



NWCI Policy Position Paper on Abortion

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Acknowledgements

In May 2012 the National Women's Council of Ireland established a working group to provide our members and friends with a space and opportunity to develop the work of the NWCI on advancing the right to a safe and legal abortion for women in Ireland. This policy position paper is the result of this group's work and we would like to thank all the members in bringing this paper to completion.

In particular we would like to thank Maeve Taylor of the Irish Family Planning Association and Judy Walsh, Head of Equality Studies Centre, UCD, for their considerable contribution to the paper, to Ann Irwin and Therese Caherty for final edit.

Foreword

The National Women's Council of Ireland (NWCI) is a feminist non-governmental membership organisation of women's groups in Ireland with over 160 member organisations. As the representative organisation of women in Ireland, the NWCI's vision is of an Ireland where all women and men have equal power to shape society and their own lives and the NWCI mission is to achieve women's equality, empowering women to work together to remove structural, political, economic, cultural and affective inequalities.

Abortion is a significant contention in Irish society and one that remains unresolved. The NWCI acknowledges the entrenched social, religious and political views on both sides of the debate. Though recent events have brought abortion back into the public domain, the NWCI has worked on the issue over the last thirty years and the NWCI position on abortion has developed over time in recognition of the diversity and evolution of views in the area.

NWCI members have mandated the NWCI to adopt a pro-choice position on abortion that is rooted in an analysis of gender equality, women's human rights¹ and social inclusion. NWCI members supported a motion brought to the NWCI Annual General Meeting in 2009, which called for development of a policy seeking provision of safe, legal abortion for women in this State. This echoed many previous motions at NWCI AGMs calling for access to abortion services. The current position paper articulates that mandate.

The case of Savita Halappanavar is tragic and has moved the Irish nation. Behind this case are thousands of women living in Ireland who have faced, and continue to face, crisis pregnancies in a jurisdiction that denies them access to a service provided as a right in most developed countries. The number of women who have died or been seriously wounded physically and psychologically as a result is unknown but testimonies in the Irish media since Savita Halappanavar's death suggest there are many. It is time that this stopped. It is time for Irish society, as a true democracy, to make a clear statement that it values women's right to reproductive autonomy and provide for safe and legal abortion in Ireland.

Executive Summary

This position paper articulates the mandate by NWCI members for the NWCI to adopt a pro-choice position on abortion. It sets out this position and examines the current situation in relation to abortion and the law in Ireland, including the report of the Expert Group on the Judgement of A, B and C, as well as current medical practice. It outlines the impact on women who seek abortion outside the jurisdiction and examines abortion in the context of women's Human Rights. Finally it looks at trends in European law and public support for abortion in this country. It concludes with a number of recommendations for policy change.

For the NWCI, gender inequality is an intersection of socio-economic, political and cultural inequalities that significantly affect women's lives. The NWCI views the denial of access to safe and legal abortion in Ireland in this context. For the NWCI, access to safe and legal abortion is indistinguishably linked to human rights values and principles. Failure to provide for safe and legal abortion in Ireland contravenes these rights. Ireland's prohibitive regulation of abortion and the discriminatory nature of its application have been consistently subject to criticism by international human rights monitoring bodies.

While abortion is legal in Ireland where there is a real and substantial risk to the life of the pregnant woman, including the risk of suicide, this right is largely theoretical. Dating from 1861, the Offences Against the Persons Act remains the basis of criminal law on abortion in Ireland. It criminalises women who procure a miscarriage and anybody who assists them, resulting in the 'chilling' effect that this has on women and doctors. In 1983 the Eighth Amendment to the Constitution gave equal rights to the mother and the unborn child. In 1992, in what became known as the X case, the Supreme Court interpreted the article as guaranteeing the right to terminate a pregnancy lawfully and within the State where there is a real and substantial risk to the life, as opposed to the health, of the mother and included the threat of suicide. No legislation has ever been enacted to implement this decision.

In the absence of clear legislation, the medical profession rely on Medical Council Guidelines. These guidelines provide no adequate guidance on what counts as a real and substantial risk to life, as opposed to the health, of the woman. In November 2012, the report of the Expert Group on the Judgment in *A, B and C v Ireland* was published. The report is unambiguous about Ireland's legal obligations and finds the implementation option that would be constitutionally, legally, and procedurally sound to give effect to the judgement of the European Court of Human Rights in the *A, B and C v Ireland* case is a combination of legislation and regulation.

The decision to have an abortion is not one that women take lightly. A pregnancy, planned or unplanned, can become a crisis pregnancy for a range of complex personal, social and economic reasons, including concern for the well-being of other children, diagnosis of serious foetal abnormality, financial worries, pre-existing health problems, including mental health problems, and relationship issues. Over 4,200 women in Ireland travel abroad to access abortion services every year. For all of them, the stress involved in deciding to have an abortion is exacerbated by having to travel to another country to access abortion services, by the expense involved, by feelings of fear and stigma, by secrecy, by a sense of isolation or by lack of support. The need to travel abroad to avail of abortion services causes significant financial, emotional, physical and psychological hardship.

The shift in public attitudes to abortion has been significant in the last decade. Opinion polls and research from 2004-2012 consistently show increased support for access within Ireland. The most recent found that significant majorities were in favour of abortion in Ireland.

The NWCI recommendations for policy changes are:

1. Immediate repeal of the provisions of the Offences Against the Person Act 1861 in relation to abortion.
2. Immediate legislation to implement the Supreme Court ruling in the *X Case* and the judgment of the European Court of Human Rights in the *A, B and C v Ireland* case. This legislation should include:
 - i. Criteria and procedures that allow for a practical assessment by doctors and women of a 'real and substantial risk' to the life of the pregnant woman including risk of suicide;
 - ii. A framework to examine/resolve differences of opinion between a woman and her doctor or doctors;
 - iii. A duty of care on health service providers to ensure that women receive appropriate information and care, including post-abortion care.
3. Promptly initiate the constitutional reform and enact the legislative changes necessary to introduce safe and legal abortion in Ireland.

NWCI Position: Achieving Gender Equality – The Importance of Reproductive Rights

Women are generally more likely to experience infringements of their right to sexual and reproductive health given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Persistent stereotyping of women's roles within society and the family establish and fuel societal norms. Many of these norms are based on the belief that the freedom of a woman, especially with regard to her sexual identity, should be curtailed and regulated. The criminal laws and other legal restrictions examined in the present report facilitate and justify state control over woman's life, such as forcing women to continue unwanted or unplanned pregnancies.

***United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2011).*²**

Gender inequality significantly affects women's lives, and cuts across an intersection of socio-economic, political and cultural boundaries. Since the foundation of the National Women's Council of Ireland (NWCI) in 1973, Ireland has made considerable progress on women's equality. Despite this, full gender equality has yet to be achieved. Women in Ireland continue to work fewer hours, earn less and are under-represented in the Oireachtas and in local and regional authorities compared to men³. Women are far less likely to be in the labour force and are almost 25 times more likely to be looking after home/family than men. In 2009, women's income was around 73% of men's. Disposable income for households headed by a male continues to be significantly higher than that of households headed by a female; deprivation and poverty rates are higher for women and for households headed by a woman, compared with men or households headed by a man⁴.

It is in this wider context that women with crisis pregnancies are denied access to safe and legal abortion in Ireland. Abortion is criminalised in almost all circumstances, including when the pregnancy is the result of rape or incest and when the pregnancy has been established as unviable. Women and girls needing abortion services must travel abroad. This imposes significant financial, psychological and physical hardship on them, particularly those with health problems including mental health problems, financial worries, concern about the well-being of other children, or relationship issues. The stress involved in making this decision is compounded by having to travel to another country to access abortion services, by the expense involved, by feelings of fear and stigma, by secrecy, by a sense of isolation or by lack of support. The denial of abortion services further disadvantages vulnerable, marginalised and deprived women and girls who cannot raise the necessary funds to travel abroad, who cannot leave the jurisdiction because of immigration restrictions, or who are in State care.

The NWCI contends that the lack of access to reproductive health care, including abortion, intersects with other structural and systemic forms of discrimination against women and needs to be discussed within the framework of gender inequality. Abortion is too often isolated from issues such as socio-economic inequalities, health inequalities, barriers to active participation and inequality of opportunities and of outcomes—matters which directly affect an individual woman's decision-making process and are inextricably linked to gender equality. The NWCI, therefore, views access to

safe and legal abortion in Ireland in an overall context of gender equality, including the context of human rights and social justice.

For the NWCI, and the women we represent, access to safe and legal abortion is indistinguishably linked to human rights values and principles that protect a woman's right to privacy, her right to bodily integrity, her right to self-determination, her right to be free from inhuman, cruel and degrading treatment and her right to accessible, appropriate and quality health care, as guaranteed by international human rights instruments. Failure to provide for safe and legal abortion in Ireland consistently contravenes these rights.

The NWCI views reproductive health and rights within a social justice framework, highlighting the right to have and not to have children and linking it to other fundamental human rights such as the right to decent housing, the right to access good education, and the right to have access to health care. Ethnicity, culture, social class, income poverty, location, sexual orientation, age, disability and other differences can all contribute to the inequalities in women's lives and impinge on decisions concerning their health and wellbeing.

The reality is that many women in Ireland experience crisis pregnancies. In 2010, according to the Irish Contraception and Crisis Pregnancy Study, one in every seven pregnancies for women in Ireland were crisis pregnancies⁵. Pregnancy can become a crisis due to a range of diverse personal circumstances. These are often located within persistent gender inequalities and intersect with other circumstances in women's lives, including socio-economic status, disability/ability, immigration status, or where lack of government action in certain areas leaves women without a choice.

