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Reproductive Health and Human Rights: Lessons from Ireland

By Tanya Saroj Bakhru¹

Abstract

The years between 2008-2013 were a period of economic austerity and ideological turmoil in Ireland. Alongside the tragic death of Savita Halappanavar, a woman who died in 2012 due to complications resulting from her refused request for an abortion in an Irish hospital, economic, political and ideological forces converged to promote a tipping point in the demand for full sexual and reproductive rights for women in Ireland. Within this temporal *moment*, a “convergence of various economic, political and ideological forces that make possible the emergence of specific kinds of practices” (Barndt, 2008, p. 36), the Irish Family Planning Association (IFPA) responded with a call to action based on human rights discourse. There was a unique and compelling approach for social change. While most governmental advisors at the time were calling for reductions in social services, the IFPA spoke out for the necessity of increased government support for women’s health. Specifically, they shed light on the restrictive and discriminatory treatment of women and their sexual and reproductive rights by pointing to the discrepancies in Irish law, service provision and international human rights covenants to which Ireland was a signatory.

This paper examines the ways in which the Irish Family Planning Association responded to the tumultuous times and advanced women’s reproductive freedom based on the principles of the universality of human rights. Using the IFPA as a case study, my work employs a content analysis of over 400 pages of documents including IFPA generated annual reports, submissions and publications between 2008-2013 (inclusive) to investigate how, in this particular “moment,” advocacy based on notions of human rights can advance women’s sexual and reproductive health. In this paper, I will discuss two major findings that emerged from my examination of IFPA documents. They are: a) the ways in which the IFPA framed the current state of sexual and reproductive health for women in Ireland in relation to international human rights conventions and treaties to which Ireland is a signatory as a response to the ambiguous and discriminatory nature of Irish law and practice regarding sexual and reproductive health; and b) the ways in which the IFPA called on the Irish state to take responsibility for the provision of health care services and protection of women’s bodily integrity in light of the intense burden which economically disadvantaged women in Ireland suffered as a part of the implementation of post-2008 recession austerity measures.

Keywords: Sexual and Reproductive Rights, Human Rights, Transnational Women’s Health, Irish women

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Introduction

The years between 2008-2013 were a period of economic austerity and ideological turmoil in Ireland. Alongside the tragic death of Savita Halappanavar, a woman who died in 2012 due to complications resulting from her refused request for an abortion in an Irish hospital economic, political and ideological forces converged to promote a tipping point in the demand for full sexual and reproductive rights for women in Ireland. This paper examines the ways in which the Irish Family Planning Association (IFPA) responded to the tumultuous times and advanced women's reproductive freedom based on the principles of the universality of human rights. This case study shows how the action of the IFPA served in their pursuit of women's total equality and bodily autonomy.

By 2008, the economic prosperity Ireland experienced in the 1990s and early 2000s came to an end. The period known as the "Celtic Tiger," roughly 1990-2008, resulted in Ireland having one of the highest GNPs per capita in the European Union (McGinnity, Russell, Watson, Kingston, & Kelly, 2014, p. 3). The Celtic Tiger caused many international bodies to recognize Ireland as exemplary, both in terms of economic performance, and as a model of the most positive effects of globalization. In the ongoing years of the Celtic Tiger, Ireland achieved high economic growth rates, full employment and a significant rise in living standards, turning it from one of the poorest countries in Europe into one of the richest. These advances came in dramatic contrast to the rest of Europe, which experienced a slowing of the economy during that time.

However, these "good times" came to an end in 2008 when the Irish economy experienced a harsh fallout from the global economic crisis. The following approximately five-year period saw the implementation of an austerity plan from the government (BBC, 2010) aimed to cut billions of Euros. The severity of this plan was compounded by the bailout agreement made with Ireland and the International Monetary Fund and European Union (McGinnity et al., 2014). The agreement was scheduled to end in 2013. As a 2014 report by the Irish Equality Authority and the Economic and Social Research Institute states:

The crisis [in Ireland] was triggered by the global financial crisis and the bursting of the property bubble. This led to a banking crisis and subsequent fiscal crisis for the state, as tax revenue plunged and the cost of guaranteeing the banks escalated, and culminated in the intervention of the IMF [International Monetary Fund], European Central Bank [ECB] and European Commission [EC] to 'bail out' the Irish economy. (McGinnity et al., p. 4)

The IMF, ECB and EC, often referred to as the "Troika," insisted on furthering already implemented austerity measures that cut greatly needed welfare systems.

