentina, UN Doc. CRC/C/ARG/CO/3-4 (2010) para. 59 ("The Committee recommends that the State party... Take urgent measures to reduce maternal deaths related to abortions, in particular ensuring that the provision on non-punishable abortion, especially for girls and women victims of rape, is known and enforced by the medical profession without intervention by the courts and at their own request"); CESCR Concluding Observations: Peru, UN Doc. E/C.12/PER/CO/2-4 (2012) para. 21 ("it recommends that the criminal code be amended so that consensual sexual relations between adolescents are no longer considered as a criminal offence and that abortion in case of pregnancy as a result of rape is not penalized."); CESCR Concluding Observations: Kenya, UN Doc. E/C.12/KEN/CO/1 (2008), para. 33 ("The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by... decriminalizing abortion in certain situations, including rape and incest."); HRC Concluding Observations: Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20 ("The State party should, pursuant to article 3 of its Constitution, include additional exceptions to the prohibition of abortion so as to save women from having to resort to clandestine abortion services that endanger their lives or health in cases such as pregnancy resulting from rape or incest.")

within 28 days after birth". We must caution against including this level of specificity in the legislation.

Firstly, if any guidance is to be set out on determining a fatal foetal impairment, this should be included in the medical guidelines and not enshrined in law. Secondly, we recommend a shift in approach from arbitrary cut-off points for predicted survival to a more human approach which facilitates a personal or family decision being made on the basis of advice around the medical prognosis and what it entails for quality of life after birth. Enshrining time limits into law, whether 28 days or more expanded timeframes, creates an impossible burden for doctors to come up with exact predictions. This will likely create delays preventing timely access to services.

- ***Access to abortion in cases of severe foetal impairment***

It is important to note that UN human rights treaty bodies have not limited their calls for access to abortion to cases in which foetal impairments are such that stillbirth or death immediately after birth is a virtual certainty. The UN Committee on the Elimination of Discrimination against Women has called on the Irish government to legalise access to abortion in cases of "severe impairment of the foetus"³⁰, as it had in its concluding observations on other states.³¹ This has also been raised during the review of Ireland's human rights record by the UN Committee on the Rights of the Child which criticised Ireland's criminalisation of abortion including in cases of "severe foetal impairment".³²

Severe foetal impairments can lead to a high degree of suffering after birth, and many women and couples opt for an abortion for altruistic reasons.³³ Furthermore, where Ireland has been found by the UN Human Rights Committee to have violated the rights of two women carrying pregnancies with fatal foetal impairments in its 2016 *Mellet v Ireland* and 2017 *Whelan v Ireland* decisions, failure to deny women and girls and other pregnant people access in cases of severe impairments makes the State vulnerable to further litigation before UN human rights treaty bodies. We recommend ensuring the legislation provides for access to abortion in cases of severe foetal impairment, in line with the requirements of international human rights law and standards.

- ***Unintended denial of access to abortion in cases of fatal foetal impairment***

Failure to incorporate a "severe foetal impairment" ground within Ireland's legal framework for access to abortion will not only compound the suffering of women, girls and couples whose pregnancies carry the genetic markers for severe conditions; it may also impact access for women and families whose pregnancies have fatal foetal impairments, as there is no clear line between what constitutes a severe as opposed to a fatal foetal impairment. During the Joint Oireachtas Committee hearings, expert evidence advised against being prescriptive and using

³⁰ Concluding observations on the combined sixth and seventh periodic reports of Ireland, UN Doc. CEDAW/C/IRL/CO/6-7 (2017) para. 43.

³¹ In its July 2014 concluding observations on Peru, for example, the CEDAW Committee recommended that the state "[e]xtend the grounds for legalization of abortion to cases of rape, incest and severe foetal impairment." CEDAW Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014) para. 36(a); CEDAW Concluding Observations: Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012) para. 34.

³² UN Committee on the Rights of the Child, Concluding observations on the combined third and fourth periodic reports of Ireland UN Doc. CRC/C/IRL/CO/3-4 (2016) para. 57.

