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# The 2013 Irish legislation on abortion: turning-point or missed opportunity?

A critical analysis from a human rights perspective

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## **Abstract**

While Ireland is being targeted by a worldwide Amnesty International campaign on sexual and reproductive rights, a reflection on the Irish legal framework on abortion is deemed necessary. The present work assesses whether the Protection of Life During Pregnancy Act approved by the Irish Parliament in July 2013 represents a step forward or a missed opportunity for the protection of women's reproductive rights in Ireland. After illustrating the legal, political and social developments on the issue of abortion since the introduction of the Eighth Amendment of the Constitution in 1983, the focus will move to the analysis of the 2013 Act. The assessment will be twofold. On the one hand, at a national level, the alleged shortcomings of its practical impact will be illustrated. On the other hand, at the international level, the legislation will be evaluated in the light of its compliance with the Irish obligations under International Human Rights Law. Finally, it will be concluded that the Protection of Life During Pregnancy Act has to be welcomed, since it fills a thirty-year lasting legislative gap, but it falls short of human rights requirements and does not bring any major practical improvement in the majority of women's lives.

## Table of Acronyms

AI:	Amnesty International
APOCC:	All Party Oireachtas Committee on the Constitution
ARC:	Abortion Rights Campaign
BPAS:	British Pregnancy Agency Service
CAT:	Convention Against Torture
CCPR:	Covenant on Civil and Political Rights
CEDAW:	Convention on the Elimination of all forms of Discrimination Against Women
CESCR:	Covenant on Economic Social and Cultural Rights
CFRR:	Centre For Reproductive Rights
CO:	Concluding Observation
CoE:	Council of Europe
CPA:	Crisis Pregnancy Agency
CRG:	Constitution Review Group
CSO:	Civil Society Association
DFC:	Doctors For Choice
ECHR:	European Convention of Human Rights
ECtHR:	European Court of Human Rights
EU:	European Union
GC:	General Comment
GPC:	Galway Pro-Choice
GR:	General Recommendation
GSB:	General Scheme of the Bill
HIQA:	Health Information and Quality Authority
HR:	Human Rights
HRW:	Human Rights Watch

HSE:	Health Service Executive
IFPA:	Irish Family Planning Association
IHRC:	Irish Human Rights Commission
IMELDA:	Ireland Making England a Lawful Destination for Abortion
Ir.H.C.	Irish High Court
Ir.S.C.	Irish Supreme Court
JCHC:	Joint Committee on Health and Children
MS:	Member State
MTB:	Medical Treatment Bill
NUIG:	National University of Ireland Galway
NWCI:	National Women's Council of Ireland
OAPA:	Offences Against Person Act
PLDPA:	Protection of Life During Pregnancy Act
SPUC:	Society for the Protection of Unborn Children
SR:	Special Rapporteur
SU:	Student Union
TD:	Teachta Dála (Deputy)
TFMR:	Terminations For Medical Reasons Ireland
UCD:	University College Dublin
UDHR:	Universal Declaration of Human Rights
UK:	United Kingdom of Great Britain and Northern Ireland
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
WHO:	World Health Organisation

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## 1.

### Introduction

Reproductive rights fall within a very recent human rights (HR) field of interest, situated at the intersection of fundamental human axes such as gender relations, population policies, health issues and bio-ethical and religious questions.

2014 is an important year to remind their fundamental importance within both the HR and development frameworks. It marks, indeed, the Twentieth Anniversary of the Cairo International Conference on Population and Development, where the concept of “reproductive rights” made its first appearance<sup>1</sup>. The +20 Review on the implementation of the Cairo Plan of Action<sup>2</sup>, held in April, placed reproductive rights back on the foreground of worldwide attention, acknowledging both the progresses and the gaps yet to fill<sup>3</sup>. By stressing once more the crucial importance of sexual and reproductive health and rights, it renewed the commitment towards their protection<sup>4</sup> and furthermore indicated their major role in the field of development. Indeed, many international organisations<sup>5</sup>, as well as a worldwide advocacy campaign<sup>6</sup>, suggested their inclusion within the future development goals of the UN Post-2015 Agenda.

Furthermore, the coincidence of this multi-layered attention inspired one of the most prominent international HR Non-Governmental Organisations, Amnesty International (AI), to launch in February 2014 a two-year worldwide campaign called “My Body My Rights”<sup>7</sup>. This deals with several sexual and reproductive health issues and one of the

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<sup>1</sup> UN, ICPD Report, Cairo 1994, A/CONF.171/13/Rev.1, para.7.3 (hereafter: ICPD Cairo Report).

<sup>2</sup> 47<sup>th</sup> Session of the UN Commission on Population and Development, 7-11 April 2014, New York, at <<http://www.un.org/en/development/desa/population/commission/sessions/2014/index.shtml>> (consulted on 4 July 2014).

<sup>3</sup> UN Commission of Population and Development, Resolution 2014/1.

<sup>4</sup> Convention on Elimination of all forms of Discrimination Against Women, 2014.

<sup>5</sup> WHO, UNFPA, UNICEF and UNAIDS within the UN System Task Team on the Post-2015 Development Agenda, 8<sup>th</sup> Thematic Think Piece, 2012, p.9.

<sup>6</sup> Women’s Global Network for Reproductive Rights (WGNRR), at <<http://wgnrr.org/>> (consulted on 4 July 2014).

<sup>7</sup> AI, 2014.

seven countries focused upon is precisely Ireland. As Kelly Mackey affirmed, “Ireland being selected is hugely important, because on the global level it was identified as being exemplary in how far short is performing on meeting its human rights obligations”<sup>8</sup> regarding women’s access to safe and legal abortion. This focus is particularly meaningful, since Ireland is considered -by one of the leading international organisations dealing with HR - as a worldwide negative example regarding women’s reproductive rights. Furthermore, this choice is particularly striking, since it coincided with the entering into force of the first piece of legislation regulating abortion ever approved by the Irish Parliament: the Protection of Life During Pregnancy Act (PLDPA).

Therefore, the question rises automatically whether this Act could signify a step forward on the recognition of the reproductive right to safe abortion within the Irish legal framework or if it might represent a missed opportunity to finally change a critical situation. The objective of the present work is precisely to answer this question, through a critical analysis of the legislation from a HR perspective.

After illustrating the legal and social background that in the past three decades led to the last year significant legislative change (Chapter 2), the focus will move to the 2013 Act. Its political pathway will be depicted and subsequently it will be critically analysed on two different levels. On the one hand, from a legal, political and social point of view, the Act will be assessed both with a personal evaluation as well as through the flaws noticed by some Civil Society Organizations (CSOs) working in Ireland for women’s reproductive rights (Chapter 3). On the other hand, the HR issues arising from the Act will be discussed according to International Human Rights Law (IHRL) (Chapter 4).

Regarding the methodology used for the research, the following sources were consulted. The examination of the social and political framework regarding abortion in Ireland has been focused on the existing academic literature, as well as on the available Irish online press. On the other hand, concerning the Irish legal framework, it has been necessary to consult Irish legislation and official documents, as well as jurisprudence both at national (High and Supreme Court) and at European level (European Court of Justice and European Court of Human Rights). Concerning the analysis of the Act,

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<sup>8</sup> Interview with Kelly Mackey, AI-Ireland, Dublin, 14 May 2014.

beyond the personal study of the legislation in its first and final drafts, its comprehensive and multi-layered critical evaluation has emerged thanks to the broad consultation of the CSOs' submissions and briefings<sup>9</sup>. Furthermore, the HR legal perspective included in the last part of the assessment of the legislation derives from the body of instruments, recommendations and jurisprudence issued by the major international and regional HR institutions. Finally, a significant part of the present research was conducted through interviews in person with CSOs dealing with women's reproductive rights at local, national and international level<sup>10</sup>.

The aim of the present work is to produce a critical analysis of the PLDPA from a HR perspective. Therefore, it is not the author's intention to enter in the merits of the ideological Irish debate on the thorny issue of abortion, providing the reader with the argumentations of the two sides of the dispute, since this would lead too far in a different area of research. Nor is it in the author's will to support one side or another of the dispute, on the basis of biased ideological arguments. The present research wants to be an academic study based on IHRL. Therefore, whenever the analysis could seem ideologically biased, it contrarily only reflects the position taken by IHRL on women's reproductive rights. As it will be clear throughout the analysis, while acknowledging the cultural specificity of different countries, this framework tends to support women's reproductive self-determination.

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<sup>9</sup> The associations whose material was consulted are: AI-Ireland, Human Rights Watch (HRW), Centre for Reproductive Rights (CFRR), Irish Human Rights Commission (IHRC), Irish Council for Civil Liberties (ICCL), Irish Family Planning Association (IFPA), Doctors For Choice (DFC), Abortion Rights Campaign (ARC) and Galway Pro-Choice (GPC).

<sup>10</sup> The associations interviewed are: DFC, ARC, AI-Ireland, IFPA and GPC.

## 2.

### Irish legal and social background<sup>11</sup>

#### 2.1. Constitution, identity and the fight against abortion

“To the Irish, the abortion ‘problem’ [...] encompasses far more fundamental and searching questions about who we are as people, as a nation, about the role of women, how we structure our relationships, what are the informing values of our young republic and what makes us different or similar to other nations?”<sup>12</sup>

To understand the spirit of a nation is always worth looking at its founding Act: the Constitution. In the case of Ireland the importance of this document is even bigger, since it symbolised, after the freedom from the British oppressor gained through a decolonisation war, the proclamation of an independent Republic, and the expression of a proper Irish national ethos. The quest for identity, for the “perceived notion of what Irish society is”<sup>13</sup> is even felt as more necessary since –like in all the countries with a past of colonisation– it represents the direct consequence of centuries of occupation and embodies an understandable will to start its own separate history. It is the “post-colonial need for culturally authentic values”<sup>14</sup>, an “urge to mark Irishness distinctively”<sup>15</sup> by constructing it in anti-British terms.

The main source of diversity –and therefore identity-, which had always shaped the resistance against the colonising power, was the religion. The 1937 Constitution

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<sup>11</sup> For further assessments on the Irish history on abortion legislation see Cole, 1993; Ward, 1995; Sterling, 1997; HRW, 2010; McGuinness, 2011; Rhinehart, 2013; Bacik, 2013; Holland, 2013. Furthermore, DFC and IFPA produced timeframes that can be consulted at their websites <<http://doctorsforchoiceireland.com/abortion-timeline-2/>> and <<http://www.ifpa.ie/Hot-Topics/Abortion/Abortion-in-Ireland-Timeline>> (consulted on 25 May 2014).

<sup>12</sup> Holland, 2013, p.33.

<sup>13</sup> Hanafin, 1997, p.249.

<sup>14</sup> Fletcher, 2001, p.573.

<sup>15</sup> Ibidem, p.568.

(*Bunreacht Na hÉireann*)<sup>16</sup>, indeed, had a strong input from the Rome Catholic Church, extremely powerful in Ireland<sup>17</sup>: supervised in some parts by the Archbishop of Dublin, it was sent to the Vatican twice for reviews and comments before its final approval by the Irish People<sup>18</sup>. Significantly -and maybe not surprisingly given this drafting process- its Preamble is dedicated to the “Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and State must be referred”<sup>19</sup>.

Against this Catholic background, the Irish woman was consequently culturally constructed in the constitutional discourse as a mother, whose role is within four walls carrying out her reproductive functions. Indeed, Article 41.2 describes women as “mothers [having] duties in the home [who] shall not be obliged by economic necessity”<sup>20</sup> to neglect them while engaging in labour. The Irish “wom(b)an” -as Hanafin re-names her with an insightful wordplay<sup>21</sup>- was shaped as a sort of passive reproducing-machine with no possible free election of any other type of life but the one she is naturally made for. A job outside the house would, indeed, be only an undesirable obligation out of necessity, rather than a preferred option. In conclusion, “choice is often completely absent in this as in many aspects of the lives of women as constitutionally predicated”<sup>22</sup>.

This cultural perception resulted in framing the debate around abortion mostly in terms of cultural identity, religious and moral issues, rather than from medical or legal perspectives. Throughout the past thirty years, indeed, this *leitmotif* has been particularly evident in the official governmental position, as well as within the anti-abortion side of the social debate surrounding the evolving Irish legal framework.

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<sup>16</sup> Although the 1937 Constitution was the third of Ireland after the independence (following the 1919 procedural one and the 1922 Constitution of the Free State) it was the first with a proper Irish stamp and without British influence.

<sup>17</sup> “The Irish Church is different to the other nations’ Catholic churches, not only by virtue of its intense relationship with the people, but also because of the central role it has had in the foundation and subsequent administration of the Irish State. Its role in the provision of education, healthcare, social services and the alleviation of poverty predate the State’s foundation” (Holland, 2013, p.38).

<sup>18</sup> Ibidem, p.35.

<sup>19</sup> Constitution of Ireland, 1937, Preamble.

<sup>20</sup> Ibidem, Article 41.2. It is worth noticing that the United Nations (UN) Human Rights Committee (HRC) expressed several times its concerns on this article for the negative effects it has on equality between man and woman (A/55/40, 21 July 2000, para.20; CCPR/C/IRL/CO/3, 30 July 2008, para.10).

<sup>21</sup> Hanafin, 1997, p.257.

<sup>22</sup> Ibidem, p.262.

## **2.2. The genesis: criminalisation of abortion and constitutional protection of the life of the unborn**

Since the XIX century, abortion has been a criminal offence in Ireland. Indeed, the ‘Offences Against the Person Act’ (OAPA), adopted by the Parliament of the United Kingdom of Great Britain and Ireland<sup>23</sup> in 1861, enshrined two sections regarding “Attempts to procure abortion”. Section 58 dealt with the administration and use of drugs or other instruments to procure abortion, establishing that “every woman” intending to procure her own miscarriage and “whosoever” found in helping her “shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life”<sup>24</sup>. In addition, Section 59, concerning the procurement and supply of the aforementioned tools to cause abortion, set that “whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever [...] shall be guilty of a misdemeanour, and being convicted thereof shall be liable to be kept in penal servitude”<sup>25</sup>.

Therefore, imprisonment (lifetime or for an undefined amount of years) represented the penalty for anyone involved in the performance of an abortion (the woman, the practitioner and the supplier). As will be discussed further in the present work, this punishment has been in force in Ireland until last year’s repeal.

The Irish ban on abortion was absolute, but apart from the aforementioned criminal provisions, until very recently no major legislative provision has been adopted on the matter. However, in the early 1980s the issue started to draw the political and popular attention. The main reason for it has to be sought in the approval in 1979 of the ‘Health (Family Planning) Act’, which legalised the use of contraceptive methods under medical prescription, and if the person interested “sought the contraceptives for the purpose, *bona fide*, of family planning or for adequate medical reasons and in appropriate circumstances”<sup>26</sup>. The fear of a possible consequent liberalisation of abortion pushed the Government to include in the legislation the Section 10 named “Saver in relation to

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<sup>23</sup> Between the 1800 Acts of Union and the 1927 Royal and Parliamentary Titles Act, this was the formal name of the United Kingdom (UK), unifying the two kingdoms of Great Britain and Ireland.

<sup>24</sup> OAPA, 1861, Section 58.

<sup>25</sup> *Ibidem*, Section 59.

<sup>26</sup> Health (Family Planning) Act, 1979, Section 4(1)(b)(ii).

abortion”. This explicit clarification established that nothing in the Act should be interpreted as authorising neither the procuring of abortion, nor anything constituting an offence under Sections 58 and 59 of the OAPA, nor the importation in Ireland of abortifacients<sup>27</sup>.

Nevertheless, the inclusion of this guarantee did not exhaust the controversy on the issue, which left its legacy in the public opinion debates of the following years. The fear was also very present that “the constitutional right to privacy could be interpreted as grounding a right to abortion, as had happened in the United States”<sup>28</sup>. This eventually led to the formation in 1981 of a ‘Pro-life Amendment Campaign’, pushing for a clear constitutional protection of the right to life of the foetus<sup>29</sup>. This was decisive for the inclusion in the Irish Constitution, through a referendum held on 7 September 1983<sup>30</sup>, of the Eighth Amendment<sup>31</sup>. Article 40.3.3, which equates the life of the foetus and of the pregnant woman, declares that: “The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right”<sup>32</sup>.

This Article with its wording -namely “unborn”, “mother”, “equal right to life”, “respect [...] defend and vindicate”- has been, from its approval on, at the very core of all the political, judiciary and social Irish debate on abortion. It constitutes, indeed, the statutory genesis and the obliged point of reference of all the judgments, legislative discussions, foreign States’ observations, European negotiations and the reason for the occurrences in the last thirty years of Irish history regarding abortion.

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<sup>27</sup> Ibidem, Section 10.

<sup>28</sup> Fletcher, 2001, p.575.

<sup>29</sup> Rhinehart, 2013.

<sup>30</sup> It was passed by 67% voting in favour and 33% against (percentages personally derived by the Department of Environment, Community and Local Government, 2013).

<sup>31</sup> Eighth Amendment of the Constitution Act, 1983.

<sup>32</sup> Constitution of Ireland, Art. 40.3.3 as amended on 7 September 1983.

### **2.3. 1992: a landmark year in the history of abortion in Ireland**

Not even ten years after the adoption of Article 40.3.3, the first clarifications on the practical implications of its theoretical meaning were needed. In this sense, 1992 is an important year for the further interpretation and explanation of the Irish position on abortion. The inputs for these deeper developments came almost simultaneously from the judiciary field, both at national and European level. Moreover, 1992 was also the year of the proud reaffirmation of the Irish anti-abortion attitude in front of all the other Member States (MS) during the very act of establishment of the European Union (EU).

#### **2.3.1. Irish Supreme Court: the *X case***

“For the first time Ireland now heard its politicians speak openly about the possibility of an abortion carried out in Ireland.”<sup>33</sup>

A 14-year-old girl known as X, suicidal after the discovery of being pregnant as a result of rape, decided together with her parents to travel to the United Kingdom (UK) to have an abortion. After reporting the fact to the Garda Síochána (Irish Police) and having informed it about their plans<sup>34</sup>, the family -already in England- received an injunction from the Irish High Court, requested by the Attorney General. It restrained the girl and her parents from interfering with the right to life of the unborn, from leaving the jurisdiction for nine months, and from arranging an abortion within or outside the jurisdiction<sup>35</sup>. The parents decided to immediately come back to Ireland with their daughter and eventually appealed the decision before the Supreme Court. This latter overturned the judgment in their favour, with a majority of four judges against one: the final outcome set aside the High Court order and paved the path for a further understanding of the Irish Constitution. In their reading of the Article 40.3.3, indeed, the judges ruled that “if it is established as a matter of probability that there is a real and

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<sup>33</sup> Holland, 2013, p.57.

<sup>34</sup> The family consulted the Police on whether the foetus' DNA could be afterwards used as evidence to prosecute the rapist.

<sup>35</sup> *The Attorney General v X* (Ir.S.C., 1992), para.7.



substantial risk to the life, as distinct from the health, of the mother, which can only be avoided by the termination of her pregnancy, such termination is permissible”<sup>36</sup>. Furthermore, it was established that this risk of life allowing for a lawful abortion in Ireland did not need to be imminent or unavoidable<sup>37</sup>, neither it needed to be linked only to physical illness, but could also derive from a threatened suicide<sup>38</sup>.

This decision shocked the nation, since the main concern at the core of the international scandal provoked by the *X case* was the prohibition to travel abroad for having a termination imposed on a teenager raped girl, not the fact that the termination could have been legal within Ireland. It was the first time that a case of lawful abortion was foreseeable within the Irish borders<sup>39</sup>. Regarding the right to travel, nevertheless, the judges were more cautious. Three of them affirmed that this right was not absolute and could legitimately be restricted for the protection of the unborn life<sup>40</sup>. On the other hand, the other two held that the freedom of movement could not be restricted because of a particular intent, and suggested that by travelling to another jurisdiction a person is automatically subjected to the new State’s laws<sup>41</sup>. Moreover, McCarthy J acknowledged that it would have been extremely hypocritical and ironic to prevent one single girl from travelling –what is more, pregnant as a result of a crime-, while it was well known that “whatever the exact numbers are [...] in the eight years since the enactment of the [Eighth] Amendment, many thousands of Irish women have chosen to travel to England to have abortions”<sup>42</sup>.

In addition, on that occasion, another important political message was sent to the Irish Government by the highest judiciary body of the nation: “in the context of the eight years that have passed since the Amendment was adopted [...] the failure by the

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<sup>36</sup> Ibidem, para.37.

<sup>37</sup> Finlay J stated that the fact “that the life of the unborn could only be terminated if it were established that an inevitable or immediate risk to the life of the mother existed, for the avoidance of which a termination of the pregnancy was necessary, insufficiently vindicates the mother’s right to life” (Ibidem, para.36).

<sup>38</sup> Egan J affirmed that “the risk must be to her life but it is irrelevant, in my view, that it should be a risk of self-destruction rather than a risk to life for any other reason” (Ibidem, para.183).

<sup>39</sup> According to Article 34.4.6 of the Constitution, “the decision of the Supreme Court shall in all cases be final and definitive”.

<sup>40</sup> In the present case, X was entitled to travel because the abortion would have been lawful also in Ireland.

<sup>41</sup> *The Attorney General v X* (Ir.S.C., 1992), para.153.

<sup>42</sup> Ibidem, para.154.

legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable. What are pregnant women to do? What are the parents of a pregnant girl under age to do? What are the medical professionals to do? They have no guidelines save what may be gleaned from the judgments in this case.”<sup>43</sup>

At that moment nobody could imagine how true those words would reveal to be, and that the *X case* would indeed represent for the following twenty years the only guarantee of enforcement of a constitutional provision, completely lacking any kind of further regulation. It also served as a landmark for other similar situations judged in the following years.

Indeed, in 1997 an analogous case of a 13-year-old girl, suicidal because of her pregnancy resulting from rape, was brought before the High Court by her parents, who wanted to prevent her to travel to the UK to have an abortion. Applying the *X case* outcome, the High Court ruled in favour of Miss C, considering her case as meeting the constitutional requirements for a lawful termination within Ireland<sup>44</sup>.

