AMNESTY INTERNATIONAL

# Submission to Department of Health on the three-year review of the Health (Regulation of Termination of Pregnancy) Act 2018

1 April 2022

## Introduction

Amnesty International (AI) Ireland welcomes the opportunity to make this submission to the Department's three-year review of 2018 Act.

AI Ireland is a signatory to the submission made by the Abortion Working Group (AWG), which comprises over 20 civil society organisations and healthcare providers led by the National Women's Council.[1] Therefore, in this separate submission, we outline some concerns and recommendations additional to those in the AWG submission.

The **AWG submission** highlights significant legal changes and practice improvements required if the Act is to guarantee equal and accessible abortion access to women, girls and other pregnant people. Its recommendations (paraphrased/summarised in parts) include:

- Fully decriminalise abortion to remove the chilling effect on healthcare providers
- Remove the mandatory three-day wait period to ensure timely access to abortion care on request
- Remove the 12-week gestational limit for abortion on request and enable access up to viability to ensure that no woman or pregnant person is forced to travel abroad for essential reproductive healthcare
- Remove the requirement of likelihood of death of the foetus before/within 28 days of birth for access to abortion on the ground of fatal foetal anomaly
- Maintain and enhance the telemedicine option for early abortion care so that all women and pregnant people can avail of remote consultation and medication delivery if this is their preference and clinically appropriate
- Replace the phrase 'conscientious objection' with 'conscience-based refusal to provide care' as the effect is refusing to provide a healthcare service, protected by law, to a patient
- Require medical practitioners to record abortion requests, whether or not abortion care was provided, and to where the service-user was referred in the case of conscience-based refusal of care; ensure this is monitored by the Irish Medical Council
- Establish robust data collection to monitor service provision; expand the current publicly available abortion dataset to include wait times, and recording of refusal of care and referral onwards
- Invest in nationwide promotion of MyOptions through traditional and digital media as the first step towards accessing abortion in Ireland; ensure its information is accessible, and

[1] https://www.nwci.ie/images/uploads/Abortion_Working_Group_joint-submission__final_March_2022.pdf

interpretation and translation services are available; explore its feasibility as a booking and not just information service
- Address regional gaps in abortion services in the community and hospital network
- Address the additional barriers faced by the migrant community and Northern Irish residents
- Support service user choice, and enable elective surgical care
- Legislate to address the absence of Safe Access Zones outside facilities where abortion care is provided
- Include gender inclusive language throughout the Act, i.e. "women and pregnant persons"
- Improve training and professional development of healthcare providers
- Expedite the Programme for Government commitment to develop inclusive and age-appropriate RSE and SPHE curricula across primary and post-primary levels, including on LGBTI+ relationships
- Address rogue pregnancy agencies through regulation

## Review Process

AI Ireland urges that the Department of Health's focus and aim in this review be on ensuring safe and timely access to abortion services in law, policy and practice, in a manner respectful of pregnant people's human rights to health, bodily integrity, autonomy, privacy, equality and dignity. It is important that the Department, in conducting this process, ensures that the substance of the Act, and not just its operation in a narrow sense, is reviewed.

Abortion care is health care, and a human right. The review must ensure that the legal, policy regulatory frameworks and practice on abortion are effective in enabling universal access to abortion, post-abortion care and evidence-based, non-biased abortion-related information for all women, girls and pregnant people, including as part of comprehensive sexual and reproductive health services, goods and information.

The Department must also recognise that access to abortion and reproductive health is more than a healthcare matter: the ability to control one's reproduction and to decide if, whether and when to have children is essential for the full realisation of the wider human rights of women, girls and all people who can become pregnant. This review must consider that the ability to make decisions about one's body, sexuality and reproduction is at the core of gender, economic and social justice.

It will also be important that the Department views its review remit as extending to how women's, girls and other pregnant people's ability to control their reproductive life is impacted by the conditions of their social and physical environment. The Government has an obligation to ensure that these conditions enable them to make informed and autonomous decisions in line with their life aspirations and to realise and enjoy their human rights.