³³ See the story of Laoise's mother in Amnesty International, She is not a criminal: The impact of Ireland's abortion law (EUR 29/1597/2015) 58-59.

the term “lethal” or “fatal” abnormality. The Committee was informed that very few predictions can be made in medicine with 100% certainty.³⁴ Those caring for individuals and couples who receive these devastating diagnoses described consultations around the appropriate care pathway as “complex discussion[s] that require a description of risk and probability.”³⁵ The Committee was further advised that individuals or parents, in consultation with their doctor, are the people best able to make decisions in their individual circumstances.³⁶

Any lack of clarity in the law around whether an abortion may be provided or not will inevitably result in a chilling factor, particularly given that it is proposed to continue the specific criminal offence for medical professionals performing abortion procedures outside lawful grounds. As previously stated, we recommend that the legislation recognise that there is no clear line between severe and fatal foetal impairments, and in its provisions guarantee access to abortion in cases of both, in line with international human rights law and standards.

e. Head 7

i. Removal of three-day waiting period

Under section 2 of Head 7, the Updated General Scheme requires a waiting or ‘reflection’ period of 72 hours to elapse between the time the pregnancy has been dated and the provision of abortion services. However, mandatory waiting periods have been identified by the WHO as a barrier preventing timely access to services.³⁷ Furthermore the UN Committee on the Elimination of Discrimination against Women (CEDAW) has recommended the elimination of medically unnecessary waiting periods for abortion as they pose a barrier to access.³⁸ Mandatory waiting periods cause delay in access to services, which may result in denial of services due to gestational limits on legal grounds. They increase the cost of accessing abortion services, for example for women who need to take time off work to attend doctor’s appointments and for women who need to travel distances to access their nearest service. Most women have already been thoughtful, and considered their options and life circumstances before seeking access to abortion services; for those who are undecided, there is nothing in the law preventing these women from taking the time they need to reach their decision. In this way, imposing a mandatory waiting period demeans women as competent decision-makers. Also, mandatory waiting periods cannot be used as a substitute for measures to ensure women receive the full accurate information they need to make the best decisions about whether or not to continue pregnancies. As recently noted jointly by the UN CEDAW Committee and Committee on the Rights of Persons with Disabilities, “States must take effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and ensure that women have access to evidence-based and unbiased information in this regard”.³⁹ This should be the priority for government policy, and not addressed through burdensome and unhelpful statutory provisions.

We recommend that provision for a waiting or ‘reflection’ period of any duration be removed from the law. However, if any form of a waiting period is retained in the legislation, exceptions must be introduced for cases where a woman or girl requests access to abortion close to the gestational limit, to ensure that the waiting period does not act as a barrier to abortion services.

³⁴ Dr Peter Thompson, 29 November 2017.

³⁵ Ibid.

³⁶ Dr Peter Boylan, 18 October 2017.

³⁷ WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2012, second edition, 95 – 97.

³⁸ See CEDAW Committee, *Concluding Observations: Hungary*, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7- 8 (2013).

³⁹ “Stop regression on sexual and reproductive rights of women and girls, UN experts urge”, 5 September 2018, Geneva, at <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23503&LangID=E>.

Furthermore, in this situation, medical guidelines must clarify from what point the waiting period begins, and ensure that the waiting period does not cause a situation where multiple visits are required as this will present a barrier to access for many women, particularly those from geographically remote areas who have to travel a significant distance to their local service, as well as those who struggle to arrange childcare or to get time off work.

ii. Best practice for pregnancy-dating

In Head 7, section 5, the Updated General Scheme calls for pregnancies to be dated from the first day of a woman's last menstrual period. This is problematic for two reasons. Firstly, as many women will not have become pregnant on the first date of their last period, this reduces the 12-week period for some women; it may leave them with only six weeks in which to consider all options and reach a decision.

Secondly, it is common for women to experience irregular periods. This is particularly true for adolescents, women entering menopause and women with health conditions. Amenorrhoea, or the absence of menstruation, can be caused by a variety of factors including stress, the use of hormonal contraceptives, uterine polyps or fibroids, endometriosis, pelvic inflammatory disease, polycystic ovarian syndrome and a host of other underlying medical conditions. Dating a pregnancy from the first date of a woman's last menstrual period may preclude many of these women from accessing the services they need.