As the government moved to guarantee all the banking debt, huge amounts of private debt became massive amounts of public debt (Barry & Conroy, 2012, slide 2; Hardiman & Regan, 2013, p. 9). For example, significant cuts to health care services were among the many detrimental effects of the austerity measure implementation. Expenditure on health services, provided by the Health Service Executive (HSE), decreased by 11 per cent. As a National Economic and Social Council report (2013) states,

The largest absolute falls in expenditure were in primary care and the medical card scheme (down 17 per cent, and accounting for 23 per cent of this expenditure in 2008); grants to outside agencies (down 12 per cent, and representing 27 per

cent of this spend in 2008); and clinical spending (down 20 per cent, and representing 7 per cent of this expenditure in 2008). (p. 97)

Such cuts further entrenched a neoliberal global capitalist ideology, like those adopted by the World Bank and IMF in the 1980s in the form of Structural Adjustment Policies, that shifts public goods and services, such as health care provision, from mostly public to private responsibility. Overall, consequences of the imposed austerity measures included an increase in unemployment, decrease in income and wealth, increase of economic vulnerability and poverty, decrease in household consumption, increase in personal debt and limitations to good-quality, accessible and affordable public-service provision (National Economic and Social Council, 2013, p. xv).

Simultaneously, within the five-year period referenced above, two significant events served to energize the women's health and pro-abortion movements in Ireland: the European Court of Human Rights verdict in the case of *A, B & C vs. Ireland*, which urged the Irish State to legislate for the provision of abortion services; and the death of Savita Halappanavar, resulting from the refusal by hospital authorities for her request of an abortion. Both these issues will be discussed in greater detail below.

Within this temporal *moment*, a "convergence of various economic, political and ideological forces that make possible the emergence of specific kinds of practices" (Barndt, 2008, p. 36), the IFPA responded with a call to action based on human rights discourse. Theirs was a unique and compelling approach for social change. While most governmental advisors at the time were calling for reductions in social services, the IFPA spoke out for the necessity of increased government support for women's health. Specifically, they shed light on the restrictive and discriminatory treatment of women and their sexual and reproductive rights by pointing to the discrepancies in Irish law, service provision and international human rights covenants to which Ireland was a signatory.

Using the IFPA as a case study, my work employs a content analysis of over 400 pages of documents including IFPA generated annual reports, submissions and publications between 2008-2013 (inclusive) to investigate how, in this particular "moment," advocacy based on notions of human rights can advance women's sexual and reproductive health. I accessed all of the examined reports through the IFPA website. I see the easy accessibility of such documents as contributing to an available global discourse on women's reproductive health and rights.

Between 2003-2007 I lived, worked and studied in Dublin, Ireland. I was a student in the Women's Education Research and Resource Centre at University College Dublin conducting research on sexual and reproductive health in the context of globalization in Ireland. It has been eight years since I moved from Dublin to California. I am now an Associate Professor in Women, Gender and Sexuality Studies at San Jose State University - a significant geographic and social distance from my life in Dublin. However, I have continued to observe transformative events unfolding in Ireland that created an electric and dynamic surge in grassroots energy and people calling for a transformation in the sexual and reproductive political landscape there. I feel strongly that there is a great deal that can be learned about feminist praxis, organizing and multi-dimensional coalition building from feminist activists and agitators in Ireland as they engage with issues of sexual and reproductive rights and demand social change.

As I share my work and thoughts, I want to be clear that it is not my intention in this paper to speak for or on behalf of women in Ireland. Rather, as a transnational feminist scholar², I look

² Transnational feminist notions largely inform the perspective I adopt in this paper. These include a commitment to addressing the asymmetries of globalization/capitalist re-colonization as well as the implementation of an

to Ireland with a feminist curiosity and ask: what lessons can women's health movement(s) in varying geographic and social contexts learn from the Irish case in the use of human rights discourse to promote positive change in sexual and reproductive health matters?

In this paper, I will discuss two major findings that emerged from my examination of IFPA documents. They are: a) the ways in which the IFPA framed the current state of sexual and reproductive health for women in Ireland in relation to international human rights conventions and treaties to which Ireland is a signatory as a response to the ambiguous and discriminatory nature of Irish law and practice regarding sexual and reproductive health; and b) the ways in which the IFPA called on the Irish state to take responsibility for the provision of health care services and protection of women's bodily integrity in light of the intense burden which economically disadvantaged women in Ireland suffered as a part of the implementation of post-2008 recession austerity measures.