### **2.3.2. European Court of Human Rights: *Open Door and Dublin Well Woman v Ireland***

Some months after the Supreme Court delivered its judgment on the *X case*, Irish restrictions on abortion were once more put under scrutiny, this time concerning HR issues rising at the European level. The Strasbourg Court, indeed, had to analyse, in the *Open Door and Dublin Well Woman v Ireland* case, the injunctions imposed in 1986 by the Irish High Court on those counselling societies providing information about abortion services available abroad<sup>45</sup>. Both the Irish Courts considered unlawful the delivering of such information, under the Constitutional requirement of respecting, protecting and vindicating the right to life of the unborn.

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<sup>43</sup> Ibidem, para.147.

<sup>44</sup> *A and B v Eastern Health Board* (Ir.H.C., 1998).

<sup>45</sup> *The Attorney General at the relation of the SPUC (Ireland) Ltd v. Open Door Counselling Ltd and Dublin Well Woman Centre Ltd* (Ir.H.C., 1988). The Supreme Court two years after repealed the appeal, substantially confirming the High Court judgment.

To form its judgment, the ECtHR looked at similar Irish case. In this other occasion, the same pro-life association that in 1986 had asked for the closure of the two counselling centres of the *Open Door case*, brought before the High Court three years later some students of the University College Dublin, for publishing information material on abortion outside Ireland<sup>46</sup>. However, in this last case, the European Court of Justice (ECJ) -asked for a preliminary ruling by the High Court<sup>47</sup> - determined that the right to information concerning abortion services outside Ireland was protected by Community Law, since abortion constituted a service under the Treaty of Rome. Therefore, a MS could not prevent agencies having economic relationships with foreign abortion clinics from delivering information<sup>48</sup>.

After acknowledging the aforementioned, the Strasbourg Court considered the case under the light of the protection of HR. While declaring that Article 2 -brought to the table by the Irish State- did not enshrine the protection of the right to life of the foetus<sup>49</sup>, the judges found a breach of Article 10, since they held that the restriction was not necessary in a democratic society, as the “freedom of expression is also applicable to ‘information’ or ‘ideas’ that offend, shock or disturb the State or any sector of the population [according to] the demands of that pluralism, tolerance and broadmindedness without which there is no ‘democratic society’”<sup>50</sup>.

Moreover, they deemed the injunction disproportionate for four main reasons. It was too severe, imposing a “‘perpetual’ restraint on the provision of information”<sup>51</sup>. It was also not justifiable, because “the link between the provision of information and the destruction of unborn life is not as definite as contended”<sup>52</sup>, given that the counsellors did not advocate for the termination of pregnancy, but only provided information on which women could independently ground their final decision. The prohibition was

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<sup>46</sup> *SPUC (Ireland) Ltd v. Grogan and Others* (Ir.H.C., 1989).

<sup>47</sup> Under Article 177 of the Rome Treaty (1957).

<sup>48</sup> *SPUC (Ireland) Ltd v. Stephen Grogan and Others* (ECJ, 1991). However, since the SU was not considered an economic subject, the injunction for them remained valid. Nevertheless, this ruling of the ECJ was extremely important *a posteriori* for the *Open Door case*.

<sup>49</sup> As in all the previous abortion-related cases concerning a hypothetical right to life of the foetus: see *Brüggemann and Scheuten v Federal Republic of Germany* (ECtHR, 1977), *Paton v UK* (Eur Comm HR, 1980), *RH v Norway* (Eur Comm HR, 1992).

<sup>50</sup> *Open Door and Dublin Well Woman v Ireland* (ECtHR, 1992), para.71.

<sup>51</sup> *Ibidem*, para.73.

<sup>52</sup> *Ibidem*, para.75.

even judged ineffective, because the “information that the injunction sought to restrict was already available elsewhere”<sup>53</sup>. Finally, it was harmful both from the point of view of women’s health, for delaying the operation “due to lack of proper counselling”<sup>54</sup>, and also considering the difficult accessibility to alternative sources of information for “women who were not sufficiently resourceful or had not the necessary level of education”<sup>55</sup>.

### **2.3.3. The response to the Courts: three constitutional referenda**

As a reaction to the further interpretations of Article 40.3.3 enshrined in the two aforementioned judgements, on 25 November 1992 three referenda were held to amend the Constitution. The Twelfth Amendment, trying to overturn the ruling of the *X case*, stating that suicide could not be considered a sufficient threat to justify an abortion, was rejected by a large majority of 62% of the voters. Ten years later even a second attempt to introduce this anti-suicide clause in the Constitution was defeated<sup>56</sup>. On the other hand, the Thirteenth<sup>57</sup> and Fourteenth<sup>58</sup> Amendments, respectively dealing with the right to travel and to information, were passed with the 60% and 57% of the population in favour<sup>59</sup>.

A further legislative response to comply with the ECtHR judgment and regulate for the Fourteenth Amendment arrived in 1995, with the ‘Regulation on Information

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<sup>53</sup> Ibidem, para.76.

<sup>54</sup> Ibidem, para.77.

<sup>55</sup> Idem.

<sup>56</sup> The Twenty-fifth Amendment did not pass the Constitutional referendum in 2002 (Department of Environment, Community and Local Government, 2013, p.68).

<sup>57</sup> “This subsection shall not limit freedom to travel between the State and another state” (Thirteenth Amendment of the Constitution Act, 1992). This amendment was the the Irish public opinion reaction to the *X case* scandal, and not the direct implementation of that judgement. It was used fifteen years later by the High Court in favour of Miss D, a 17-year-old girl with an anencephalic pregnancy, who was prevented from travelling for having an abortion by the social workers of the Health Service Executive that had her in care.

<sup>58</sup> “This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state” (Fourteenth Amendment of the Constitution Act, 1992).

<sup>59</sup> Department of Environment, Community and Local Government, 2013, pp.47-49.

(Termination of Pregnancies Outside the State) Act'. In a quite restrictive wording<sup>60</sup>, the legislation confirmed the lawfulness of abortion-related information, counselling and advice, but only when they are “truthful and objective, fully inform the woman of all the courses of action that are open to her [...] and do not advocate or promote, and are not accompanied by any advocacy or promotion of the termination of pregnancy”<sup>61</sup>. All behaviours in contravention of the Act from either counsellors or body corporate constitute a criminal offence and are punishable with a fine or even imprisonment.

#### **2.3.4. Ireland in the EU: anti-abortion clause in the Maastricht Treaty**

In the meantime, Ireland showed publicly the importance of the issue of abortion before all the MS of the at-that-time dawning EU. Perceived as a national matter on which no foreign interference was welcomed, the Irish Government was afraid that the loss of sovereignty caused by the entry in the EU might affect its legal framework on abortion. To avoid that this could compromise the popular support during the referendum for the entrance of Ireland in the European Community was of the utmost necessity. Therefore, at the moment of the ratification of the Maastricht Treaty, Ireland required the inclusion of a separate Protocol guaranteeing that “[n]othing in the Treaty on European Union, or in the Treaties establishing the European Communities, or in the Treaties or Acts modifying or supplementing those Treaties, shall affect the application in Ireland of Article 40.3.3 of the Constitution of Ireland”<sup>62</sup>.

The same kind of negotiations took place in 2008 during the ratification process of the Lisbon Treaty, a further regulatory instrument for the by-then consolidated EU. In that occasion, an ‘opt out’ Protocol, almost identical to the one annexed to the previous document, was included in the body of the Treaty<sup>63</sup>. A further confirmation of this attention on the subject can be found in another document on the ‘Concerns of the Irish

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<sup>60</sup> Throughout its body, the Act is structured in a prohibition-directed way, stating in the negative perspective what “shall not be lawful”, rather than what “shall be lawful”. This has a quite clear psychological effect.

<sup>61</sup> Information Act, 1995, Section 5(b)(iii).

<sup>62</sup> Maastricht Treaty, 1992, Protocol 17.

<sup>63</sup> Lisbon Treaty, 2008, Protocol 35.

People on the Treaty of Lisbon’, drafted in 2011<sup>64</sup>. This latter was linked to the fear of possible consequences of the legally binding status accorded by the Lisbon Treaty to the European Charter of Fundamental Rights on the Irish abortion situation.

The Irish deep concerns on the issue of abortion, emerging through this continuative reaffirmation of a non-negotiable independence on the matter, are evident. It is deemed to be a core value shaping the nation, marking the difference between it and the other European countries, even in common official documents.

#### **2.4. 2010: *A, B and C v Ireland*, the final call for legislation**

The Article 40.3.3 of the Irish Constitution kept being at the very heart of the judicial discussion and interpretation. After the *Open Door case* of the 1990s, indeed, other two Irish abortion-related cases reached the ECtHR in the first decade of the XXI century.

The first, *D v Ireland*, was considered inadmissible for not having exhausted the domestic remedies. The applicant, pregnant with twins, in a routine pre-natal control received the terrible news that one foetus stopped developing and died, while the other had a fatal genetic abnormality non-viable outside the womb. Unwilling to carry on the pregnancy, knowing that no one of her two children would survive, D saw herself forced to travel to the UK for an abortion. However, the European judges agreed with the Irish Government that the example of the *X case* showed the “potential of judicial development”<sup>65</sup> concerning the interpretation of the Eighth Amendment of the Constitution. In this specific case, indeed, there was some margin for a revision of the constitutional meaning of the term “unborn”, since the right to life of a foetus not capable of independent life outside the womb can be hardly vindicated. The ECtHR, thus, reached the conclusion that it would have been possible that, if consulted on the matter, the Irish Courts would have declared that foetuses with fatal abnormalities do not meet the requirements to be included within the constitutional protection of the life of the “unborn”. Therefore, this could have been a possible ground for requesting a lawful abortion.

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<sup>64</sup> Draft Protocol on the concerns of the Irish people on the Lisbon Treaty, 2011.

<sup>65</sup> *D v Ireland* (ECtHR, 2006), para.69.

A few years later, a third situation was brought to the attention of the Strasbourg Court, again challenging the extremely limited lawfulness of the termination of pregnancy in Ireland, and alleging that such restrictions violated women's HR. This was the case of three women (known as A, B and C to protect their identities) forced to travel to the UK for the impossibility, in law or in practice, of having an abortion performed in Ireland. Applicant A was an alcoholic indigent woman, with her previous four children in the care of the State, to be able to recover from her personal issues. In such a delicate moment, she felt that an unwanted pregnancy would have seriously undermined her process of recuperation and future reunification of her existing family, besides deteriorating her mental health. Applicant B, a single woman not planning to have a baby, became unintentionally pregnant after the failure of the 'morning after pill'. She did not feel for her well-being to carry on with an unplanned pregnancy. Finally, applicant C was in remission after having been undergoing for three years chemotherapy to cure a rare form of cancer and had been clearly advised by the doctors against becoming pregnant, since this treatment plus other follow-up tests would have been dangerous for her health and life and for the foetus. When she found out that, in the meantime, she had become unintentionally pregnant, after not being able to receive exhaustive information on the real risks she or the foetus were running, she decided to travel abroad to have an abortion.

The *A, B and C* (hereafter: *ABC*) *judgment*, although crucial for the future of Irish abortion legal framework, after considering the "acute sensitivity of the moral and ethical issues raised by the question of abortion"<sup>66</sup> substantially upheld the very restrictive Irish position. In fact, the judges decided only in favour of applicant C, who claimed a violation of her right to access an abortion on a ground included in the Irish Constitution, namely her right to life<sup>67</sup>. On the other hand, for the two other applicants, who were requesting the medical treatment for health and well-being reasons, a wide margin of appreciation was judged appropriate. This judicial deference towards the

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<sup>66</sup> *ABC v Ireland* (ECtHR, 2010), para.236.

<sup>67</sup> The Court, indeed, assessed that in this case "she would not obtain treatment for that cancer in Ireland while pregnant" (Ibidem, para.250), therefore Ireland would have been responsible for her death, for not implementing in practice a constitutional right. This indeed happened in 1983, when Sheila Hodgers was not allowed to continue the therapy against cancer, since she was pregnant, and subsequently died (Holland, 2013, p.95).

understanding of the matter in Ireland shows the huge weight and respect allowed by the Strasbourg Court to the issue of abortion, perceived as an important moral value of the Irish State.

Regarding the merits of the case, after having dismissed all the other allegations of violations under the ECHR<sup>68</sup>, the Court considered in all three situations the possible violation of Article 8 (Right to private and family life). Eventually, the judges denied the occurrence of any substantial violation, since “Article 8 cannot, accordingly, be interpreted as conferring a right to abortion”<sup>69</sup> and found only its procedural breach<sup>70</sup> in the case of applicant C. This was mainly due to a situation of “substantial uncertainty”<sup>71</sup> surrounding the issue of the lawfulness of abortion in some specific circumstances, such as when the pregnant woman’s life was at risk. This was firstly attributed to a lack of legislative guidelines providing “the criteria by which a doctor is to assess that risk”<sup>72</sup>. Secondly, the Court noticed the absence of any sort of “framework whereby any difference of opinion between the woman and her doctor or between different doctors consulted, or whereby an understandable hesitancy on the part of a woman or doctor, could be examined and resolved”<sup>73</sup>. Furthermore, the judges deemed very disproportionate the severe criminal provisions of life-imprisonment for performing an unlawful abortion, especially when the conditions of its lawfulness were so blurred. These represented, in such a confused situation, a “significant chilling factor for both women and doctors”<sup>74</sup>.

The ECtHR held that there was a urgent need for legal clarity. Once more -almost twenty years after the *X case*-, another Court officially reaffirmed that the “striking discordance between the theoretical right to a lawful abortion in Ireland on grounds of a

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<sup>68</sup> These were Article 3 (Prohibition of torture), 13 (Right to an effective remedy) and 14 (Prohibition of discrimination) for all three applicants, and for applicant C also the claim of a violation of Article 2 (Right to life).

<sup>69</sup> *ABC v Ireland* (ECtHR, 2010), para.214.

<sup>70</sup> The first time that the Court required such positive obligations under that article was in the landmark judgement of *Tysic v Poland* (ECtHR, 2007).

<sup>71</sup> *ABC v Ireland* (ECtHR, 2010), para.254.

<sup>72</sup> *Ibidem*, para.253.

<sup>73</sup> *Idem*.

<sup>74</sup> *Ibidem*, para.254.



relevant risk to a woman's life and the reality of its practical implementation"<sup>75</sup> was no more sustainable.

## 2.5. The social dimension of the phenomenon

“Sail away,  
Sail away,  
Sail away,  
12 women a day  
across the Irish Sea  
Ireland sends them away...  
but shhhhh!  
Ireland thinks it's abortion free!”<sup>76</sup>

Asked by the Strasbourg judges in the *ABC case*, Ireland was not able to provide the exact number of lawful abortions performed in Ireland, thereby failing, according to HRW, “the most basic due diligence standards”<sup>77</sup> concerning the monitoring of the effects of national policies. From the side of the Government, indeed, no systematic data were collected on the number of effective medical procedures carried out at national level under the *X case* ruling. The only available official statistics concern the experiencing of crisis pregnancies by women and men, gathered in a periodical survey<sup>78</sup>. The first time that numbers of lawful abortions performed in Ireland were revealed publicly was in January 2013 by medical experts: the average disclosed was around thirty per year, although they were officially recorded as miscarriages or perinatal deaths<sup>79</sup>.

To fill this gap of official information, IFPA tried to collect quantitative data based on other Agencies' recordings. Due to the lack of information on lawful abortions, the IFPA statistics focus on two phenomena: the illegal abortions performed within Ireland and the women that travel to have a termination abroad. Concerning the first, according to the data of the Irish Medicines' Board, in 2009, 1.216 illegal packets of abortifacient

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<sup>75</sup> *ABC v Ireland* (ECtHR, 2010), para.264.

<sup>76</sup> Performance by the group IMELDA (see *infra*).

<sup>77</sup> HRW, 2010, p.14.

<sup>78</sup> The last survey in 2010 found that the 35% of pregnant women experienced crisis pregnancy, and one quarter of this percentage has self-harming or suicidal thoughts, while one fifth of them terminated the pregnancy (Crisis Pregnancy Programme, 2012, p.90).

<sup>79</sup> Holland, 2013.

drugs were seized by the Irish Customs Authorities, providing strong evidence that the practice of illegal abortion is well established<sup>80</sup>. Regarding the second aspect of the issue, an IFPA research -gathering the data provided by the ‘UK Department of Health’s Statistics on Irish women accessing abortion services in England and Wales’ and other official records from The Netherlands- calculated that between 1980 and 2013 “at least 159.779 women travelled from the Republic of Ireland for safe abortion services abroad”<sup>81</sup>. This is an underestimation, since is based only on the women that gave an Irish residence address at the abortion clinics abroad, while a lot of them usually do not reveal it for confidentiality, or provide a different one<sup>82</sup>.

This question of the Irish “abortion tourism”<sup>83</sup> mainly towards the UK was recognised during the *ABC judgement* as a severe psychological, physical and financial burden<sup>84</sup> for all three applicants. Such a massive social phenomenon involves on average more than 4.000 Irish women per year, namely 12 per day, “which means that one woman every two hours is forced to pack and leave”<sup>85</sup>. To help women facing this difficult journey, several associations, both Irish and British, offer financial, psychological or logistic support<sup>86</sup>. Referred even by Irish politicians as the “English solution to an Irish problem”<sup>87</sup>, this situation has also become the main focus of several initiatives<sup>88</sup>, books<sup>89</sup> and documentaries<sup>90</sup>.

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<sup>80</sup> An increasing number of women order abortion pills online, mostly through a worldwide women’s support network called “Women on web” (<<https://www.womenonweb.org/>>).

<sup>81</sup> IFPA, ‘Statistics’, <at <http://www.ifpa.ie/Hot-Topics/Abortion/Statistics>> (consulted on 11 July 2014).

<sup>82</sup> “Therefore unofficial estimations tend to consider the numbers between 150.000 and 200.000 women” (interview with Richie Keane, DFC, Dublin, 7 April 2014).

<sup>83</sup> Cole, 1993, p.117.

<sup>84</sup> *ABC v Ireland* (ECtHR, 2010), paras.128-129.

<sup>85</sup> Interview with Richie Keane, DFC, Dublin, 7 April 2014.

<sup>86</sup> Marie Stopes Reproductive Choices (<<http://www.reproductivechoices.ie/>>), based in Dublin, provides information. The Abortion Support Network (<<https://www.abortionsupport.org.uk/>>) is a CSO based in the UK providing practical financial and logistic assistance for the journey. The British Pregnancy Advisory Service (BPAS) (<<http://www.bpas.org/bpaswoman>>), based in the UK, performs the majority of abortions to Irish women.

<sup>87</sup> Justice Minister Alan Shatter quoted in Connolly and English, *The Irish Examiner*, 9 July 2013.

<sup>88</sup> For example, the group of English women called IMELDA (Ireland Making England a Lawful Destination for Abortion) performs in the streets of London to raise awareness on the issue.

<sup>89</sup> IFPA, *The Irish journey. Women’s stories of abortion*, 2000.

<sup>90</sup> For instance: “50,000 Secret Journeys” (1994) by Hilary Dully, “Like a ship in the night” (2006) by Melissa Thompson, “Taking the boat” (2013) by Lisa Keogh and a still on-going project called “Take the boat” by Camille Hamet and Séréna Robin available at <<http://www.touscoprod.com/en/taketheboat>> (consulted on 29 May 2014).

Another notable social aspect of the abortion issue in Ireland is the attitude of the Irish population towards it. Indeed, it has changed throughout the decades, since the judicial and political events involving Ireland led to a necessary public debate, which contributed little by little to the erosion of the taboo. One of the last opinion polls<sup>91</sup> shows that 89% of Irish people agrees with abortion if the woman's life is at risk and 78% also in situation of risk for her health. Furthermore, for 81% of the population, abortion should be allowed also in situation of rape and almost the same percentage (83%) considers it admissible even in case of fatal foetal abnormalities. Finally, 39% thinks that abortion should be available whenever the woman deems it in her best interest. Only 11% of Irish population nowadays considers it absolutely unconceivable under any circumstances.

Thirty years ago these numbers wouldn't have been even imaginable. This is the signal of a deep social change that has to be kept in mind.

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<sup>91</sup> Ipsos MRBI, *The Irish Times*, 13 June 2013.

### 3.

#### **The Protection of Life During Pregnancy Act 2013: a political and legal analysis**

##### **3.1. The emerging legislation on abortion**

As aforementioned, since the inclusion of the Eighth Amendment in the Irish Constitution in 1983 no major legislative step was taken by the Government in order to implement and clarify that constitutional provision. Indeed, as noticed by some commentators, “the Irish government is notorious for sidestepping and redirecting when it comes to dealing with issues surrounding reproductive rights, leading to the phrase ‘an Irish solution to an Irish problem’”<sup>92</sup>.

##### **3.1.1. Governmental and social dynamics on abortion**

However, the issue of abortion has been an intermittent focus in the Irish Government agenda since the mid-1990s, being also the object of open discussions and hearings with CSOs and stakeholder groups on the practicability of different legislative options.

Indeed, it constituted one of the issues raised by the Constitution Review Group (CRG) established in 1995 with the purpose of identifying the areas where constitutional change might be necessary. The ‘CRG Report’ of 1996, concluding its revision of Article 40.3.3, recommended the “introduction of legislation covering such matters as definitions<sup>93</sup>, protection for appropriate medical intervention, certification of ‘real and substantial risk to the life of the mother’ and a time-limit on lawful termination of pregnancy”<sup>94</sup>. In order to work on the findings of the CRG, the Irish Government

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<sup>92</sup> Rhinehart, 2013, p.974.

<sup>93</sup> The term under scrutiny in the Report is “unborn”, whose meaning is left to a problematic interpretation.

<sup>94</sup> CRG, 1996, p.256.

appointed experts to form two All Party Oireachtas<sup>95</sup> Committees on the Constitution (APOCC 1996-1997 and 1997-2002). In particular, the second Committee published in 2000 the Fifth Progress Report on ‘Abortion’, representing the final official outcome of a period of national consultation on the issue: it drew suggestions both from the previous ‘CRG Report’ and also from a ‘Green Paper on Abortion’ published in 1999 by the Department of the Taoiseach<sup>96</sup>.

The main aim of this last document, after a broad analysis of the medical and legal aspects of the question contextualised in a wider social and international perspective, was to consider the possible constitutional and legislative options to address the issue. The approaches contemplated were the following: “(i) an absolute constitutional ban on abortion; (ii) an amendment of the constitutional provisions so as to restrict the application of the *X case* [eliminating the case of suicidality]; (iii) the retention of the *status quo*; (iv) The retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion; (v) legislation to regulate abortion in circumstances defined by the *X case*; (vi) a reversion to the position as it pertained prior to 1983 [with the deletion of Article 40.3.3]; (vii) permitting abortion on grounds beyond those specified in the *X case*”<sup>97</sup>.