Women's experience in employment can often influence whether a pregnancy is or becomes a crisis. In a literature review of research on pregnancy and employment carried out for the Crisis Pregnancy Programme,⁶ Russell and Banks (2011) cite studies showing that a crisis pregnancy may not initially be interpreted as such but may become so as circumstances change, including in a woman's employment.⁷ Research cited also suggests that the likelihood of crisis pregnancy is strongly related to work-life balance policies adopted by employers, workplace culture and maternity arrangements.⁸ The authors cite a nationally representative survey of the population, which found 28% of women and 23% of men had experienced a crisis pregnancy. They report that while crisis pregnancies occur among child-bearing women of all ages, women in their early twenties are more likely to experience one. This coincides with the age at which most women enter a critical phase in their employment experience or career. Three per cent cited 'work' and 5% cited 'financial reasons/unemployment' as reasons for the pregnancy becoming a crisis.⁹ The authors also refer to further research suggesting that the absence or presence of flexible working arrangements influences decision-making in crisis pregnancy. In this instance, women assess whether having a child will have a detrimental effect on their career trajectories and assess how they will cope with parenthood in their current education or employment circumstances (Redmond *et al*, 2006).¹⁰

The outcome of crisis pregnancy varies but according to the same Irish Contraception and Crisis Pregnancy Study, 21% of crisis pregnancies and 4% of all pregnancies end in abortion. While the reasons for women deciding abortion is the best option are many and varied, studies have found a link between their employment and the decision to have an abortion.¹¹ In a qualitative study carried out in abortion clinics in the UK, more than one-third of the Irish women who had had an abortion said career and job-related reasons had strongly influenced their decision. The authors report that in deciding to terminate a pregnancy the women were not rejecting motherhood per se, but motherhood in circumstances where they were financially unstable, beginning careers or in education.

Though Ireland permits abortion in very restrictive circumstances, in reality abortion is not available even when women may have a constitutional right to abortion. This is due to the fact that legislation that would clarify the circumstances in which abortion is permissible and which would protect the woman and her doctor(s) is absent. Ireland, therefore, exports its abortion problem and women are forced to travel abroad to obtain one, often when they are ill or have had traumatic news of an unviable pregnancy or in other difficult circumstances. In 2011, at least 4,149 women travelled to the UK for an abortion with an additional number travelling to The Netherlands and other countries.¹² Between 1980 and 2011, at least 152,061 women living in Ireland travelled to England and Wales to access safe abortion services. The statistics are widely accepted to be an underestimation as not all women living in the Republic of Ireland provide their Irish address. Other women who cannot travel because they do not have the money or because their legal status in Ireland prevents them from travelling may be forced to carry an unwanted pregnancy to term or may import abortion pills unlawfully via the internet.

Stigma and the lack of support services in Ireland can add to a woman's distress on her return. It is incorrect and misleading, however, to assume that a woman who has had an abortion will develop psychological distress as a result of her decision. Though some women experience distress, the reason for this is often attributable to an inability to access safe and legal abortion in their own country, and the added stress inherent in this situation.

Highly restrictive abortion laws are not associated with lower abortion rates. As outlined elsewhere in this paper, evidence shows that countries with unrestricted access to early termination of pregnancy do not report higher rates than countries with more restricted access and a comprehensive global study of abortion has concluded that rates are similar in countries where it is legal and those where it is not, suggesting that outlawing the procedure does little to deter women seeking it.

The provision of safe and legal abortion in Ireland would simply provide a service, of which many women are already availing. The effect of providing access to abortion services *in* Ireland enables women to avail of abortion in a way that respects and supports their right to choose.

The NWCi believes that achieving access to safe and legal abortion in Ireland is critical to advancing the position of women in Irish society. Women must be able to make decisions about their own bodies and health care free from coercion, discrimination and threat of violence: this, crucially, includes the decision to carry a pregnancy to term or to seek an abortion and exercise these rights without discrimination.

The effects of recession and consequent austerity must be taken into account. Anecdotally, we know that austerity is having an impact on many women and on their views on pregnancy and crisis pregnancy and their subsequent actions. The Irish Contraception and Crisis Pregnancy Study recommends that crisis pregnancy prevention efforts need to bear in mind the impact of the recession¹³.

Abortion and the Law in Ireland

While abortion is legal in Ireland where there is a real and substantial risk to the life of the pregnant woman, including the risk of suicide, this right is largely theoretical. In its submission to the European Court of Human Rights in 2011, for example, the government was unable to point to a single lawful abortion carried out in the State.¹⁴

Irish law does not permit abortion in cases where a woman is pregnant as a result of rape; where carrying the pregnancy to term puts the physical or mental health or wellbeing of the woman in danger; where the foetus has a severe abnormality incompatible with life outside of the womb; or where a woman has particular difficulties in travelling outside the State (e.g. the case of asylum seekers).

The Offences Against the Persons Act (1861) remains the basis of criminal law on abortion in Ireland. It criminalises women who 'procure a miscarriage' and those who assist them, e.g. a doctor, imposing a maximum penalty of life imprisonment in both cases.¹⁵ Healthcare workers and others who provide drugs or other instruments to assist with an unlawful abortion are subject to imprisonment for three years.¹⁶ The legislation also imposes strict constraints on the provision of abortion-related information making it a crime for anyone to knowingly supply the means to 'procure a miscarriage'.¹⁷ The European Court of Human Rights has found this Act to have a 'chilling effect'¹⁸, which refers to women and doctors fearing prosecution and the influence this has on their decisions.

In 1983, a referendum on the Eighth Amendment to the Constitution to insert Article 40.3.3 was passed. It gave equal rights to the mother and the unborn. It states: 'The State acknowledges the right to life of the unborn and, with due regard to the equal right of the life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.' To date, no legislation has been enacted to give effect to Article 40.3.3, a fact consistently criticised by the Irish courts.

In 1992, in what became known as the X case, the Attorney General was granted an injunction to prevent a 14-year-old girl pregnant as a result of rape from seeking an abortion abroad. This injunction was appealed to the Supreme Court, whose interpretation of Article 40.3.3 held that the Constitution guarantees the right to terminate a pregnancy lawfully and within the State where there is a real and substantial risk to her life (as distinct from her health) which can only be averted by terminating the pregnancy. It stated that risk of suicide may constitute a real and substantial risk to life.¹⁹

In a subsequent referendum, three amendments to the Constitution were considered:

- The Twelfth Amendment proposed that the prohibition on abortions would apply even in cases where the pregnant woman was suicidal. This was rejected.
- The Thirteenth Amendment proposed that the prohibition on abortion would not limit the freedom of pregnant women to travel out of the state. This was passed.
- The Fourteenth Amendment proposed that the prohibition of abortion would not limit the right to distribute information about abortion services in foreign countries. This was passed.

No legislation was subsequently enacted to implement the Supreme Court judgment despite the finding in the X case that this failure to clarify the circumstances in which lawful abortion was possible was 'inexcusable'.²⁰ Without such legislation, women and their doctors have no guidance on the law and run a risk of criminal conviction and imprisonment should a decision taken in a medical consultation be found not to accord with Article 40.3.3. To avoid the criminal law, women have no

option but to travel to another jurisdiction to seek abortion, even in cases where it is lawful in Ireland.

A, B and C v Ireland

In 2009, three women, known as A, B and C, challenged Ireland's restrictive abortion laws at the European Court of Human Rights. Applicant A had children in the care of the State as a result of personal problems and considered a further child would jeopardise the successful reunification of her existing family. Applicant B was not prepared to become a parent. Applicant C was in remission from cancer when she became pregnant. Unaware that she was pregnant she underwent a series of check-ups contraindicated during pregnancy. Upon learning she was pregnant, she was unable to find a doctor willing to make a determination as to whether her life would be at risk if she continued with the pregnancy or how the foetus might have been affected by the tests she had undergone.

On December 16, 2010, the Grand Chamber of the Court unanimously held that Ireland's failure to give effect to Applicant C's constitutionally guaranteed right to abortion in the case of a life-threatening pregnancy constituted a violation of Article 8 of the European Convention on Human Rights.

The Court considered that the uncertainty generated by the lack of legislative implementation of Article 40.3.3, and more particularly by the lack of effective and accessible procedures to establish a right to an abortion under that provision, has resulted in a striking discordance between the theoretical right to a lawful abortion in Ireland and the reality of its practical implementation.

Regarding the two other applicants, the Court found that Irish laws prohibiting Applicants A and B from terminating their pregnancies in Ireland for health and wellbeing reasons interfered with their right to respect for their private lives. While recognising the serious physical, financial and psychological impacts of travelling abroad for abortion services, the Court, by a majority vote of eleven votes to six, held that because Applicants A and B could lawfully travel to England for an abortion and access pre- and post-abortion information and medical care in Ireland, there was no violation of Article 8.²¹

In 2010, the European Court of Human Rights ruling in the case of *A, B and C v Ireland* that Ireland's failure to implement the existing constitutional right to a lawful abortion in the case of C when a woman's life is at risk violates Article 8 of the European Convention on Human Rights (ECHR). The Court found that:

1. No criteria had been laid down in law by which a 'real and substantial' risk to a woman's life could be measured.
2. There was no framework in place to resolve any difference of opinion between a woman and her doctor or between doctors.
3. The serious criminal penalties for having or assisting in an unlawful abortion would constitute a significant 'chilling factor' for women and their doctors, regardless of whether prosecutions have been pursued under the 1861 Offences Against the Person Act.

As a signatory to the European Convention on Human Rights, Ireland is obliged to implement the court's judgement. In January 2012, the Government established an expert group to recommend a series of options on how to do this. The final report was presented in November 2012.