In my reading of IFPA documents, the organization challenged the State to be accountable for women's rights in Ireland, rather than allowing a situation to continue where those who can afford and have access to travel can acquire services. When speaking of human rights in these modes, the Irish Family Planning Association exemplifies a strategy of using human rights discourse and frameworks in a way that connects a variety of sexual and reproductive health topics, spanning beyond a single issue or a singular group of people, to such crucial notions as reproductive freedom and autonomy. Framing sexual and reproductive health in this way can be an effective tool in highlighting the fundamental need for women to have the power and resources necessary to make and carry out informed decisions about their reproductive and sexual lives (Correa & Petchesky, 1994) in a variety of global contexts.

Abortion Law in Ireland Presently

Historically, abortion law in Ireland has been informed by the *1861 Offences Against the Person Act* which criminalized both those seeking as well as those performing abortion; the penalty being life in imprisonment. This law has served as the basis of criminal law on abortion in Ireland. The 1861 Act has been interpreted and amended throughout the years creating a situation where current abortion law in Ireland is ambiguous, restrictive and unjust. The Eighth Amendment primarily shapes modern day interpretations of the law to the Irish Constitution in 1983. The Eighth Amendment (Article 40.3.3) has a:

three-part provision relating to reproductive choice: first, a statement of a constitutionally protected foetal right to life to be protected and vindicated as far as practicable and with due regard to the equal right to life of the pregnant woman, a right to travel, and a right to receive information relating to reproductive choices. (Enright, et al., 2015, The Legal Status Quo section)

intersectional set of understandings, tools, and practices such as paying attention to the raced, classed, and gendered ways that globalization and capitalist patriarchies (re)structure colonial and neocolonial relations of domination and subordination; grappling with the complex and contradictory ways that individual and collective agency are shaped by and in turn shape processes of globalization; and thinking about women in similar contexts across the world, in different geographical spaces, rather than as all women across the world. In other words, at the heart of my scholarly investigation is an attempt to understand what the connections are between politics of knowledge and the spaces, places, and locations that we occupy as well as learning how to be location specific without being location bound. In keeping these ideas in mind this work aims to illuminate the connectivity, collective responsibility, and mutual accountability women have to each with and to each other around the world (Nagar & Swarr, 2010, p. 5).

The most restrictive aspects of Article 40.3.3 state that:

The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right. (2015, The Legal Status Quo section)

Legislation attempting to clarify key elements of the article continues to create tremendous ambiguity for women and medical professionals in determining when an abortion might be lawful within Irish borders. Thus, Irish law only allows for abortion when the *life* of a woman is threatened. There is no consideration for how the continuance of a pregnancy might affect the *health* of a woman. Unfortunately, there are many instances where the imperiled health of a pregnant woman can ultimately cause her death.

The ambiguity in Irish law has created an untenable situation in which thousands of women each year are forced to travel outside Ireland to access abortion services. The IFPA states that, “Between 1980 and 2014, at least 161,987 women living in Ireland travelled to England and Wales to access safe abortion services. Women living in Ireland also access abortion services in other European countries” (Irish Family Planning Association, 2015b). While the number each year has decreased consistently over the past ten years due to a higher level of contraceptive use among young adults (HSE Sexual Health & Crisis Pregnancy Programme, 2015), Irish abortion laws end up requiring women to travel outside the country for basic reproductive health services. Alternatively, women may opt to self-induce abortion at home by ordering medicine online. This method of procuring an abortion is also illegal in Ireland and while it is difficult to say exactly how many women seek abortion in this way, “the Health Products Regulatory Authority, working with Customs officials, seized 28 packages, containing 635 tablets, in 2011. By last year the numbers had almost doubled, to 1,017 tablets detained from 60 importations, suggesting that more pills are being imported” (Holland, 2015). Such restrictive regulations thereby place the burden to access sometimes life-saving health care on to women, themselves. Thus, ambiguity in Irish law has led to a disparity in access to sexual and reproductive health services – medical procedures that become accessible only to those women who have the finances, knowledge, legal status and time to travel outside Ireland for safe help with a crisis pregnancy.

Verdict in the A, B and C vs. Ireland Case

The restrictive and ambiguous legal circumstances described above prompted three women in 2005 to take a case against Ireland to the European Court of Human Rights³. An oral hearing of the case was delivered before the Grand Chamber of 17 Judges on December 9, 2009.