In addition, the review should involve accessing and assessing all evidence-based, accurate information and the benefits of scientific progress. In this regard, AI Ireland particularly expects that the review will fully utilise and benefit from the World Health Organisation's (WHO) new *Abortion care guideline* published on 22 March 2022 as a core resource and benchmark.[2]

[2] *Abortion care guideline*. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO, at https://www.who.int/publications/i/item/9789240039483

## Non-discrimination in access to services for adolescents and other groups

The review must identify and address the barriers in law, policy and practice certain groups inevitably experience, including on grounds of nationality, ethnicity, socioeconomic status, disability, migrant or refugee status, age or geographic location.

Regarding women, girls and pregnant people with disabilities, compliance with the UN Convention on the Rights of Persons with Disabilities (CRPD) should be specifically assessed (especially given Ireland's upcoming first review by that UN treaty body). This should include an assessment of accessibility of abortion care (see AWG submission in this regard); also, how people's exercising legal capacity in respect of reproductive autonomy and decisions about terminating their pregnancies is respected, protected and fulfilled. Relevant interfacing with the Assisted Decision-Making (Capacity) Act 2015 and other legislation should be assessed to ensure compliance with the CRPD.

The review must also fully consider the specific requirements of the UN Convention on the Rights of the Child. 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 "... 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."

## Move away from restrictions/limits based on grounds and gestational age

It is the right of every woman, girl or person who can become pregnant to abortion care, provided in a manner that respects their rights, autonomy, dignity and needs in the context of their lived experiences, circumstances, aspirations and views. States must ensure that abortions are available as early as possible and as late as necessary to respond to the specific needs of pregnant people.

In this regard, it is significant that in its new 2022 *Abortion care guideline* mentioned above, the WHO recommends against laws (and other regulations) that restrict abortion by grounds (section 2.2.2, pp. 26,27 – Law & Policy Recommendation 2: Grounds-based approaches) and that prohibit abortion based on gestational age limits (section 2.2.3, pp 28, 29 - Law & Policy Recommendation 3: Gestational age limits). These two sections are reproduced in full in Annex 2 below.

In order to identify the impacts of grounds-based approaches on abortion seekers and health workers, a systematic review of studies published between 2010 and 2021 was undertaken by WHO, with Ireland one of the countries covered by those studies. The reviewed evidence revealed the many negative impacts of grounds-based laws on abortion, including their contribution to delayed abortion and denial of abortion: see Annex 2 below for details of the findings.

AI Ireland therefore strongly urges that these important WHO recommendations not only be given serious consideration in the course of this review, but ultimately adopted in the review conclusions.

Also, the following observations on the lawful grounds and gestational limits set for abortion care in the 2018 Act should be interpreted as strongly caveated in this light.

## Risk to life or serious harm to health ground

- *Respecting autonomous decision-making*

For abortions outside the 12-week on-request period where there is a "risk to the life, or of serious harm to the health, of the pregnant woman", Section 9 requires that two medical practitioners must certify that risk. This provision does not clarify the role the woman'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. There should be provision in law or policy for the participation of the woman, girl or pregnant 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.[3] In New Zealand, women were required to get certification from two doctors before an abortion can be performed, which the committee described as "nullifying their autonomy."[4] 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.[5]

In order to respect the autonomous decision-making of the patient as required by international human rights law, the Act should 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.

- *Removing gestational limits from risk to health or life ground*

Under the Act a termination of pregnancy may be performed to avert a risk to the life, or of serious harm to the health, of a pregnant person 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, under international human rights law, from imposing reasonable restrictions on abortion services, such as gestational limits, such restrictions must not undermine pregnant people's human rights. There must be flexibility in regulations in order to ensure that their human rights can be protected throughout pregnancy. In many 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 of incest.