Report of the Expert Group on the Judgment in *A, B and C v Ireland*

In November 2012, the report of the Expert Group on the Judgment in *A, B and C v Ireland* was published. Its terms of reference were:

1. To examine the judgement in *A, B and C v Ireland* of the European Court of Human Rights.
2. To elucidate its implications for the provision of health care services to pregnant women in Ireland.
3. To recommend a series of options on how to implement the judgement taking into account the constitutional, legal, medical, and ethical considerations involved in the formulation of public policy in this area and the over-riding need for speedy action.

The report states that the general principles necessary for implementation of the European Court of Human Rights judgement begin with an acknowledgement that a constitutional right exists as identified and explained in the *X case* judgment of the Supreme Court.

The report does not present options that would allow termination of pregnancy in circumstances that fall outside the limited constitutional right. Nor does it propose options that would be more restrictive than existing case law allows. The options outlined in the expert group's report address only the small but significant number of cases that arise each year where pregnancy presents a risk to the life of the pregnant woman, with a view to ensuring that all necessary medical treatment can be carried out within the law in these cases.

The report is grounded in four principles that govern all the options discussed and seek to strike the appropriate balance between a woman's right to a termination where her life is at risk and the constitutional obligation to protect and vindicate as far as practicable the life of the unborn:

1. The entitlement to have **the right to lawful termination of pregnancy** ascertained should be established.
2. The State's constitutional **obligations under Article 40.3.3°** should be reflected in the options proposed to implement this judgement.
3. Termination of pregnancy should be considered a medical treatment regardless of whether the **risk to the life of the woman arises on physical or mental health grounds**.
4. It will **always be a matter for the patient to decide** if she wishes to proceed with a termination following a decision that it is clinically appropriate medical treatment.²²

The report is unambiguous about Ireland's legal obligation under the ruling. It quotes the judgement's reference to the 'striking discordance between the theoretical right to lawful abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation'. It states that a legislative or regulatory regime providing effective and accessible procedures whereby pregnant women can establish whether they are entitled to a lawful abortion must be put in place. In addition, it states that it would obviously be insufficient for the State to interpret the court's judgement as requiring only a procedure to establish entitlement to termination without also giving access to such necessary treatment.²³ By necessary implication, this requires access to abortion services in the State.

The report provides a number of non-statutory and statutory options for implementation, including guidelines, regulation, legislation and legislation plus regulation. Although, in its conclusion, the

Expert Group says it was not its function to specify how the judgement should be implemented but rather to provide options, it finds the implementation option that would be constitutionally, legally, and procedurally sound is a combination of legislation and regulation. Primary or amending legislation would regulate access to lawful termination of pregnancy in Ireland in accordance with the *X Case*, the requirements of the European Convention on Human Rights and the judgment in *A, B and C v Ireland*. This legislation would provide for the drafting of regulations to deal with relevant detailed and practical matters such as changing medical practices and scientific advances, as well as addressing emerging challenges to implementation. Most aspects of the provision of lawful termination of pregnancy would be set out in primary legislation, with certain operational matters delegated to the Minister to govern by way of regulation.²⁴

The advantages of this option, according to the report, are that:

- It fulfils the requirements of the judgement.
- It provides for appropriate checks and balances between the powers of the legislature and the executive, and
- It is amenable to changes arising in clinical practice and scientific advances.

Such legislation would update the 1861 Act and remove the chilling effect, since legal protection from prosecution would be assured by compliance with the legislation.

Medical Practice and Abortion

In October 2012, Savita Halappanavar presented at University Hospital Galway 17 weeks into her pregnancy and suffering from severe back pains. Doctors informed her that she was having a miscarriage, and then, over a three-day period, denied her repeated requests to terminate her pregnancy as her condition worsened. According to reports, the doctors told her they couldn't offer her treatment because they could still detect a foetal heartbeat, even though they had told Ms, Halappanavar and her husband that the foetus was not viable. On October 28, just days after the foetal heartbeat stopped, Savita Halappanavar died²⁵.

On November 14th, the circumstances surrounding the death of Savita Halappanavar were reported in the media. Since, the case has drawn extensive international attention and has renewed calls for the Irish Government to legislate for what is a constitutional right to abortion in the case where the life of the mother is in danger. A number of sources have called for legislation to go further and legislate for access to safe and legal abortion in Ireland.

No other country in Europe makes the distinction made in Irish law, which permits abortion to save a woman's life, but not to preserve her health.²⁶ In assessing when an abortion is medically required, this absence of legislation places doctors in a difficult position. The most recent Medical Council Guidelines²⁷ provide information on the position of abortion in Ireland:

- 21.1 Abortion is illegal in Ireland except where there is a real and substantial risk to the life (as distinct from the health) of the mother. Under current legal precedent, this exception includes where there is a clear and substantial risk to the life of the mother arising from a threat of suicide. You should undertake a full assessment of any such risk in light of the clinical research on this issue.
- 21.2 It is lawful to provide information in Ireland about abortions abroad, subject to strict conditions. It is not lawful to encourage or advocate an abortion in individual cases.
- 21.3 You have a duty to provide care, support and follow-up services for women who have an abortion abroad.
- 21.4 In current obstetrical practice, rare complications can arise where therapeutic intervention (including termination of a pregnancy) is required at a stage when, due to extreme immaturity of the baby, there may be little or no hope of the baby surviving. In these exceptional circumstances, it may be necessary to intervene to terminate the pregnancy to protect the life of the mother, while making every effort to preserve the life of the baby.

However the guidelines provide no adequate guidance on what counts as a real and substantial risk to life, as opposed to the health, of the woman. A health risk can turn into a risk to her life in particular circumstances, and it can be difficult in practice for doctors to judge when intervention is legally justified. In the recent hearings before the Joint Oireachtas Committee on Health and Children the Master of the National Maternity Hospital, Holles Street stated that there had been three cases of intervention before viability to save a woman's life while the Master of the Rotunda Hospital reported that he was aware of six situations in the past year where a pregnant woman would have died without intervention and the incidence of potentially life threatening complications in pregnancy is rising due to the increasing age of women having children and the increased incidence of health risks (e.g. obesity).

The Master of the National Maternity Hospital at Holles Street stated recently: 'Existing rules do not help in assessing when a risk to health becomes a risk to life.'²⁸

'Do I have to wait until she is unwell, critically ill – at what stage can I make provision to offer her good, sensible healthcare? I do not want to wait until she is dying before I intervene, I want to protect her. I take into account her wishes as well.'

Dr Rhona Mahony, Master of the National Maternity Hospital at Holles Street, Irish Times, November 27, 2012

In addition, guidelines alone are insufficient. Doctors know they face the threat of significant criminal sanction if they perform a termination, which could be subsequently judged not to qualify as life-saving. Many are therefore reluctant to make a determination that a woman's life is at risk, and as a result women may not be getting the life-saving abortions to which they are legally entitled.

This was the situation of Applicant C in the A, B and C case, and was referred to by the European Court of Human Rights as the 'chilling effect'.²⁹

Guidelines are insufficient to protect doctors from prosecution based on a subsequent assertion that a particular case did not in fact fall within the *X Case* criteria. In their judgment in the A, B and C case, the court emphasised the legal uncertainty caused by current provisions. The judgement stated that the criminal provisions of the 1861 Offences Against the Person Act would constitute a significant chilling factor for women and doctors in the medical consultation process, regardless of whether prosecutions had in fact been made.³⁰ In the context of fear of criminal prosecution, medical services providers are effectively prevented from exercising clinical discretion in their patients' best interests and applying best clinical practice and intervening when a serious health risk presents.³¹ In practice, doctors decline to decide and seriously ill women must leave the State.³²

Women's Testimonies

In 2010, a woman called Michelle Harte became pregnant whilst in remission from cancer. She was refused an abortion on the basis her life was not under 'immediate threat'.

In Ms Harte's words: 'Why is it that such a simple medical treatment is not available, even when a mother's life is at risk? Anyone else who was even half as sick as I am shouldn't have to uproot themselves and fly over to England. It's not fair and it's not humane.'

*Upon returning to Ireland, Michelle Harte stated: 'There was no follow-up support, either medically or emotionally. It was back to the hospital and continue with the cancer treatment as if nothing had happened.'*³³

Michelle Harte subsequently sued for violation of her human rights, after a hospital ethics forum decided against authorising an abortion, on the basis that her life was not under 'immediate threat'.

The State paid substantial compensation to Michelle Harte in July 2011. Her solicitor Michael Boylan of Augustus Cullen Law told a national newspaper that her case was settled in just three months.

In March 2012, the Minister for Health explained the process a woman who required a life-saving abortion would have to undertake. It would be the responsibility of her doctor to determine whether the criteria at law were met. If so, a termination could lawfully occur. In the case of disagreement between a woman and her doctor, or refusal of necessary life-saving treatment, she

could seek a second medical opinion or could apply to the High Court for orders directing the necessary treatment to be provided. In such a case, the seriously ill woman could also subsequently bring a complaint to the Medical Council or initiate proceedings on the basis of medical negligence under the law of tort. The Minister acknowledged that the scenarios described above were not deemed satisfactory or appropriate by the European Court of Human Rights.³⁴

By situating women's decision making in a context of criminality, the law infringes on women's dignity and autonomy. The 2011 interim report of the UN Special Rapporteur on the Right to Health highlighted the way in which criminal law shifts the burden of realising the right to health away from the State and onto pregnant women, some of whom may be seriously ill. The woman must seek treatment and an individual doctor must make a legal determination in a context where a medical decision could become the subject of a criminal enquiry, a prosecution and potentially result in a criminal conviction.³⁵ The World Health Organisation highlights the importance of an enabling regulatory and policy environment to ensure that every woman who is legally eligible has ready access to good-quality abortion services³⁶.

Doctors' Testimonies³⁷

"Is termination of pregnancy ever necessary? I would say yes. In our hospital last year we had six situations where I can absolutely tell you for sure, that if intervention had not been made, if that mother had not died soon after the event, she would have died subsequently."