The women, known as A, B and C to protect their confidentiality, argued that Ireland has breached their human rights under Articles 2 (Right to Life), 3

³ The European Convention on Human Rights is an international treaty that created the European Court of Human Rights. The Court hears cases from individuals or States, in which the applicants assert that their rights under the Convention have been violated by a member State. Anyone may submit an application to if they have personally and directly been the victim of a violation of the rights and guarantees set out in the Convention or its Protocols. For more information see http://www.echr.coe.int/Documents/Questions_Answers_ENG.pdf.

(Prohibition of Torture), 8 (Right to Respect for Family and Private Life) and 14 (Prohibition of Discrimination) of the European Convention on Human Rights. (Irish Family Planning Association, 2015c)

In 2010 the European Court of Human Rights ruled that applicant C's human rights were violated under Article 8 of the European Court of Human Rights by the Irish State in its failure to implement existing constitutional law (Irish Family Planning Association, 2015c). The Irish Family Planning Association was instrumental in facilitating the case and supporting the applicants.

In 2012, several years after the verdict was delivered, the Irish government established an expert group to review and respond to the European Court of Human Rights judgment (Irish Family Planning Association, 2015a). In late 2012 the expert group released its report and in 2013 the government introduced the Protection of Life During Pregnancy Act into law. While the Protection of Life During Pregnancy Act was intended to clarify the conditions under which abortion should be available within the parameters of the Irish Constitution, it only complicated the issue further (Holland, 2014). Thus, legal clarity and availability of abortion as a basic human right of women did not advance as a result of the verdict in the A, B and C case.

Death of Savita Halappanavar

The anticipated consequences of such ambiguity in Irish law and the delay of the State to clarify its own constitution came to a head in October 2012. Savita Halappanavar, an immigrant to Ireland of Indian decent, died due to complications resulting from her refused request for an abortion in an Irish hospital. Although amniotic fluids had broken, she was miscarrying, and her foetus was not viable outside the womb, Savita and her husband, Praveen, were told that because foetal heartbeat was still present and because "Ireland is a Catholic country" an abortion was not possible. The result of the mismanagement of Halappanavar's case led to her death from septicemia and E. coli, causing shock to the body and multi-organ failure (Lentin, 2013, p. 130).

Savita Halappanavar's death sent a tremor through the nation and within days thousands protested on the streets of Dublin in remembrance of her and to demand change in the country's abortion laws (Fallon, 2012). Investigation into Halappanavar's death found "a failure in the provision of the most basic elements of patient care" (Health Information and Quality Authority, 2013, para. 2). Furthermore, "interpretation of the law related to lawful termination in Ireland is considered to have been a material contributory factor" in her death (Waterfield, 2013, para. 3). The case of Savita Halappanavar made apparent that Irish abortion laws' lack of clarity in the distinction between the *life* and the *health* of the mother creates an unsustainable situation that puts women's lives at risk. It also made transparent, yet again, that the Irish state's long-standing reliance on a woman's ability to travel at will to neighboring countries, such as the UK, to access abortion services will inevitably fail to protect women who are not able, for whatever reasons, to travel without restriction. Furthermore, the circumstances of Halappanavar's death reinforce a history of indignity that women in Ireland have endured, time and again, when facing a crisis pregnancy. Notable cases include: the 1984 case of Ann Lovett, a young girl who had concealed her pregnancy only to die giving birth alone in the town grotto under a statue of the Virgin Mary (O'Doherty, 2014); the 1992 case of a young woman known as "X" who was refused the right to travel for an abortion after becoming pregnant as a result of rape even though her pregnancy was a risk to her life due to the threat of suicide; the 1997 case of a young girl known as "C" who faced obstacles in terminating a pregnancy that was an outcome of rape; and the 2007 "D" case in which

a young woman in the care of the State was refused right to travel to terminate an anencephalic pregnancy (Irish Family Planning Association, 2015c; see also Quilty, Kennedy, & Conlon, 2016).

The public outcry at Savita Halappanavar's death was in response to the ongoing disrespect and disregard for women's bodily autonomy on the part of the State. As such, this tragic event contributed greatly to an energizing of the Irish pro-abortion movement that continues currently with tremendous momentum. In the midst of the economic and social turmoil I described above, the Irish Family Planning Association continued to stand as Ireland's leading organization in sexual and reproductive health service provision and advocacy.