[3] UN Doc. CEDAW-C-NZL-CO-7 (2012), paras. 33-34.
[4] Ibid.
[5] UN Doc. CEDAW/-C-TLS-CO-2-3 (2015) para 31(a).

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. 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 also risks forcing 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, 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 currently legal position that there must be a risk of "serious harm" to the woman's health for the health 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 trauma a woman or girl has not been able to present to services within the current 12-week limit for abortion on request. This is no less of a health issue, and her access must be facilitated.

- *Requirement of 'serious harm' to health*

The risk to health ground in the Act 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' should 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.

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. 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.

## Foetal impairment ground

The Act limits access to an abortion on this ground to only where there is "a condition affecting the foetus that is likely to lead to the death of the foetus either before or within 28 days after birth". Firstly, if any guidance is to be set out on determining a severe or fatal foetal impairment, this should be included in medical guidelines and not enshrined in law. Secondly, we recommend instead of arbitrary cut-off points for predicted survival a more human rights based 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 health professionals to come up with exact predictions. As predicted in 2018, this has indeed created delays preventing timely access to abortion services, and denied access to many pregnant people entirely.

It is important again 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",[6] as it had in its concluding observations on other states.[7] 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".[8]

We again recommend that the Act be amended so that no medically artificial line is drawn between 'severe' and 'fatal' foetal impairments, and that it guarantee access to abortion in cases of both, in line with international human rights law and standards. How precisely the amendment should be worded to achieve this outcome is the Irish Government's responsibility. (It is important to note again the WHO's advising against these or other grounds for restricting access to abortion.)

Failure to ensure that women can access timely abortion in these cases only compounds the suffering of women, girls and couples. Statistics show that women are still having to travel to England and Wales (and likely elsewhere) for abortion care, in circumstances very similar to those in which Ireland was found to violated the human rights to two women in the 2016 *Mellet v Ireland* and 2017 *Whelan v Ireland* decisions by the UN Human Rights Committee. The complexities and harrowing experiences of having to navigate the 2018 Act are outlined in the submission report to this review by the Terminations for Medical Reasons organisation.[9]

Any lack of clarity in the law around whether an abortion may be provided or not will inevitably result in a chilling factor for health professionals, particularly if (unadvisedly) it continues to remain the specific criminal offence to perform abortion procedures outside lawful grounds.

### Definition of medical practitioner

The Act defines a 'medical practitioner' as one "who is for the time being registered in the register". As the Irish Medical Council's register includes only medical doctors, this definition places unnecessary limits on who can provide abortion services as it is out of step with international best practice. The WHO *Abortion care guideline* advises that a range of types of trained health workers can safely, effectively and satisfactorily perform some or all specific abortion-related tasks. AI Ireland recommends that the definition of who can provide abortion services be expanded in line with international best practice, and to the appropriate degree left to medical guidelines rather than legislation.

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

[7] 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.

[8] 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.

[9] Terminations for Medical Reasons: The women and families left behind by Repeal", https://lmcsupport.ie/wp-content/uploads/2022/03/TFMR-Review-Report_FINAL_2022-1.pdf

## Criminalisation of assisting someone in obtaining an unlawful abortion

As mentioned above, the AWG submission recommends that healthcare providers who facilitate or provide abortion medication or services beyond lawful grounds should not be criminalised.

AI Ireland adds that states must additionally refrain from punishing, through the enforcement of any law or policy, anyone who assists or in any way helps people obtain abortion medication or services.

Section 23(2) of the Act made it an offence "for a person to prescribe, administer, supply or procure any drug, substance… knowing that it is intended to be used or employed with the intent to end the life of a foetus". Section 23(4) made it an offence to "aid, abet, counsel or procure a pregnant woman to intentionally end, or attempt to end, the life of the foetus of that pregnant woman otherwise than in accordance with the provisions of this Act". These provisions have the same sort of potential chilling effect on healthcare professionals as criminalising the provision of unlawful abortions. They also risk criminalising a parent, friend or other trusted person who acts in good faith to assist with accessing, for instance, medical abortion pills to which access might not otherwise be possible, including due to legal or other barriers.