Dr. Sam Coulter Smyth, Master of the Rotunda Hospital. January 2013

"Within the Supreme Court Judgement there is a lack of clarification surrounding what exactly constitutes a "real and substantial risk to life". It must be pointed out that the expected legislation to provide greater clarity did not follow the Supreme Court judgement. as Justice McCarthy pointed out, "No matter how high the probability that the mother will die, it is not a certainty." Doctors may rarely be certain that the pregnant woman will inevitably die as a result of her pregnancy. In addition, it is not clear whether or not the risk to life must be immediate or may it be delayed. An example would be women with concurrent disease where there is concern that the additional physiological burden of pregnancy poses a significant risk to life which may increase as the pregnancy develops."

"The critical question arises as to how a substantial risk of mortality is defined. Can it be a 10% risk of death or an 80% risk of death or a requirement for intensive care support? It must be recognised that it is clinically difficult, if not impossible at times, to distinguish with certainty the difference between risk to health and risk to life? It is clear that the measure of substantial risk to life is open to interpretation and must be a matter of opinion based on medical judgement and not fact. For those who argue that the broad concepts contained in the judgement of the X case are sufficient, it must be pointed out that this judgement is not supported by legislation and/or regulation. Meanwhile the 1861 Offences Against the Person Act is current law which remains in force insofar as the provisions of this law are not inconsistent with the Constitution. In itself the provisions of the 1861 Act are not clear in relation to their scope and content. Therefore it is very important that medical practitioners and women are afforded legal protection to allow for appropriate flexibility to make professional clinical decisions based on medical probability of risk to life rather than certainty. It is not clear to me that such legal protection currently exists."

Dr. Rhona Mahony, Master of the National Maternity Hospital, Holles Street. January 2013

Psychological, Physical and Financial Costs of Abortion – The Reality for Women in Ireland

Even with legislation to realise the constitutional right to abortion where there is a real and substantial risk to the life of the mother, Ireland will still have one of the most restrictive regimes in the world. Yet restrictive laws and criminalisation do not deter women from terminating pregnancies: women in Ireland *are* seeking abortions. The failure to provide services in Ireland creates considerable psychological, physical and financial hardship for those who are either forced to travel outside the country for abortion or forced to carry an unwanted pregnancy to term because of restrictions imposed on them.

The decision to have an abortion is not one that women take lightly. ICCP-2010³⁸ defines a crisis pregnancy as one that represents a personal crisis or an emotional trauma in either of the following circumstances: (a) a pregnancy that began as a crisis or (b) a pregnancy that develops into a crisis before the birth due to a change in circumstances. A pregnancy, planned or unplanned, can become a crisis pregnancy for a range of complex personal social and economic reasons, including concern for the well-being of other children, diagnosis of serious foetal abnormality, financial worries, pre-existing health problems, including mental health problems, and relationship issues.

Women and girls who gave Republic of Ireland addresses at abortion clinics in England and Wales 2002-2011

Year	All ages	Under 16	16-17	18-19	20-24	25-29	30-34	35-39	40 and over
2011	4,149	37	111	295	1,109	1,051	755	534	257
2010	4,402	41	115	303	1,181	1,137	789	565	271
2009	4,422	38	155	291	1,234	1,164	759	523	258
2008	4,600	27	140	344	1,296	1,232	841	499	221
2007	4,686	47	147	350	1,387	1,282	790	474	209
2006	5,042	39	194	419	1505	1370	824	491	200
2005	5,585	39	173	482	1759	1451	860	541	280
2004	6,217	49	209	540	1963	1663	951	607	235
2003	6,320	42	242	552	2090	1597	954	579	264
2002	6,522	54	245	615	2258	1604	928	552	263
2001	6,673	12	29	903	2,404	1,685	875	508	239

According to a Crisis Pregnancy Programme Report, pregnancies ending in abortion increased from 2% in 2003 to 4% in 2010.³⁹ For women, 21% of all crisis pregnancies ended in abortion.⁴⁰

Figures from the Department of Health in the UK for the number of women and girls who gave Republic of Ireland addresses at abortion clinics in England and Wales show that in 2011, 4,200 women gave Irish addresses at UK abortion clinics.⁴¹ Many others give no details or travel to countries such as the Netherlands or Spain.⁴² In the ten years between 2001 and 2011, 58,618 Irish women and girls obtained an abortion in a clinic in the UK or Wales. An additional 1,470 women obtained an abortion in The Netherlands between 2005 and 2010. Between 1980 and 2011, at least 152,061 women living in Ireland have travelled to England and Wales to access safe abortion services. Crucially, these figures are probably an underestimation of the true numbers as many Irish women give no Irish address for reasons of confidentiality.⁴³

These women are from all walks of life and include those who have been raped; who have serious health problems and whose pregnancy puts their lives at risk. They are constitutionally entitled to terminate the pregnancy in Ireland.

For all of them, the stress involved in deciding to have an abortion is exacerbated by having to travel to another country to access abortion services, by the expense involved, by feelings of fear and stigma, by secrecy, by a sense of isolation or by lack of support.⁴⁴

Doctors' Testimonies

In their daily work family doctors see the reality of the failure of the State to legalise abortion. They see the palpable horror of the woman who awaits a pregnancy test that she fears is positive. She must face this situation in the knowledge that she cannot have an abortion in Ireland. Most often, women with unwanted pregnancies make decisions about abortion without support and in silence. In spite of this many chose abortion as their best option. However it is not always as simple as that.

As with so many other health issues, class issues have a significant impact on any decision. It costs about €1,000 to travel to England from Ireland for an abortion, covering clinic costs, travel and accommodation costs. This amount of money is rarely immediately available to women in poverty or low-paying jobs or who are raising children alone. Family doctors have seen women get credit union loans, not pay the mortgage, take the Holy Communion savings, the holiday money and money from under granny's mattress. Money lenders have been involved, with the woman eventually paying several times over - such is the desperation of women to control their fertility as they see fit. Child-care issues are highly significant for many women particularly in a silent community where excuses must be made for why one is away for the weekend. Teenage women are particularly vulnerable to cost issues and many opt to continue the pregnancy as the costs become insurmountable.

*A direct consequence of the financial issue is that Irish women have more late abortions than the average English woman. Late abortions after 14 weeks involve more invasive procedures, general rather than local anaesthetics and a greater risk to health. The delay is contributed to by difficulties in getting good information about abortion services in England, delays in raising the money, and the need to arrange the trip in secret. Airline strikes and bad weather on the ferries take on a new meaning on Monday mornings when the distraught woman rings the surgery to see if she still has time to reschedule. Similarly an asylum seeker must be told that if she travels to the UK for an abortion she is likely to forfeit her asylum application. The result is she must now face an enforced pregnancy. These are examples of the silence around women and abortion in Ireland - their distress is not documented or considered valid. **Dr Mary Favier, Doctors for Choice.**⁴⁵*

Women's Testimonies⁴⁶

'I am wholly satisfied I made the right decision and have no regrets about going through with a termination 15 years ago this month. However, I have not yet let go of the fury I feel at being forced into a corner by those who know little or nothing about how a young pregnant girl feels. As a professional married woman in my mid-30s, I loathe the secrecy and stigma associated with this topic in Ireland. I deeply resent those, my husband included, who demand my silence, and I wish people realised how "going to England" damages one's sense of worth.'

'The whole experience was dreadful; how could it not be? But, undoubtedly, it was made more awful by virtue of the fact I had to travel to London. What people don't want to acknowledge, but probably know, is that Irish mummies, sisters, aunts and friends have a shared experience of abortion from which no one is separated by too many degrees.'

In one woman's words, 'My husband and I felt no shame about the decision we had made, but this journey made us feel like criminals'. Such treatment and the need to travel to the UK, according to another woman, 'made an already traumatic experience feel infinitely worse.'

Women travelling from Ireland tend to have later abortions⁴⁷ because of the need to organise the logistics of travel, including having to raise significant funds, organise childcare, negotiate time off work and make travel and accommodation plans. Seriously ill women are forced to travel without a proper referral from their doctor and so the clinic they attend for the termination has no proper medical records.⁴⁸

Women with a diagnosis of foetal abnormality incompatible with life outside the womb and those who decide to terminate a pregnancy because of risk to their health or life are effectively abandoned by the Irish health services and made to feel like criminals.⁴⁹ Some who have had abortions because of a fatal foetal abnormality report being refused subsequent genetic testing and experiencing a repeat of the same situation with a later pregnancy.⁵⁰

Women's Testimonies⁵¹

Claire's story

....when I had my scan I was told that my beautiful daughter had a condition called anencephaly.. the short of it was that our daughter had no hope of surviving and would die without a doubt. To say we were heartbroken is an understatement. We were told in Ireland I had to carry my baby full term, I was told I would not be bought in early, I would not be given a C section and I would have to go through the labour. Alternatively I could travel to the UK to terminate our pregnancy. How would I cope emotionally? How could I keeping growing day by day and feel this baby inside me? How would I deal with the questions from well-meaning people – when is your baby due etc.! How could I watch my perfect baby struggle and die in my arms? After much deliberation I felt it would be too difficult to continue with the pregnancy knowing our daughter was going to die and opted for a termination in the UK the day before New Year's Eve in 2010 at 24 weeks pregnant. Because of our laws I was not allowed receive any help from the hospital here. I was given one recommendation of a well- known UK clinic and we went with this. I was treated so coldly. I had to leave my home, my comfortable surroundings and travel to a strange country. This situation was difficult enough to cope with without having the added problems of travelling to the UK. I had to leave my own local hospital where I felt safe, where I knew I could be looked after. I had horrible cold care in the UK. On the advice of the clinic, I was told I could book flights home for the same day of the termination. I have since been told that this was very dangerous to travel after a surgical abortion at 24 weeks gestation following a general anaesthetic again, something that should not have been an issue if my hospital were allowed induce my labour early. Had I been allowed stay here I would not have had the health risk of flying home. I could have had all my family around me. I could have had my own comforts .I could have seen my lovely daughter and buried her close to me. Now, I will never know what she looked like and I have no place to visit her.