The 2000 APOCC ‘Progress Report’, after having evaluated these proposals of action, and not being able to reach an internal agreement on the matter, reduced them to three options open for consideration. The first one was to reduce the number of crisis pregnancies and consequently the rate of abortions; the second option consisted in adding to the first a legislation protecting medical intervention to save the woman’s life; the third one was to accompany the aforementioned actions also with an amendment of the Constitution<sup>98</sup>. The first -and weakest- approach prevailed at that moment, thus in 2002 the Health Service Executive (HSE) created a Crisis Pregnancy Agency (CPA)<sup>99</sup>.

After this five-year intensive period in which the abortion issue seemed to be at the very top of the Government agenda, for the following decade, until the *ABC judgment* in 2010, there has not been any major legislative step forward. As aforesaid, precisely

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<sup>95</sup> Means Parliament in Irish language.

<sup>96</sup> Means Prime Minister in Irish language.

<sup>97</sup> Department of Taoiseach, 1999, para.7.16.

<sup>98</sup> APOCC, 2000, pp.116-119.

<sup>99</sup> Bacik, 2013, p.29.

this lack of legislative clarity was considered by the Strasbourg judges one of the main points to find Ireland in procedural violation of Article 8. In November 2011 an ‘Expert Group on the Execution of the ABC judgment’ was established to report on the possible actions to be taken in order to comply with the ECtHR requests<sup>100</sup>. The first meeting was held in January 2012 and the final Report was due during summer.

While the Expert Group was at work, the aftermath of the European Court judgment, jointly with the 20<sup>th</sup> anniversary of the *X case* ruling, triggered months of particularly lively civil society activism from both sides of the debate<sup>101</sup>. Pro-choice associations started to form a massive movement for finally having legislation on the *X case*<sup>102</sup>, while, in order to draw attention to the phenomenon, some women broke the taboo and publicly witnessed their painful experiences of abortions abroad in the media and in direct hearings with politicians<sup>103</sup>. On the other hand, Youth Defence, an anti-abortion association, organised a nationwide very impacting advertising campaign called “Abortion tears her life apart”, with the slogan “There is always a better answer” and gigantic pictures of fetuses sucking their thumbs and desperate women in tears. This was perceived as very offensive by a considerable part of the population and caused tons of complaints to the national Advertising Standards Authority<sup>104</sup>. However, as a backfire effect, it also inspired a new indignant generation of pro-choice activists to take action. One of these outcomes was the gathering of several minor and local pro-choice groups who “felt the urge to be more impacting on the national level”<sup>105</sup>: in this way ARC -nowadays one of the most prominent Irish advocacy organisations- came into existence. In that agitated moment, the social debate reached also the Students’ Union and the college campuses, where thereafter referenda on the official position of every university concerning abortion were held<sup>106</sup>.

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<sup>100</sup> See Chapter 2.

<sup>101</sup> Holland, 2013, p.62.

<sup>102</sup> Ibidem, p.63.

<sup>103</sup> Idem.

<sup>104</sup> Idem.

<sup>105</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>106</sup> The National University of Ireland in Galway (NUIG) was among the firsts in the early 2013 to adopt a pro-choice stance, position that was reaffirmed in 2014 by defeating a counter-referendum calling for a ‘neutral’ position on the matter. Also the national Union of Students approved a motion at the annual General Assembly in 2013 supporting ARC.

But right in the midst of such a social and political turmoil, a dramatic event broke the silence surrounding the worst of the possible occurrences: women under this legislative uncertainty could seriously die. It constituted the final trigger for legislative action.

### **3.1.2. Savita's death: the tragedy that shook a nation<sup>107</sup>**

“I have lost her. I'm talking about this because it shouldn't happen to anyone else. It was all in their hands and they just let her go. How can you let a young woman go to save a baby who will die anyway?”<sup>108</sup>

On 21 October 2012 Savita Halappanavar, a seventeen-week pregnant Indian woman of 31 years old, living in Galway with her husband Praveen, entered the University College Hospital of Galway in severe back pain for what would have revealed to be an on-going inevitable miscarriage. One week later, on 28 October, after days of agony, Savita died from septicaemia and multi-organ failure, after being refused a termination of pregnancy, which both her and her husband had requested three times, due to the failure of the medical personnel of assessing the gravity of the situation. The doctors and nurses that had Savita in care during that week felt the huge burden of the life-imprisonment and the legislative uncertainty on the lawfulness of performing an abortion while the heartbeat of the dying foetus was still present<sup>109</sup>.

The news appeared two weeks later on the front page of *The Irish Times* in an article entitled “Woman ‘denied a termination’ dies in hospital”<sup>110</sup> by the journalist Kitty Holland, contacted by the local association GPC<sup>111</sup>. It shook the Irish public opinion and

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<sup>107</sup> This recalls the title of the book written by Kitty Holland, reporter for *The Irish Times* who first brought the Savita Halappanavar's story to the national attention.

<sup>108</sup> Praveen Halappanavar, Savita's husband, in Holland, 2013, p.75.

<sup>109</sup> *Idem.* Besides, the midwife Ann Maria Burke explicitly expressed to Savita and Praveen her perception of the issue as “a catholic thing”, therefore impossible to deal with in the way they wanted, namely with an abortion (hearings for the Coroner inquest, *ibidem*, p.174).

<sup>110</sup> Holland, *Irish Times*, 14 November 2012.

<sup>111</sup> The members of that new-born association were reached by Savita's friends to have some help to clarify the Irish legislative situation on abortion. Eventually GPC was essential for the huge impact that the news had at national and international level. Indeed, other two non-national women died in Savita's same conditions in the immediately previous years, but the news passed almost unnoticed (Interview with three members of GPC, Galway, 3 June 2014).

immediately went around the world, causing a proper shockwave directed at the Irish State.

Internationally, within the HR field, the reactions were outraged. In a press release of 17 November, for example, AI declared that “the tragic case of Savita Halappanavar illustrates a gap in Irish law and policy on the most basic human rights level -that is a woman’s right to access abortion where her life is at risk-”<sup>112</sup>. However, the words of HRW were even sharper and filled with bitterness, while drawing a lesson from the tragic occurrence: “the Irish government knows full well what is required to meet Ireland’s human rights obligations with respect to access to abortion, but has chosen to shirk that responsibility. The spotlight that one family’s terrible loss of life has shone on this failing could help to end this unacceptable, damaging, and sometimes lethal state of affairs”<sup>113</sup>. Due to its well-known delaying strategy of avoidance to deal with such a thorny issue, the Irish Government waited to act until it was too late.

At national level, the news represented the last straw after a whole year of turmoil that made both population and politicians feel the *status quo* as no more sustainable. Although, as aforementioned, for the previous twenty years Ireland had already dealt with dramatic cases related to abortion issues, none had had such a huge impact. As Holland points out, “all had involved real women in unspeakable circumstances, but they had all been anonymous. This time we knew Savita’s name, her face. She was a person with whom we women could identify and Praveen a man with whom husbands, partners, brothers, fathers could all identify”<sup>114</sup>. This humanisation of the matter changed the terms of the social and political debate on abortion, jointly with the common consciousness that the death of that Indian woman, whose smile appeared in all the press and newscasts all over the world, could have been lawfully avoided<sup>115</sup>.

As the journalist Kitty Holland reports in her book, most of the Irish civil society reaction was firstly of deep and sincere sadness and shame, feelings later transformed

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<sup>112</sup> AI News, at <<http://www.amnesty.org/en/news/ireland-abortion-issue-must-be-clarified-irish-government-2012-11-17>> (consulted on 30 May 2014).

<sup>113</sup> HRW, at <<http://www.hrw.org/news/2012/11/16/ireland-death-woman-denied-abortion-should-spur-reform>> (consulted on 30 May 2014).

<sup>114</sup> Holland, 2013, p.88.

<sup>115</sup> Indeed, an abortion could have been deemed lawful and hopefully would have been performed, if only the personnel of the Galway Hospital had adequately conducted all the necessary medical tests, properly assessing Savita’s actual risk of life.



into anger and outrage<sup>116</sup>. Demonstrations to express solidarity to Savita's family were organised in all the main cities the days after the disclosure of the news, TV and Radio broadcasts were fully dedicated to the tragedy, direct lines with women phoning and telling their own stories went on for hours<sup>117</sup>. The Pandora's Box of shame and stigma had been finally opened.

The tragedy shocked even the most anti-abortion politicians, who publicly declared being ready to reconsider their hard-line position, since "the State should act"<sup>118</sup> in order to make the clarity deserved both by the medical practitioners and the women and to avoid further deaths. The urgent need for legislation was (at last) felt from every party, but a fundamental question remained: "Why d[id] something like this have to happen to make people wake up on the issue of abortion?"<sup>119</sup>

### **In pursuit of the truth**

"The lack of clarity in many laws is a serious dysfunction, because too often it results in preventable death."<sup>120</sup>

Three separate inquiries were undertaken to assess the circumstances of Savita's death.

An initial inquest, carried out by the Coroner, delivered on 19 April 2013 a unanimous verdict of "medical misadventure"<sup>121</sup>.

A second investigation, undertaken by the HSE and chaired by an independent expert in obstetrics and gynaecology, published a 'Final Report' on 13 June 2013 revealing some principal causal factors<sup>122</sup> for the death, focusing on two main problems. The first was "a lack of recognition of the gravity of the situation and of the increasing risk to the mother which led to passive approaches and delays in aggressive treatment"<sup>123</sup>. The second had to do with the failure to offer all options available to a patient experiencing

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<sup>116</sup> Holland, 2013, p.96-101.

<sup>117</sup> Idem.

<sup>118</sup> TD (Deputy) for Meath East Regina Doherty, in ibidem, p.86.

<sup>119</sup> Ibidem, p.85.

<sup>120</sup> Cook, Dickens, 2003, p.15.

<sup>121</sup> O'Carroll, *The Journal*, 19 April 2013.

<sup>122</sup> HSE, 2013, p.56.

<sup>123</sup> Ibidem, p.5.

inevitable miscarriage due to the medical team's "assessment of the legal context in which their clinical professional judgement was to be exercised"<sup>124</sup>. Indeed, when asking for a termination of pregnancy, Savita and Praveen were answered that "under Irish law, if there's no evidence of risk to the life of the mother, our hands are tied so long as there's a foetal heart"<sup>125</sup>. To conclude, the inquest confirmed that "concerns about the law, whether clear or not, impacted on the exercise of clinical professional judgment"<sup>126</sup> and recommended (once more) the immediate introduction of a legislation clarifying the situation and considering the management of circumstances of inevitable miscarriage as a ground to guarantee a termination for medical and clinical reasons<sup>127</sup>.

A further third inquiry, carried out by the Health Information and Quality Authority (HIQA), delivered a Report on 7 October 2013 focused mainly on the severe flaws in the medical care at the Galway University Hospital. Indeed, the totally inadequate care and monitoring was evident in a number of missed opportunities characterised by the "failure in the provision of the most basic elements of patient care to Savita Halappanavar and also the failure to recognise and act upon signs of her clinical deterioration in a timely and appropriate manner"<sup>128</sup>. The final recommendations concerned the need to review and improve the maternity services, with particular attention, amongst other medical advices, for guaranteeing the respect of the "patient choice"<sup>129</sup>.

The aforementioned three inquests provided with clear clinical reports, but they did not seek any responsibility or individual accountability. Justice was still not done for the family. Therefore, in September 2013, Praveen issued legal proceedings before the High Court for medical negligence and violation of constitutional right to life against the HSE and the consultant obstetrician who refused Savita the termination<sup>130</sup>.

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<sup>124</sup> *Idem*.

<sup>125</sup> *Ibidem*, p.33. (See also the recording of the hearings of Dr Astbury for the Coroner inquest, Holland, 2013, p.180).

<sup>126</sup> HSE, 2013, p.69.

<sup>127</sup> *Ibidem*, Recommendation 4b, p.17.

<sup>128</sup> HIQA, 2013, p.22.

<sup>129</sup> *Ibidem*, p.24.

<sup>130</sup> Crawford, *The Irish Independent*, 21 September 2013.

In May 2014, after receiving for over one-year time insisting hate mails threatening him unless he would leave the country, Praveen eventually decided to depart from Galway and migrate to the US<sup>131</sup>.

### **3.1.3. Expert Group Report: the need to legislate**

The ‘Expert Group Report on the implementation of the ABC judgment’ was delivered to the Government the night before the Savita’s news was broken in the media, and made public two weeks later, on 27 November 2012<sup>132</sup>. In its pages, the Report confirmed that one of the most important requirements set by the ECtHR in its judgment was the urgency to bring legislative clarity –whose absence had been crucial in the Galway facts- in order to make a right, which was in theory lawful, also effectively accessible in practice. This made necessary the existence of a procedure to establish the entitlement of an abortion and also concrete steps to access the termination, even facing cases of disagreement between woman and doctor or between doctors.

Concerning the first point on determining whether or not a woman is lawfully entitled to have an abortion, a series of issues were taken into account and several options were analysed and left for further Government considerations: the test to apply with the needed requirements to be met, the qualification of the doctors involved in the decision process, their number and field of expertise, the particular case of emergencies and the location where to perform the medical procedure<sup>133</sup>.

With regard to the effective access to the treatment, some further considerations were made. After exploring the requirements set both in the *ABC judgment* and in the *Tysic v Poland case*<sup>134</sup>, the ‘Report’ concluded that the Formal Review Process had to be held by an independent and competent body, should give the woman the opportunity to be heard, must produce written reasons for its decision and had to be timely. Furthermore,

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<sup>131</sup> McDonald, *The Irish Independent*, 2 May 2014.

<sup>132</sup> Holland, 2013, p.147

<sup>133</sup> Expert Group on the ABC case, 2012, Chapter 6.

<sup>134</sup> *Tysic v Poland* (ECtHR, 2007).

the composition of this Review Panel, the conscientious objection and its limitations, and the need for an overall monitoring system were discussed<sup>135</sup>.

Beyond all the aforementioned issues with their several options, the only thing clarified, in order to implement the ECtHR judgment, was that “legislation, in some form, is the most appropriate way in which to regulate access to lawful abortion in Ireland”<sup>136</sup>. The legislative options considered were the introduction of legislation alone or accompanied by regulations in form of guidelines, with a preference for this latter.

Eventually, on 18 December 2012, the Government announced the decision to bring the Irish abortion law in line with the Strasbourg Court requirements, in the advised mixed formula of legislation and regulations<sup>137</sup>.

#### **3.1.4. The political pathway of the Protection of Life During Pregnancy Act**

“If the Irish law on abortion is changed, I would think my daughter has been sacrificed for a good cause.”<sup>138</sup>

Beyond the recommendations included in the ‘Expert Group Report’, the Government deemed necessary also gathering contributions to draft the legislation from the relevant stakeholders and CSOs. Therefore, the Oireachtas Joint Committee on Health and Children (hereafter Joint Committee) organised two rounds of public hearings. The first one, with medical, legal, church and advocacy groups, was held in January 2013 and led to the drafting of the Heads of the Bill which were published on 30 April<sup>139</sup>. Following the publication of that General Scheme, another series of public hearings was organised in May, this time only with medical and legal experts, in order to analyse in depth the draft. After further modifications following the May consultations, eventually the final version of the legislation was presented by the Government for the parliamentary discussion in June<sup>140</sup>.

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<sup>135</sup> Expert Group on the ABC case, 2012, Chapter 7.

<sup>136</sup> Ibidem, p.47.

<sup>137</sup> Reilly, *The Journal*, 18 December 2012.

<sup>138</sup> Andanappa, Savita’s father, in Holland 2013, p.92.

<sup>139</sup> Irish Government News Service, *MerrionStreet.ie*, 30 April 2013.

<sup>140</sup> Ibidem, 13 June 2013.

## January hearings

The preliminary hearings started on 8 January, with the first day dedicated to the medical groups. The issue at the core of the discussion was the inclusion of the ground of suicidality to allow a termination of pregnancy, in line with the *X case*. On the one hand, it was stressed that suicide is a major cause of death for pregnant women, mostly due to unwanted pregnancies; therefore it should be a basic ground to allow abortion within the new legislation<sup>141</sup>. On the other hand, it was contrarily noted that the risk of suicide derives mostly from mental illness issues that must be cured with the appropriated treatments, and not with an abortion, since there is no scientific proof that it would lead to any benefit for the woman<sup>142</sup>. Moreover, the fear was expressed that, due to the unpredictability of the diagnosis of will to commit suicide, such a ground for allowing lawful terminations would result in a sensitive increase of the number of requests, opening the ‘floodgates’ for a much more permissive abortion regime<sup>143</sup>. Further issues raised included the criminalisation of doctors and women and the urgent need for legal clarity and practical guidelines on the threshold of risk of life required to make an abortion legal<sup>144</sup>.

The second day of hearings (9 January) was devoted to the analysis of the arising legal issues. The main point touched was whether the constitutional protection of life of the ‘unborn’ could legally extend also to foetuses non-viable outside the womb, either for fatal foetal abnormalities<sup>145</sup> or in situations of inevitable miscarriage (like in Savita’s case). This question was brought by the ICCL, which recalled the statements of the Irish Government before the Strasbourg judges in the *D v Ireland* case<sup>146</sup>. It also mentioned the recent ECtHR judgment *RR v Poland*, about a woman carrying a foetus with fatal

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<sup>141</sup> Veronica O’Keane, professor and consultant psychiatrist, in Joint Committee on Health and Children (JCHC), 2013, p.25.

<sup>142</sup> Patricia Casey, Iona Institute for Religion and Society, in *ibidem*, p.17.

<sup>143</sup> The self-evident constitutional reasons why this could not happen can be found well explained in De Londras and Graham, 2013.

<sup>144</sup> Rhona Mahony, Master obstetrician, in JCHC, 2013, p.23.

<sup>145</sup> This point was further stressed in the following day with the submission of Terminations For Medical Reasons Ireland (TFMR).

<sup>146</sup> See Chapter 2.

abnormality who was denied an abortion, where the ECtHR found a violation of Article 3 of prohibition of torture<sup>147</sup>.

The third and last day of this first round of hearings (10 January) saw the participation of the several Churches present in Ireland and advocacy groups from both sides pro-choice<sup>148</sup> and pro-life. The respective positions were heard in a dialogic, calm and institutional context. Furthermore, the Joint Committee invited HRW to make a written submission and AI made one spontaneously. Both these internationally recognised HR NGOs stressed the failure of Ireland in complying with its international HR obligations, with particular attention to the women's right to health and in situations of pregnancy as a result of crime<sup>149</sup>.

### **The General Scheme of the Bill (GSB)**

As aforementioned, on 30 April 2013, for the first time in the history of the State, an Irish Government published draft abortion legislation. After the calmness and professionalism which characterised the hearings some months earlier, the harsh ideological debate exploded again, mostly coming from the disappointed pro-life side. A 'moral Rubicon' had been crossed<sup>150</sup>, and from that point of no return the Catholic Bishops declared the excommunication<sup>151</sup> of the politicians who would vote the new Bill into law<sup>152</sup>, since it would legalise the 'direct and intentional killing of unborn children'<sup>153</sup>. The anti-abortion CSOs organised a series of rallies over two months in May and June, in addition sending postcards to the TDs urging them to refrain from approving the legislation<sup>154</sup>. TDs affirmed to have received physical and psychological threats<sup>155</sup>. Regina Doherty -member of the Government conservative party Fine Gael-,

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<sup>147</sup> JCHC, 2013, p.28.

<sup>148</sup> Among others, the NWCI, IFPA and DFC were present.

<sup>149</sup> JCHC, 2013, pp.47 and 54.

<sup>150</sup> Affirmed by David Quinn of the Iona Institute, in Holland, 2013, p.227.

<sup>151</sup> See Canon of Law, 1983, Can.1398.

<sup>152</sup> Nolan and O'Brien, *The Sunday Times*, 19 May 2013.

<sup>153</sup> Holland, 2013, p.229.

<sup>154</sup> *Idem*.

<sup>155</sup> "The level of abuse and physical threat that I personally am getting at the moment is off the wall. I have a number of people who at the moment are going to burn my house with my children in it. They are going to spit at me when I walk inside the Church grounds Sunday morning at Mass. I have received an email where I was going to have my throat cut from my neck to my navel and my entrails were going to spill out" (Regina Doherty, *ibidem*, p.231)

one of the politicians harassed, answered in her defence: “What we are doing is legislating to protect women’s lives, and I make no apologies for that. None whatsoever”<sup>156</sup>. And to the threats of excommunication from the Bishops, she replied: “They don’t and won’t get rid of me that easily, no. No, my faith is a hell of a lot larger than the Catholic Church as a physical body”<sup>157</sup>. The harsh controversy on abortion had started again.

### **May hearings**

In this intense climate, the Joint Committee held three additional days of hearings to discuss the Heads of the Bill. During the first day (17 May) with medical and obstetrics experts, the debate was again so completely absorbed by suicidality that “one could be forgiven for thinking that this Bill is about the risk of suicide in pregnancy”<sup>158</sup>.

The second day (20 May), dealing with psychiatry and other medical specialities, deepened this same discussion, trying to assess the real ability to accurately predict suicide. Some psychiatrists strongly opposed the widely alleged impossibility of assessing suicide: “we train our medical students, our junior doctors to assess suicide risk. We do it all the time”<sup>159</sup>. Nevertheless, the fear that women would more likely pretend to be suicidal in order to have access to abortion was still very present at that stage of the debate<sup>160</sup>. However, the opposite effect -namely the reduction of the suicide rate during pregnancy deriving from less restrictive legislations and legal abortion- was pointed out by an international expert’s research<sup>161</sup>.

The last day of hearings (21 May), hosting the legal experts, focused on some legal and ethical issues. Doubts were raised by some attendants about the real legal obligation of Ireland to legislate in line with the *X case*<sup>162</sup>. In addition, the absence in the draft of temporal limits for a lawful abortion worried some experts, to whom the Government

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<sup>156</sup> Ibidem, p.232.

<sup>157</sup> Idem.

<sup>158</sup> Ibidem, p.233. However, this should not have been a matter of legislative debate, since, as the ICCL pointed out, it is a settled principle since 1992, which can only be reversed by another Supreme Court decision overturning the *X case* or by a constitutional referendum.