ENDS//

**For further information, please contact Fiona Crowley, Research and Legal Manager at fcrowley@amnesty.ie or 01 863 8300**

## Annex 1 - Key elements of Amnesty International's 2020 policy on abortion

The following are the key elements of Amnesty International's policy on abortion (the full policy is available at https://www.amnesty.org/en/documents/pol30/2846/2020/en/; an Explanatory Note providing additional guidance and rationale for this updated policy is at https://www.amnesty.org/en/documents/pol30/2847/2020/en/):

### 1. Every woman, girl or person who can become pregnant has the right to abortion, provided in a manner that respects their dignity, autonomy and needs in the context of their lived circumstances, experiences, aspirations and views

- Every pregnant person should be able to make decisions related to their pregnancy that are in line with their own life experiences, circumstances, aspirations and views. They must have access to evidence-based, non-biased information about their pregnancy in a form and format that they can understand, non-biased and non-directive counselling, and any necessary support to facilitate autonomous decision-making.
- Abortions must be undertaken freely with the consent of the pregnant person and without force, coercion, violence or discrimination, the need for third-party consent, or the threat of legal sanction.
- No one should be compelled to seek or obtain an unsafe abortion or to die or be subjected to unnecessary suffering from an unsafe abortion.
- No one should be mistreated, humiliated or degraded or be at risk of violence or social exclusion for seeking abortion care or for having an abortion.
- No one's full status as a rights holder and equal subject before the law at all stages of their lives can be suspended, diminished or mandatorily set aside because of pregnancy or, more broadly, because of their sex, sexual orientation, gender, gender identity or expression, age, race, geographic location, nationality, ethnicity, caste, class, disability, migrant or refugee status, and minority or Indigenous identity, among other factors.

### 2. Abortion and post-abortion care should be available, accessible, affordable, acceptable and of good quality. They should be provided with respect for pregnant persons' rights, autonomy, dignity, privacy and confidentiality, and with informed consent

States must ensure:

- That abortions are available as early as possible and as late as necessary to respond to the specific needs of pregnant people.[10]
- Available, accessible, acceptable, affordable,[11] good quality abortion care upon request so pregnant people do not feel compelled to take unnecessary risks to terminate their pregnancies.

[10] Amnesty International acknowledges that states may regulate access to abortion, including by setting gestational limits but, like all other restrictions, gestational limits should not be considered reasonable by default. Rather, where appropriate, there should be a human rights analysis of the legal, policy and other regulatory measures on abortion in a particular country and context that is based on human rights principles and the impact of the restrictions on the human rights of pregnant people. See the Explanatory Note to this policy, Section 5.3, for further details.

[11] This includes provision of services free or otherwise structured to ensure individuals and families are not disproportionately burdened with health expenses, and people without sufficient means should be provided with the support necessary to cover the costs. See CESCR Committee, General Comment 22 on the right to sexual and reproductive health (Article 12 of ICESCR), UN Doc. E/C.12/GC/22 (2016), para. 17.

- Abortion service provision with informed consent that complies with pregnant persons' rights, autonomy, dignity, privacy and confidentiality.
- Accessible medical (using abortion medication) and surgical abortion methods based on evidence-based standards, to serve the individual needs of pregnant people.
- Access to care in a range of settings (for example, formal health-care settings; primary, secondary and tertiary health-care centres; mobile clinics; and telehealth) and trained providers to ensure access to abortion care, particularly in remote and rural settings.
- Access to post-abortion care for people who are managing complications from a miscarriage or abortion, regardless of the legality of abortion, and regulate refusals of care for lawful services (including based on conscience), prohibit the denial of such care on any grounds, including based on conscience or beliefs.
- Access to comprehensive sexual and reproductive health services, goods and information, with respect for pregnant persons' sexual and reproductive autonomy, dignity, privacy and confidentiality, and human rights. Such services should be provided in an equal and non-discriminatory manner, ensuring pregnant individuals' equal access to sexual and reproductive health care, including abortion and post-abortion care, modern contraceptives and evidence-based, non-biased information, including information on their pregnancies.
- That health-care providers receive training on providing abortion and post-abortion care and miscarriage treatment in a compassionate and ethical manner. This should include training on the social determinants and medical necessity of abortion and on ethical and acceptable care. Training for health-care providers should also cover relevant laws and policies related to abortion and the rights of all people who can become pregnant.