We urge that any recommendations the government wishes to make as to how pregnancy should be dated, be outlined in medical guidelines and not in law.

iii. Ensuring flexibility in gestational limits for 'on request' access

Flexibility should be provided around access to abortion in early pregnancy, too. For example, in Finland, abortion can be provided after the 12-week limit for adolescents, and for any reason accepted by the National Board of Medico-Legal Affairs. Such a provision recognises that there may be challenging circumstances beyond the control of the woman or girl, which may have delayed her accessing the procedure within 12 weeks, and that she should not be denied access to the abortion she needs because of factors beyond her control. This flexibility around challenging cases should be included in the draft legislation, particularly the subsection that provides for access up to 12 weeks without restriction as to reason.

f. Head 8 - Automatic review process

Head 8 sets out the process through which a woman or a person acting on her behalf, may appeal the decision to deny her access to an abortion. Head 8(1)a requires that she be informed in writing of the opportunity to make an application to review the decision; however, this is not best practice and it puts the onus on the woman herself to hold the health system accountable for realising her rights within it. When a woman or girl is denied access to an abortion, for whatever reason, the review process should be triggered automatically. She should not have to submit a request for a review. She should be informed that it initiates automatically once the refusal is given and that if she no longer wants the review, she can withdraw if she so chooses. This is common practice in other European countries, including Sweden and Croatia.

g. Head 11 - Duration of review committee's deliberations

Head 11(1) states that the review committee shall complete its review within seven days. This is a long time in the context of pregnancy. If the pregnancy is nearing gestational limits for

abortion provision, clear exceptions must be made, and a decision reached in an acceptable timeframe.

h. Head 12 - The right to be heard in review proceedings

Head 12(2) states that a pregnant woman or anyone acting on her behalf may inform the review committee that she wishes to be heard. This is not best practice. A woman or girl or pregnant person must be informed that she has a right to be heard, not just that she can be heard if she wishes. This needs to be clarified, along with the supports that will be made available to her in navigating and participating in the review process.

i. Head 14 - Non-discrimination in access to services for adolescents and other groups

This legislation must ensure that any barriers certain groups will/may experience are identified and addressed. This includes women and girls with disabilities, including in respect of their legal capacity to consent to or refuse treatment, and relevant interfacing with the Assisted Decision-Making (Capacity) Act 2015. In respect of adolescent girls' access to services and their evolving capacity to consent to medical treatment, since 2015, the UN Committee on the Rights of the Child has consistently recommended that states:

“Decriminalize abortions in all circumstances and review legislation with a view to ensuring children’s access to safe abortion and post-abortion care services. The views of the child should always be heard and respected in abortion decisions.”⁴⁰

The legislation must emphasise pregnant people's reproductive autonomy, even where the decision-making capacity of the woman, girl or pregnant person is perceived to be compromised, and when necessary pregnant people should be supported to make decisions about their pregnancies.

j. Head 15 - Regulating conscience-based refusal to provide care in line with human rights standards and international best practice

While Head 15 includes some detail as to how conscience-based refusal to provide care will be regulated by the state, additional detail would ensure regulation is human rights compliant. For example, the draft legislation should commit to ensuring an adequate number of trained providers, and guarantee an effective referral system so that conscience-based refusal to provide care does not act as a barrier to women and girls receiving the care they need.

While international human rights law does not require states to allow conscience-based refusals to abortion, the UN human rights treaty bodies have noted that where states do allow for it, they must regulate it to ensure that it does not deny or hinder women's access to lawful services. They have explicitly confirmed that the relevant regulatory framework must ensure an obligation on healthcare providers to refer women to alternative health providers⁴¹ and must not allow

⁴⁰ CRC/C/GMB/CO/2-3; CRC/C/HND/CO/4-5; CRC/C/HTI/CO/2-3CRC; CRC/C/GBR/CO/5; CRC/C/ZWE/CO/2; CRC/C/SLE/CO/3-5; CRC/C/BTN/CO/3-5. This is also in CRC General Comment 20 on Adolescents. See CRC/C/GC/20, art. 60.