<sup>159</sup> Dr. McCarthy, consultant perinatal psychiatrist, in ibidem, p.237.

<sup>160</sup> Ibidem, 235.

<sup>161</sup> Peadar O’Grady, in JCHC, 2013(a), p.228.

<sup>162</sup> Paul Brady, ibidem, p.294. For a further discussion on his position, see also Brady, 2013.

assured that at later stages of the pregnancy a life-saving termination would be substituted by an early delivery<sup>163</sup>. The last issue worth mentioning is the protests caused by the criminalisation of the woman undergoing an unlawful abortion, considered a “disproportionate and unfair response”<sup>164</sup>.

Once more, as already happened some months earlier, the hearings were conducted in a respectful and engaging manner<sup>165</sup>.

### **Parliamentary discussion**

After the last Government’s modifications following the second round of hearings, the Protection of Life During Pregnancy Bill was introduced on 16 June in the Dáil. It passed through a vigorous debate, mostly during the Report Stage, when 165 amendments were proposed<sup>166</sup>. Given the sensitivity and delicacy of the issue, the Government decided not to use the guillotine motion to accelerate the legislative process, but to go through all of them. This reopened the debate towards the inclusion in the legislation of broader grounds for abortion, but in the end no amendment was approved by the Chamber. After very harsh and intense discussions, continuative pressure by the Catholic Church<sup>167</sup> and threats to TDs and Ministers<sup>168</sup>, “two late-nights sittings and one attempt by the High Court the day before to try to prevent the vote to be taken”<sup>169</sup>, and with the Parliamentary building surrounded by both sides people demonstrating and praying, eventually the Bill was passed at 00.25, the morning of 12 July, by 127 votes to 31<sup>170</sup>.

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<sup>163</sup> Junior Minister for Primary Care Alex White, JCHC, 2013(a), p.844-5.

<sup>164</sup> Ruth Fletcher, *ibidem*, p.821.

<sup>165</sup> O’Sullivan et Al., 2013, p.13.

<sup>166</sup> Dáil Éireann, 9 July 2014, at <<http://www.oireachtas.ie/documents/bills28/bills/2013/6613/b6613d-drn.pdf>> (consulted on 5 June 2014).

<sup>167</sup> In that period, Cardinal Sean Brady described the legislation as “a legislative and political Trojan Horse which heralds a much more liberal and aggressive abortion regime in Ireland” (Holland, 2013, p.252).

<sup>168</sup> The Minister of Health received written warnings that his house would be burnt down. Furthermore the Taoiseach declared: “I’m getting medals, scapulars, plastic fetuses, letters written in blood, telephone calls all over the system and is not confined to me” (*ibidem*, pp.251-2).

<sup>169</sup> *Ibidem*, p.251.

<sup>170</sup> Oireachtas debates, Dáil Éireann, available at <<http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2013071100069?opendocument>> (consulted on 5 June 2014).



The passage through the Seanad (the upper Chamber) was faster: introduced the 15<sup>th</sup> of the same month<sup>171</sup>, after further passionate discussions it was approved unamended on 23 July by 39 votes to 14<sup>172</sup>. During the parliamentary approval of the legislation, the Government party Fine Gael lost five TDs, including the Minister of State for European Affairs, and two Senators, who voted strongly against the Bill.

The Bill was finally signed into law by the President of Ireland Mr Higgins on 30 July, without further referral to the Supreme Court for a constitutionality test<sup>173</sup> and entered into force 1 January 2014. However, the guidelines that -as promised by the Government in 2012- should have accompanied the legislation to guarantee its proper implementation have not been published yet at the moment of writing, although a drafting group was appointed in August 2013<sup>174</sup>. This severely undermines the correct enforcement of the Act and for this reason has caused several criticisms towards the Minister of Health<sup>175</sup>.

### 3.2. Critical analysis of the 2013 Act

In 2013, the final outcome of thirty years of Irish social and political debates was the mere codification of the reality already in place since the *X case* in 1992. The ‘Protection of Life During Pregnancy Act’ (PLDPA), indeed, puts into place only

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<sup>171</sup> The Minister of Health presented the Bill assuring that it was a legislation whose intent was not to introduce new rights, but to confirm the existing ones and the ban on abortion. (Oireachtas debates, Seanad Éireann, available at <<http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/seanad2013071500022?opendocument>>, consulted on 5 June 2014).

<sup>172</sup> Oireachtas debates, Seanad Éireann, available at <<http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/seanad2013071600041?opendocument>> (consulted on 5 June 2014).

<sup>173</sup> It was decided, under suggestion of the Council of State, that it would be better to leave it open for later challenges in Courts on a case-to-case basis, rather than to analyse it immediately through abstract hypothetical considerations (Sheahan, *The Irish Independent*, 30 July 2013).

<sup>174</sup> In April 2014 the Department of Health declared to have signed the guidelines for the appeal process, promising that they would be published soon. Regarding the clinical guidelines for the medical process of assessment for doctors, it was said that this was a task for the HSE. See <<http://www.irishhealth.com/article.html?id=23615&ss=abortion%20guidelines>> (consulted on 2 June 2014).

<sup>175</sup> The College of Psychiatrists has even “advised its members not to participate in review panels [...] until clinical guidelines will be in place” (Holland, *The Irish Times*, 3 January 2014).

minimal requirements, but vital. It regulates the lawfulness of abortion in case of risk of life of the pregnant woman, including threatened suicide. The Act differentiates the medical assessment procedure, depending on the origin of such a risk: only one medical practitioner is required in situations of physical emergency, two when there is a physical risk but not immediate, and three in cases of alleged suicidal attempts. A review pathway for divergences of opinion is set, jointly with regulations on the conscientious objection. Furthermore, the criminal section condemns women, medical practitioners and body corporate involved in performing an unlawful abortion to fourteen years of imprisonment.

The present chapter will analyse in depth the form and contents of the Act, when deemed necessary comparing them with its ‘General Scheme’ and with the ‘Medical Treatment Bill’ (MTB)<sup>176</sup>, in order to understand the political evolution of this legislation. The analysis will strictly follow the PLDPA structure, divided in three main Parts plus an annexed Schedule. The author’s considerations will be integrated with the CSOs’ recommendations issued during and after the drafting process, together with the comments gathered during the interviews personally conducted.

### **3.2.1. The title**

The first thing worth pointing out is the title of the Act and its meaning. Indeed, all the interviewed CSOs were surprised by the fact that the original working title changed during the drafting process. The fact that from the former “Protection of maternal life Bill”<sup>177</sup> the word “maternal” was finally removed, leaving undetermined the life that has to be safeguarded, already says a lot on the strategies underlying this transformation. Indeed, this has been widely perceived as a symbolic political compromise to gloss over the real issue of the legislation, to “make it more nuanced towards the protection of the

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<sup>176</sup> In April and November 2012, two Private Members’ Bills on abortion, called the ‘Medical Treatment (Termination of pregnancy in case of risk to life of the pregnant woman) Bill’, proposed by the TD Clare Daly of the United Left Alliance (ULA), were widely rejected by the Dáil. They had some positive points compared with the current legislation which is worth sometimes pointing out.

<sup>177</sup> O’Connell, *The Journal*, 30 April 2013.

unborn”<sup>178</sup> and, thus, to obtain the “opening appeasement of the anti-abortion lobby”<sup>179</sup>. It represents a “very political title, very strategic not to upset either side of the debate...is almost a genius the one who created this title”<sup>180</sup>, since it means everything and nothing at the same time.

The fact that it is not expressly specified to which life the title is referring to “highlights the crucial problem in this limited legislation”<sup>181</sup>: the total deference towards the foetal life, rather than the one of the woman. The legislators’ priority appears clear in an explanatory note of the April Heads of the Bill, where the need of defending the life of the woman as well had to be stressed further. Indeed, it is there specified that the constitutional vindication of the life of the unborn must “not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn”<sup>182</sup>. Two things are striking in this last sentence. First, it appears questionable the need to specify that “there is a woman surrounding the womb who should not be left to die”<sup>183</sup>. Second, the fact that this temporary shift of focus towards the woman’s life needs to be immediately put back in the light that the loss of her life would inevitably result in the loss of the unborn life appears regrettable. It seems as if the life of the woman did not deserve an absolute protection *per se*, but only because it is essential for preserving the foetal life.

To sum up, no CSO is satisfied with the title, which leaves a huge room for ambiguity, and the IHRC even proposed to replace it with a longer and more explanatory one, for the purpose of clarity<sup>184</sup>.

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<sup>178</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>179</sup> Holland, 2013, p.228.

<sup>180</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>181</sup> GPC, 2013, p.5.

<sup>182</sup> GSB 2013, Explanatory Note of Head 2.

<sup>183</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>184</sup> IHRC, 2013, p.5.

### 3.2.2. Part 1: Preliminary and General

The First Part includes Sections 1 to 6, among which the most substantive one is Section 2 on ‘Interpretation’. The analysis will focus on three main definitions given under this chapter.

#### “Unborn”

The first and most discussed term is “unborn”, directly derived from Article 40.3.3 of the Irish Constitution. Already in 1983 the then Attorney General expressed his concerns on the ambiguous and unsatisfactory wording of the proposed Eighth Amendment, foreseeing that it would “lead inevitably to confusion and uncertainty”<sup>185</sup> among both medical and legal professionals. He furthermore pointed out that the word “unborn”<sup>186</sup>, generally considered and defined in English dictionaries as an adjective, for the first time was unusually being used “as a noun standing on its own”<sup>187</sup>. Besides being grammatically incorrect, the word “unborn” is also not medically supported. In fact, there is a widespread call for substituting this word with the medical term “foetus”<sup>188</sup>.

Beyond these terminological aspects of the issue, there is also a more substantial question to address. The unborn is recognised as a “human life”, concept that is often repeated throughout the body of the Act<sup>189</sup>. However, as Kelly Mackey from AI-Ireland pointed out, this definition is completely at odds with all the HR treaties and international instruments in place<sup>190</sup>, since the HR to life starts to apply from birth<sup>191</sup>.

Nevertheless, the most substantially problematic question arising from the term “unborn” is its interpretation. Its scope was deeply debated in Irish public discussions

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<sup>185</sup> O’Carroll, *The Journal*, 27 December 2013.

<sup>186</sup> It is worth noticing that the meaning in the Irish language version is the same: literally, ‘the life of the living who has not been born’.

<sup>187</sup> O’Carroll, *The Journal*, 27 December 2013.

<sup>188</sup> For example see DFC, 2013(a), p.3.

<sup>189</sup> PLDPA 2013, Sections 7(1), 7(1)(a)(ii), 8(1), 8(1)(b), 9(1), 9(1)(a)(ii), 13(3)(b) and 22(1).

<sup>190</sup> UDHR (Art.3), CCPR (Art.6) and ECHR (Art.2).

<sup>191</sup> Interview with Kelly Mackey, AI-Ireland, Dublin, 14 May 2014.

and Court's rulings in the past thirty years<sup>192</sup>. In the Act, the word is flatly defined in a very descriptive way as "a life during the period of time commencing after implantation in the womb of a woman and ending on the complete emergence of the life from the body of the woman"<sup>193</sup>.

The main criticism coming from the CSOs dealing with reproductive rights is that this understanding of the term is only focused on the period of life inside the womb and does not address the foetus' viability outside it. Regarding this point, for example, ARC suggests adding to the aforementioned definition the final clause "save where this life will not survive outside of the womb"<sup>194</sup>. On the other hand, IFPA recommends a complete change in the definition as a "foetus capable of independent life"<sup>195</sup>. These simple corrections would be fundamental for the clarification of two difficult situations that unfortunately some pregnant women have to face. Indeed, the legislation, as it is formulated now, does not address the cases of fatal foetal abnormality and inevitable miscarriage, both involving the lives of foetuses that will not survive outside the womb.

Since the success of vindicating the right to life of a foetus that will anyway die after the birth is quite contestable, in *D v Ireland*, the Irish Government itself foresaw the reasonable exclusion of foetuses with fatal abnormalities from the constitutional protection provided for the "unborn"<sup>196</sup>. However, this sensible assertion made before the Strasbourg Court was eventually not implemented in the new legislation.

Another similar missed opportunity to reinterpret the term "unborn" excluding non-viable foetuses arises from the complete silence on circumstances of inevitable miscarriage. The gap of clarity that led to Savita's death –which was, as aforementioned, one of the main reasons for accelerating the drafting of the Act- is surprisingly not filled by the new legislation. Under the PLDPA, every foetus within the maternal womb, regardless the prospects for its possible future life, is constitutionally protected and its life is equated to the pregnant woman's one.

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<sup>192</sup> See Chapter 2.

<sup>193</sup> PLDPA 2013, Section 2(1).

<sup>194</sup> ARC, 2013, p.3.

<sup>195</sup> IFPA, 2013(b), p.1.

<sup>196</sup> See Chapter 2.

### **“Medical procedure”**

The Interpretation Section also gives the definition of the “medical procedure”, which “includes the prescribing, by a medical practitioner, of any drug or medical treatment<sup>197</sup> [...] in the course of which, or as a result of which, an unborn human life is ended<sup>198</sup>”.

It is worth noticing that linguistically this represented a significant change compared to the first draft of the Bill, which, instead, used pervasively the term “termination of pregnancy” to describe the procedure. It is important to point out this shift in the language, since it clearly shows Fine Gael’s political fear of being seen as “the one who for the first time in history imported abortion in Ireland”<sup>199</sup>. Therefore, the neutrality of the substitutive word “medical procedure” instead of “termination of pregnancy” -which was still referring too directly to the reality of the operation-, appears to be very functional for further disguising the operation that was being regulated. “Ireland has a great taste for euphemism”<sup>200</sup>, a member of GPC declared during the interview. “Just in case God’s reading it!”<sup>201</sup>, echoed another one.

Moreover, as it might be noticed, the word abortion is never mentioned in no one of the two drafts, surrounded as it is by an aura of toxicity and stigma<sup>202</sup>. This can also be explained by the Irish understanding of the word. Indeed, from a legal point of view, in Ireland “abortion” means “the intentional destruction by any means of unborn human life”<sup>203</sup>, but “does not include the carrying out of a medical procedure”<sup>204</sup> necessary to save the life of the pregnant woman. Thus, according to the aforementioned interpretation, the present legislation does not regulate the lawfulness of abortion, practice that, on the other hand, keeps strictly prohibited and criminalised.

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<sup>197</sup> PLDPA 2013, Section 2(1).

<sup>198</sup> Ibidem, Sections 7(1), 8(1) and 9(1).

<sup>199</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>200</sup> Interview with John Walshe, GPC, Galway, 3 June 2014.

<sup>201</sup> Interview with Dette McLoughlin, GPC, Galway, 3 June 2014.

<sup>202</sup> Idem.

<sup>203</sup> See the failed Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill, 2001, Section 1(1).

<sup>204</sup> Ibidem, Section 1(2).

## **“Woman”**

One of the main flaws of the law is hidden in the innocently broad and all-encompassing definition of the term “woman” as a “female of any age”<sup>205</sup>. This lack of consideration for the intersection with the gender of other social grounds of identity<sup>206</sup>, which give rise to a multiplicity of different “women”, is at the origin of several practical shortcomings of the legislation, which will be discussed in the last Chapter.

### **3.2.3. Part 2: Medical Procedures Lawful Under Act**

This Second Part includes Sections 7 to 15, which are the core provisions of the Act, dealing with the grounds of entitlement to a lawful abortion (Chapter 1) and the review procedure in case of disagreement (Chapter 2).

#### **3.2.3.1 Chapter 1: Risk of loss of life of pregnant woman**

This First Chapter addresses the medical situations that allow a lawful termination of pregnancy in Ireland. As the title says, the only ground for requiring the aforementioned medical procedure is the risk of loss of life of the pregnant woman, which can be the result of three different cases: “physical illness” (Section 7), “physical illness in emergency” (Section 8) and “suicide” (Section 9).

An important change in the wording of this part of the Act, compared to the GSB, is the affirmative nuance in which the lawfulness is framed. Following the call for clarity of IFPA in its May submission<sup>207</sup> on the Heads of the Bill, the previous “it is not an offence” –a negative formula still mainly stressing the criminalisation aspect- was changed in the affirmative “it shall be lawful”. Although the legal meaning is not modified, this change of wording psychologically avoids the inhibition caused by a constant recall to the criminal sanctions.

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<sup>205</sup> PLDPA 2013, Section 2(1).

<sup>206</sup> Such as age, ethnicity, nationality, language, religion, etc.

<sup>207</sup> IFPA, 2013(a), p.10.

Thus a termination of pregnancy under Sections 7, 8 and 9 “shall be lawful”<sup>208</sup> when “there is a real and substantial risk of loss of the woman’s life”<sup>209</sup> that in the “reasonable opinion”<sup>210</sup> of the medical practitioners “can only be averted by carrying out the medical procedure”<sup>211</sup>. Given this definition, two main points have to be stressed.

### **“Real and substantial risk of life”**

The first one concerns the meaning of the formula “real and substantial risk of life”. Medicine is not an exact science, therefore there is no precise medical predictability for the level of emergency of a specific situation. “At what point, along a nebulous grey line between ill-health and life-threatening illness does a ‘real and substantial risk’ arise?”<sup>212</sup> This zone of uncertainty, still not clarified by the legislation, was the main problem bringing Savita’s case to such degeneration. The “staff felt unable to proceed, as the Rubicon of ‘real and substantial risk’ had not been crossed”<sup>213</sup>. As Richie Keane, from DFC, affirmed: “the only way that you are certain is that the woman is dead”<sup>214</sup>. This is tragically what happened in Galway, and what, unfortunately, is likely to continue happening under this new legislation.

A further shortcoming of this first point is its non-compliance with the *X case* ruling: indeed, the Supreme Court explicitly declared that the risk had not to be immediate or imminent to allow a termination<sup>215</sup>, but in the Act there is no trace of this clause. To fill this gap, IFPA suggests that “all references to ‘real and substantial risk’ should be qualified by the phrase ‘as a matter of probability’”<sup>216</sup> and that “Section 7 should be renamed: Risk of Loss of Life from Physical Illness, Not Being Immediate or Imminent”<sup>217</sup>.

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<sup>208</sup> PLDPA 2013, Sections 7(1), 8(1) and 9(1).

<sup>209</sup> Ibidem, Sections 7(1)(a)(i), 8(1)(a) and 9(1)(a)(i).

<sup>210</sup> Ibidem, Sections 7(1)(a)(ii), 8(1)(b) and 9(1)(a)(ii).

<sup>211</sup> Idem.

<sup>212</sup> DFC, 2013(a), p.6.

<sup>213</sup> Idem.

<sup>214</sup> Interview with Richie Keane, DFC, Dublin, 7 April 2014.

<sup>215</sup> See Chapter 2.

<sup>216</sup> IFPA, 2013(b), p.4. For similar recommendations see also ICCL, 2013(a), p.344.

<sup>217</sup> Ibidem. For similar recommendations see also ARC, 2013.



### **“Reasonable opinion”**

The second aspect to analyse regards the concept of “reasonable opinion”, defined as “an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable”<sup>218</sup>. This same definition is given in both drafts of the Act, but while in the first version is only explicitly put in the Head 1 Interpretation, in the final Act it is instead redundantly put into the body of the text in brackets every time the concept is needed. This sort of constant warning -regarding the constitutional duty to protect the unborn- produces a clear discouraging effect. Furthermore, the word “reasonable” does not satisfy some of the CSOs, which expressed their concerns within their submissions. On the one hand, DFC calls for the elimination of the adjective, leaving only “opinion”<sup>219</sup>, while on the other hand Maeve Taylor from IFPA would substitute it with “clinical”, “medical” or “professional”<sup>220</sup>.

### **Risk of suicide**

The PLDPA marks in several clauses a strong differentiation between physical and mental life-threatening problems, both in emergency and in ordinary situations.

Indeed, although no basis exists in medicine “for differentiating between a medical and a psychiatric emergency”<sup>221</sup>, Section 8 only includes physical health complications leading to an immediate risk for the pregnant woman’s life, not even considering the possibility that a suicidal urgency could exist.

Such a diversified treatment is also reserved to physical and mental problems regarding the medical assessment procedure for the eligibility of the woman for a lawful abortion. Indeed, the requirement of two medical practitioners (an obstetrician and another medical specialist) for a physical risk of life turns into three (an obstetrician and two psychiatrists) for a suicidal woman. Since it would have been against the Supreme Court ruling in the *X case* not to include this ground in the new legislation, the setting up of stricter parameters and assessment procedures for suicidal pregnant women was the logical outcome of the entire parliamentary debate on suicidality and of the fear for

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<sup>218</sup> PLDPA 2013, Sections 7(1)(a)(ii) and 9(1)(a)(ii).

<sup>219</sup> DFC, 2013(a), p.3.

<sup>220</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>221</sup> DFC, 2013(a), p.7.

the opening of floodgates for ‘abortion on demand’. Nevertheless, all the shortcomings of a possible rigid approach to the suicide issue had been already pointed out in the ‘Expert Group Report’ of November 2012<sup>222</sup>. Therefore, choosing this option, the Government was well aware to go against the Expert Group’s advice.

Thus, suicidal pregnant women are considered a ‘separate case’, treated differently both from the pregnant women at risk for physical illnesses and also from suicidal women who are not pregnant. The former are visited by two doctors and the latter only by one, since the “diagnosis of expressed suicide intent is a routine process for psychiatrists”<sup>223</sup>. It is hard not to think of non-scientific explanations -such as the aforementioned fear for a too indulgent abortion regime- to understand the requirement of “a second psychiatrist when this does not occur when a pregnancy is not involved”<sup>224</sup>. Beyond being discouraged by the ‘Expert Group Report’ and not being supported by the ordinary medical practice, this restrictive assessment is not even imposed by the *X case*<sup>225</sup>. The extra burden that this procedure is likely to put on the already extremely vulnerable suicidal pregnant women can be considered undesirable.

Several other elements, beyond the already discussed additional doctor, attracted criticisms. The first concern regards the presence on the assessing board of an obstetrician, who does not have expertise in the psychiatric field in order to give an opinion counting for the unanimity of the decision. Moreover, the requirement that one of the two psychiatrists should be familiar with the provision of mental health services to women in respect to pregnancy, childbirth or post-partum care -namely should be a perinatal psychiatrist- is disputable. Indeed, notwithstanding the importance of their presence and expertise to calm the general fear of unpredictability of suicide, perinatal psychiatrists usually help pregnant women to cope with mental issues other than the pregnancy itself until the delivery stage<sup>226</sup>. They are therefore not familiar with suicidal thoughts directly coming from the fact of being pregnant<sup>227</sup>. Furthermore, all the

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<sup>222</sup> Expert Group Report, 2012, p.35.