Asylum seeking women must apply and pay for an emergency visa from the Department of Justice, as well as a visa to enter the UK or The Netherlands, often having to wait for up to six to eight weeks for the paperwork or may not be able to travel at all. Other women for whom travel from Ireland is impossible are often forced to continue with an unwanted or problematic pregnancy while others resort to unlawful means within the State, such as ordering often untrustworthy medication online to self-induce abortion that may put their health at risk. According to the World Health Organisation: 'In countries where induced abortion is legally highly restricted and/or unavailable, safe abortion has frequently become the privilege of the rich, while poor women have little choice but to resort to

unsafe providers, causing deaths and morbidities that become the social and financial responsibility of the public health system.⁵²

Women and girls who experience the most difficulty are those already marginalised and disadvantaged, those with little or no income, women with care responsibilities, women with disabilities, women with a mental illness, women experiencing violence, young women, asylum seekers and women who are undocumented. It can be argued that the Government's failure to legislate amounts to indirect discrimination on several grounds including disability and 'race'.⁵³

The court's finding in *A, B and C v Ireland* that there had been no violation of the rights of Applicants A and B rested on the fact that they could avail of abortion services in another state.⁵⁴ If a woman unable to travel outside Ireland to have an abortion, or who experienced significant delay in travelling, were to take a case, it would be open to the court to find a violation of the Convention in these circumstances.⁵⁵

Women's Testimonies⁵⁶

Aoife was sixteen years old and living in a rural part of Ireland when she became pregnant. She was unable to access information on abortion services until she began university in Dublin and subsequently travelled to the UK 'alone and extremely distressed'. As a result of the delay in accessing information, Aoife was almost 28 weeks pregnant when she had an abortion. She experienced much hardship in raising the necessary funds to travel: 'I had to go to my ex-boyfriend. His first line was 'are you sure it's mine?' It was very humiliating. He had to involve his brother who was appalled'.

Aisling experienced much difficulty in accessing diagnostic tests in the early part of her pregnancy. As a result, she discovered at a late stage that her foetus had developed a severe abnormality. 'I saw the consultant at this visit. He was extremely quick and dismissive. He was very defensive... why these tests? Did I know they could lead to an abortion? Did I know they could be wrong and so I could abort a healthy child?' Aisling paid for the diagnostic tests herself. After being refused a second scan by the ultrasound department, she arranged to have one abroad and subsequently accessed abortion services in a European country. 'I was very angry, I felt let down, maltreated.' When Aisling enquired about genetic testing upon her return to Ireland, the hospital told her to 'come back when you're pregnant again'.

Sarah described what she called 'the shame factor' in being forced to travel abroad to access abortion services. 'Having to lie to everyone, the lies and the shame make you feel like you're doing something really wrong, like a drug dealer. The travel part is so difficult. I don't think people know this...It is still so traumatic even if you can afford it'.

A comprehensive global study of abortion⁵⁷ has concluded that abortion rates are similar in countries where it is legal and those where it is not, suggesting that outlawing the procedure does little to deter women seeking it. In a forthcoming report⁵⁸, Sedgh G *et al* state that highly restrictive abortion laws are not associated with lower abortion rates. For example, the abortion rate is 29 per 1,000 women of childbearing age in Africa and 32 per 1,000 in Latin America—regions in which abortion is illegal under most circumstances in the majority of countries. The rate is 12 per 1,000 in Western Europe, where abortion is generally permitted on broad grounds.

Abortion and Women's Human Rights

The lack of access to safe and legal abortion affects the human rights of women; namely, the right to bodily integrity, the right to equality before the law, the right to be free from inhuman and cruel treatment, the right not to be discriminated against on grounds of gender, the right to health and the right to life. These rights are guaranteed by a range of international instruments including the Universal Declaration on Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women, and the Convention Against Torture.⁵⁹

International human rights law affords states a broad margin of appreciation in deciding how rights are interpreted and implemented and whether abortion should be available.⁶⁰ However, human rights law increasingly recognises that the harms caused by criminal sanctions, as well as the failure to regulate the circumstances in which lawful terminations can be obtained⁶¹ may violate women's rights to health, private life and the right to be free from discrimination amongst others.⁶² According to a World Health Organisation study of the applicable human rights standards: 'International, regional and national human rights bodies and courts increasingly recommend decriminalisation of abortion, and provision of abortion care, to protect a woman's life and health, and in cases of rape, based on a woman's complaint. Ensuring that laws, even when restrictive, are interpreted and implemented to promote and protect women's health is essential.'⁶³

These developments were endorsed by the Parliamentary Assembly of the Council of Europe in 2008 when it adopted a report issued by the Committee on Equal Opportunities for Women and Men entitled Access to Safe and Legal Abortion in Europe.⁶⁴ It called on member states to decriminalise abortion within reasonable gestational limits, guarantee women's effective exercise of their right to safe and legal abortion, allow them freedom of choice and offer the conditions for a free and enlightened choice without specifically promoting abortion, and to remove restrictions that hinder access to abortion.

Criminal laws and other legal restrictions on sexual and reproductive health may have a negative impact on the right to health in many ways including by interfering with human dignity. Respect for dignity is fundamental to the realisation of all rights. Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health.

United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2011).⁶⁵

UN treaty monitoring bodies⁶⁶ have recommended that states:

- Take action to prevent unsafe abortion, including by amending restrictive laws that threaten women's and girls' lives;⁶⁷
- Provide legal abortion in cases where the continued pregnancy endangers the health of women and girls;⁶⁸
- Provide legal abortion in cases of rape and incest;⁶⁹
- Amend laws that criminalise medical procedures, including abortion, needed only by women and/or that punish women who undergo those procedures.⁷⁰

Since 2005 the UN Human Rights Committee, the UN Committee on the Elimination of all Forms of Discrimination Against Women, the UN Committee Against Torture, the Council of Europe Commissioner for Human Rights and the European Court of Human Rights have all criticised Ireland's regulation of abortion as being inadequate to fulfil Ireland's human rights obligations. At the Universal Review Process in 2011, nine countries asked questions or made recommendations to Ireland in relation to abortion – all critical of the existing law.⁷¹ It is worth highlighting here that the

Irish courts have consistently criticised government failure to legislate including being described as 'inexcusable' by the Supreme Court twenty years ago and still nothing has been done.⁷²

Ireland's prohibitive regulation of abortion and the discriminatory nature of its application have been consistently subject to criticism by international human rights monitoring bodies due to the following factors:⁷³

- The extremely restrictive legal regime whereby abortion is lawful only to save the life, as distinct from the health, of a pregnant woman and in no other circumstances including in cases of rape;⁷⁴
- The failure of successive governments to give legislative effect to even this limited right, so that abortion is not in practice available in any circumstances;⁷⁵
- The need for women who seek abortion to travel to other jurisdictions to avail of these services and the consequent psychological, financial, and health burdens that these women incur;⁷⁶
- The discriminatory ways in which the regulation of abortion affects vulnerable groups of women including minors, undocumented women, migrant women, and women living in poverty.⁷⁷

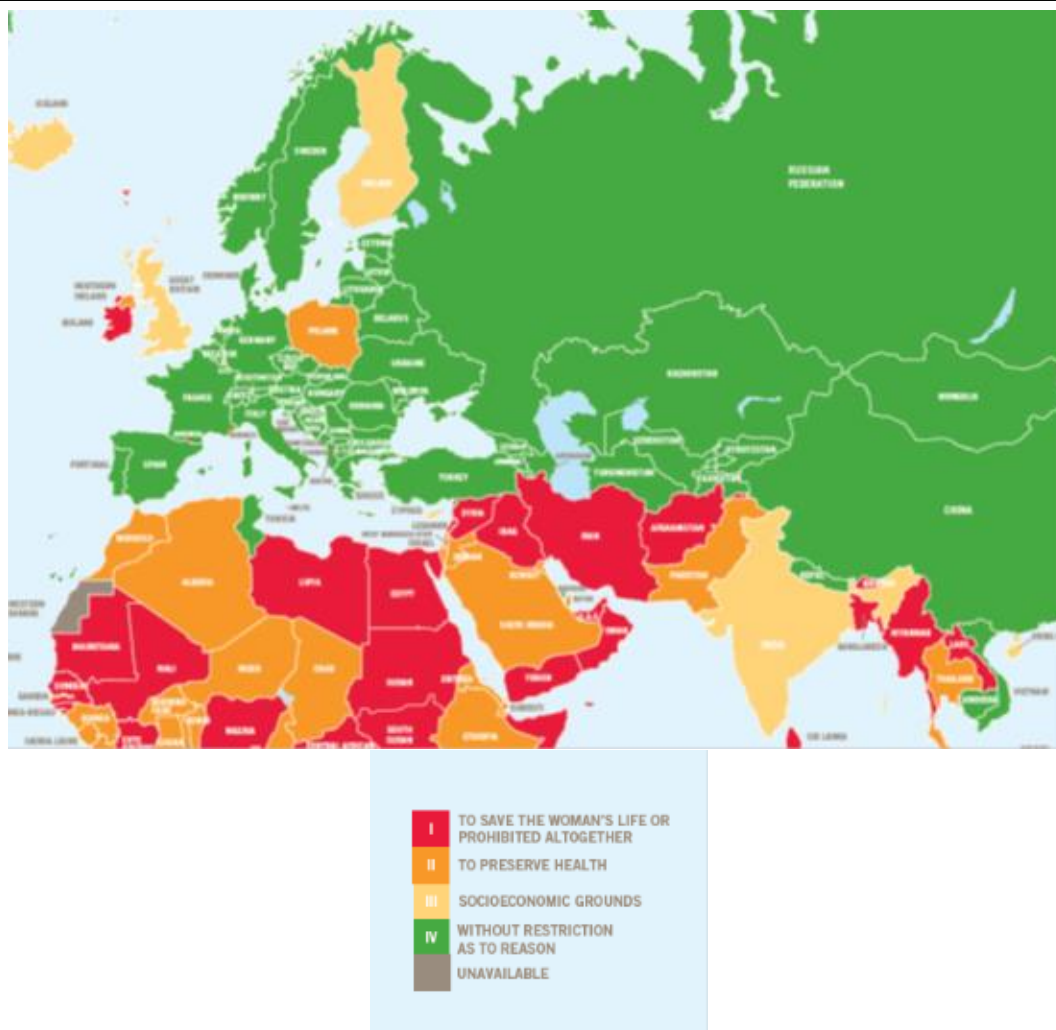
In 2008, the Council of Europe Committee considered access to safe and legal abortion in Europe. The Committee on Equal Opportunities for Women and Men concluded: 'Abortion is legal in the vast majority of the Council of Europe member states. The Committee on Equal Opportunities for Women and Men considers that a ban on abortions does not result in fewer abortions, but mainly leads to clandestine abortions, which are more traumatic and more dangerous. By the same token, the Committee notes that in many of the states where abortion is legal, numerous conditions are imposed which restrict the effective access to safe abortion.' It recommended that the Parliamentary Assembly should therefore invite the member states of the Council of Europe to:

- Decriminalise abortion, if they have not already done so;
- Guarantee women's effective exercise of their right to abortion and lift restrictions which hinder, de jure or de facto, access to safe abortion;
- Adopt appropriate sexual and reproductive health strategies, including access of women and men to contraception at a reasonable cost and of a suitable nature for them as well as compulsory relationships and sex education for young people.⁷⁸

The Committee of Social, Health and Family Affairs fully endorsed the recommendations made. It also underlined the public health impact of criminalisation of abortion; unsafe abortion; unmet need of contraception and the lack of proper information and education on sexual and reproductive health.⁷⁹

Trends in European Law

Ireland is an outlier in its failure to provide for safe and legal abortion. According to the European Court of Human Rights, contrary to the Irish government's submission, the court considers that there is indeed a consensus among a substantial majority of the contracting states of the Council of Europe towards allowing abortion on broader grounds than accorded under Irish law.⁸⁰ In most European states, termination of pregnancy can be performed in early pregnancy at a woman's request.⁸¹ Luxembourg permits termination of pregnancy on physical and mental health indications. Cyprus, Finland, and the UK further include socio-economic indications. Ireland, Malta and Poland have restrictive regimes.



Source: http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/AbortionMap_2011.pdf

Evidence shows that countries with unrestricted access to early termination of pregnancy did not report higher rates than countries with more restricted access.⁸² The improved availability of effective contraceptives, reproductive health services and better sexual health education in schools can better explain the decrease in official rates of abortion in different EU countries rather than how strict or liberal the abortion laws are.⁸³

The Netherlands

Abortion is available up to viability, which is defined at 24 weeks after conception; after 24 weeks, abortion is available only in the case of foetal impairment incompatible with life. According to the Dutch abortion law, abortion is allowed when a woman believes she is in an 'emergency situation' that is 'incontrovertible.' There is a six-day waiting period (except when there is imminent danger to the life or health of the woman).

Spain

Abortion is available without giving reasons up to 14 weeks, and up to 22 weeks if there is risk to life or health, and at any time if a foetal abnormality that is incompatible with life is detected. The woman must give her express consent to the voluntary interruption of a pregnancy. She must provide her consent in writing in order to ensure a correct application of the relevant criminal sanctions. If a woman is aged 16 to 17, one of her parents or tutors will need to be informed of the decision. However, the relevant person will not be informed if the pregnant woman alleges in a well-founded way that informing the parent or tutor of her decision would cause a serious conflict.

Sweden

Abortion is available without giving reasons up to 18 weeks and thereafter until viability, if pregnancy entails grave danger to life or health of the mother. After viability (around 22 weeks), no abortions are permitted unless the woman's life is at risk. A woman must be offered counselling before and after the procedure is performed. If the woman who requests an abortion has not reached the age of 18, the health care provider needs to settle certain routines for determination of whether any information should be provided to the woman's legal guardians or not; health care providers must ensure that any woman who has had an abortion is examined afterwards to make sure the procedure was successful.

Czech Republic

Abortion is available up to 12 weeks provided a woman submits a written application and the woman has no health condition that prevents termination. Abortion is available after 12 weeks in case of risk to a woman's health or life—a detailed and exhaustive list of medical conditions exists within which the woman's health risk must fall.

France

Abortion is available up to 12 weeks without giving reasons. Termination beyond 12 weeks or in the case of foetal impairment is available if the continuation of the pregnancy seriously endangers the woman's health or if there is a strong probability that the foetus is suffering from a particularly serious and incurable defect. If a woman's life is at risk, the abortion may only be performed upon the approval of a multi-disciplinary advisory team composed of at least three people: two practising physicians (one of whom has to be in G&O and the other of the woman's choosing) and a third professional such as a social worker or psychologist. French abortion law does not clarify what can 'seriously endanger the woman's health,' thus giving the physicians significant discretion.

United Kingdom

Abortion is permitted up to 24 weeks. Abortion is allowed if the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or of any existing children of the pregnant woman. Two medical professionals have to certify that the conditions allowing a woman to terminate her pregnancy have been satisfied. The UK also permits abortion on socio-economic grounds.

Support for Legalisation of Abortion

The shift in public attitudes to abortion has been significant in the last decade. Opinion polls and research from 2004-2012 consistently show increased support for access within Ireland.

- In February 2013 an Irish Times / Ipsos MRBI poll of 1,000 voters in face-to-face interviews in all constituencies found that 84% felt that abortion should be allowed when the woman's life is at risk, 79% felt that abortion should be allowed whenever the foetus cannot survive outside the womb, 78% felt that abortion should be allowed in cases of rape or incest, 71% felt that abortion should be allowed where the woman is suicidal as a result of the pregnancy, 70% felt that abortion should be allowed when the woman's health is at risk, and 37% felt that abortion should be provided when a woman deems it to be in her best interest.
- In January 2013 a Sunday Times / Behaviour and Attitudes poll of 916 voters found that 87% would support legislation to provide abortion where the woman's life was in danger for reasons other than threat of suicide, 80% would support legislation to provide abortion where there was a foetal abnormality meaning the baby could not survive outside of the womb, 74% would support legislation to provide abortion where the pregnancy was a result of rape, and 59% would support legislation to provide abortion where the woman displayed suicidal feelings. Overall, 92% supported allowing abortion in one of these four circumstances, while 51% supported allowing abortion in all four circumstances.
- In December 2012, an opinion poll by Red C and The Sunday Business Post indicated a large majority in favour of legislating for the X case:
 - 85% of respondents supported legislation for the *X Case*, which means allowing abortion where the mother's life is threatened, including by suicide.
 - 63% of respondents supported a constitutional amendment to limit the *X Case*, by excluding a threat of suicide as a ground for abortion, but still allowing abortion where the mother's life is threatened outside of suicide.
 - 82% of respondents supported a constitutional amendment to extend the right to abortion to all cases where the health of the mother is seriously threatened and also in cases of rape.
 - 36% of respondents supported a constitutional amendment to allow for legal abortion in any case where a woman requests it.
- In September 2012, a Sunday Times Behaviour and Attitude Poll found 80% of people said they would support a change in the law to permit abortion in cases where the mother's life is at risk. Support was highest among males, those aged 18-54 years, among ABC1 white collar workers, and people living in the Greater Dublin area. Among political party supporters, support was highest among Labour and Green Party supporters (each at 91%). Fine Gael supporters stood at 84%. The lowest level of support was among Fianna Fáil supporters (79%) and Sinn Féin supporters (75%).
- In 2011, a study of 500 established GPs and almost 250 GPs in training revealed that 75% of Irish GPs believing there are situations in which abortion should be available in Ireland with 52% believing it should be available to any woman who chooses it.
- In 2010, an Irish Examiner/Red C Poll found 60% of people supported legal abortion and three in five aged 18-35 believed it should be legalised.
- Also in 2010, a Marie Stopes/YouGov opinion poll indicated that 79% of those questioned favoured liberalisation of Irish abortion laws in certain circumstances.
- In 2007, an Irish Times Behaviour and Attitudes Poll found 54% of women believe the government should act to permit abortion.
- A 2004 Crisis Pregnancy Agency study found 90% of those aged 18-45 support abortion in certain circumstances, with 51% stating that women should always have to right to choose an abortion.

Clearly, a significant majority of people in Ireland support legislating for abortion where the mother's life is threatened, including by suicide, and another significant majority support extending the right to abortion to all cases where the health of the mother is seriously threatened and also in cases of rape and fatal foetal abnormalities. Those who support legal abortion in any case where a woman requests it indicate that a considerable minority support the right to choose in Ireland. The NWCI is currently undertaking a campaign that calls on TDs and Senators to support the Expert Group recommendation on legislation plus regulation to give effect to the X case. To date (January 2013), we have registered over 72,000 emails from more than 16,000 people in every constituency in Ireland.

