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EXECUTIVE SUMMARY

Introduction: Information About AIMS Ireland

AIMSI was founded in 2007 and its mission is to support a woman's human rights and her choices in childbirth by promoting best international practice guidelines and the use of evidence-based research in maternity care settings. We lobby on behalf of pregnant women as well as provide information and support to women. The majority of women contacting AIMSI are looking for support in relation to traumatic birth experiences, many of whom complain of feeling undermined or not listened to during pregnancy, labour and birth. Recurring issues are: lack of informed consent and informed refusal.

Recommendations and comment on a head by head basis:

Head 1 – Interpretation

AIMSI have difficulties with the terms 'unborn' and 'woman' as they are not clearly defined and can lead to ambiguous interpretation. The Bill should also revert to its original title.

Head 2 – Risk of loss of life from physical illness, not being a risk of self destruction

This is theoretically an improvement on current legislation but in pratice Article 40.3.3 still dictates that there must be a "real and substantial risk to a woman's life" before a termination can be carried out

Head 3 – Risk of loss of life from physical illness in a medical emergency

Again, this is theoretically an improvement on current legislation but it is still narrowly restricted by Article 40.3.3

Head 4 – Risk of loss of life from self destruction

A general lack of knowledge of mental health difficulties and suicidal ideation means that this head incorporates an excessively cumbersome treatment pathway for a pregnant woman who is suicidal and is choosing to terminate her pregnancy. The idea of a woman having to be assessed by a potential 6 doctors and to also have her confidential details shared with her GP is untenable. Rather than doing anything to help mitigate the stigma attached to both mental health difficulties and abortion, it continues to distance the medical profession and the government from the woman at the heart of the matter. If a woman can maintain her privacy and dignity (and she can afford to pay for it), she will more than likely make the choice to go to another jurisdiction to access abortion services, rather than face undue interrogation in Ireland.

Head 5 – Medical opinion to be in the form and manner prescribed by the Minister

It is reasonable to expect that there is proper documentation of any and all medical procedures and interventions in all obstetric units in the Republic of Ireland. In fact, AIMSI would welcome the same kind of rigorous and detailed data collection when it comes to documenting all surgical and non-emergency interventions performed on women in the maternity services

Head 6 to 9 - Formal Medical Review Procedures

The review procedure for Heads 2 and 4 is thorough but it is also not timely if a woman is seriously physically ill or if she is intent on ending her life. The time given to convene a panel, to review the case and to report whether there is real and substantial risk to the life of the woman could potentially take up to two weeks. In the case of pregnancy and the legal right to abortion, if there is a real and substantial risk to a woman's life, every hour and every day

counts. Women who are facing a pregnancy that is threatening their very existence should not be made to wait weeks in order to have a final decision on her legal right to act on her decision.

Head 10 - Formal medical review reports to Minister

While review reports can help to track the frequency and grounds for review, it may also be worthwhile to track the frequency and grounds for why women forego the review panel and choose to terminate their pregnancy in another jurisdiction.

Head 11 – Notifications

As it stands, there is absolutely no comparison data for Irish women who must travel abroad to access abortion services. This major gap in data renders the proposed notifications data statistically invalid. The data that will be gathered on these notifications will only be able to describe discrete or skewed data – ie. it will only represent a very small sample with narrowly defined parameters.

Head 12 - Conscientious Objection

Due to the sensitive nature of the issue of abortion it is reasonable to allow a conscience clause for practitioners. This must be balanced with the rights of a woman to be treated in a non-judgmental and dignified manner.

Head 13 - Travel and Information

This is a reasonable and standard provision for this legislation.

Head 14 to 17 - Regulations and certification of opinions referred to in this Act

This is a reasonable and standard provision for this legislation.

Head 18 – Repeal and consequential amendments

The repeal of Sections 58 and 59 of the Offences Against the Person Act 1861 is welcome; however, the stark reality for pregnant woman in Ireland is that Article 40.3.3 hangs like a spectre over her care as there are myriad instances where her human rights are overridden by this ambiguously worded and legally flawed amendment.

Head 19 – Offence

The laws in Ireland with regards to abortion are draconian and outdated. They have not kept pace with the changing culture, women's rights, human rights and the values of the Irish people. There is nothing "clear" or "modern" about the threat of incarcerating a pregnant woman for intending to procure an abortion in the country of her residence, while turning a blind eye to the thousands of women annually who make the trip to the UK – this can only be described as hypocrisy.