<sup>223</sup> Idem.

<sup>224</sup> Idem.

<sup>225</sup> ICCL, 2013(a), p.347.

<sup>226</sup> IFPA, 2013(c), p.6.

<sup>227</sup> Community psychologists would be more indicated to address suicidal thoughts deriving directly from the event of pregnancy (idem).

medical practitioners involved in the assessment have to be attached to an approved institution within the Act, which narrows the array of personnel available for a prompt procedure<sup>228</sup>. And finally, an additional fourth decision-making level is left open, with the possibility of further consulting the woman's general practitioner (GP).

Such "overly-stringent requirements"<sup>229</sup> represent concrete obstacles: they might cause unnecessary delays, considerable stress and could make the access to abortion ineffective and unavailable, thus may be still in procedural breach of Article 8<sup>230</sup>. Indeed, this excessive assessment could possibly have the adverse effect of keeping pushing women to travel abroad, instead of undergoing such an intrusive procedure. Furthermore this can be deemed to be stigmatising and potentially discriminatory<sup>231</sup>, since is based on a fundamental distrust towards women's decisions, in situations where their problem is not clearly detectable with medical instruments or numerical indexes.

The recommendation of the CSOs is unanimously to equate physical and mental health issues in the medical assessment to allow an abortion: the opinion of two medical practitioners (one GP and one psychiatrist) is deemed to be fairer and would reflect the reality of crisis pregnancy<sup>232</sup>.

### **Accessibility to the assessment procedure**

The main concern raised by the Strasbourg Court judgement in the *ABC case*, which led to the recognition of a breach of Article 8, was the practical inaccessibility of a lawful right<sup>233</sup>. Unfortunately, it can be affirmed that the PLDPA does not solve this main shortcoming of the Irish legal framework, since the access to the assessment procedure and also -as it will be discussed later- to the review pathway are not clearly conceived and explained.

First of all, the Act does not stress enough the fundamental role of Primary Care in the provision of health services<sup>234</sup>. The GPs are the doctors who are more familiar with

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<sup>228</sup> The possible solutions to help the accessibility to the procedure will be further discussed in the following paragraphs.

<sup>229</sup> ICCL, 2013(a), p.348.

<sup>230</sup> Ibidem, p.347.

<sup>231</sup> See also IFPA (2013(b)) and ICCL (2013(a)).

<sup>232</sup> DFC, 2013(a), p.3.

<sup>233</sup> *ABC v Ireland* (ECtHR, 2010), para.253-254.

<sup>234</sup> See DFC (2013(a)) and IFPA (2013(c)).

the patients, having with them a long-term professional relationship and therefore knowing their personal medical history. Furthermore, concerning pregnancies, “all ante-natal care up to 16 weeks gestation is undertaken by GPs alone in Ireland. Only from 16 weeks onwards do most women have their first scheduled hospital based obstetric appointment”<sup>235</sup>. Thus, totally at odds with the ordinary medical practice, when it comes to crisis pregnancies the GPs are relegated only to the marginal position of a possible last consultation<sup>236</sup>.

Another serious flaw of the current legislation is that the Act does not mention how a woman should start these consultations in the approved structures, namely how to access the assessment panel. As Maeve Taylor, from IFPA, puts it: “the Act, as it is conceived now, assumes the patient to have found access to the ways giving effect to her right [...]. It is as if the woman was sort of ‘magicked’ into the hospital in front of this panel”<sup>237</sup>. In substance, it is taken for granted that the GP will be able to refer the pregnant woman to an obstetrician in an approved structure. However, this excludes those women who are not under medical care, for whom there is no clear pathway established to guarantee their effective right to have access to health services<sup>238</sup>.

Therefore, the publication of the long-promised guidelines ensuring clear referral paths and timeframes<sup>239</sup> is essential for the practical accessibility of a lawful termination of pregnancy.

### 3.2.3.2. Chapter 2: Reviews

This Chapter represents the answer to one of the main requirements of the *ABC v Ireland* and *Tysiąc v Poland judgements* on the necessary legal framework to solve disputes of opinion. It establishes that for this purpose the HSE has to appoint a national permanent Review Panel of ten medical practitioners (Section 11). In cases of no or non-unanimous positive opinion from the doctors in the situations included in Sections

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<sup>235</sup> DFC, 2013(a), p.7.

<sup>236</sup> PLDPA 2013, Sections 7(3) and 9(4).

<sup>237</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>238</sup> IHRC, 2013, p.19.

<sup>239</sup> IFPA, 2013(b).

7 and 9 (Section 10), and no later than three days after the request, the HSE has to appoint some members from the Review Panel to form the Review Committee, whose specific composition must reflect the respective initial assessment panel (Section 12). Within seven days from its establishment, after further examining and hearing the pregnant woman, the Review Committee has to deliver its outcome to the woman in a written form (Section 13 and 14). Finally, each year on 30 June, the HSE will submit an annual report containing information about all the reviews carried out and their results, omitting any identification either of the woman requesting it or of the medical practitioners involved (Section 15).

### **Refusal of care**

The first element on which the analysis will focus is the situation in which one of the medical practitioners appointed to assess the woman's risk of life does not give an opinion. The consequences of this situation of 'refusal of care' are not adequately addressed. Indeed, this absence of opinion is not covered by the woman's entitlement to seek a further opinion, as it would be the best practice recommended by the 'Guide to professional conduct and ethics' issued by the Medical Council<sup>240</sup>. Indeed, according to the medical ethics, the first obligation of any medical practitioner is to "act in the best interest of the patient"<sup>241</sup>. Therefore, in this case, since the number of opinions to which the woman would be lawfully entitled is not met, a further medical opinion to fill the gap should be provided before entering the second phase of referral to the Review Committee.

As the next Part of the Act will explain, the current legislation obliges a medical practitioner who, being a conscientious objector, refuses to perform an abortion to refer the patient to another doctor in order to comply with the obligations towards the patient. Nevertheless, in the case of simply giving an opinion, no regulation of conscientious objection seems to be deemed necessary. Therefore, an entitlement to a second opinion, in case of refusal to give one, should be clearly established in this Part of the Act<sup>242</sup>.

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<sup>240</sup> Medical Council, 2009, para.9.1.

<sup>241</sup> Ibidem, para.4.1.

<sup>242</sup> This provision was present in the rejected MTB 2012, Section 5(2)(a).

### **Legal concerns**

The clarity and transparency of the review procedure are the first important requirements stressed by all the CSOs. As explicitly stated in the *Tysiqc case*, the Committee has to provide written grounds for its decisions, whether positive or negative. The PLDPA sets the duty to “give notice in writing of its determinations to the woman”<sup>243</sup>, but in order to fulfil the Strasbourg requirements not only the outcome should be communicated, but also the reasoning behind it<sup>244</sup>. Furthermore, the Review Committee should be obliged to make available the documents used for the decision to the woman<sup>245</sup>. This is of the utmost importance, mostly in case of a negative outcome, since this documentation might be fundamental for the woman to seek a judicial review of the deliberation<sup>246</sup>.

However, in the Act the possibility for the woman to proceed legally with an appeal before the High Court, in case of a negative answer of the Review Committee, is not clarified. In this case free legal advice and representation should be provided throughout the proceedings<sup>247</sup>, together with anonymity, in order to ensure that the “judicial review is an ‘accessible and effective’ procedure for vindicating the human rights engaged”<sup>248</sup>. These additional provisions would certainly bring the legislation in compliance with Article 8 of ECHR, in light of the *P and S v Poland judgement*, requiring a “regulatory framework of adjudicatory and enforcement machinery protecting individuals’ rights”<sup>249</sup>.

### **Increased anguish and pain**

The redoubled number of medical practitioners who, by the end of the review procedure, will have assessed the pregnant woman’s entitlement to a lawful termination could represent a severe added psychological and physical burden and reinforce even more the different consideration of physical and psychological illnesses. On the one

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<sup>243</sup> PLDPA 2013, Section 13(3)(b).

<sup>244</sup> IFPA, 2013(b), p.6.

<sup>245</sup> IFPA (ibidem, p.7) suggests to make stronger the duty and substitute “shall” to “may” in Section 14(2).

<sup>246</sup> IHRC, 2013, p.3. See also DFC, 2013, p.47.

<sup>247</sup> IHRC, 2013, p.4; GPC, 2013, p.2.

<sup>248</sup> IHRC, 2013, p.31.

<sup>249</sup> *P and S v Poland* (ECtHR, 2012), para.95.

hand, in the first case eventually the total amount of doctors examining the woman will be four (five counting also the GP). On the other hand, concerning the suicidality risk, she will be visited by no less than six medical practitioners (four psychiatrists and two obstetricians), not to include the GP. These multiple medical examinations to which the pregnant woman, in a difficult personal moment, has to be subjected show the “intrusiveness of the procedure”<sup>250</sup>, which could possibly increase the “mental anguish and suffering in an already vulnerable person”<sup>251</sup>, mostly in the case of suicidal pregnant women. This “traumatising process of assessment”<sup>252</sup> is once more very likely to be in breach of Article 8. Both IHRC<sup>253</sup> and IFPA<sup>254</sup> suggest, therefore, in the psychological case, to include in the procedure only one further psychiatric opinion, thus equating it to the physical illness review.

#### **Accessibility to the review procedure**

“The availability of a review mechanism for the woman or girl is crucial to accessibility and effectiveness”<sup>255</sup> of the procedure, representing the two main requirements of the *ABC judgement*. Nevertheless, this is again not guaranteed by the present Act. Indeed, as for the first phase of assessment, the PLDPA does not mention how the woman is supposed to request the appointment of a Review Committee to challenge the first negative opinion received and try to have access to the treatment.

However, the problem is not only the unclear trigger to the review mechanism, but also, once before the Committee, who will have the last word on the woman’s entitlement to a lawful abortion. The Act does not mention specific requirements for the appointment of the Panel experts, nor establishes clearly how the process will be carried out. Therefore, the ICCL calls for an open and transparent appointment by the HSE of the national Review Panel, which has to be formed by medical practitioners “subscribing the core Nolan Principles of integrity, objectivity, accountability, openness

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<sup>250</sup> IHRC, 2013, p.4.

<sup>251</sup> IFPA, 2013(c), p.7.

<sup>252</sup> ARC, 2013(a), p.1.

<sup>253</sup> IHRC, 2013, p.32.

<sup>254</sup> IFPA, 2013(b), p.5.

<sup>255</sup> IHRC, 2013, p.29.

and honesty”<sup>256</sup>. In addition to these fundamental qualities, a crucial element to guarantee the effectiveness and accessibility of the review procedure, pointed out by all the CSOs, would be that the experts sitting on the Panel cannot be conscientious objectors. In fact, this would completely undermine the impartiality of the assessment and would represent an insuperable obstacle to the enjoyment of a fair procedure<sup>257</sup>. For this purpose, GPC suggests compiling a national Official Register of objectors who have to be barred from the Panel. The doctors that “believe that abortion is never a necessary medical treatment [and] signed the Dublin Declaration on Maternal Healthcare”<sup>258</sup> should not be called to decide on specific possibly life-threatening cases, since their mind is already made up and their opinion already well-known<sup>259</sup>.

A further obstacle to the accessibility of the review procedure concerns its timeframe. Indeed, the current legislation establishes a maximum time-limit of ten days waiting for a woman whose life is presumably at risk. According to the CSOs, this is excessive, considering that Savita, not being in a dangerous situation when she entered the hospital, died within only one week. Therefore, IFPA suggests reducing the number of days allowed to the Review Committee to examine the case from seven to three<sup>260</sup>, in order for the woman to wait in total only a maximum of six days. In fact, a considerable delay could practically work as a further deterrent, possibly pushing more women to travel abroad for having a quicker abortion. Furthermore, the speed and urgency of the procedure are not stressed enough in the Act, which might cause additional problems. According to ARC, “the lack of emphasis on the immediacy of access to treatment results in women still not having the legal certainty of when they may access an abortion”<sup>261</sup>.

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<sup>256</sup> ICCL, 2013(a), p.350.

<sup>257</sup> Ibidem, p.356.

<sup>258</sup> GPC, 2013, p.8.

<sup>259</sup> ICCL (2013(a)) and AI-Ireland (2013 and 2013(a)).

<sup>260</sup> IFPA, 2013(b), p.6. See also GPC (2013) and AI-Ireland (2013(a)).

<sup>261</sup> ARC, 2013, p.3.



### **3.2.4. Part 3: Miscellaneous**

This Third and last Part of the PLDPA (Sections 16 to 23) deals with all the collateral aspects necessary for the realisation of the core provisions, together with the criminal sections.

#### **Section 16: Consent**

This Section was not included in the first draft of the Bill presented in April and this caused great concern among the CSOs. In particular, IFPA pointed out in the submission to the Joint Committee in May that “pregnant woman’s wishes and views must be central in any decision-making about a pregnancy that involves the risk to her life”<sup>262</sup>. Therefore, to give women a more active role in the decision process it is crucial to establish by law the obligation to ask for their consent. This is why Section 16 was inserted in the PLDPA, jointly with other repeated formulas such as “with the pregnant woman’s agreement”<sup>263</sup> regarding her approval on the consultation of her GP.

Contrarily to the very detailed provisions included in the rejected MTB 2012<sup>264</sup>, no further regulations are provided on the consent procedure in the PLDPA. Therefore, for the policies in place, medical practitioners have to refer to the Medical Council Guide<sup>265</sup> and the National Consent Policy<sup>266</sup>.

#### **Section 17: Conscientious objection**

Unlike the precedent Section 16, this Section 17 represents a step backwards compared to the first draft. Indeed, the April formulation was much clearer and strongly worded than the current one. It was divided in four paragraphs that clarified the situations and modalities for the doctors to express their conscientious objection,

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<sup>262</sup> IFPA, 2013(a), p.5.

<sup>263</sup> PLDPA 2013, Sections 7(3) and 9(4).

<sup>264</sup> MTB (No.2), November 2012, Section 8.

<sup>265</sup> Medical Council, 2009, para.33 (General principles); para.34 (Capacity to consent, waiting for the Assisted decision-making ‘Capacity’ Bill 2013, still under parliamentary discussion, see <<http://www.oireachtas.ie/viewdoc.asp?DocID=24147&&CatID=59>>); para.35 (Informed consent to medical treatment); para.36 (Information for patients), para.43 (Children and minors).

<sup>266</sup> National Consent Advisory Group, 2013. The document examines how to deal with consent given by minors, patients with limited-English proficiency, and mental and physical disabled people.

whereas the final text of the Act only contains three points. A previous paragraph regarding the specific prohibition for entire medical structures to refuse the treatment on grounds of conscientious objection has been eliminated. Furthermore, while the previous version stated very clearly that the conscientious objector “*will have a duty to ensure that another colleague takes over the care of the patient as per current medical ethics*”<sup>267</sup>, the current Act rephrased the concept in the weaker “*shall make such arrangements for the transfer of care [...] as may be necessary to enable the woman to avail of the medical procedure concerned*”<sup>268</sup>. It can be easily concluded that the emphasis on the duty to care according to medical ethics, both for institutions and medical practitioners, disappeared from the text.

Indeed, in the PLDPA the “refusal of care -rather than the duty to care- is located within the sphere of conscience”<sup>269</sup>. The right to conscientious objection of the individuals is not balanced by the correspondent duty of the healthcare structures to ensure women’s care. This was completely reversed in Clare Daly’s MTB 2012, where even the heading of the section regulating the conscientious objection was called “Obligation to provide medical treatment”<sup>270</sup>. Under that chapter, the medical institutions were explicitly forbidden to object performing a treatment<sup>271</sup> and they even had the duty to assure the necessary percentage of available personnel, in order to guarantee women an effective access to lawful abortion<sup>272</sup>.

Since concerns arise regarding the “potential for conscientious obstruction”<sup>273</sup> coming from the present Act, there is a need to give more importance to the duty to care and to reconcile the conscientious objection with the patient’s interests<sup>274</sup>. Indeed, as the ECtHR recently required in two abortion-related Polish cases, “States are obliged to organise their health care services in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not

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<sup>267</sup> GSB 2013, Head 12(4), emphasis added.

<sup>268</sup> PLDPA 2013, Section 17(3), emphasis added.

<sup>269</sup> IFPA, 2013(c), p.7.

<sup>270</sup> MTB (No2), November 2012, Section 7.

<sup>271</sup> Ibidem, Section 7(3).

<sup>272</sup> Ibidem, Section 7(2).

<sup>273</sup> DFC, 2013(a), p.3. See for a further discussion of the topic Global Doctors For Choice, 2013.

<sup>274</sup> ICCL, 2013(a), p.356.

prevent patients from obtaining access to services to which they are entitled under the applicable legislation”<sup>275</sup>.

Therefore, firstly, the refusal of care should be clearly prohibited<sup>276</sup> and sanctioned<sup>277</sup>, or at least, according to the Medical Council Guide, limited to “exceptional circumstances”<sup>278</sup>. Secondly, the conscientious objection must be regulated within a timeframe that can allow for an expedite referral to another practitioner<sup>279</sup>. Thirdly, the conscientious objection has to be forbidden in situations of emergency and immediate risk of the woman’s life<sup>280</sup>. Indeed, the freedom of conscience –protected by both the Irish Constitution<sup>281</sup> and the ECHR<sup>282</sup>- is not absolute and can be limited by the rights of others, in this case women’s right to life. The requirement that doctors carry out life-saving treatments regardless their conscientious objection is included in the legislation in Section 17(2). However, in case a medical practitioner deliberately refused to perform a termination on the grounds of his conscience, well knowing the harm being caused to the woman, a specific offence should be established. This would be, indeed, the last useful point in order to regulate the conscientious objection: the accountability of the medical personnel<sup>283</sup>.

### **Section 18: Travel and Information**

This provision on the freedom of travelling and receiving information substantially recalls the 1992 Thirteenth and Fourteenth Amendments of the Constitution, reaffirming their validity. However, one may argue that the right to travel abroad to have an abortion which would be illegal in Ireland<sup>284</sup> could be seen as a Government’s inner acknowledgement of the necessity of the treatment. It is more: “the availability of safe abortion services in other EU countries [...] has played a significant role in allowing the

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<sup>275</sup> *RR v Poland* (2011) para.206 and *P and S v Poland* (2012) para.106. See also the SR on the Right to Health, 2011, para.65(m).

<sup>276</sup> ICCL, 2013(a), p.356.

<sup>277</sup> IFPA, 2013(c), p.7.

<sup>278</sup> Medical Council, 2009, para.9.1.

<sup>279</sup> AI-Ireland (2013(a)) and ICCL (2013(a), p.356).

<sup>280</sup> Medical Council, 2009, para.10.3.

<sup>281</sup> Article 44.

<sup>282</sup> Article 9.

<sup>283</sup> IHRC, 2013, p.51.

<sup>284</sup> PLDPA 2013, Section 18(2).

Irish Government to abdicate its responsibility to protect the human rights of women who require access to abortion”<sup>285</sup>. As an interview, conducted by HRW, reports: “there is a huge amount of hypocrisy in the Irish situation. One of the main reasons that abortion remains illegal is because they can export their problem, because women can travel”<sup>286</sup>.

## **Section 20: Notifications**

No later than four weeks after being performed, all the terminations of pregnancy carried out all over Ireland must be noticed directly to the Minister of Health, who every year by 30 June has to include also these data in the report to be laid before the Oireachtas<sup>287</sup>. While the Act specifies that this annual report does not have to contain anything that could lead to the identification either of the woman or of the doctor<sup>288</sup>, this is not explicitly required for the single records kept by the different hospitals. Indeed, the anonymity clause to protect anyone involved from harassment and stigma is only valid for the public document, whereas the notifications must include the date, structure and lawful ground for the termination as well as the “Medical Council registration number”<sup>289</sup> of the medical practitioner who performed the abortion. This latter represents an unnecessary information for the Minister and, in case of disclosure<sup>290</sup>, would expose the medical practitioner to the stigma “of being labelled as an abortionist”<sup>291</sup> by anti-choice groups. It is deemed necessary, therefore, to exclude it from the reports.

Nevertheless, the issue of anonymity in the context of abortion can be approached from two opposite perspectives. On the one hand, it is a necessary expedient in order to

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<sup>285</sup> See HRW, 2010, p.16.

<sup>286</sup> Ann Furedi, BPAS, in idem. This subject will be further discussed in Chapter 4.

<sup>287</sup> The first one will be published in June 2015, see <<http://www.irishhealth.com/article.html?id=23615&ss=abortion%20guidelines>> (consulted on 2 June 2014).

<sup>288</sup> PLDPA 2013, Section 20(6)(a), (b) and (c). In the April draft the anonymity was required only for the woman (GSB 2013, Head 11(3)).

<sup>289</sup> Ibidem, Section 20(3)(a).

<sup>290</sup> For the data protection aspect, the PLDPA does not provide any further clarification, as the IHRC noticed (2013, p.40). Therefore it has to be assumed that for any guidance one should refer to the ‘Data Protection Act’ 1988 (as amended in 2003) and to the Medical Council Guide, 2009, Section C (Medical Records and Confidentiality).

<sup>291</sup> A doctor interviewed by HRW, 2010, p.19.

practically protect both doctors and women from possible social harassment and stigmatisation. On the other hand, however, the maintenance of silence and secrecy around abortion, directly deriving from this anonymity requirement, could reinforce the social perception of it as something to hide and be ashamed of<sup>292</sup>. As Sinéad Corcoran from ARC noticed, “it is regrettable that there has to be that kind of protection: it is a medical procedure, and a doctor should be able to practice it as they would anything else”<sup>293</sup>.

As a concluding remark, IFPA deems the whole Section an “unnecessary additional process of reporting”<sup>294</sup>, whose main effect will be treating differently the termination of pregnancy from any other ordinary medical procedure. Indeed, its recording will be separated from all the rest of the hospital data, already collected by the Hospital In Patient Enquiry (HIPE). Therefore, the suggestion is made of deleting the whole Section 20 or at least paragraph 20(3)(a).