### 3. States have a positive obligation to create an enabling and supportive environment for people to make autonomous decisions about their pregnancies.

- States must guarantee the right of everyone who is pregnant or can become pregnant to make autonomous pregnancy-related decisions. This should include the right to have access to evidence-based, non-biased, accessible and rights-based information about their pregnancies and support necessary to make such autonomous decisions, without the need for third-party consent.
- States must remove barriers to safe abortion services. These include laws, policies and practices that impede pregnant people from accessing safe abortion services, such as financial, social, geographic, detention-related and disability-related barriers (for example, physical barriers, lack of access to evidence-based, non-biased information and discriminatory attitudes, substituted decision-making by a guardian, parent or doctor), the need for third-party consent, biased counselling, denial of care for lawful services (including based on conscience or beliefs) and mandatory waiting periods.
- States must recognise the legal capacity of women, girls and pregnant persons with disabilities to make autonomous decisions about sexuality, reproduction and pregnancy irrespective of mental capacity and must provide any supports necessary to facilitate such informed and autonomous decision-making.
- States should take measures to ensure that nobody feels compelled to continue a pregnancy or to have an abortion, whether this is because of violations of human rights, such as gender or intersectional discrimination, or as a result of restrictions on access to abortion.

- States must ensure that all people have access to comprehensive sexuality education (CSE), both in and outside of education settings, which is evidence-based, age-appropriate, gender-sensitive and grounded in human rights.[12] CSE programmes must promote gender equality and avoid perpetuating discriminatory stereotypes, including on gender, sexual orientation or other status. CSE programmes must also account for the evolving capacity of children and adolescents and provide them with the knowledge and skills necessary to make informed and autonomous decisions.
- States must identify and address the underlying factors that foster and promote gender, racial, ethnic, class, disability and other intersecting forms of discrimination that contribute to reproductive oppression, promote and perpetuate the restrictive and punitive regulation of abortion and fuel stigma and discrimination against people who have, or are presumed to have, sought or obtained abortions.
- States must directly confront stigma related to sexuality, sex, disability, unintended pregnancies and abortion that impedes sexual and reproductive autonomy, restricts access to safe abortion, fosters and perpetuates gender inequality and facilitates ableism.[13]
- States must ensure pregnant people have accurate, non-biased information about and access to services and support, including health care, social security and means to obtain an adequate standard of living, so that they are empowered to make free decisions, in line with their life aspirations and views, about whether to carry their pregnancy to term, and that they are not compelled to seek recourse to abortion due to denial of their economic and social rights.

## 4. Abortion must be fully decriminalised

- States must fully decriminalise abortion (that is, remove abortion from criminal law). They must also remove any laws or policies and end any practices that directly or indirectly punish people for seeking, obtaining, providing or assisting with securing and/or obtaining an abortion.
- States must refrain from punishing, through the enforcement of any law or policy:
  - ✓ anyone who seeks or obtains, or is suspected of seeking or obtaining, an abortion;
  - ✓ health-care providers who facilitate or provide abortion medication or services; and
  - ✓ others who assist or in any way help people obtain abortion medication or services.
- States must immediately drop criminal charges, expunge resulting criminal records and release all individuals who have been imprisoned for having an abortion, miscarriage, or another pregnancy-related complication or for having procured abortion medication. The same must be done for health-care providers and others punished solely for performing abortions or facilitating or helping people to obtain abortion medication or services.
- Full decriminalisation of abortion is an essential component of respecting, protecting and fulfilling the human rights of all people who can become pregnant. However, it is not sufficient in itself and must be accompanied by the fulfilment

[12] Such education should be based on accurate information about sexuality, sexual and reproductive health, human rights and empowerment, non-discrimination, gender equality and gender roles, sexual behaviour, sexual abuse, gender-based violence and harmful practices.