The Sexual and Reproductive Rights Movement Promoted by the Irish Family Planning Association

Started in 1969, the Irish Family Planning Association is a national voluntary organization and registered charity whose administrative offices are located in the Dublin City Centre. For founding members of the Irish Family Planning Association, the main focus was to transform the overall climate in Ireland with regard to reproductive health and family planning in order to make information and services accessible to everyone.

At the time of its inception, the IFPA was concerned with the substandard health and social circumstances of many families in Ireland. At the forefront were the effects on the lives of women with repeated unwanted pregnancies (Irish Family Planning Association, 2005a). The goals and aims with which the IFPA began are "now part of a broader policy to protect and promote individual basic human rights in reproductive health, relationships and sexuality" (Irish Family Planning Association, 2004). The Irish Family Planning Association acts as service provider and reproductive health advocate, making regular submissions to the national government as well as international bodies concerning the state of reproductive health legislation. In this way, the organization serves as a source of expert knowledge in areas of reproductive health (Bakhru, 2007, p. 121).

Analysis of the IFPA's Advocacy for Women's Sexual and Reproductive Rights

My analysis of IFPA documents between 2008 and 2013 showed that one of the most significant and meaningful strategies this organization used to bring attention to the contradictions and ambiguities of Irish abortion law was through contrasting it with various human rights conventions and treatises to which Ireland is a signatory and often ratified and is therefore obligated to uphold gender equality and nondiscrimination⁴. For example, the 2011 submission to the UN Committee Against Torture, to which Ireland states:

The disproportionate and ineffective nature of Ireland's abortion ban runs contrary to a number of UN human rights treaties to which Ireland is a signatory. Specifically, Ireland is in breach of its obligations under the International Covenant on Civil and Political Rights, the International Covenant on Economic,

⁴ The UN Convention Against Torture was signed by Ireland in 1992 and ratified in 2002. The International Covenant on Civil and Political Rights was signed by Ireland in 1973 and ratified in 1989. The International Covenant on Economic, Social, and Cultural Rights was signed by Ireland in 1973 and ratified in 1989. Ireland became a party to the Convention on the Elimination of All Forms of Discrimination Against Women through accession in 1985.

Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women. Several international human rights bodies including the UN Human Rights Committee, UN Committee on the Elimination of Discrimination against Women, Council of Europe Commissioner for Human Rights and the European Court of Human Rights, have expressed concern over Ireland's severely restrictive abortion laws and failure to clarify the circumstances under which lawful abortions may take place. (p. 4)

More explicitly, the 2008 submission to the UN Human Rights Committee states:

The Irish ban on abortion is among the most restrictive in the world. This ban, alongside the failure of the state to clarify the law on its operation, constitutes a violation of Articles 2 (Right to an Effective Remedy), 3 (Right to Equality and Non-Discrimination), 6 (Right to Life), 7 (Freedom from Torture, Cruel Treatment, and Punishment), 17 (Right to Privacy) and 24 of the International Covenant on Civil and Political Rights. (p. 1)

The submission then goes on to discuss in detail the ways in which each article mentioned above was violated.

In their discussion of Ireland's abortion restrictions, as they relate to international conventions, the IFPA consistently emphasized that by ignoring these covenants, the Irish government was perpetuating gender inequality and discrimination. The 2008 submission to the UN Human Rights Committee states:

The Irish abortion law discriminates on the basis of sex because men are able to access the full range of medically necessary health care, including contraception, sterilisation and treatment for sexually transmitted diseases. In contrast, legal barriers to abortion, a medical treatment required only by women, constitutes a violation of nondiscrimination norms. (p. 8)

Another example occurs in the 2011 Universal Period Review, which reads:

The effect of the Irish abortion laws is to discriminate on the basis of sex because men are able to access the full range of medically necessary reproductive health services and women are not. The State has not only failed to provide equal health care but is singling out and criminalizing medical care that only women need. The Irish abortion restrictions deprive women of the ability to make the decisions about their family life and instead force them to put their health at risk in pursuit of the State's goal to "protect the life of the unborn." Men are not required to sacrifice their bodily integrity and authority to make decisions about family life, even to preserve the life of an actual alive child. (p. 3)

By advocating for sexual and reproductive rights, namely abortion rights, in the context of human rights and gender equality, the IFPA has continued to invoke women's equality as a cornerstone of creating change.

Such an approach to sexual and reproductive health advocacy is significant because it

recognizes a deeper, more substantive meaning behind the need for a change in law or adherence to international treaties alone. Connecting back to the International Conference on Population and Development Program of Action (ICPD POA) in 1994, the IFPA is continuing the effort toward achieving gender equality, equity and empowerment of women while focusing on sexual and reproductive health. The ICPD POA recognized that women's control and decision making over their own bodies is closely linked to the full materialization of gender equality.