### **Section 21: Special powers to the Minister**

This Section represents a major addition, absent in the first draft of the Bill, concerning a “further decision-making layer”<sup>295</sup> to the legislation. This provision establishes that when a serious risk of failure to comply with the Act occurs in any of the appropriate institutions and there is an on-going investigation, the Minister of Health can ensure that the termination of pregnancy object of the dispute is not carried out, by notice in writing to the head of the structure concerned<sup>296</sup>. However, the conditions under which this may happen are not clarified, nor it is explained what a “serious risk of failure to comply” with the Act may constitute in practice. This absence of measurable parameters causes an extremely blurred and uncertain situation, which overrides all the aforementioned provisions of the PLDPA, giving extraordinary decisional power to the Minister and creating an added inhibitory effect to the whole procedure.

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<sup>292</sup> Interview with Richie Keane, DFC, Dublin, 7 April 2014.

<sup>293</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>294</sup> IFPA, 2013(b), p.7.

<sup>295</sup> IHRC, 2013, p.42.

<sup>296</sup> This is not applying to the situations of emergency under Section 8.

Indeed, in the way it is currently framed, “there are lots of ways that this provision might be abused”<sup>297</sup>. As Maeve Taylor from IFPA sees it, in absence of any explicit evidences’ requirement, ministerial inspections could be sent either following anti-abortion ideological stances or after targeting a particular hospital which, from the reports, results as being particularly disposed to perform abortions. This represents an extreme abuse of such a norm that cannot be categorically excluded, although hopefully it is not likely to happen. This Section could give rise to situations creating additional barriers, with the “potential to remove the already limited right of the women to access a lawful termination of pregnancy”<sup>298</sup>.

The eventual allowance of these special powers to the Minister is interpreted by the CSOs as evidently showing how politicised the debate on abortion was among the Government parties. To make sure that the Act would be passed, a further monitoring mechanism was required in order to please those politicians concerned with what they considered the most liberal and permissive of the abortion legislations<sup>299</sup>.

### **Section 22 and 23: Offences**

This criminal part is certainly the most controversial and debated of the entire legislation, since its introduction was highly political and surprised the CSOs defending women’s reproductive rights. In these two final Sections, indeed, the Act establishes that the punishment for the offence of performing an unlawful abortion, meaning “intentionally destroy unborn human life”<sup>300</sup>, will be of fourteen years of jail. This penalty equally extends to all the actors involved: women, medical practitioners (Section 22) and the body corporate whose consent, connivance or wilful neglect allowed carrying out the practice within the structure under its responsibility (Section 23).

The first thing that must be noticed, before turning to the analysis of the meaning and consequences of this part, is the very pejorative change in the wording of the title of Section 22 between the first and the last draft of the Act. Indeed, it was modified from

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<sup>297</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>298</sup> IHRC, 2013, p.42.

<sup>299</sup> One of their major concerns was, for example, the lack of time limits for a lawful abortion (Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014).

<sup>300</sup> PLDPA 2013, Section 22(1).

the legally neutral “Offence” to the highly judgemental “Destruction of unborn human life” in the current Act. Although it is just a title, whose modification does not change anything from a legal perspective, the inhibitory psychological impact of the term “destruction” is quite predictable. According to Richie Keane from DFC, “this is not medical terminology, but is loaded with religious morality”<sup>301</sup>. On the other hand, for Sinéad Corcoran from ARC “this is such an emotive and provocative sentence”<sup>302</sup>, while IFPA recommends to change the word “destroy” with “end”<sup>303</sup>.

Moving to the analysis, the three main substantial criticisms regarding these provisions are that they are inconsistent, disproportionate and create a chilling effect<sup>304</sup> on both women and medical personnel<sup>305</sup>.

The inherent inconsistency of the PLDPA when dealing with the phenomenon of unlawful abortion appears quite clear. Indeed, besides the severe criminal sanctions imposed on women having unlawful terminations in Ireland, the parallel constitutional right to legally have the same kind of operation abroad -recalled in Section 18- legitimates thousands of women every year to have abortions elsewhere. As DFC properly points out, the explicit right to travel for the purpose of having an abortion strikes with the level of gravity given to the same procedure, considered a crime if committed within the Irish borders<sup>306</sup>. The freedom allowed seems to represent an implicit recognition of the reality that a huge amount of women will anyway seek to undergo such operation<sup>307</sup>.

Furthermore, the criminalisation aspect appears to put in some circumstances a severe additional burden on women who are experiencing serious illness problems, or pregnancies resulting from crimes –rape or incest-, or whose babies will inevitably die after birth, due to fatal genetic abnormalities<sup>308</sup>. A criminal sanction threatening women in such circumstances is deemed by all CSOs to be disproportionate, because it adds

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<sup>301</sup> Interview with Richie Keane, DFC, Dublin, 7 April 2014.

<sup>302</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>303</sup> IFPA, 2013(b), p.9.

<sup>304</sup> It represents the inhibitory effect that criminal sanctions have even on exercising legitimate actions.

<sup>305</sup> IFPA, 2013(b), p.9.

<sup>306</sup> DFC, 2013(a), p.10. Therefore, the explicit consideration on the appropriateness of the length of imprisonment “due to the gravity of the crime” included in the GSB (Explanatory note of Head 19) is deemed “particularly offensive” (DFC, 2013(a), p.3).

<sup>307</sup> The statistics of women travelling per year (see *infra*) remained almost unvaried since the 1980s.

<sup>308</sup> IHRC, 2013, p.45.

further distress to the physical or mental pain and suffering already characterising those situations. Moreover, the disproportion is particularly striking in cases of pregnancy as a result of crime, since “the extreme consequence of all this would be that a raped woman or girl having an unlawful abortion would be imprisoned for longer than her rapist”<sup>309</sup>.

Finally, although not stopping women from having abortions, the penalty of fourteen years of imprisonment does represent a severely intimidating factor for all the actors involved. Firstly for the women, since they will less likely seek post-abortion care, which could lead to a very dangerous situation in cases of post-operation complications and need for urgent medical assistance<sup>310</sup>. Secondly, the fear of prosecution could also push doctors to hesitate before providing treatment to patients<sup>311</sup>, which interferes with the woman-doctor therapeutic relationship and might undermine women’s health and the medical practitioner’s sought for her best interest. It seems therefore “clear that the law protects neither the patient nor the healthcare providers they interact with”<sup>312</sup>. In addition, the onerous same level of criminal liability imposed on the body corporate<sup>313</sup> could lead hospitals to implement cautious and “restrictive internal governance procedures”<sup>314</sup> and create a tense climate that might consistently undermine the provision of quality healthcare. According to DFC, this multi-layered chilling effect “will encourage secrecy, terror and desperation”<sup>315</sup>, using the criminalisation as an instrument of social control and substantially making this legislation unworkable<sup>316</sup>.

In conclusion, these criminal provisions do not substantially change the situation of chilling effect created by the repealed sections 58 and 59 of the OAPA of 1861 and strongly condemned by the ECtHR in the *ABC judgement*. On the contrary, the CSOs accuse the current legislation of even reinforcing it. First, the extension of the criminal liability to the body corporate increments a climate of fear of prosecution, including even within people not directly involved in the procedure. Second, as Sinéad Corcoran

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<sup>309</sup> Interview with Joseph Loughnane, GPC, Galway, 3 June 2014.

<sup>310</sup> IFPA (2013(b), p.9) and ARC (2013, p.2).

<sup>311</sup> ARC, 2013, p.2.

<sup>312</sup> *Idem*.

<sup>313</sup> IHRC, 2013, p.44.

<sup>314</sup> IFPA, 2013(c), p.9.

<sup>315</sup> DFC, 2013(a), p.3.

<sup>316</sup> DFC suggests as best model to follow the Canadian one, providing free, public and decriminalised abortion services (*ibidem*, p.10).



from ARC noted, comparing it with the precedent life-imprisonment, “although the length of punishment is minor, it renders it more practical and more likely to happen”<sup>317</sup>. Third, the fact that such a penalty has been decided in the XXI century in a European country, at odds with the general decriminalising trend of the past decades, appears worrying.<sup>318</sup> Fourth, taking together the Sections 15 and 20-23 of the PLDPA, the present legislation puts an “unprecedented and unwarranted degree of Ministerial and parliamentary scrutiny [and of criminalisation] on an aspect of healthcare”<sup>319</sup>.

### 3.2.5. Schedule

This Appendix concludes the Act with the list of Appropriate Institutions where all the aforementioned procedures can be lawfully carried out. Their number was increased from the first to the final draft, including some non-maternity units and two catholic voluntary hospitals<sup>320</sup>. However, a major concern expressed by the CSOs on this point is the exclusion from the list of Primary Care structures, which would make much easier the access to the legislation for the women in need<sup>321</sup>. By not including all the available institutions, the Act creates geographical barriers for accessibility, causing *a priori* unnecessary delays<sup>322</sup>.

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<sup>317</sup> Interview with Sinéad Corcoran, ARC, Dublin, 25 April 2014.

<sup>318</sup> Much more suitable with our time was the “Offences” Section of Clare Daly’s MTB, which deemed whosoever harassing or intimidating women, medical practitioners or third persons involved in the medical procedure as being guilty of an offence (Sections 10-14).

<sup>319</sup> IFPA, 2013(c), p.9. A precedent of such a criminalisation can be found in the Regulation of Information Act 1995, in which however the amount of years of jail is not specified.

<sup>320</sup> Holland, 2013, p.239. The inclusion of the Mater Misericordiae and the S.Vincent’s University Hospitals caused some discussion for their religious character collapsing with the institutional prohibition of conscientious objection. This brought to the resignation in August 2013 of Father Kevin Doran from the board of Directors of the Mater Misericordiae due to his conscientious conflicts.

<sup>321</sup> IFPA, 2013(c), p.5.

<sup>322</sup> ICCL, 2013(a).

## 4.

### Human rights based analysis

#### 4.1. International Human Rights Law and abortion

“Authoritative interpretations of International Law recognise that obtaining a safe and legal abortion is crucial to women’s effective enjoyment and exercise of their human rights”<sup>323</sup>. Indeed, the different States’ regulations on abortion have raised a number of HR related issues under the main UN HR treaty-bodies’ reviews as well as within the individual complaints procedures. HRW estimated that since the mid-1990s “over 122 concluding observations concerning at least ninety-three countries”<sup>324</sup> have been produced concerning abortion and represent now an important body of jurisprudence.

The most common observation that can be found in the majority of these Concluding Observations (CO) and General Comments (GC) and Recommendations (GR) is the link between restrictive legislations on abortion, consequent higher rates of illegal and unsafe abortions and eventually increased maternal mortality and morbidity. However, this is not the only risk run by women when abortion is subject to extremely strict limitations. It is widely recognised that “firmly established human rights are jeopardized and prejudiced by restrictive and punitive abortion laws and practices”<sup>325</sup>.

Furthermore, the UN treaty-monitoring bodies have also expressed their concerns on the criminal aspects of the legislations on abortion and have commonly called for decriminalising the procedure when women’s lives or health are at risk, as well as when pregnancy is the result of rape or incest and when the woman is carrying a foetus with fatal abnormalities<sup>326</sup>.

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<sup>323</sup> HRW, 2010, p.43.

<sup>324</sup> Idem.

<sup>325</sup> Idem. For a detailed discussion, see *infra*.

<sup>326</sup> Zampas, Gher, 2008, p.288. For a further discussion, see *infra*.

Not only at international level, but also at the regional one, HR institutions are recognising the right to choose on their own body and to access to abortion as fundamental issues for women to enjoy a broader range of rights. For example, the African Union in 2003 approved the African Women's Protocol, which is the only legally binding HR treaty explicitly including in its Article 14(2)c<sup>327</sup> a women's right to abortion on all the grounds of request except for the socio-economic necessity. Some years later, in 2006 the Inter-American Commission Rapporteur for the Rights of Women deemed Nicaragua's total abortion ban to be contrary to International Human Rights Law principles, jeopardising women's rights<sup>328</sup>. Lastly, in 2008 the Parliamentary Assembly of the Council of Europe (CoE) adopted Resolution 1607 on "Access to safe and legal abortion in Europe". By affirming "the right of all human beings, in particular women, to respect for their physical integrity and the freedom to control their own bodies"<sup>329</sup>, the resolution states that "abortion should not be banned within reasonable gestational limits"<sup>330</sup> and calls upon the MS for its decriminalisation.

The present chapter will deal with the analysis of the HR issues arising from the 2013 Act, which represents the specific focus of the present work. In the next paragraph the treaty bodies' position on abortion in Ireland will be considered through the different aspects raised by the COs issued in the last fifteen years. Subsequently, in the following section, the diverse HR flaws of the PLDPA will be the object of discussion. Finally, the last part will focus on the first treaty body examination of the new Irish abortion legislation: the upcoming Human Rights Committee (HRC) Fourth Periodic Review of Ireland in July 2014.

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<sup>327</sup> African Union, 2003.

<sup>328</sup> Zampas, Gher, 2008, p.279.

<sup>329</sup> PACE Res.1607, 16 April 2008, para.6.

<sup>330</sup> Ibidem, para.4.

## 4.2. Human rights bodies, Ireland and abortion in the past years

“You lose your rights basically when you are pregnant here.”<sup>331</sup>

Throughout the last fifteen years, both at the international and regional level, HR institutions have very frequently questioned Ireland on the matter of abortion.

In its COs of 1999 and 2005, regarding the second, third, fourth and fifth Irish Periodic Reports, the Convention on Elimination of Discrimination Against Women (CEDAW) Committee was concerned by the extremely restrictive abortion law, which forces women to travel abroad to lawfully terminate their pregnancies<sup>332</sup>. The review stressed the deep disparity created within the female population by this situation, between women that can afford to travel and the caused “hardship for vulnerable groups, such as female asylum seekers who cannot leave the territory of the State”<sup>333</sup>. The CEDAW Committee on both occasions recommended Ireland to “facilitate a national dialogue on women’s right to reproductive health, including on the very restrictive abortion laws”<sup>334</sup>.

The main critical issue raised by the HRC during the second periodic review in 2000 concerning the Irish approach to abortion was the absence of rape within the lawful grounds to allow an abortion. According to the HRC’s interpretation, not preventing women from continuing with unwanted pregnancies in these specific circumstances “is incompatible with obligations arising under the Covenant (art. 7) and General Comment No. 28”<sup>335</sup>. Therefore, the Committee considers that forcing a woman to carry on a pregnancy resulting from rape or incest is a violation of the right to be free from torture and cruel, inhuman or degrading treatment. Indeed, in order to be in compliance with Article 7, every State Party is required to provide information on whether it “gives access to safe abortion to women who have become pregnant as a result of rape”<sup>336</sup>.

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<sup>331</sup> Praveen, Savita’s husband, in Holland, 2013, p.219.

<sup>332</sup> CEDAW, CO-Ireland, CEDAW/C/1999/L.2/Add.4, 25 June 1999, para.185.

<sup>333</sup> *Idem*.

<sup>334</sup> CEDAW, CO-Ireland CEDAW/C/IRL/CO/4-5, 22 July 2005, para.397.

<sup>335</sup> HRC, GC28, CCPR/C/21/Rev.1/Add.10, 29 March 2000, para.24 (hereafter: HRC, GC28).

<sup>336</sup> HRC, CO-Ireland, A/55/40, 21 July 2000, para.11.

In the following HRC third periodic review of 2008, Ireland was further urged to “bring its abortion laws into line with the Covenant”<sup>337</sup> and to “take measures to help women avoid unwanted pregnancies so that they do not have to resort to illegal or unsafe abortions that could put their lives at risk (article 6) or have abortions abroad (article 26 and 6)”<sup>338</sup>. In these recommendations the Committee explicitly considers the Irish restrictive abortion legislation as a threat to women’s life and equality before the law<sup>339</sup>.

In his 2008 and 2011<sup>340</sup> reports on his visits to Ireland, the CoE HR Commissioner Mr Thomas Hammarberg brought to the attention of the CoE the substantial uncertainty arising from the blurred definition of the term “unborn” and the absence of any legislation to regulate the *X case*. He stressed the dramatic consequences that this situation could cause “especially in such cases in which vulnerable women such as minors and migrants are concerned”<sup>341</sup>. In his Recommendation 19, the Commissioner therefore urged Ireland to “clarify the scope of legal abortions through statutory law in line with domestic jurisprudence and provide for adequate services for carrying out such abortions”<sup>342</sup>. However, the Irish Government stated that it had “no plans to bring forward further constitutional or legislative proposals”<sup>343</sup>.

The national authorities’ unwillingness to legislate had to change radically after the 2010 Strasbourg *ABC judgment*. The outcome of this latter was mentioned during several following HR reviews on Ireland, which stressed the need to legislate at least for what was already lawful. The first one was, in 2011, the initial Convention Against Torture (CAT) Committee review. In paragraph 26 of that CO, entitled “abortion”, after acknowledging the violations found in the *ABC case* and the need for legislation, the CAT Committee expressed its concerns regarding the criminalisation of both women and doctors, which “may raise issues that constitute a breach to the Convention”<sup>344</sup>. It

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<sup>337</sup> HRC, CO-Ireland, CCPR/C/IRL/CO/3, 30 July 2008, para.13.

<sup>338</sup> *Idem*.

<sup>339</sup> *Idem*.

<sup>340</sup> CommDH(2011)27, 15 September 2011, para.15.

<sup>341</sup> CommDH(2008)9, 30 April 2008, para.80.

<sup>342</sup> *Ibidem*, Recommendation 19. The same recommendations were made in the following Report CommDH(2011)27, 15 September 2011, para.15.

<sup>343</sup> *Idem*.

<sup>344</sup> CAT, CO-Ireland, CAT/C/IRL/CO/1, 17 June 2011, para.26.

furthermore recognised the particularly difficult situation faced by minors, migrants and women in poverty, which could amount to cruel, inhuman or degrading treatment (CIDT) under Article 16. The Committee eventually called for a clarification of the situation through statutory law<sup>345</sup>.

The same year, during the Universal Periodic Review (UPR), in the interactive dialogue phase a number of States questioned Ireland on its national attitude on abortion and on the absence of a long-needed legislation<sup>346</sup>. Several countries gave recommendations on this issue, although none of them enjoyed the support of Ireland<sup>347</sup>, mostly because they regarded the inclusion of broader grounds for legal abortion. Norway<sup>348</sup>, for example, asked Ireland to bring its legislation into line with the CCPR standards; Denmark<sup>349</sup> suggested allowing abortion also in cases of pregnancies resulting from rape or incest and, together with Slovenia<sup>350</sup>, when the physical or mental health or well-being of the woman is at risk. Moreover, Spain<sup>351</sup> recommended decriminalise abortion under certain circumstances and finally the UK<sup>352</sup> and the Netherlands<sup>353</sup> expressed their wish for the prompt establishment of an adequate legislation and healthcare services within Ireland<sup>354</sup>.

The UN Special Rapporteur (SR) on the Right to Health, Anand Grover, in a visit to Ireland in December 2012 gave a speech at the NWCI on women and health, and recommended to the Irish Government to legislate for including health within the grounds for a lawful abortion. Moreover, recalling his 2011 Interim Report, he strongly condemned the criminalisation of any aspect of reproductive health as discriminatory

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<sup>345</sup> *Idem*.

<sup>346</sup> France and Germany's comments, in UPR-Ireland, A/HRC/19/9, 21 December 2011, paras.57 and 103.

<sup>347</sup> *Ibidem*, para.108.

<sup>348</sup> *Ibidem*, para.108.4.

<sup>349</sup> *Ibidem*, para.108.6.

<sup>350</sup> *Ibidem*, para.108.7.

<sup>351</sup> *Ibidem*, para.108.8.

<sup>352</sup> *Ibidem*, para.108.5.

<sup>353</sup> *Ibidem*, para.108.9.

<sup>354</sup> It is worth noticing that these two countries are the two main destination of Irish women going abroad to have a termination (see IFPA, 'Statistics', <at <http://www.ifpa.ie/Hot-Topics/Abortion/Statistics>> (consulted on 29/05/2014)).

and undermining women's dignity and equality<sup>355</sup>. In an interview realised in that same occasion by Kitty Holland, the Irish journalist that few months earlier had broken Savita's death story, he further affirmed to be "particularly concerned about Ireland... You cannot afford to lose people's lives like this. It would not have happened in India. There is a lot of distress and discussion about Ms Halappanavar's death. Maybe out of this tragedy something good will come"<sup>356</sup>.

The Act, whose approval as aforementioned was accelerated precisely due to that death, will be now analysed from a HR perspective.

### **4.3. Human Rights issues arising from the PLDPA**

#### **4.3.1. Right to life**

The protection of life of the pregnant woman as a ground for requesting a legal abortion is the main objective for the introduction of the current abortion legislation in Ireland. However, even when not at risk at the moment of requesting an abortion, a woman's life can be threatened by the denial of a lawful termination within a restrictive legislative framework. Indeed, the HRC explicitly requires States Parties, in order to comply with Article 6 of the CCPR, to take all the adequate measures "to ensure that [women] do not have to undertake life-threatening clandestine abortions"<sup>357</sup>.

Furthermore, according to the HRC interpretation of the right to life, the State actions must not be limited to the negative obligations (respect) of refraining from causing loss of lives, but include also positive duties (protect and fulfil). Among these, States are required to take all the appropriate measures in order to "increase life expectancy"<sup>358</sup>, which, as a corollary, necessarily encompasses a particular attention on adequate healthcare services. The HRC furthermore clarifies that the right to life "should not be

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<sup>355</sup> UN SR Health, Presentation at the NWCI, 17 December 2012, at <<https://www.youtube.com/watch?v=s0FLFD61vxE>> (consulted on 26 June 2014) (hereafter: UN SR Health, Presentation).

<sup>356</sup> Holland, 2013, p.154.

<sup>357</sup> HRC, GC28, para.10.

<sup>358</sup> HRC, GC6, 1982, in HRI/GEN/1/Rev.9 (Vol. I), pp.176-177, para.5.

interpreted narrowly”<sup>359</sup>. This broad understanding is reflected, in *KL v Peru*, by a Committee Member’s opinion –although dissenting- that even only endangering a person’s life can amount to a violation of Article 6 of the CCPR<sup>360</sup>. A very comprehensive interpretation of the right to life is quite clear in the HRC vision and, therefore, “for purposes of adequate policy-making, the right to health and the right to life should be seen by the State as part of a continuum rather than as two separate concerns, in particular when addressing health conditions that pose a grave danger to a person’s life”<sup>361</sup>.