Head 20 – Commencement

This is a reasonable and standard provision for this legislation.

<u>Conclusion</u>

The obvious conclusion is that even if a country has legal restrictions on abortion, women will continue to choose to terminate their unintended pregnancies. To deny that this is happening in Ireland is to deny the very personal and intimate reproductive choices of thousands of Irish women. It also denies the reality that thousands of women, who can afford it, make the annual journey to the UK or elsewhere in Europe to access an abortion.

Introduction: Information About AIMS Ireland

In 2007, the Association for Improvement in Maternity Services Ireland (AIMSI) was started by a group of women who collectively declared that the maternity services in Ireland had treated them in a manner that was less than satisfactory – many of them claiming to have suffered an outright breach of their human rights. The mission of AIMSI is to highlight the rights of women to be autonomous in their reproductive choices and to promote practices that are supported by evidence-based research and international best practice. Improving the Irish maternity services includes many factors that rely heavily on a woman's right to make choices about all aspects of her care in pregnancy, labour and birth. For example, a woman should be allowed to choose where and how she gives birth in line with supportive scientific evidence and international best practice that is documented by the World Health Organisation (WHO). AIMSI would like to see *National Guidelines*, the annual publication of *Obstetrical Clinical Reports* and a clear *Charter of Patient's Rights in Maternity Services* among other changes that fully support a woman during her pregnancy, labour and birth.

While AIMSI lobbies and campaigns on behalf of women, we also provide support and information to women. We receive hundreds of emails and phone calls annually to our voluntary Support & Information Officers. Many of these contacts tell a compelling story of being badly let down by the maternity care providers in Ireland. Most of these harrowing stories involve women being forced to undergo procedures and interventions, which are often unnecessary, without giving their informed consent or informed refusal. It is far too common for women to experience being operated on, rather than collaborated with, when it comes to their maternity care.

Recommendations on a Head by Head Basis:

- **Head 1 - Interpretation**

While it is understandable that the definitions in this Bill must succinctly and clearly be defined, it is somewhat disconcerting to see “unborn” and “woman” being given interpretation. “Unborn” is not a scientific term and is only necessary to define because of the relationship it has to Article 40.3.3 of the Constitution. It is not a legal definition, as such, and it is arguably a term based more on moral ideology than scientific evidence. The Government has redefined “unborn” for the purpose of this Bill (ie. life begins at implantation, not at conception), which seems arbitrary and unnecessarily restrictive. If the definition of “unborn” is fluid, then why have it defined at all OR why not extend the definition to mean 6, 12 or 24 weeks post-conception? It is an intentionally emotive term and AIMSI would argue that it is not medically or scientifically evidenced.

With regard to defining a “woman”, it would seem that this Bill discriminates against those individuals who may identify as one gender but have the sex traits of another. While this may seem like a small detail, it is thought to be of great consequence in many other jurisdictions. For example, in March 2013, the Canadian government passed Bill C279 that ensures equality for transgendered people. Where does a transgendered individual in Ireland (particularly one who may find themselves with an unintended pregnancy) go to seek support and does the law protect them? It seems rather archaic that a “woman” must be defined for the sake of any legislation and it starkly highlights the simplicity with which the government wants to define women. The X case, itself, involved a 14 year old girl, not a “woman” by legal definition, but a child or minor. Does the law protect them, as well? AIMSI takes exception to the complete removal of any reference to women in the title of this Bill and would ask that it revert to its original name: The Protection of Maternal Life Bill 2013.

- **Head 2 - Risk of loss of life from physical illness, not being a risk of self destruction**

This is reasonable; however, the restrictive nature of this legislation and the spectre of Article 40.3.3 remove any clarity, respect and dignity for women who may have to make the choice to terminate a pregnancy due to physical illness. One would hope that what transpires through legislation and medical regulation is that women who are in need of a termination in order to preserve their life do not have to undergo what women before them have had to endure – particularly those women who ended up losing their lives due to delays in getting the medical treatment for which they were allegedly entitled *vis a vis* the 1992 Supreme Court ruing on the X case. While the explanatory note states that as per the X case ruling, “it is not necessary for medical practitioners to be of the opinion that the risk to the woman’s life is inevitable or immediate” (p.7), this still leaves a chilling effect as to what constitutes a “real and substantial risk to the woman’s life” as it is still seen as distinct from her health. The recent death and subsequent inquest of Savita Halappanavar demonstrated that a lack of legal clarity between a risk to a

woman's life and her health underpinned the delay of a termination that would have saved her life, according to expert witness, Dr Peter Boylan (Cullen, P, Irish Times, April 18, 2013)