NWCI Recommendations for Policy Change

There is no choice in relation to policy change. As it is put in the Report of the Expert Group on the Judgment in *A, B And C V Ireland*, arising from the judgment of the European Court of Human Rights, Ireland is under a legal obligation to put in place and implement a legislative or regulatory regime providing effective and accessible procedures whereby pregnant women can establish their entitlement to a lawful abortion in accordance with Article 40.3.3° of the Constitution as interpreted by the Supreme Court in the *X Case*, and, by necessary implication, access to abortion services in the State. It would obviously be insufficient for the State to interpret the court's judgment as requiring only a procedure to establish entitlement to termination without also giving access to such necessary treatment.

As outlined above, significant public demand exists for abortion services in Ireland to reflect the Constitutional provision and, further, to include abortion where the health of the mother is seriously threatened and also in cases of rape and a significant minority demand for legal abortion in any case where a woman requests it.

Our laws are out of step with public opinion and the time has come to introduce legislation to provide access to abortion services in Ireland. Political leadership and political will are needed to decriminalise reproductive health services to ensure that women who need an abortion can avail of it in their own country.

The NWCI calls for:

1. Immediate repeal of the provisions of the Offences Against the Person Act 1861 in relation to abortion.
2. Immediate legislation to implement the Supreme Court ruling in the *X Case* and the judgement of the European Court of Human Rights in the *A, B and C v Ireland* case. This legislation should include:
 - iv. Criteria and procedures that allow for a practical assessment by doctors and women of a 'real and substantial risk' to the life of the pregnant woman including risk of suicide;
 - v. A framework to examine/resolve differences of opinion between a woman and her doctor or doctors;
 - vi. A duty of care on health service providers to ensure that women receive appropriate information and care, including post-abortion care.
3. Promptly initiate the constitutional reform and enact the legislative changes necessary to introduce safe and legal abortion in Ireland.

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- ³CSO (2011) *Women & Men in Ireland*
- ⁴CSO (2012) EU SILC 2010
- ⁵Orla McBride, Karen Morgan and Hannah McGee. Crisis Pregnancy Programme Report No. 24, Irish Contraception and Crisis Pregnancy Study 2010, (ICCP-2010), A Survey of the General Population
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<http://www.crisispregnancy.ie/pub/reportsixteen.pdf>
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<http://www.crisispregnancy.ie/pub/reportsixteen.pdf>
- ¹¹Mahon, E., Conlon, C. and Dillon, L. (1998) *Women and Crisis Pregnancy*, Dublin: The Stationery Office quoted in Russell and Banks (2011).
- ¹²Figures compiled by the UK Department of Health to view go to <http://www.ifpa.ie/Hot-Topics/Abortion/Statistics>
- ¹³Ibid, p. 154
- ¹⁴In its submission to the European Court of Human Rights in *A, B and C v Ireland*(2011) 53 EHRR 13, the government was unable to point to a single lawful abortion that had been carried out in the State. The only statistics referred to by the government concerned ectopic pregnancies (para 189).
- ¹⁵Offences Against the Person Act 1861, section 58.
- ¹⁶Offences Against the Person Act 1861, section 59.
- ¹⁷Offences Against the Person Act, 1861, sections 58 and 59; Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act 1995.
- ¹⁸See the decision of the European Court of Human Rights judgment in the case of *A, B AND C v. Ireland* (section 254) and the Report of the Expert Group on the Judgment in *A, B and C v Ireland*.
- ¹⁹*Attorney General v. X and Others* [1992] 1 IR 1.
- ²⁰[1992] 1 IR 1, at p. 82 *per* McCarthy J.
- ²¹Text taken from the IFPA <http://www.ifpa.ie/Hot-Topics/Abortion/ABC-v-Ireland>
- ²²Para 5.2, page 27
- ²³Para 4.7, page 25
- ²⁴Ibid, p. 49
- ²⁵The Savita Halappanavar case is currently the subject of a clinical review by the Health Service Executive, under statutory investigation by the Health Information and Quality Authority (HIQA) and the inquest into the death is due to be completed in April 2013.
- ²⁶Amicus Brief by the Centre for Reproductive Rights and the International Reproductive and Sexual Health Law Programme, Faculty of Law, University of Toronto to EU Court of Human Rights in *A, B and C v Ireland*, p. 6
http://reproductiverights.org/sites/crr.civicactions.net/files/documents/ABC_v_Ireland_briefFINAL_PDF.pdf
- ²⁷Irish Medical Council (2009) *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 7th Edition, Section 21.
- ²⁸Irish Times, November 27, 2012

²⁹ Amicus Brief by Doctors for Choice, Ireland, and the British Pregnancy Advisory Service, UK, submitted to the European Court of Human Rights (pursuant to Article 36.2 ECHR and Rule 44.2 of the Rules of Court) in relation to A, B and C v Ireland.

³⁰ Section 254, Case of A, B AND C v. Ireland, Judgment, Strasbourg, 16 December 2010

³¹ Amicus Brief by Doctors for Choice, Ireland, and the British Pregnancy Advisory Service, UK

³² In argument before the European Court of Human Rights during *A, B and C v Ireland*(2011) 53 EHRR 13, the State was unable to point to a single lawful life-saving abortion that had been carried out in Ireland. The related issue of conscientious objection is also not regulated by Irish law. In *RR v Poland* (2011) 53 EHRR 31 the European Court of Human Rights stated that States are obliged to “organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals [...] does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation” (para 206).

³³ The Irish Times December 21, 2010

³⁴ Irish Family Planning Association communication to the Committee of Ministers of the Council of Europe: DH-DD(2012)1135EDH-DD(2012)1135E

³⁵ Irish Family Planning Association: Criminal Laws & Women’s Right To Health. June 20, 2012 Side Event at the 20th Session of the UN Human Rights Council organised by Action Canada for Population and Development (ACPD)

³⁶ See World Health Organization (2012) *Safe Abortion: Technical and Policy Guidance for Health Systems*, second edition (Geneva: WHO).

³⁷ Testimonies of the Masters of the National maternity hospitals before Joint Oireachtas Committee on Health and Children 8th of January 2013

³⁸ Orla McBride, Karen Morgan and Hannah McGee. Crisis Pregnancy Programme Report No. 24, Irish Contraception and Crisis Pregnancy Study 2010, (ICCP-2010), A Survey of the General Population, p. 23

³⁹ Crisis Pregnancy Programme Report No. 24, p. 79

⁴⁰ Ibid p. 90

⁴¹ Department of Health (2012) *Abortion Statistics, England and Wales: 2011*:

<http://transparency.dh.gov.uk/2012/05/29/abortion-statistics-2011/> [accessed 17 September 2012]

⁴² According to statistics compiled by the HSE Crisis Pregnancy Programme, 1,470 women travelled from Ireland to the Netherlands from 2005-2009 to access safe abortion services. See further:

<http://www.crisispregnancy.ie/news/number-of-women-giving-irish-addresses-at-uk-abortion-clinics-decreases-for-tenth-year-in-a-row-according-to-department-of-health-uk/> [accessed 17 September 2012]

⁴³ Irish Family Planning Association: Abortion Statistics <http://www.ifpa.ie/Hot-Topics/Abortion/Statistics>

⁴⁴ Irish Family Planning Association. Psychological, Physical and Financial Costs of Abortion <http://www.ifpa.ie/node/506>

⁴⁵ Dr Mary Favier (2003) *Repressing Abortion in Ireland*: <http://struggle.ws/wsm/rbr/rbr7/abortion.html>[accessed 17 September 2012]

⁴⁶ Irish Times March 24 2012: *Stories of abortion: by people who have been through it*: Kathy Sheridan.

⁴⁷ Department of Health (2012) op cit

⁴⁸ Irish Times January 16 2012: *New expert group must vindicate right to abortion*: opinion piece by Niall Behan, IFPA.

⁴⁹ Irish Times December 21, 2010; February 25 and March 24 2012. See Box 2

⁵⁰ Irish Family Planning Association (2012) *Travelling for Abortion Services: Psychological, Physical and Financial Burdens* (Dublin: Irish Family Planning Association): <http://www.ifpa.ie/Media-Info>

Such situations run counter to the ECHR: *RR v Poland*(2011) 53 EHRR 31.

⁵¹ Termination for Medical Reasons Ireland submission to the Oireachtas Committee on Health and Children 4th of January 2013

⁵² World Health Organization (2012) *Safe Abortion: Technical and Policy Guidance for Health Systems*, second edition (Geneva: WHO), at p.11.

⁵³ The ‘race’ and disability grounds are provided for under the Equal Status Acts 2000-2011, which prohibit discrimination in the provisions of goods and services.

⁵⁴ *A, B and C v Ireland*(2011) 53 EHRR 13, para 241.

⁵⁵ On the continuing lack of clarity as to the right to travel see J. Schweppe (2011) ‘Taking Responsibility for the “Abortion Issue”’: Some Thoughts on Legislative Reform in the Aftermath of A, B and C’, *Irish Journal of Family*

Law 2011(2), 50-56. The extraordinary difficulties faced by some girls and women in travelling outside the jurisdiction are illustrated by the 2007 'Miss D case'. A 17 year old girl under the care of the Health Service Executive was forced to bring a case to the High Court to compel the HSE to permit her to travel to the UK for an abortion: *Miss D v HSE, District Judge and Attorney General* (Unreported, High Court, McKechnie J., 9 May 2007).