In contrast with all the aforementioned recommendations, by introducing the PLDPA, Ireland is the only MS of the CoE forcing doctors to make the distinction between saving women’s lives and protecting their health as grounds for the lawfulness of abortion<sup>362</sup>. This extremely narrow interpretation of the right to life entailed in the Irish legal framework causes problems, particularly within the medical practice<sup>363</sup>. Indeed, “to require a woman to wait until her health has deteriorated to such an extent that her life is at risk in order to receive treatment is contrary to medical ethics”<sup>364</sup>.

#### **4.3.2. Right to health and safe and accessible services**

According to Article 12 of the Covenant on Economic Social and Cultural Rights (CESCR), the right to health encompasses both physical and mental conditions, but is not only limited to this aspect of corporal and psychological well-being. According to the interpretation of the CESCR Committee, indeed, it includes also freedoms and

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<sup>359</sup> Ibidem, para.2.

<sup>360</sup> HRC, *KL v Peru*, Dissenting opinion by Committee Member Solari-Yrigoyen, CCPR/C/85/D/1153/2003, 22 November 2005.

<sup>361</sup> HRW, 2010, p.21. See also AI-Ireland (2013), IFPA (2013(b)), DFC (2013(a)).

<sup>362</sup> IFPA, 2013, p.5. According to an IFPA survey on 12 European countries, none of them makes such a distinction between life and health, and in general the majority allows abortion on risk of life, health and on foetal abnormalities grounds. Moreover, during the initial stage of pregnancy almost all countries permit also abortion on request (ibidem, p.15).

<sup>363</sup> See DFC, 2013(a), p.6.

<sup>364</sup> IFPA and SRI, 2011, p.2.



entitlements, such as the “right to control one's health and body, including sexual and reproductive freedom”<sup>365</sup>.

On the other hand, the CEDAW emphasises particularly the reproductive aspects of the health sphere, such as access to family planning, pregnancy and lactation care<sup>366</sup>. In its GR 24 the CEDAW Committee requires all States Parties to remove all sorts of barriers, even restrictive legislations, to women’s “pursuit of their health goals”<sup>367</sup> and access to appropriate healthcare services, which must be also available, acceptable and of adequate quality<sup>368</sup>. Very restrictive abortion laws do not comply with these standards and, indeed, the denial of a therapeutic abortion has been deemed in breach of women’s right to health<sup>369</sup>. Such adverse effects are acknowledged also by the CESCR Committee, which in several COs recommended allowing abortion for therapeutic reasons<sup>370</sup>. Therefore, it is likely that the 2015 Third Periodic Review of Ireland under the CESCR will have same outcome.

Indeed, the PLDPA seriously affects Irish women’s health and violates their rights of access to safe reproductive healthcare facilities. In Ireland, unsafe backstreet abortions jointly with the purchase of abortifacient drugs on the web<sup>371</sup> represent the last (illegal) resort of the women who are unable to travel to get a safe termination. However, also the option of going abroad to have a safe and legal abortion can have a severe impact on the health even of those women who can afford the journey. Indeed, the time needed to make the travel arrangements might cause unnecessary delays in the performance of the medical procedure that can jeopardise women’s health in several ways. On the one

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<sup>365</sup> CESCR Committee, GC14, E/C.12/2000/4, 11 August 2000, para.8 (hereafter: CESCR Committee, GC14).

<sup>366</sup> UN, CEDAW, 1979, Article 12.

<sup>367</sup> CEDAW Committee, GR24, A/54/38/Rev.1, 5 February 1999, para.14 (hereafter: CEDAW Committee, GR24).

<sup>368</sup> CESCR Committee, GC14.

<sup>369</sup> See *LC v Peru* brought before the CEDAW Committee, where, after being refused a termination of pregnancy necessary to perform an urgent surgical operation, the girl’s health conditions deteriorated until she ended up having a life-paralysis (CEDAW/C/50/D/22/2009, 25 November 2011) (hereafter: CEDAW Committee, *LC v Peru*).

<sup>370</sup> CESCR Committee: CO-Chile, E/C.12/1/Add.105, 26 November 2004, para.53; CO-Malta, E/C.12/1/Add.101, 26 November 2004, para.41; CO-Monaco, E/C.12/MCO/CO/1, 13 June 2006, para.23. It has to be born in mind that an abortion is considered “medically necessary” when the pregnancy aggravates a pre-existing condition, impedes the treatment of a condition, interferes with or prevents a diagnosis or has extremely negative impact upon the physical or mental health of the woman (see Cook, Dickens, 2003, p.37).

<sup>371</sup> HRW, 2010, p.36.

hand, women needing an abortion for illness-related issues might experience deteriorations of their already precarious health conditions<sup>372</sup>. On the other hand, women wishing to have a termination for other reasons could be forced, due to the delay, to undergo more invasive operations at advanced stages of their pregnancies<sup>373</sup>. Furthermore, time, costs and stigma play a major role during the journey in increasing health risks, since in order to accelerate the procedure and shorten the stay, women generally avoid or limit pre- and post-abortion care, and request more often surgical abortions, quicker but more invasive than the medical (non-surgical) ones<sup>374</sup>.

A further major problem stressed by DFC is the lack of education and training of Irish medical practitioners on how to perform terminations of pregnancy, due to a gap in the medical curricula at University<sup>375</sup>. This undermines the delivery of appropriate healthcare services even within the lawful cases. As declared by DFC, the need for an adaptation of University careers in accordance with the PLDPA is of the utmost importance<sup>376</sup>.

#### **4.3.3. Right to information**

In its GC 14 the CESCR Committee recognised the particular importance of the right to have adequate information in relation to health<sup>377</sup>. The same access to sexual and health information and education, “including information and advice on family planning”<sup>378</sup>, free from “prejudice and discrimination”<sup>379</sup> is recommended by the CEDAW Committee. In its first periodic review on Ireland, in 1993, the HRC expressed concerns for a lack of appropriate information on abortion<sup>380</sup>.

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<sup>372</sup> See CEDAW Committee, *LC v Peru*.

<sup>373</sup> Generally, only up to nine weeks of gestation women can require a medical abortion (HRW, 2010, p.31).

<sup>374</sup> IFPA, 2013, p.4.

<sup>375</sup> Since the procedure was illegal, Medicine programmes did not include it within the subjects taught. Interview with Richie Keane, DFC, Dublin, 7 April 2014.

<sup>376</sup> *Idem*.

<sup>377</sup> CESCR Committee, GC14.

<sup>378</sup> UN, CEDAW, 1979, Article 10(h).

<sup>379</sup> CEDAW Committee, GR24, para.18.

<sup>380</sup> HRC, CO-Ireland, CCPR/C/79/Add.21, para.15.

However, the Information Act 1995 -draw on Section 18 of the PLDPA- do not seem to fill the gap. According to HRW, indeed, up to now Ireland does not comply with its positive obligation of fulfilling the right of information on abortion, by failing to disseminate it and to make it available to all women<sup>381</sup>. Furthermore, the State does not even comply with the second positive obligation of protecting the right, since there are no controls on unregulated private agencies deliberately giving misleading and inaccurate information<sup>382</sup>. Indeed, the 1995 Act prevents information providers from advocating for abortion, but does not prohibit the opposite, namely trying to persuade women against having a termination. The Irish State, even under the PLDPA, continues to delegate its duty to comply with providing adequate information on abortion to independent non-governmental organisations<sup>383</sup>.

#### **4.3.4. Right to be free from violence**

According to the Beijing Platform of 1995, “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence”<sup>384</sup>. Forcing women to continue with pregnancies against their will is considered by the CEDAW Committee an aspect of gender-based violence. The UN SR on Violence Against Women further clarifies this concept, affirming that restrictive abortion legislations subject women “to excessive pregnancies and childbearing against their will”<sup>385</sup>, causing increased and preventable harm and rising rates of maternal mortality and morbidity. Therefore, within the measures required to tackle violence against women, the CEDAW Committee calls States to “ensure that measures are taken to prevent coercion in regard to fertility and reproduction”<sup>386</sup>.

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<sup>381</sup> HRW, 2010, p.22.

<sup>382</sup> Ibidem, p.25-27.

<sup>383</sup> See Marie Stopes Reproductive Choices, in Dublin, at <<http://www.reproductivechoices.ie/>> (consulted on 29 June 2014).

<sup>384</sup> UN, FWCW Report, Beijing1995, A/CONF.177/20/Rev.1, para.96 (hereafter: FWCW Beijing Report).

<sup>385</sup> SRVAW, E/CN.4/1999/68/Add.4, 21 January 1999, para.57.

<sup>386</sup> CEDAW Committee, GR19, A/47/38, 1992.

However, beyond this general remark, a specific ground for denying abortion is of concern regarding the aspect of gender-based violence. In case the pregnancy is resulting from rape or incest, indeed, forcing women to keep the baby increases the already great suffering of being victims of sexual violence. Some academics, quite provocatively, even describe it as a form of “forced pregnancy”<sup>387</sup>, since the term refers both to “forced initiation of pregnancy and forced continuation of pregnancy”<sup>388</sup>.

The PLDPA, a legislation which criminalises victims of rape who want to terminate their pregnancies, violates the HR of those women and also “the human right requirement of victim rehabilitation”<sup>389</sup>. Indeed, “a rape victim is entitled to the fullest rehabilitation possible [which] must address both the continuing impact of the initial violation and its after effects, including a pregnancy which the victim may not wish to bring to term”<sup>390</sup>. Also according to the World Health Organisation (WHO) ‘Guidelines for medico-legal care for victims of sexual violence’, within the range of support services to be provided to victims of sexual crimes there is also the access to safe and legal abortion following the woman’s will<sup>391</sup>.

#### **4.3.5. Right to be free from cruel, inhuman or degrading treatment (CIDT)**

The unlawfulness of abortion to terminate pregnancies resulting from rape can also amount to a breach of an *ius cogens* principle, reaching the threshold of severity to be considered CIDT. Indeed, recently the CAT Committee broadened the scope of torture and CIDT: if previously it regarded exclusively detention setting, through the recognition of gender as a key factor, the Committee acknowledged that “medical treatment, particularly involving reproductive decisions”<sup>392</sup> represented a specific context of risk for women. It moreover concluded that, in circumstances where victims of rape are denied an abortion, “for the woman in question, this situation entails

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<sup>387</sup> The use of the term in this context has no international criminal meaning, but is purely descriptive.

<sup>388</sup> Cook, Dickens, 2003, p.11.

<sup>389</sup> *Idem*.

<sup>390</sup> AI-Ireland, 2013, p.9.

<sup>391</sup> WHO, 2003, p.2.

<sup>392</sup> CAT Committee, GC2, CAT/C/GC/2, 24 January 2008, para.22.

constant exposure to the violation committed against her and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression”<sup>393</sup>.

Also the HRC in its GC 28, in order to assess compliance with Article 7 of the Covenant, explicitly requires States to include in their periodic reports information on access to abortion in cases of rape<sup>394</sup>. Beyond COs and GCs, there is a growing body of jurisprudence on CIDT and situations of denied abortions in circumstances of rape, as showed by the outcome of the individual complaint of *LMR v Argentina*<sup>395</sup> before the HRC and by the ECtHR judgement on *P and S v Poland*<sup>396</sup>.

The other ground of denied abortion whose consequences have been considered amounting to CIDT is the case of women carrying foetuses with fatal abnormalities who are non-viable outside the womb. The severe physical and mental suffering<sup>397</sup> caused to a woman obliged to continue a pregnancy, whose already-known outcome will be a stillbirth or a child dying few hours after the delivery, has been considered again both by the HRC in *KL v Peru* and by the ECtHR in *RR v Poland*<sup>398</sup> as provoking a foreseeable and avoidable “state of deep depression”<sup>399</sup>. In order to prevent these situations, the ECtHR stressed the necessity to access timely prenatal examinations to be able to make an informed choice on whether having an abortion or not.

In Ireland, the PLDPA does not take into account the severe suffering caused to a pregnant woman forced to carry to term a potentially painful pregnancy, neither for its origins (rape or incest) nor for what will be its outcome (a non-viable foetus).

However, above all, the absence in the Act of the legal ground of fatal foetal abnormalities is particularly striking. Indeed, it would have constituted the only situation potentially not in breach of the current constitutional framework of Article

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<sup>393</sup> CAT Committee, CO-Nicaragua, CAT/C/NIC/CO/1, 2009, para.16.

<sup>394</sup> HRC, GC28, para.11.

<sup>395</sup> HRC, CCPR/C/101/D/1608/2007, 28 April 2011.

<sup>396</sup> *P and S v Poland* (ECtHR, 2012).

<sup>397</sup> “Typical physical health consequences may include polyhydramnios, postural hypotension, premature membrane rupture, breech birth, or other forms of dystocia, and amniotic embolism. Equally important are the potential consequences on the emotional health of the pregnant woman, including anxiety, severe depression, and post-traumatic stress disorder (PTSD)” (HRW, 2010, p.28 n.76).

<sup>398</sup> *RR v Poland* (ECtHR, 2011).

<sup>399</sup> HRC, *KL v Peru*, CCPR/C/85/D/1153/2003, 22 November 2005, para.6.3.

40.3.3<sup>400</sup>. The Termination For Medical Reasons (TFMR), a group of Irish parents having faced critical situations for the non-viability of their children, strongly advocated during the legislative process for its inclusion in the new abortion legislation, by publicly presenting their personal stories of suffering<sup>401</sup>. They furthermore denounce the lack of a consistent system for accessing genetic examinations in Ireland, for the absence of a “national protocol that regulates antenatal screening”<sup>402</sup>, which violates their right to information and impedes a timely decision on the actions to take.

Furthermore, not only the obligation to continue the pregnancy against the woman’s will in this circumstance amounts to CIDT, but even the option of travelling can be very painful. Indeed, women carrying foetuses with fatal abnormalities experience during the journey a “deep sense of feeling abandoned”<sup>403</sup> by the Irish State in an extremely difficult time, when a much wanted pregnancy results in a non-viable life. As testified by a woman of the TFMR group, “it made an already traumatic situation infinitely worse [...] we fall into a category that the Irish State chooses to ignore and, worse, to stigmatise”<sup>404</sup>. Leaving the country feeling “like criminals”<sup>405</sup>, without the family support in a foreign country, once the operation is done women “have to leave the foetus’ remains behind and may receive the ashes by commercial courier”<sup>406</sup>. This undermines “women’s ability to mourn the loss of their pregnancy”<sup>407</sup> and causes extreme pain and mental suffering and anguish.

The Centre For Reproductive Rights (CFRR) presented before the HRC in 2013<sup>408</sup> and 2014<sup>409</sup> two individual complaints on behalf of two Irish women in this situation.

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<sup>400</sup> See Irish Government declarations on the interpretation of the term “unborn” in *D v Ireland*, Chapter 2. See also IHRC, 2013, p.46.

<sup>401</sup> See <<http://www.terminationformedicalreasons.com/homepage-featured/personal-stories/>> (consulted on 29 June 2014).

<sup>402</sup> HRW, 2010, p.28.

<sup>403</sup> CFRR, 2014, p.12.

<sup>404</sup> Ruth Bowie, in *ibidem*, p.13.

<sup>405</sup> Amanda Mellet, in *ibidem*, p.15.

<sup>406</sup> *Idem*.

<sup>407</sup> *Idem*.

<sup>408</sup> Case presented on behalf of Amanda Mellet the 13 November 2013, see <<http://reproductiverights.org/en/press-room/irish-woman-forced-to-travel-abroad-for-abortion-brings-case-to-united-nations>> (consulted on 29 June 2014).

<sup>409</sup> Case presented on behalf of Siobán Whelan the 13 March 2014, see <<http://reproductiverights.org/en/press-room/CRR-brings-second-Ireland-case>> (consulted on 29 June 2014).

It is also likely that, regardless the ground on which women seek an abortion, the psychological, physical, financial and social burden of travelling -recognised also in the *ABC judgement*<sup>410</sup>- alone “could have potentially the cumulative effect of reaching the threshold of CIDT”<sup>411</sup>.

#### **4.3.6. Right to privacy and family life**

States’ regulations on women’s body and reproductive functions represent an intrusion in the most intimate sphere of their life. Indeed, the right to privacy, as interpreted by the ECtHR through its jurisprudence on Article 8, is a broadly-encompassing right, including, among other features, personal autonomy, physical and psychological integrity and the decision on one’s own sexual and reproductive life<sup>412</sup>. A pregnant woman’s right to privacy should entitle her “to decide whether or not to undergo an abortion without undue government interference”<sup>413</sup>. The legal requirement of continuing with an unwanted pregnancy, therefore, “arguably constitutes a government’s intrusion upon a woman’s body in violation of this right”<sup>414</sup>.

In the light of the aforementioned, the PLDPA, and particularly some provisions, raise some issues. First, generally speaking, extremely restrictive abortion legislation - such as the Irish one- inevitably interferes more with women’s right to privacy and personal autonomy, as well as with their ability to decide about family life. In fact, it narrows the lawful requests for abortion to very specific and rare cases, denying access to the procedure to the almost totality of women living in Ireland.

Second, even the option to travel abroad for all the women excluded by the Act still interferes with their right to privacy and family life. On the one hand, indeed, one woman every two hours leaves her home to receive a treatment in a foreign country, within an unfamiliar environment and mostly without the support of the family in a

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<sup>410</sup> *ABC v Ireland* (EctHR, 2010), paras.126-128.

<sup>411</sup> ICCL, 2014, p.119.

<sup>412</sup> Weinstein, 2012.

<sup>413</sup> HRW, 2005, p.16.

<sup>414</sup> *Ibidem*, p.15.

moment of need<sup>415</sup>. Forcing thousands of women every year to live such situations represents a huge interference in their family lives. On the other hand, for the women carrying foetuses with fatal abnormalities, the aforementioned impossibility to mourn the loss and the necessity to leave its remains behind add a further privacy and family life violation to the difficulty of the journey.

Third, as already explained, the review procedure to assess suicidal women's entitlement to a lawful abortion, which involves four psychiatrists and two obstetricians, is deemed to be very intrusive and might violate the psychological integrity of already extremely fragile and vulnerable women.

#### **4.3.7. Right to reproductive self-determination**

As aforementioned, linked with the right to privacy there is the right to control over one's own body and its reproductive functions. On this regard, the CEDAW recognises women the right to "decide freely and responsibly on the number and spacing of their children"<sup>416</sup>. This right is further recalled in consensus documents such as the Cairo and Beijing Declarations, included in the field of the "reproductive rights"<sup>417</sup>. In its GR 21<sup>418</sup>, the CEDAW Committee explains the origins and importance of this right to women: the child-bearing and raising puts a disproportionate responsibility on women and shapes their lives, access to education, employment and, in general, their personal development. Therefore, in order to be empowered in several aspects of their existences, it is paramount that women are able to have the size of family they desire. "For these reasons, women are entitled to decide on the number and spacing of their children"<sup>419</sup>.

Although abortion is in several international instruments explicitly excluded from the family planning services<sup>420</sup>, it is however widely recognised by the treaty bodies that in certain circumstances, when external negative factors occur making the pregnancy

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<sup>415</sup> As Amanda Mellet said describing her emotions after the abortion: "I would have wished for nothing more than to curl up in my own bed at home with my family nearby to support" (CFRR, 2014, p.17).

<sup>416</sup> UN, CEDAW, 1979, Article 16(1)(e).

<sup>417</sup> ICPD Cairo Report, para.7.3; FWCW Beijing Report, paras.95 and 223.

<sup>418</sup> CEDAW, GR21, A/49/38, 1994.

<sup>419</sup> Ibidem, para.21.

<sup>420</sup> See, for example: ICPD Cairo Report, para.8.25; FWCW Beijing Report, para.106(k).



unwanted –its criminal origin, its non-viable outcome, or the health or life-threatening consequences it might have-, abortion is the last resort to safeguard the pregnant woman’s rights<sup>421</sup>. It gives women facing difficult situations the opportunity to make a choice in their best interest. Indeed, since the choice to have an abortion represents an extremely personal and generally suffered decision, it is well-established at international level that women should be recognised the adequate agency of subjects having control on their own body, without Governments ruling on it<sup>422</sup>.

The PLDPA, by establishing the barely minimum ground of risk of life as the only occasion in which women have the legal option to choose over their bodies regarding a termination of their pregnancies -regardless other different cases of emergency that could lead them to make that choice- clearly violates the women’s right of reproductive self-determination.

#### **4.3.8. Right to be free from discrimination**

There are two degrees on which the legislation under examination does not respect this right. The first, at the general level of the population as a whole, regards the relations between men and women. The second level concerns a further differentiation originating from the effects that the PLDPA produces within the female population living in Ireland.

##### **4.3.8.1. Discrimination against women**

As the CEDAW Committee openly affirms in its GR 24, “it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women”<sup>423</sup>. Abortion is clearly one of those services, therefore “restrictive abortion laws and practices are gender discriminatory”<sup>424</sup>. In order to respect

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<sup>421</sup> HRW, 2005, p.19.

<sup>422</sup> See UN SR Health, Presentation.

<sup>423</sup> CEDAW Committee, GR24, para.11.

<sup>424</sup> AI-Ireland, 2013, p.4.

and protect the women's right to substantive equality with men -since there is no widely prohibited masculine healthcare service-, abortion should be made available at least in the grounds of necessity<sup>425</sup>. In terms of *de facto* gender equality, indeed, prohibitive regulations on abortion, such as the PLDPA, have a gender discriminating effect in their practical effects. "Forcing a woman to bear the burden of an unwanted pregnancy [...] imposes a heavy burden on women, severely restricting their lives. Men are not similarly affected"<sup>426</sup>.

Furthermore, such restrictive abortion legislation, result of the catholic legacy in the national morality, fosters "stereotypical notions of womanhood as motherhood and cultural understandings that motherhood is the natural and only pathway that pregnant women may want to follow"<sup>427</sup>. This is part of what is called in Article 5 of the CEDAW "social and cultural patterns" that have the effect of undermining gender equality. According to the CEDAW, however, even acknowledging the different cultural beliefs and peculiarities characterising every State, they cannot constitute an excuse exempting them from respecting the principle of non-discrimination between genders. Therefore, in the same article, the Convention requires the States, among other measures, to modify the patterns leading to *de facto* discrimination and eliminate practices based on stereotyped roles<sup>428</sup>.