- **Head 3 - Risk of loss of life from physical illness in a medical emergency**

This is reasonable as in an emergency there may only be one doctor present; however, a medical practitioner should never have to be concerned about whether or not she/he is committing a criminal offense when carrying out a termination due to a medical emergency. It seems safe to assume that doctors will always be working according to a strict ethical and professional medical code that preserves life unless otherwise clinically indicated. Similarly to Head 2, Article 40.3.3 legally binds the medical practitioner to determining if there is a "real and substantial risk to a woman's life", even in a medical emergency.

- **Head 4 – Risk of loss of life from self destruction**

This is reasonable as it allows for a termination of pregnancy in accordance with the 1992 Supreme Court ruling on the X case. However, this still lacks significantly in providing clarity for the practical approach to caring for a suicidal pregnant woman. Much of the confusion on this particular head can be explained by a general lack of knowledge about suicide and the difficulty in predicting who will go on to complete a suicide and who will not. It stands to reason that if a woman is suicidal and pregnant, she may not want to face an obstetrician and two psychiatrists, and possibly the input of her GP. It is highly unlikely that this opens up any opportunity for a distressed, and possibly suicidal, pregnant woman to feel supported and cared for by her medical team in her choice to undergo a termination when she is faced with assessment by 3 doctors and a possible review by a further 3 doctors. It seems more likely and practical that a woman will want to seek anonymity and far less judgment by traveling to another jurisdiction for a termination. It is disconcerting to read a reference to the 25th Amendment (Protection of Human Life in Pregnancy, 2001) in the explanatory notes in this section (and in heads 1, 2 and 12), particularly as this is an amendment that was defeated by popular vote in a referendum in 2002. It is unclear why it is being referenced, except to further emphasise the position of the government.

Perhaps the two most worrying aspects of this head are as follows:

> **(1)** That it is acceptable for a woman's right to confidentiality to be breached even if she has not agreed to the sharing of her information with other medical doctors, namely her GP. The decision whether sensitive medical information is shared should rest solely with the consent of the woman involved. If a woman refuses consent, her desire to maintain confidentiality should be upheld and if this is breached, then appropriate guidelines and sanctions should be issued to protect a woman's right to privacy and confidentiality in this situation
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> **(2)** That rather than doing anything to help mitigate the stigma attached to both mental health difficulties and abortion, it continues to distance the medical profession and the government from the woman at the heart of the matter and it further perpetuates a negative stereotype. The discrimination of women who find themselves in this emotionally devastating position – of carrying an unintended

> pregnancy and of *seeing no way out of this difficulty* - only serves to isolate women and to highlight power differences. Link and Phelan (2006) found in their research on stigma and abortion that on an individual level, those being stigmatized feel shame, guilt and disgrace, leaving them with little power to access resources that can change their situation. The stigma and the stereotype of the woman who seeks an abortion separate her from the 'morally upright' woman, which results in the woman seeking an abortion as being "blamed for their own exclusion".

The stigma and negative social attitudes of some people towards abortion should not be ignored as this has far reaching effects on the women who have experienced abortion care. In Ireland, this means that the vast majority of women who have had abortions have had to travel to other jurisdictions to obtain a legal abortion. For the Irish government to ignore this cold fact means that it is complicit in promulgating the secrecy and shame inherent in social attitudes to abortion. This can have a devastating impact on a woman's health as if she has experienced any complications due to an abortion, she may be reticent about seeking treatment due to the pervasive negative attitudes and stigma associated with this choice. Recent research supports the expansion of service providers to combat the "isolation of women undergoing abortion by attending not only to clinical/technical aspects of the procedure but also to women's psychological/emotional sensitivities surrounding the event" (Astbury-Ward et al., 2012). This would be a much more compassionate and humane way of providing a service to women who are threatening suicide and finding it impossible to cope with an unintended pregnancy.