[13] "Ableism" is defined as discrimination or prejudice against individuals with disabilities (Merriam-Webster Dictionary) or discrimination in favour of able-bodied people (Oxford English Dictionary).

of states' other positive obligations related to abortion as referenced throughout this policy.

## 5. All legal, policy and regulatory frameworks around abortion should be assessed for their human rights compliance

- States must prioritise the concerns, lived experiences and human rights of women, girls and all people who can become pregnant in formulating laws and policies that regulate abortion and eliminate abortion-related stigma and discrimination.
- States must ensure that women, girls and people who can become pregnant are adequately consulted and can meaningfully participate in the formulation and monitoring and evaluation of abortion-related laws and policies, in accordance with their right to full, effective and meaningful participation in law and policy-making on issues that affect their lives.
- Legal, policy and regulatory frameworks around abortion should be assessed to ensure that they respect and protect the human rights of women, girls and all people who can become pregnant. The assessment should include the impact on the rights to life, health, privacy, education, access to evidence-based, accurate information and the benefits of scientific progress, freedom of conscience, freedom from torture and other ill-treatment, and to equality and non-discrimination.
- States must reform all legal, policy and regulatory frameworks that relate to abortion or impact pregnancy-related decision-making to ensure that:
  - ✓ the sexual and reproductive autonomy of women, girls and all people who can become pregnant lie at their centre;
  - ✓ they respect, protect and fulfil the human rights of pregnant people;
  - ✓ they realise gender equality and economic and social rights.
- Legal protection of human rights, including the right to life, commences at birth.[14] While states may have a legitimate interest in protecting maternal and foetal health, abortion should not be regulated under criminal or punitive laws and policies, and abortion-related laws and policies must not accord legal rights to gametes, zygotes, embryos, or foetuses. Research and evidence indicate that foetal health is best protected through promoting pregnant persons' health and wellbeing[15] and in non-criminalised legal and policy environments.
- States must ensure that women, girls and people who can become pregnant have timely access to justice, and meaningful and effective remedies when their sexual and reproductive rights have been violated, including access to legal aid and information about the existence of such remedies. In cases where third parties violate individuals' sexual and reproductive rights, states must ensure that such violations are investigated and that perpetrators are held to account and those who suffered such violations are provided remedies.

[14] Amnesty International does not take a position on when a human life begins, which is a moral and ethical issue for each individual to decide for themselves in line with their conscience, but our policy affirms that the legal protection of human rights, including the right to life, commences at birth.

[15] See CEDAW Article 12; see also CEDAW Committee, General Recommendation 24 on Women and Health, UN Doc. A/54/38/Rev.1 (1999), para. 31(c).

## Annex 2 – Extract from *Abortion care guideline*, World Health Organisation 2022 (pp 26–29)

### 2.2.2 Grounds-based approaches to controlling access to abortion

National laws in most countries permit some abortions, even in settings where abortion is criminalized. Usually abortions will still be permitted under prescribed "grounds", or specific circumstances. The circumstances under which abortion is permitted vary widely across different countries. Some of these circumstances reflect clinical indications (e.g. risk to the health of the pregnant woman or fetal impairment), some relate to the circumstances of conception (e.g. rape), and some relate to socioeconomic circumstances (e.g. economic hardship). Grounds-based approaches are commonly accompanied by gestational age limits, often varying depending on the specific condition under which abortion is permitted. In some countries, abortion is available on request up to a specified gestational age and then limited to specific grounds thereafter.