56 Human Rights Watch (2010) *A State of Isolation: Access to Abortion for Women in Ireland* (New York: Human Rights Watch): www.hrw.org/sites/default/files/reports/ireland0110webwcover.pdf

57 *Abortion Worldwide: A Decade of Uneven Progress, 2011*, Guttmacher Institute,

58 Sedgh G et al., *Induced abortion worldwide in 2008: levels and trends*, *Lancet*, 2012, (forthcoming) taken from http://www.guttmacher.org/pubs/fb_IAW.html#1

59 Irish Family Planning Association: *Abortion and Human Rights* <http://www.ifpa.ie/Hot-Topics/Abortion/Abortion-Human-Rights>. See generally the Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254) (2011). See also the 2006 decision of the Columbian constitutional court which decriminalised abortion in Columbia and drew extensively on international human rights standards and commitments in removing the ban on abortion (Sentencia C-355 de 2006 Corte Constitucional (C-355/2006 case): <http://english.corteconstitucional.gov.co/> [accessed 17 September 2012])

⁶⁰ Exceptionally, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides for an explicit right to an abortion in defined circumstances (Article 14 (2)(c)). See further C. Ngwena (2010) 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa', *Human Rights Quarterly* 32(4), 783-864.

⁶¹ See e.g. the decisions of the European Court of Human Rights in *Tysiąc v Poland* (2007) 45 EHRR 42; *A, B and C v Ireland* (2011) 53 EHRR 13; *RR v Poland* (2011) 53 EHRR 31. Indeed in *RR v. Poland* the European Court of Human Rights found for the first time that the denial of an abortion-related medical service, specifically a referral for an amniocentesis, could amount to inhuman and degrading treatment under Article 3 of the ECHR. In *LC v. Peru*, UN Doc. CEDAW/C/50/D/22/2009 (4 November 2011) the UN Committee on the Elimination of Discrimination against Women found that Peru, by denying a minor who had been sexually abused access to therapeutic abortion violated several provisions of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

⁶² See generally C. Zampas and J.M. Gher (2008) 'Abortion as a Human Right: International and Regional Standards', *Human Rights Law Review* 8(2), 249-294; W. Nowicka (2011) 'Sexual and reproductive rights and the human rights agenda: controversial and contested', *Reproductive Health Matters* 19(38), 119-128.

⁶³ World Health Organization (2012) *Safe Abortion: Technical and Policy Guidance for Health Systems*, second edition (Geneva: WHO), at p.87.

⁶⁴ Council of Europe Parliamentary Assembly, *Resolution 1607 on access to safe and legal abortion in Europe*, 15th sitting, 16 April 2008:

<http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm> [accessed 17 September 2012].

⁶⁵ Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254) (2011), p.6.

⁶⁶ A comprehensive account of these recommendations is set out in Chapter 4 of the World Health Organization's report (2012) *Safe Abortion: Technical and Policy Guidance for Health Systems*, second edition (Geneva: WHO).

⁶⁷ E.g. the Human Rights Committee, the body that interprets and monitors States parties' compliance with the International Covenant on Civil and Political Rights (ICCPR), has repeatedly emphasised the threat to women's lives posed by prohibitions on abortion that cause women to seek unsafe abortions and has repeatedly called upon states to liberalise laws on abortion: Human Rights Committee (2000) *General Comment 28: Equality of Rights Between Men and Women (Article 3)*, CCPR/C/21/Rev.1/Add.10, para 10; *Concluding Observations of the Human Rights Committee: United Republic of Tanzania*, 18/08/98, UN Doc. CCPR/C/79/Add.97, para 15; *Concluding Observations of the Human Rights Committee: Venezuela*, 26/04/2001, UN Doc. CCPR/CO/71/VEN, para 19; *Concluding Observations of the Human Rights Committee: Poland*, 05/11/2004, UN Doc. CCPR/CO/82/POL, para 8; *Concluding Observations of the Human Rights Committee: Bolivia*, 05/05/97, UN Doc. CCPR/C/79/Add.74, para 22.

⁶⁸ In *KL v. Peru* (Communication no. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003, 2005) the Human Rights Committee found that state failure to enable the applicant to benefit from a therapeutic abortion caused the depression and emotional distress she experienced, and thus constituted a violation of Article 7 ICCPR (freedom from torture or cruel, inhuman or degrading treatment or punishment). See also, Committee on Economic Social and Cultural Rights (2004) *Concluding Observations: Malta*, E/C.12/1/Add.101, 4 December 2004, para 41; Committee on Economic Social and Cultural Rights (2006) *Concluding observations: Monaco*, E/C.12/MCO/CO/1, 13 June 2006, para 23; Committee on the Elimination of Discrimination against Women (2004) *Concluding comments: Dominican Republic*, A/59/38(SUPP), 18 August 2004, para 309.

⁶⁹ See e.g. *LC v. Peru*, UN Doc. CEDAW/C/50/D/22/2009 (4 November 2011); See also, Human Rights Committee (2000) *General Comment 28: Equality of Rights Between Men and Women (Article 3)*, CCPR/C/21/Rev.1/Add.10; Committee on Economic Social and Cultural Rights (2004) *Concluding Observations: Malta*, E/C.12/1/Add.101, 4 December 2004, para 41; Committee on Economic, Social and Cultural Rights (2004) *Concluding observations: Chile*, E/C.12/1/Add.105, 1 December 2004, para 53; Committee on Economic Social and Cultural Rights (2006) *Concluding observations: Monaco*, E/C.12/MCO/CO/1, 13 June 2006, para 23; Committee on the Elimination of Discrimination against Women (2007) *Concluding comments: Honduras*, 10 August 2007; Committee on the Rights of the Child (2007) *Concluding observations: Chile*, 23 April 2007.

⁷⁰ See e.g. Committee on the Elimination of Discrimination against Women (2007) *Concluding comments: Brazil*, CEDAW/C/BRA/CO/6, 10 August 2007, para 30; Committee on the Elimination of Discrimination against Women (2011) *Concluding observations: Sri Lanka*, CEDAW/C/LKA/CO/7, 4 February 2011, para 37; Human Rights Committee (2010) *Concluding observations: El Salvador*, CCPR/C/SLV/CO/6, 18 November 2010, para 10. In 1999 the CEDAW Committee recommended that when possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion: UN Committee on the Elimination of Discrimination Against Women, *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1.

⁷¹ Human Rights Council (2011) *Report of the Working Group on the Universal Periodic Review: Ireland*, A/HRC/19/9, 21 December 2011: <http://www.ohchr.org/EN/HRBodies/UPR/PAGES/IESession12.aspx>

⁷² [1992] 1 IR 1, at p.82 per McCarthy J: “the failure of the legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable.” See also *Roche v Roche and others* [2010] 2 ILRM 411; [2009] IESC 82.

⁷³ Irish Family Planning Association: Abortion and Human Rights <http://www.ifpa.ie/Hot-Topics/Abortion/Abortion-Human-Rights>

⁷⁴ Committee on the Elimination of Discrimination against Women (2005) *Concluding Comments: Ireland*, CEDAW/C/IRL/CO/4-5, 22 July 2005, paras 38-39; Human Rights Committee (2000) *Concluding Observations of the Human Rights Committee: Ireland*, A/55/40, 24 July 2000, paras 23-24; Human Rights Committee (2008) *Concluding Observations of the Human Rights Committee: Ireland*, CCPR/C/IRL/CO/3, 30 July 2008, para 13.

⁷⁵ UN Committee Against Torture (2011) *Consideration of reports submitted by States parties under article 19 of the Convention: Ireland*, 17 June 2011, CAT/C/IRL/CO/1, para 26; Council of Europe Commissioner for Human Rights (2008) *Report by the Commissioner for Human Rights, Mr Thomas Hammarberg, on his visit to Ireland 26-30 November 2007*, CommDH(2008)9 (Strasbourg: Office of the Commissioner for Human Rights Council of Europe): <https://wcd.coe.int/ViewDoc.jsp?id=1283555>; Council of Europe Commissioner for Human Rights (2011) *Report by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe, following his visit to Ireland from 1 to 2 June 2011*, CommDH(2011)27 (Strasbourg: Office of the Commissioner for Human Rights Council of Europe): <https://wcd.coe.int/ViewDoc.jsp?id=1831077> [accessed 17 September 2012]

⁷⁶ Committee on the Elimination of Discrimination against Women (1999) *Concluding Observations: Ireland*, CEDAW/C/1999/L.2/Add.4, 25 June 1999, paras 185-186.

⁷⁷ UN Committee Against Torture (2011) *Consideration of reports submitted by States parties under article 19 of the Convention: Ireland*, 17 June 2011, CAT/C/IRL/CO/1, para 26; Council of Europe Commissioner for Human Rights (2011) *Report by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe, following his visit to Ireland from 1 to 2 June 2011*, CommDH(2011)27 (Strasbourg: Office of the Commissioner for Human Rights Council of Europe), para 15.

⁷⁸ Council of Europe Doc. 11537: Committee on Equal Opportunities for Women and Men, Access to safe and legal abortion in Europe, 8 April 2008, <http://assembly.coe.int/main.asp?Link=/documents/workingdocs/doc08/edoc11537.htm>

⁷⁹ Council of Europe Doc. 11576: Committee on Social, Health and Family Affairs report, Access to safe and legal abortion in Europe, 15 April 2008,

<http://assembly.coe.int/main.asp?Link=/documents/workingdocs/doc08/edoc11576.htm>

⁸⁰ See *A, B and C v Ireland* (2011) 53 EHRR 13, para 235.

⁸¹ See further International Planned Parenthood Federation (2012) *Abortion Legislation in Europe* (Brussels: International Planned Parenthood Federation):

<http://www.ippfen.org/en/Resources/Publications/Abortion+legislation+in+Europe.htm>; Gissler et al (2012)

'Terminations of pregnancy in the European Union', *BJOG: An International Journal of Obstetrics & Gynaecology* 119, 324–332.

⁸² See M. Gissler et al (2012) 'Terminations of pregnancy in the European Union', *BJOG: An International Journal of Obstetrics & Gynaecology* 119, 324–332.

⁸³ See also C.F. Westoff (2005) *Recent Trends in Abortion and Contraception in 12 Countries* (Calverton, Maryland: ORC Macro).