- **Head 5 – Medical opinion to be in the form and manner prescribed by the Minister**

It is reasonable to expect that there is proper documentation of any and all medical procedures and interventions in each and every obstetric unit in the Republic of Ireland. In fact, AIMSI would welcome the same kind of rigorous and detailed data collection when it comes to documenting all surgical and non-emergency interventions performed on women in the maternity services.

- **Heads 6 – 9 Formal Medical Review Procedures**

The review procedure for Heads 2 and 4 is thorough but it is also not timely if a woman is seriously physically ill or if she is intent on ending her life. The time given to convene a panel, to review the case and to report whether there is real and substantial risk to the life of the woman could potentially take up to two weeks. In the case of pregnancy and the legal right to abortion, if there is a real and substantial risk to a woman's life, every hour and every day counts. Women who are facing a pregnancy that is threatening their very existence should not be made to wait weeks in order to have a final decision on her legal right to act on her decision. This scenario should be regarded as a medical emergency and, therefore, provision should be made to treat a woman in the same manner as outlined in Head 3.

- **Head 10 – Formal medical review reports to Minister**

This is a reasonable, if not mandatory, requirement to ascertain how women are availing, or not, of the new legislation. With regards to the subheads (a) to (e), AIMSI are particularly concerned with (d) the outcome of the review. The explanatory note says:

> "if it were to transpire that all terminations that had taken place had gone through the formal review process, this might indicate that further guidance is required from the professional bodies"(p. 21).

Equally, it may indicate that further guidance is needed if this data reveals that women who are suicidal are making the decision to forego the review panel and to travel, if they have the means and accessibility, rather than undergoing a procedure that should be legally and medically available to them in Ireland. It should be documented if these women are continuing to leave Irish soil to access abortion services simply because the pathways of care are cumbersome and excessively stringent at a time when these women should be treated with compassion and support.

- **Head 11 – Notifications**

This is a reasonable and necessary step in order to begin gathering accurate records on the frequency of terminations carried out in Ireland (not just under this legislation but in all circumstances). It is important to keep in mind that any data recorded on abortions in Ireland will be confounded by the missing data – namely the thousands of women annually who make the trip to other jurisdictions to access abortion services and those who manage to access abortifacient medications. Statistics have been used in the past to egregiously support maternal mortality rates in Ireland, with many individuals misrepresenting the data as supporting one of the "best places in the world to have a baby". These same individuals ignored the fact that the maternity mortality rate in Ireland doubled overnight when the Confidential Maternal Death Enquiry Report (2012) was published.

While Ireland still remains a relatively safe place to have a baby in terms of maternal mortality, the statistics completely ignore maternal morbidity and therefore deny hundreds, if not thousands, of women who have experienced adverse events in their maternity care. Likewise, the data that is being gathered in relation to abortion in Ireland under this proposed legislation will only reveal a tiny subset of the total number of women who are accessing abortion services, here and abroad. It would be prudent to begin gathering data on abortion that is valid and reliable so that these numbers will be useful for future policy reviews. As it stands, there is absolutely no comparison data for Irish women who must travel abroad to access abortion services. This major gap in data renders the proposed notifications data statistically invalid. The data that will be gathered on these notifications will only be able to describe discrete or skewed data – ie. it will only represent a very small sample with narrowly defined parameters.

- **Head 12 – Conscientious Objection**

Every individual has the right to freedom of conscience and should, therefore, be given scope to express this right. However, this right is qualified in that a medical practitioner must balance their right to individual moral and ethical conscience with their duty of care to the patient. The idea of introducing conscientious objection into this legislation is one that is necessary but it also seems equally important to state that under this proposed contentious legislation "the exercise of conscience may not involve invidious discrimination or result in excessive harms/burdens to patients. In addition, health care professionals may not cross the line that separates refusal from obstruction" (Wicclair, M, 2011, p. 133).

In the case of Irish medical practitioners who consider themselves conscientious objectors in relation to this proposed legislation, it will be very difficult for women who are physically ill or who are experiencing suicidal ideation to be faced with doctors who have an ethical and moral objection to what a woman feels is her best and only course of action – an abortion. How will a woman be assured that her case will be heard in a non-judgmental way, without being influenced by the moral and ethical biases of the medical practitioner? The Irish Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* clearly states, in Sections B 10.1 and 10.2: "As a doctor, you must not allow your personal moral standards to influence your treatment of patients [and that] if you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them" (p. 16). It seems cruel to expose pregnant women who are suicidal, or facing a physical illness or a medical emergency, to the added distress of a practitioner who conscientiously objects to abortion.