### LAW & POLICY Recommendation 2: Grounds-based approaches

**a. Recommend against** laws and other regulations that restrict abortion by grounds.

**b. Recommend** that abortion be available on the request of the woman, girl or other pregnant person.

**Remarks:**

- Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person.
- Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This means that the content, interpretation and application of grounds-based law and policy should be revised to ensure human rights compliance. This requires that:

  I. existing grounds are defined, interpreted and applied in a human rights-compliant way;
  II. abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest or the pregnancy is not viable;
  III. abortion is available where the life and health of the woman, girl or other pregnant person is at risk;
  IV. health grounds reflect WHO's definitions of health and mental health (see Glossary); and
  V. there are no procedural requirements to "prove" or "establish" satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information, refer to Web annex A: Key international human rights standards on abortion).

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 Safe abortion guidance provided a composite recommendation related to law and policy (19); in this guideline, this has been developed into seven separate recommendations using GRADE methodology

## Rationale

International human rights law requires that abortion be available where carrying a pregnancy to term would cause a woman substantial pain or suffering, or where her life or health is at risk. States may not regulate abortion in a manner that forces women to resort to unsafe abortion and must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with unsafe abortion (for further information, please refer to Chapter 1, section 1.3.1[i] and Web annex 1: Key international human rights standards on abortion). Grounds-based approaches are often (i) too narrowly defined or (ii) too conservatively applied to ensure abortion is available in these circumstances. The aim to reduce maternal morbidity and mortality, and protect women and girls from the risks associated with unsafe abortion, can be effectively achieved by making abortion available on the request of the pregnant woman or girl.

In order to identify the impacts of grounds-based approaches on abortion seekers and health workers, a systematic review of studies published between 2010 and 2021 was undertaken, identifying 21 studies conducted in Argentina, Australia, Brazil, Chile, Colombia, Ethiopia, Ghana, the United Kingdom of Great Britain and Northern Ireland, the Islamic Republic of Iran, Ireland, Israel, Mexico, Rwanda, Thailand, the United Republic of Tanzania, the United Kingdom of Great Britain and Northern Ireland, Uruguay and Zambia. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Grounds-based approaches. The reviewed evidence showed that grounds-based laws contributed to delayed abortion, with delays occurring because of inconsistencies in interpretation or application of health grounds, women waiting for determination of their eligibility for abortion or having their claim that pregnancy resulted from rape questioned or disbelieved, overly restrictive interpretation of grounds, or disagreement within a medical team about whether a woman satisfies a legal ground. Misinterpretation of the law can also result in denial of abortion. In some cases, health workers waited for a health condition to deteriorate sufficiently to ensure that a woman satisfied a "risk to life" ground, clearly endangering the right to life and potentially violating the right to be free from torture, cruel, inhuman and degrading treatment.

Interpretation of grounds, and thus eligibility for lawful abortion, varies between providers, and providers are not always certain about the law or how it should be applied; interpretation is often narrow and incompatible with human rights law and/or with WHO's definitions of health and mental health, leading to denial of abortion. Women reported significant challenges in accessing care in circumstances where they could not obtain legal support and advice on the permitted grounds. Grounds-based approaches were found to have a particularly negative impact on women facing financial hardship and women with lower educational attainment.

The evidence reviewed for this guidance showed that grounds-based approaches have a disproportionate negative impact on women who seek abortion following rape. These women were often subjected to questioning, protracted delay and bureaucratic processes due to requirements such as reporting the crime to the police or need for a court order, even though it is not human rights compliant to make such reporting or processes a prerequisite for

accessing abortion. Even where the law provides that a woman's claim of rape is sufficient to satisfy the legal requirement, providers may require a document or authorization (e.g. court order or police report). In reality this means that obtaining an abortion following rape is laborious and time-consuming. In some cases, delays are so long that women give birth before legal eligibility is determined; in others, women choose instead to resort to unsafe abortion. Thus, "rape grounds" do not satisfy the requirement from international human rights law that abortion be available and accessible in situations of rape. These restrictions also subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The evidence also showed that grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers who wish to support patients and leave women no choice but to continue with pregnancy. Being required to continue with a pregnancy that causes significant distress violates numerous human rights. States are obligated to revise these laws to make them compatible with international human rights law.