⁴¹ See, e.g., CEDAW, General Recommendation No. 24: Article 12 of the Convention (Women and Health), para. 11, UN Doc. A/54/38/Rev.1, chap. I.

institutional refusals of care.⁴² Human rights bodies have also clarified that health professionals not directly participating in a medical procedure cannot refuse to provide care. Provisions in the legislation concerning conscience-based refusals should make it clear that such refusal does not apply to institutions or those not directly participating in the abortion procedure (for example, reception staff). While this would likely not be provided for in the Bill, it is important to note that the UN Committee on Economic, Social and Cultural Rights has specifically recommended that states should also ensure that an “adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach”.⁴³

Though it is perhaps presently less recognisable than the term ‘conscientious objection,’ the Department of Health should consider replacing the phrase ‘conscientious objection’ with the ‘conscience-based refusal to provide care’ as the effect of this action is in essence refusing to provide a healthcare service, protected by law, to a patient.

k. Head 18 – “Payment or other reward”

Head 18 sets out a new prohibition against receiving “payment or other reward” for giving information, advice or counselling to members of the public in relation to termination of pregnancy.” This has the effect of stigmatising the provision of counselling and information, and perpetuates harmful stereotypes by positioning those who need abortions as victims of ‘profiteering’ abortion providers. The onus is on the Department to demonstrate evidence of financially exploitative counselling services to justify inclusion of this head in the Updated General Scheme.

l. Head 19 – Criminalisation of health providers

The Joint Oireachtas Committee on the Eighth Amendment recommended that all criminal sanctions applying to women and girls who access abortion services be lifted. The Committee also recommended that doctors acting within the law and within a clinical context should be decriminalised. International human rights standards require abortion to be fully decriminalised, in order to eliminate the chilling factor that hinders health providers from providing abortion services. It is vital that no health provider should be dissuaded from acting in the best interests of their patient because of the fear of prosecution. However, the Updated General Scheme proposes to continue to make it a criminal offence for anyone other than the pregnant women to “intentionally end the life of a foetus otherwise than in accordance with the provisions of this Bill”, carrying a possible prison sentence of 14 years which will continue to perpetuate the chilling factor created by the criminalisation of abortion even when services are legal. Furthermore, the Updated General Scheme goes further in creating new summary offences in Head 19(3)(a).

Unlike in the Protection of Life During Pregnancy Act 2013, there will be no constitutional requirement for such a provision. Regard therefore should be had to international evidence that

⁴² See, e.g., CEDAW, Concluding Observations: Hungary, para. 31(d), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); CRC, Concluding Observations: Slovakia, paras. 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

⁴³ UN CESCR, Gen. Comment No. 22, paras. 14, 43 (“Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach. ... Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone’s access to sexual and reproductive healthcare, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations”).

criminalising medical professionals creates a chilling effect that can lead to delay or even denial in providing women lawful abortion services.

We urge that abortion is not a criminal offence in itself. Instead healthcare providers' practice should be regulated in the same way as any other medical procedure, through general criminal law and/or medical disciplinary procedures.

Additional provisions/considerations

m. Gender recognition

Throughout this submission, Amnesty Ireland refers to 'women and girls' and sometimes to "pregnant people". We recognise that whilst the majority of personal experiences with abortion relate to cisgender women and girls, it also holds true that intersex people, transgender men and boys, and people with other gender identities or who are gender non-conforming may have the reproductive capacity to become pregnant and may need abortions. We recommend that the draft legislation be read in conjunction with the Gender Recognition Act 2015, so that gender is not a direct or indirect barrier for anyone who requires access to abortion services. We further recommend that this be reflected in the definition of who can access abortion services under this law. In particular we recommend that the definition of "woman" under Head 1 be broadened to "a pregnant person of any age".

n. Review clause

In line with other recent legislation, including the Gender Recognition Act 2015 (section 7), the legislation should include a provision requiring a periodic review of the substance and operation of the Act. The Act should be periodically reviewed to ensure that women and girls are able to access safe, quality healthcare without barriers or delays; and to address in policy/guidelines any gaps, and new and emerging issues. The Act's substance must also be reviewed, to ensure that it evolves in light of developing international medical practice and human rights law (noting that what is proposed in the General Scheme currently falls short of what international human rights law requires).

o. Safety zones

Protesting against and harassment of women and girls entering facilities that offer abortion services is a known barrier to access to abortion services. The legislation should provide for safety/exclusion zones where protestors cannot intimidate or harass women seeking abortion services, and rogue pregnancy counsellors cannot engage women with misleading information.