A woman should be given unbiased and clear information and referrals to other doctors should she encounter a medical practitioner who conscientiously objects to being involved in her abortion care. The cases that are frequently brought to the courts in Poland highlight how conscientious objection can lead to lengthy delays, moral judgment and sometimes outright criminal harassment of women, even if the law supports her decision. The *Report of the Expert Group* even cautioned that "the measures that are introduced to give effect to this existing constitutional right should not act as obstacles to any woman who is legitimately entitled to seek a termination on lawful grounds" (DOHC, 2012, p.27). It would be judicious to include in this legislation clear legal safeguards that will protect a woman from having to endure the intentional obstruction or delay to abortion services due to conscientious objection.

- **Head 13 – Travel and Information**

This provides clarification that if a woman seeks an abortion in Ireland (ie. under head 2 or 4) but she encounters undue delays or unsatisfactory treatment, she is legally entitled to travel to another jurisdiction to access abortion, as the current laws allow.

- **Head 14 – 17 Regulations and certification of opinions referred to in this Act**

This is a reasonable and standard provision for proposed legislation.

- **Head 18 – Repeal and consequential amendments**

The repeal of Sections 58 and 59 of Offences Against the Person Act 1861 is a welcome change to legislation, as recommended on numerous occasions during the Oireachtas hearings in January 2013. However, it is the 8th Amendment, Article 40.3.3, that has caused the greatest amount of controversy and 'grey area' in relation to abortion. The lack of legal clarity of the terms used in Article 40.3.3 were highlighted by several TDs, Ministers, legal experts and Attorneys General when it was proposed in 1983. It is a highly unusual amendment in that it is the only one that is not a Government amendment and it is the only one where the wording was bitterly contested by several members of government before it was hastily brought to the people in a referendum. The legacy of this amendment is one that has created a chilling effect and a tangible barrier to women's equality and human rights in Ireland. As recently as last month (April 2013) the inquest into the death of Savita Halappanavar concluded with expert testimony declaring that "obstetricians [are] working in a legal 'vacuum' as to when a mother's risk of dying was high enough for them to be legally allowed to terminate a pregnancy" (Holland, K and Cullen, P, The Irish Times, April 17, 2013).

AIMSI believes that taking a decision to terminate a pregnancy is one that should be made solely between a woman and her doctor. When legal restrictions and moral guidelines are put in place to limit a woman's choice, it makes it very difficult to delineate where a risk to a mother's health ends and a risk to her life begins. How does a medical team make a decision in this kind of urgent situation on what to do with regards to the foetus? The enduring lack of clarity caused by article 40.3.3 as a constitutional guideline in such matters (notwithstanding the repeal of sections 58 and 59 of the 1861 Offenses Against the Person Act), means that the woman's life continues to be seen as equal to that of an embryo or foetus. The risk to the mother may not only be one that involves her health, and her life, but it appears to also involve a legal grey area that is trying to define what her rights are as a human being versus the rights of the foetus (as described by such notable legal experts as Peter Sutherland SC, AG in 1981 and Patrick Connolly SC, AG in 1982 in the recently released 1981 amendment papers).

AIMSI highlighted in an earlier submission to the Joint Oireachtas Committee that from a human rights perspective, the idea that a woman's life is equal to a foetus creates what Elizabeth Prochaska, human rights lawyer, calls 'foetal supremacy'. According to Prochaska, there is no basis in law for foetal supremacy. In fact, Prochaska strongly argues that "the questions being raised over abortion rights have a close relationship to a woman and her pregnancy. It is a woman's body and that's what makes human rights in childbirth some of the most fundamental human rights there are, because it involves choices a woman makes over her body" (Carpenter, L., The Guardian, December 16, 2012). The United Nations and other international organisations patently agree with Elizabeth Prochaska: that a woman's right to health is paramount and that

multiple human rights instruments support her right to not only health and life, but also her right to equality and reproductive self-determination (Center for Reproductive Rights, 2008).