Under international human rights law, States are required to ensure that women do not have to resort to unsafe abortion. The evidence from the studies described above suggests that grounds-based laws may contribute to an increase in the incidence of unsafe abortion, with people who do not satisfy a ground resorting to unlawful abortion, including unlawful self-management of abortion, some of which may be unsafe. The evidence from the studies also indirectly suggests that grounds-based laws contribute to maternal mortality, because when States shift from a grounds-based approach to permitting abortion on request in the first trimester there is a reduction in maternal mortality (especially for adolescents) as well as a reduction in fertility (birth rates). This suggests a connection between the international obligation to take steps to reduce maternal mortality and morbidity and a shift away from grounds-based approaches.

## KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO GROUNDS-BASED APPROACHES

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- Abortion must be available where carrying a pregnancy to full term would cause a woman substantial pain or suffering, where pregnancy is a result of rape or incest, or where her life or health is at risk.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

### 2.2.3 Gestational age limits

Gestational age limits are commonly specified in both liberal and restrictive abortion laws and policies. Imposed through formal law, institutional policy or personal practice by individual health workers, these limits restrict when lawful abortion may be accessed by reference to the gestational age of a pregnancy. In many countries gestational age limits are linked to grounds-based approaches, with gestational age limits varying according to the grounds or circumstances under which abortion is permitted. While methods of abortion may vary by gestational age (see Chapter 3, section 3.4), pregnancy can safely be ended regardless of gestational age. Gestational age limits are not evidence-based; they restrict when lawful abortion may be provided by any method.

International human rights law requires that quality of care be central to the provision and regulation of SRH, and thus that regulation of abortion is evidence-based, scientifically and medically appropriate, and up to date (3, para. 21). Under international human rights law, States may not regulate pregnancy or abortion in a manner that is contrary to their duty to ensure that women and girls do not have to resort to unsafe abortion, and are required to revise their laws accordingly (see Web annex A: Key international human rights standards on abortion).

#### LAW & POLICY Recommendation 3: Gestational age limits

**Recommend against** laws and other regulations that prohibit abortion based on gestational age limits.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 Safe abortion guidance provided a composite recommendation related to law and policy (19); in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

#### Rationale

In order to identify the impacts of gestational age limits on abortion seekers and health workers, a systematic review of studies published between 2010 and 2020 was undertaken, identifying 21 studies conducted in Australia, Belgium, Mexico, Nepal, South Africa, the United Kingdom and the United States of America (USA). A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Gestational age limits. The reviewed evidence demonstrated that – alone or in combination with other regulatory requirements, including grounds-based approaches – gestational age limits delayed access to abortion, especially among women seeking abortions at later gestational ages, women close to the gestational age limit and those living in areas with limited access to clinics. Gestational age limits have been found to be associated with increased rates of maternal mortality and poor health outcomes. International human rights law requires States to reform law in order to prevent unsafe abortion and reduce maternal mortality and morbidity.

The studies also showed that where women requested an abortion and were denied care due to gestational age this could result in the unwanted continuation of pregnancy, especially

among women with cognitive impairments or those who presented at 20 weeks' gestation or later. This outcome can be viewed as incompatible with the requirement in international human rights law to make abortion available when carrying a pregnancy to term would cause the woman substantial pain or suffering, regardless of pregnancy viability.

The evidence from these studies showed that women with cognitive impairments, adolescents, younger women, women living further from clinics, women who need to travel for abortion, women with lower educational attainment, women facing financial hardship and unemployed women were disproportionately impacted by gestational age limits. This points to the disproportionate impact of gestational age limits on certain groups of women, with implications for States' obligation to ensure non-discrimination and equality in provision of SRH services.

## KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO GESTATIONAL AGE LIMITS

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.