Furthermore, the absence of gender equality, due to legislations largely prohibiting women the freedom to choose over their own bodies, can have repercussions on the social status of women as second-class citizens compared to men<sup>429</sup>. Indeed, being the right to equal participation in the decision-making one of the main features of citizenship, for women with crisis pregnancies this can be undermined by the governmental obligation of giving away their decisional power over their bodies to comply with their reproductive functions anyway<sup>430</sup>. It could also affect their human

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<sup>425</sup> HRW, 2005, p.13.

<sup>426</sup> Kirilova Eriksson, 1999, p.277.

<sup>427</sup> IFPA, 2011, p.4. See also Article 41.2 of the Irish Constitution.

<sup>428</sup> UN, CEDAW, 1979, Article 5(a). See also Article 2(f).

<sup>429</sup> Cook, Dickens, 2003, p.43.

<sup>430</sup> Idem.

dignity, which “implies that human beings are to be treated as ends in themselves and not as mere means to an end”<sup>431</sup>.

#### **4.3.8.2. Neglected vulnerable categories of women**

The second level on which equality is undermined directly derives from the use of the homogeneous concept of “woman” throughout the Act. Indeed, it targets an abstract female typology, not at all adherent to the much more complex reality. As a consequence, the PLDPA only addresses a superficial and formal equality without aiming to reach a substantive one. Indeed, the absence within the Act of a ‘difference approach’<sup>432</sup>, which should consider separately all the structural disadvantages rooted in the unequal conditions within the female population and try to solve them, creates further indirect discrimination<sup>433</sup>.

In the Irish case, several vulnerable categories of women are neglected by the State regarding the accessibility of the constitutional right to travel abroad to have a safe and legal termination. As aforementioned, this critical situation already raised concerns within the past treaty bodies’ periodic reviews on Ireland, in absence of a legislation on abortion. However, the adoption of the PLDPA does not seem to have filled the gap.

Indeed, the restriction of abortion included in the 2013 Act disproportionately impacts on some vulnerable categories, for their impossibility to bypass it by travelling abroad. Indeed, although in theory all women are equally entitled to the right to travel, there are practical obstacles for some groups preventing them from enjoying this right.

The first barrier for the accessibility to this option is the financial one. Indeed, the total cost of the journey includes several factors: the operation fee -which grows as the pregnancy progressively advances-, the direct costs of flight and accommodation, and the possible further indirect costs of childcare, loss of income for the amount of days of

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<sup>431</sup> UN Commission on Human Rights, E/CN.4/Sub.2/40/rev.1, 1949, p.4.

<sup>432</sup> For an in depth discussion on the different typologies of equality, see Byrnes, 2012. The importance of looking at the differences, when discussing equality before the law, is also enshrined in Article 40.1 of the Irish Constitution.

<sup>433</sup> Formally treating everybody as equal, and in the meantime overlooking the different subjects’ peculiar needs, is an indirect way of discriminating.

leave or the additional costs for an accompanying person<sup>434</sup>. According to estimates made by HRW<sup>435</sup> and IFPA<sup>436</sup> based on the fees of BPAS and a personal research on the fees charged by the Marie Stopes International clinics in the UK<sup>437</sup>, the total amount of money necessary for the trip goes between 1000 and 2000 euros, depending on the combination of the aforementioned factors. As HRW points out, even just considering the lowest option, “for someone living under the poverty line, the cost of an abortion could easily represent more than a month salary”<sup>438</sup>. Several women need time to earn or collect the money, further delaying the operation -whose price in the meantime increases-, and others are forced to borrow loans to afford the situation<sup>439</sup>.

Furthermore, besides this general economic concern, there are some groups which have legal restrictions to travel, such as women in state of custody, minors, undocumented migrant women and asylum seekers. These latter, for instance, have the possibility to leave, but would need to get a visa and emergency temporary travel documents, with additional costs for women receiving only an allowance of less than 20 euros per week<sup>440</sup>. However, regardless any other obstacle, the asylum-seekers generally “fear the consequences of seeking permission to leave the country to have an abortion”<sup>441</sup> on their possible future status.

Moreover, even health conditions can be factors undermining the possibility to travel, for example regarding women whose health is severely at risk, but not yet life-threatening, or disabled women, both mentally and physically. For them, the journey could be a non-feasible option.

Therefore, one could affirm that the opportunity to access a safe and legal abortion abroad is more a privilege than a right, or, in other words, “the right exists if you can afford it”<sup>442</sup>. The consequence of this difficult accessibility is that these vulnerable women are normally forced either to continue their unwanted pregnancies, or to turn to

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<sup>434</sup> In case of a minor or a disabled woman, or just for any woman not to go alone.

<sup>435</sup> HRW, 2010, p.31.

<sup>436</sup> IFPA, 2013, p.4.

<sup>437</sup> See <[http://www.mariestopes.org.uk/Fees/Womens\\_services/Abortion.aspx](http://www.mariestopes.org.uk/Fees/Womens_services/Abortion.aspx)> (consulted on 1 July 2014).

<sup>438</sup> HRW, 2010, p.31.

<sup>439</sup> *Idem*.

<sup>440</sup> *Ibidem*, p.32.

<sup>441</sup> *Idem*.

<sup>442</sup> Interview with Kelly Mackey, A-I Ireland, Dublin, 14 May 2014.

backstreet clandestine abortion, or to self-induce it without medical supervision through illegal abortifacient tablets bought over the internet<sup>443</sup>. As aforementioned, usually women undergoing illegal abortions are not likely to seek any post-abortion healthcare in case of complications, for fear of prosecution. This could possibly put their health and lives at risk.

#### **4.3.9. Criminalisation and human rights**

The moral values of a State inevitably shape its legal framework. Therefore the strong influence of the Catholic ethos, historically pervasive in the Irish institutions and in part of the society, has always modelled the approach towards abortion, leading to its almost total legislative ban<sup>444</sup>. Moreover, the religious and moral perception of this practice as a sin, when coming to transform these values into legislation, pushed it into the criminal sphere<sup>445</sup>.

Nevertheless, with due respect to the moral values underneath, the call for decriminalisation of abortion is unanimous from all the international and regional HR instruments and institutions, without exceptions. In fact, it is widely recognised that considering illegal abortion as an offence exacerbates the violation of all the aforementioned women's HR<sup>446</sup>.

The first call arrived in 1995 from the Beijing Platform for Action, stating that States should “consider reviewing laws containing punitive measures against women who have undergone illegal abortions”<sup>447</sup>. Afterwards, in its GR 24 of 1999, the CEDAW Committee used almost the same wording<sup>448</sup>. Besides, also the HRC<sup>449</sup>, CESCR

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<sup>443</sup> HRW, 2010, p.38. In its CO-Argentina, the HRC expressed concern “over discriminatory aspects of the laws and policies in force, which result in disproportionate resort to illegal, unsafe abortions by poor and rural women” (CCPR/CO.70/ARG, 2000).

<sup>444</sup> See Chapter 2.

<sup>445</sup> Indeed, the Can.1398 of the Code of Canon Law (1983), in the Book VI (“Sanctions”), Part II (“Penalties for particular offences”), Title VI (“Offences against human life and liberty”), explicitly states: “A person who procures a completed abortion incurs a *latae sententiae* excommunication”.

<sup>446</sup> AI-Ireland, 2013, p.7.

<sup>447</sup> FWCW Beijing Report, para.106(k).

<sup>448</sup> A/54/38/Rev.1, 5 February 1999, para.31(c).

<sup>449</sup> Among others: “The criminalization of all abortion, with the severe penalties imposed by the legislation in force except where the mother's life is in danger, gives rise to serious problems” (CO-Guatemala, CCPR/CO/72/GTM, 27 August 2001, para.19).

Committee<sup>450</sup> and recently the CAT Committee<sup>451</sup> expressed the same concerns and view in several COs of countries' periodic reviews. Furthermore, in 2011, the UN SR on the Right to Health issued an Interim Report specifically on the impact of criminalisation on sexual and reproductive health, including abortion. In this very comprehensive document, he states that "criminal laws penalising and restricting induced abortion [...] must be eliminated [since they] infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health"<sup>452</sup>. In his opinion, criminal provisions on abortion objectify women and are antithetical to their empowerment<sup>453</sup>.

Therefore, the re-introduction in the PLDPA of the criminalisation aspect, after the repeal of Sections 58 and 59 of the OAPA of 1861, is not only "out of sync with current international norms"<sup>454</sup>, but also "inconsistent with the Irish obligations under the ECHR"<sup>455</sup>. In fact, one of the main flaws of the Irish legal framework stressed in the *ABC judgement* was the chilling effect produced by the criminalisation of unlawful abortion, which has its repercussions also on the performance of lawful services<sup>456</sup>. This fosters the stigmatisation of the practice, therefore promoting a climate of fear, shame and secrecy<sup>457</sup>. It affects the dignity, self-esteem and self-confidence of women, even when they are taking a lawful pathway to have an abortion<sup>458</sup>.

Besides, considered jointly with the possibility to travel, the criminal provisions within the PLDPA produce a further serious discriminatory effect. Indeed, they create a criminal differentiation between the innocence of those women who can afford to travel and the guilt of the poorest and most marginalised and vulnerable ones, who on the

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<sup>450</sup> Among others: "The Committee notes with concern that [...] the only cases in which an abortion is not an offence is when it is performed because the mother's life or health is endangered or when a woman with mental or psychosocial disabilities has been raped" (CO-Ecuador, E/C.12/ECU/CO/3, 13 December 2012, para.29).

<sup>451</sup> For example: "Sometimes the delivery of post-illegal abortion care is subjected to the confession of doctors who performed illegal abortion. Criminalisation of abortion may lead to situations incompatible with the freedom from torture" (CO-Chile, CAT/C/CR/32/5, 14 June 2004, para.6(j)).

<sup>452</sup> UN SR Health, 2011, para.21

<sup>453</sup> UN SR Health, Presentation.

<sup>454</sup> GPC, 2013, p.8.

<sup>455</sup> IFPA, 2013(b), p.9.

<sup>456</sup> *ABC v Ireland* (ECtHR, 2010), para.254.

<sup>457</sup> See UN SR Health, Presentation.

<sup>458</sup> See *supra* women's testimonies of feeling like criminals while travelling (CFRR, 2014, p.12).

other hand are forced by the circumstances to consider having an unlawful clandestine abortion as a last desperate resort<sup>459</sup>.

In the light of all the aforementioned recommendations on the violations produced by restrictive and criminalising abortion laws, the UN SR for the Right to Health rhetorically asks: “Is public morality a legitimate justification?”<sup>460</sup>

#### **4.3.10. Right to freedom of thought, conscience and religion**

The important question of the Irish morality in relation to the protection of the life of the “unborn” has been taken into great consideration by the ECtHR while substantially upholding the national abortion framework in the *ABC case*, giving a wide margin of appreciation for the cases of applicants A and B. Indeed, up until now, according to the jurisprudence of the Strasbourg Court, reproductive rights, and specifically abortion legislations, fall within the scope of the national sovereignty and its specific moral values, as long as there is no inconsistency between law and practice.

As stated before, the issue of abortion in Ireland has been the core of harsh and passionate debates for the last thirty years, since it deeply touches the traditional religious values that have characterised the country during centuries, due to the huge political and social power exercised by the Irish Catholic Church even before the foundation of the current State<sup>461</sup>.

As it is well-known, the freedom of thought, conscience and religion represents one of the fundamental HR enshrined in the CCPR (Article 18) and in the ECHR (Article 9), as well as being included in the Irish Constitution (Article 44.2(1)). However, with due respect for this crucial right, some comments have to be made.

First, according to the cited HR instruments themselves, this right is not absolute, but can be subjected to limitations including protection of public health and freedoms and rights of others<sup>462</sup>. On this regard, on the one hand, unsafe abortions and related increasing maternal mortality and morbidity have been recognised as a “major public

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<sup>459</sup> GPC, 2013, p.3.

<sup>460</sup> UN SR Health, Presentation.

<sup>461</sup> See Chapter 2.

<sup>462</sup> CCPR, Article 18(3); ECHR, Article 9(2).

health concern”<sup>463</sup>. On the other hand, the range of women’s rights violated by extremely restrictive abortion laws such as the PLDPA<sup>464</sup>, analysed throughout the present chapter, could represent a valid limitation to the freedom of religion<sup>465</sup>, mostly when dealing with breaches of peremptory norms such as the freedom from CIDT in the cases of rape and fatal foetal abnormality.

Second, as already stated, the CEDAW foresees cases where States have the duty to modify traditions and customs that might violate women’s rights by perpetuating gender stereotypes<sup>466</sup>. Considering the “traditional attitudes toward the restricted role of women in public life, in society and in the family”<sup>467</sup> promoted by the Constitution and its repercussions on the Irish abortion legislation, it could be argued that this is one of those cases under the CEDAW recommendations.

Third, the right to freedom of religion pertains not only to the health professionals, but also to the women of diverse religious conscience being denied an abortion on the ground of others’ religious and moral beliefs<sup>468</sup>. This did happen in the case of Savita, who is a -neither Irish nor Catholic<sup>469</sup>- victim of the imposition on her life of a different moral and ethical perspective. On this regards, DFC calls for a “secularisation” of the Irish State and its health system, since “orthodox religious views of certain sections within society should not affect the health of others that do not share such views”<sup>470</sup>.

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<sup>463</sup> ICPD Cairo Report, para.8.25.

<sup>464</sup> “Religion actually harms women every day, their physical and mental health, and it doesn’t help women’s agency, autonomy and their bodily integrity” (Interview with Richie Keane, DFC, Dublin, 7 April 2014).

<sup>465</sup> The CEDAW Committee has frequently expressed its concerns for the high incidence of conscientious objection for religious beliefs which impedes the practical accessibility of abortion to women (see CO-Italy, A/52/38.Rev.1, Part II, 12 August 1997, para.353).

<sup>466</sup> Article 5(a).

<sup>467</sup> HRC, CO-Ireland, CCPR/C/IRL/CO/3, 30 July 2008, para.10.

<sup>468</sup> See Constitution of Ireland, Article 44.2(3).

<sup>469</sup> See Canon of Law, 1983, Can.1398.

<sup>470</sup> DFC, 2013(b), p.12.



#### **4.4. Ireland under examination: HRC Fourth Periodic Review, July 2014**

As part of the monitoring process on the State's compliance under the CCPR, on 14 and 15 July 2014 Ireland will appear before the HRC in Geneva for the oral hearings of its Fourth Periodic Review. It represents the first UN HR treaty body review since the adoption of the PLDPA 2013<sup>471</sup> and is a very important appointment, since the CCPR enshrines the most part of the aforementioned HR which are possibly violated by the Act.

The written phase of the review process started two years ago, in July 2012, when Ireland submitted its 'Fourth Periodic Report'<sup>472</sup>. Afterwards, in September 2013 a 'Joint Civil Society Shadow Report' was submitted, with Section 7 dedicated to "Women's reproductive rights"<sup>473</sup>, analysing Ireland's compliance with Articles 2, 3, 6, 7, 26 of the CCPR. The adoption of the PLDPA is listed among the positive steps taken by the Irish Government, however some issues are brought to the attention of the Committee: the criminalisation, the possible breaches of the right of freedom from CIDT when abortion is denied in cases of pregnancies resulting from crime and situations of fatal foetal abnormalities, and the multiple burden of travelling abroad.

In November 2013, after taking vision of both the Reports, the HRC published a 'List of Issues'<sup>474</sup> for further clarification. Paragraph 12 on the "right to life" includes four points questioning the Irish Government on the PLDPA: a) in which way the Act is in compliance with Articles 6 and 7 and with the last HRC CO of 2008; b) whether concrete measures are being taken to clarify what "substantial risk of life" exactly means; c) whether the State has further intention to broaden the scope of the legalisation of abortion, in compliance with CCPR on the grounds of health, rape, fatal foetal abnormalities and in general non-viable fetuses<sup>475</sup>; d) in which circumstances may the

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<sup>471</sup> In a few years, also the CAT Committee will examine the 2013 Act, and from the List of issues prior to the submission of the Report, the line of the Committee questioning on the issue can already be defined (CAT/C/IRL/Q/2, 16 December 2013).

<sup>472</sup> CCPR/C/IRL/4, 25 July 2012. Since it was issued one year before the PLDPA was adopted, the present analysis will not include this report.

<sup>473</sup> ICCL, 2014, pp.116-120.

<sup>474</sup> CCPR/C/IRL/Q/4, 22 November 2013.

<sup>475</sup> Probably this wording, added to the foetal genetic abnormalities, tries to encompass all non-viable pregnancies, also due to possible complications or inevitable miscarriages.

Director of Public Prosecutions (DPP) authorise a criminal prosecution and towards whom. As it may be noticed, these are very specific and punctual questions that directly point the major flaws of the PLDPA emerged throughout the present work.

In February 2014, the Irish Government replied<sup>476</sup>. It substantially did not provide any clarification to the first and fourth questions, while, concerning the second, it referred to the soon-coming Guidelines. Furthermore, the Irish Government clearly expressed no will to amend Article 40.3.3 of the Constitution to broaden the grounds of lawful abortion.

The great amount of submissions from the CSOs<sup>477</sup> in June in response to the State's reply substantially highlights what deeply analysed and discussed in the present work. Now, the judgement is in the hands of the HRC Members, who will issue their Concluding Observations at the end of the 111<sup>th</sup> Session, on the upcoming 23 July.

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<sup>476</sup> CCPR/C/IRL/Q/4/Add.1, 27 February 2014.

<sup>477</sup> Among others: ICCL, 2014, pp.13-45; ARC, 2014; DFC, 2014; IFPA, 2014; IHRC, 2014, pp.34-37.

## 5.

### Conclusions

A thirty-year legal, political and social process was necessary in Ireland to achieve the approval of the current legislation on abortion. After the introduction in 1983 of the Eighth Amendment of the Constitution, equating the lives of the foetus and the pregnant woman, all the subsequent interpretations of this constitutional provision have been inscribed in a legal framework where abortion was deemed lawful only in cases of risk of life of the woman, included in situations of threatened suicide, as ruled in the *X case* of 1992. Nevertheless, no legislation on the issue was in place, leading to legal uncertainty, both for medical practitioners and for women. The fear of life-imprisonment established in the 1861 Act to punish people involved in illegal abortions played also a major role in the already complex Irish scenario. A condemnation in 2010 by the Strasbourg Court of this untenable situation finally triggered the legislative process, which was further accelerated by Savita Halappanavar's death.

After prolonged parliamentary hearings and debates about the different lawful grounds to include in the legislation allowing abortion, the PLDPA was signed into law in July 2013. In the end, it represents an extremely restrictive legislation, substantially just regulating the already existing situation, without taking any step further. The analysis pointed out, among the provisions raising major concerns, the uncertain interpretation of the term "unborn" leading to several practical problems, the invasive and discriminatory procedure of assessment for women at risk of suicide, the difficult accessibility of both assessment and review procedures and the criminalisation aspect.

Furthermore, from a IHRL perspective, all international and regional bodies have clearly stated on various occasions that women should have access to safe and legal abortion when their life and health are at risk, their pregnancies are resulting from rape or incest, or in cases of fatal foetal abnormalities. They also affirmed that abortion must in no circumstance be criminalised. It appears, thus, evident that the PLDPA "falls well

short of international human rights standards on women's reproductive rights"<sup>478</sup>. Furthermore, it does not even comply with the ECtHR requirements, since the rules of assessment of risk of life are not yet in place for the absence of clinical guidelines, abortion has not been decriminalised to avoid the chilling effect, and the review procedure does not meet all the qualifications requested.

To sum up, the major positive outcome of the PLDPA is that legislation is in place in Ireland that finally fills a thirty-year-lasting gap. In this sense, the generalised welcome to the Act coming from the civil society is unanimous. Furthermore, it helped to raise again the debate on the topic, bringing it to the attention of the entire country and contributing to further break the taboo<sup>479</sup>. Moreover, talking about the text of the Act, two specific provisions will have important positive effects in the future: the situations of emergency for the pregnant woman's life will be dealt with in a very rapid, efficient and clear way, and an official annual report on the exact number of legal abortions carried out in Ireland will be finally available<sup>480</sup>.

On the other hand, the intensity of the debate created during the last years for the approval of the PLDPA could leave the impression that Ireland dealt with the issue of abortion, from now on not needing any further discussion. On the contrary, an Act that legislated in 2013 for standards set twenty-one years beforehand, without taking into account the evolving circumstances and the new criteria set at regional and international levels, is very likely to cause to Ireland further criticisms, which will inevitably re-open the controversy. Indeed, "guaranteeing access to abortion services that have been legal (but inaccessible) in Ireland for decades is, while positive, clearly an insufficient step"<sup>481</sup>. Therefore, the approval of such restrictive legislation on abortion constitutes a missed "opportunity for Ireland to move beyond the bare minimum requirement to implement the judgment in A, B and C"<sup>482</sup>, which in the end is not even met. During the legislative process of drafting the law, there has been a collective call for the Irish Government "to look more comprehensively at the situations in which it should provide

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<sup>478</sup> AI-Ireland, 2013(a), p.1.

<sup>479</sup> See interviews with Sinéad Corcoran, ARC, Dublin, 25 April 2014 and members of GPC, Galway, 3 June 2014.

<sup>480</sup> Interview with Maeve Taylor, IFPA, Dublin, 14 May 2014.

<sup>481</sup> AI-Ireland, 2013, p.8.

<sup>482</sup> ICCL, 2013, p.2.

access to safe and legal abortion services, in line with the evolving interpretation of its human rights obligations”<sup>483</sup>. However, this voice remained unheard.

To conclude, some final words on the relation between abortion in Ireland and the constitutional protection of the unborn life are deemed necessary. Indeed any legislation on this issue has to be constitutionally acceptable, thus Article 40.3.3 is the obligated referring point for any action. In this light, on the one hand, firstly focusing on the present Act, the ground of the fatal foetal abnormalities could have been introduced within the current constitutional frame, as the Irish Government itself suggested before the ECtHR in *D v Ireland*. This could prevent further women’s suffering and quite predictable international condemnations, without changing the current legal framework.

On the other hand, secondly focusing on possible future steps, a referendum to amend the Constitution<sup>484</sup> seems to be the most feasible solution to open the doors for a more “progressive and human rights based approach to protect women”<sup>485</sup> and their reproductive rights.

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<sup>483</sup> AI-Ireland, 2013, p.8.

<sup>484</sup> A coalition of CSOs is involved during these months in the launch of a campaign to “Repeal the 8<sup>th</sup> Amendment”. Among them there are DFC, ARC and GPC.

<sup>485</sup> ICCL, 2013, p.2.

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