p. Notification to the Minister

The Protection of Life During Pregnancy Act requires all 'terminations' carried out under that Act to be notified to the Minister for Health. The updated General Scheme specifies that "not later than 28 days after the termination of pregnancy has been carried out, [the medical practitioner shall] forward, or cause to be forwarded, a copy of that record... to the Minister." This is unnecessary and stigmatises this particular medical procedure. It should not be retained in the upcoming legislation. Of course, data should be collected on use of services, but in the same way that other medical services are monitored and evaluated. However, in order to ensure that the legislation is meeting its stated aims, it is important for the number of women and

girls who are refused access to abortion services to be recorded and published, clearly outlining the reasons stated for refusal.

q. Miscarriage management

It is unclear whether the proposed legislation relates to some forms of miscarriage management. In the context of the Eighth Amendment having been removed from the Constitution, there should be no delays in the performance of a dilation and curettage (D&C) procedure where indicated, due to the presence of a foetal heartbeat. We know from the tragic and entirely avoidable death of Savita Halappanavar how dangerous a lack of clarity in this regard can be. The medical guidelines must clearly state that miscarriage management for women, girls and pregnant people experiencing inevitable miscarriage, must be carried out, in line with best international practice.

r. Clinical guidelines

The draft clinical guidelines to accompany the legislation should be published in tandem with, or soon after the publication of the Bill in the interest of transparency and civil society stakeholder review. The guidelines themselves should conform to best international practice. They must aim to facilitate equitable access, with special attention to avoiding and dismantling barriers that hinder access for the most marginalised, especially where their care is governed by other, interacting legislation (for example, the Assisted Decision-Making (Capacity) Act 2015). Standards and guidelines should also cover: types of abortion service, where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents, women with disabilities and other marginalised groups; special provisions for women who have experienced rape; and requirements for referral in the case of conscience-based refusal to provide care by health-care providers.

s. Self-administration of misoprostol at home

Recent discussion of the UK law, which requires those seeking abortion services to take both pills in the presence of a doctor, has highlighted the impact of this requirement on women's and girls' health. Women and girls have reported traumatic experiences of miscarrying on the journey back from the clinic, which could have been avoided by allowing them to take misoprostol (the second of two medical abortion pills) at home. This does not conform to best medical practice. The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Health signed a letter calling for the Secretary of State for Health and Social Care to allow women in England to take misoprostol in a setting of their own choice, saying this "simple measure... would significantly improve the wellbeing of women".⁴⁴ The UK government recently confirmed plans to approve home-use of medical abortion pills in early pregnancy, to take effect by the end of the year. Under the plan, women can take the second of two early abortion pills in the safe and familiar surroundings of their own home.⁴⁵ This provides a good example of why the Irish government should, from the outset, ensure that the

⁴⁴ Royal College of Obstetricians and Gynaecologists. (2018). *RCOG/FSRH statement on taking misoprostol at home*. Available at: <https://www.rcog.org.uk/en/news/rcogfsrh-statement-on-taking-misoprostol-at-home/> [Accessed 3 September 2018].

⁴⁵ "Government confirms plans to approve the home-use of early abortion pills", 25 August 2018, at <https://www.gov.uk/government/news/government-confirms-plans-to-approve-the-home-use-of-early-abortion-pills> [Accessed 5 September 2018].

medical guidelines to accompany the legislation, provide for home-use of abortion pills during early pregnancy.

The WHO safe abortion guidelines clarify that “home use of misoprostol is a safe option for women. Increasingly, after receiving the mifepristone in the clinic, women receive misoprostol for self-administration at home within 24-48 hours following the mifepristone”.⁴⁶ This is also common practice in other jurisdictions including France, Sweden, the USA and Scotland. The clinical guidelines should ensure women, girls and other pregnant people are facilitated, insofar as possible, to take mifepristone in the comfort of their own homes, should it be their preference.

t. Acceptability of services

The human rights framework requires that health services be ‘acceptable’. This relates to the medical ethics and culture of individuals in the provision of abortion care. Often, people accessing abortion services report them to be ‘acceptable’ if they have been able to exercise free and informed choice. To this end, the medical guidelines should commit to, insofar as possible, maximising the choice of method of abortion available to women, girls and pregnant people, as well as the choice of provider. The WHO safe abortion guidelines also recommends a variety of abortion methods be made available, so that the most appropriate method may be used according to the duration of the pregnancy.⁴⁷

ENDS//

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⁴⁶ WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2012, second edition, 44.

⁴⁷ Ibid, 37.