The stark reality for a pregnant woman in Ireland is that Article 40.3.3 hangs like a spectre over her care as there are myriad instances where this ambiguously worded and legally flawed amendment overrides a pregnant woman's human rights. For example, in the latest HSE Draft National Consent Policy, section 7.8.1 on Informed Consent for pregnant women states:

> "The consent of a pregnant woman is required for all health and social care interventions; however, because of the constitutional provisions on the right to life of the unborn, there is legal uncertainty regarding whether a woman's right to refuse treatment extends to the refusal of treatment which puts the rights to life of the foetus at serious risk" (p.34)

Recent media reports also suggest that Article 40.3.3 was a critical piece of legislation that led to an emergency sitting of the High Court in the case of a woman who wished to delay a caesarean section for 2 days. In this case, Senior Counsel for the hospital argued that what was at issue was "the mother's right to refuse treatment [at odds] with the right to life of the unborn" (Mac Cormaic, R, The Irish Times, March 11, 2013). The issues of informed consent and a pregnant woman's rights conflict in many aspects of the maternity services because they are determined by 'risks' rather than 'rights'. This conflict can be squarely attributed to Article 40.3.3 and the difficulties in trying to determine equal rights for both the woman and the fetus. This appears to be one of the most serious and tragic details in the Savita Halappanavar inquest, as testimony from a Consultant Obstetrician explained - namely, that there was a refusal to permit a termination until the medical team were convinced that there was a balance of probabilities (51%) of a risk to the life of the mother (Houston, M, The Irish Times, April 11, 2013). These probabilities cannot, and never will, be determined by the proposed legislation and nothing in head 3 would materially change the outcome of the Savita Halappanavar case. As long as Article 40.3.3 remains as an impervious legal barrier to a woman's right to a termination in these circumstances, the risk to a mother's life will precariously hang in the balance.

- **Head 19 – Offence**

While it is commendable that this proposed legislation includes the repeal of Sections 58 and 59 of the Offences Against the Person Act 1861, it is shocking that it also includes the possibility of up to 14 years imprisonment for a woman who undergoes an abortion that falls outside the scope of this legislation in Ireland. It appears to be a disproportionate penalty for medical treatment that a woman (who can afford it) can access in the UK. The other concern that AIMSI has about this head is that if a woman is forced through her personal and family circumstances to access abortifacient drugs to self-induce an abortion, this leaves mariginalised and vulnerable women in an inequitable position to those who are financially and socially able to access an abortion in another jurisdiction.

In 2009, the Irish Medicines Board confirmed that 1,216 packages of drugs known to induce abortions were seized by Irish customs authorities (O'Brien, C, The Irish Times, October 26, 2010). In essence, this means that somewhere in the region of 1200 women would be potentially liable to conviction and a prison sentence for resorting to illegal means to terminate a pregnancy due to the restrictive laws in Ireland. In comparison with violent crimes, such as rape and domestic abuse, the punishment proposed for a woman who is desperately attempting to terminate an unintended pregnancy is ludicrous and unjust. The proposal of these kinds of harsh penalties imposed on women whose biggest crime is more than likely attributed to the poverty, lack of resources or disability they endure makes a telling statement on how Ireland treats its vulnerable women. This is incongruous with the Ireland that emerged as a leading economy and cultural stalwart in the 21st century. The days of locking up or isolating 'fallen women' are gone. This country can do better than threatening women with 14 years in jail if they see no other way out of their life-altering predicament. The laws in Ireland with regards to abortion are draconian and outdated. They have not kept pace with the changing culture, women's rights, human rights and the values of the Irish people. There is nothing "clear" or "modern" about the threat of incarcerating a pregnant woman for intending to procure an abortion in the country of her residence, while turning a blind eye to the thousands of women annually who make the trip to the UK – this can only be described as hypocrisy.

- **Head 20 – Commencement**

  This is a reasonable and standard provision for proposed legislation.

Conclusion

What we expect from maternity services in Ireland should be in line with what is expected internationally as best practice. This reflects Minister James Reilly's statement released on December 18, 2012: "the Government is committed to ensuring that the safety of pregnant women in Ireland is maintained and strengthened. We must fulfill our duty of care towards them" (MerrionSt.ie). The WHO guidelines for maternal and reproductive health are the most widely used evidence-based research that supports women's rights in pregnancy, labour and childbirth. These guidelines recommend the most effective intervention and treatment of the more common complications in maternity settings such as: hypertensive disorders of pregnancy, haemorrhage, placental anomalies and puerperal infection. The other guidelines that the WHO issued in 2012 were on *Safe Abortion: technical and policy guidance for health systems* (2nd Ed). While the guidelines are geared towards making abortion safer in developing countries, Ireland finds itself standing among these countries when it comes to the issue of supporting women's maternal, sexual and reproductive health.

In addition to these guidelines, human rights legislation exists as a method of removing barriers and protecting women's right to reproductive and sexual health. The *International Covenant on Economic, Social and Cultural Rights* (ICESCR), part of the *International Bill on Human Rights* - ratified in Ireland in December 1989 - guarantees women the legal right to the highest attainable standard of physical and mental health and equal rights between men and women. The *European Convention on Human Rights* (ECHR) (2010) and the *European Social Charter* (ESC) (1961; 1996; 1999) also guarantee the right to health and to equality of women and men. Current restrictive abortion policies, including this proposed legislation, continue to violate international human rights law.

The main thrust of the argument for supporting the rights of women across the maternity services, whether they are choosing a home birth, a cesarean section, an intervention-free birth or an abortion is summed up succinctly by Anand Grover, UN Special Rapporteur on the Right to Health, who recently spoke at the National Women's Council of Ireland seminar on Women's Right to Health. At a UN General Assembly in August 2011, Mr Grover presented a report, in accordance with the Human Rights Council entitled: *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* This report is seen as a milestone in the area of rights to reproductive and sexual health as it plainly articulates the reasons why legal restrictions in this area constitute a violation of a woman's right to health and an "unjustifiable form of State-sanctioned coercion" (UN, 2011, p. 5). The report is disparaging of the human rights violations that are perpetuated in the few remaining countries, such as Ireland, where abortion is completely criminalised or where it is only allowed to save the life of a woman. Anand Grover said at the UN General Assembly meeting, when presenting this report:

> "Realization of the right to health requires the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls. In cases where a barrier is created by a criminal law or other legal restriction, it is the obligation of the State to remove it. The removal of such laws and legal restrictions is not subject to resource constraints and can thus not be seen as requiring only progressive realization. Barriers arising from criminal laws and other laws and policies affecting sexual and reproductive health must therefore be immediately removed in order to ensure full enjoyment of the right to health." (UN, 2011, p. 2)

The countries that have legalised abortion have generally found that abortion rates do not suddenly increase when legislation changes. In fact, many countries report that over the years abortion rates have stayed the same, or decreased, as increased information and knowledge is disseminated on the proper and effective use of contraception. A comprehensive global study by Sedgh et al., 2012, found that there was a substantial decrease in abortion rates from 1995 to 2003 and that these rates have been relatively stable since 2003. The most salient information that the researchers gleaned from this study was that regardless of the status of abortion laws,

unintended pregnancies continue to occur in all societies and woman will continue to access an abortion, whether the law restricts this or not. Evidence from countries with the most restrictive abortion laws suggests that the use of unsafe methods such as abortifacients like misoprostol is increasing widely (Sedgh et al., 2012).

The obvious conclusion is that even if a country has legal restrictions on abortion, women will continue to choose to terminate their unintended pregnancies. To deny that this is happening in Ireland is to deny the very personal and intimate reproductive choices of thousands of Irish women. It also denies the reality that thousands of women, who can afford it, make the annual journey to the UK or elsewhere in Europe to access an abortion. The loneliness and the stigma attached to this denial should not be underestimated in relation to the impact that having to leave one's family, primary care provider and supportive surroundings to access legal treatment elsewhere has on women. This is particularly poignant for women who are seriously ill or have been medically advised to seek a termination for medical reasons (ie. cancer, heart disease or fatal fetal abnormalities).

In Ireland, we have seen a sea change in attitudes over the last few decades in relation to contentious issues such as contraception, divorce and abortion. Irish citizens have become more global - living and learning in different countries and coming back to Ireland with adapted cultural values and more tolerance and acceptance of others' views. This has been demonstrated by the thousands of people who came out to support legislating for the X case in the wake of the death of Savita Halappanavar or the consistent increase in support over the last decade in the various opinion polls on abortion in Ireland. AIMSI believes that these domestic changes in attitudes combined with international human rights laws and policies uphold the need for the Irish government to introduce legislation that regulates access to the highest attainable standard of maternity care, including abortion, without interfering with a woman's right to life, health, privacy, freedom from cruel and inhumane treatment and non-discrimination.

References

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