Like the ICPD Program of Action, the IFPA has continued to urge the Irish government to repeal laws and policies that are gender biased. As Correa and Petchesky (1994) point out:

in order for women to achieve equal status with men in society, they must be respected as full moral agents with projects and ends of their own; hence they alone must determine the uses-sexual, reproductive, or other- to which their bodies and minds are put. (p. 109)

Gender equality and human rights in the context of sexual and reproductive health means affirming that a woman's body is an integral part of one's sense of self and that a whole sense of self is necessary for full participation in society (p. 113).

Socioeconomic Trends that Impede Women's Sexual and Reproductive Rights

In spite of the clarity of international conventions that place women's empowerment as central to sexual and reproductive health, within many countries, Ireland included, debates remain as to who holds the responsibility to ensure that sexual and reproductive rights are fully realized. Petchesky (2003) outlines three characteristics of the global environment in which women's health NGOs are working to develop and implement policies that place women's empowerment and equality at the center of rights discourse, which itself has the potential to overlook women's empowerment. These are: 1) macroeconomic policies aimed at growth, free trade and minimal safety nets rather than eradicating poverty, creating conditions of social justice and increasing human well-being; 2) weakened capacity of institutions at the national level responsible for health and development relative to those responsible for policing security; 3) a dominant approach to health reform that emphasizes cost effectiveness and aggregate statistics about 'life years' over better lives for women and girls (Petchesky, 2003, p. 188). Global environments characterized by the aforementioned qualities impede women's empowerment and perpetuate inequality. This is in spite of claims that integrating women into the global capitalism economy is a potential pathway toward equality. Within the context of a global capitalist culture that focuses on the freedom of the market, weakening of the state through austerity measures, and prevalence of profit-making ideology, reproductive health non-governmental organizations, like the IFPA, face a tremendous challenge to ensure that the conditions necessary to realize women's rights are being protected.

The ways that austerity programs negatively impact women's lives has been well documented (Karamessini & Rubery, 2013). As countries in economic crisis seek aid from global financial institutions, such as the International Monetary Fund, loans are made with conditions that negatively impact women's well being. These include demands to cut social services, privatize or eliminate what were previously public goods or services, and remove rules and regulations that were intended to stabilize the market. Austerity measures, much like structural adjustment policies of the past, reduce women's opportunity for employment, especially in public-sector jobs where women make up the majority of employees. Austerity measures also reduce food, housing and

health subsidies- social services that significantly impact women, especially single mothers. It has been well established that the poorest of the poor are women, often heads of households in charge of providing for children and elderly, or ill family members. As a result, those who come to rely on the social services that austerity measures cut and those who are most detrimentally impacted by such cuts are women; especially poor or marginalized women (Pettman, 2006, p. 437).

Regarding the Irish case specifically, Barry and Conroy (2013) point out that during times of economic austerities the cutting of provisions aimed at helping low income households, many of which are made up of single parents, disproportionately affected women and created new inequalities in the public sector. In their 2013 report, the National Economic and Social Council states, "It is those households that have fewest resources, however, that have the least capacity to cope and may, therefore, be more reliant on quality, accessible and affordable public services" (p. 88). Since the start of the economic crisis in Ireland, government bodies that were reduced or cut altogether included the Equality Authority, the Human Rights Commission, the Combat Poverty Agency, the Women's Health Council, the National Committee on Racism/Interculturalism, and the Crisis Pregnancy Agency (Barry & Conroy, 2013, slide 23) contributing to a lack of critical gender analysis in policy realms. Barry and Conroy point out that during times of economic calamity gender equality is cast aside as a marginal issue in the big picture of the national crisis (2013, slide 23).

In regard to sexual and reproductive health, measures taken by the government of Ireland to address the economic crisis included a significant cut to the Health Service Executive (HSE), a government agency charged with delivering health and personal social services. The combination of a decrease in health services and a simultaneous increase in need of people to utilize public health services (both a result of the economic crisis and austerity measures) resulted in the IFPA suspending medical card services, a subsidized health program, for a period in 2008. The IFPA 2008 Annual Report states that, "the IFPA was forced to suspend the provision of services to medical card clients at its main Dublin clinic due to a lack of funding from the HSE resulting in a noticeable reduction in attendances at the clinic" (p. 4). In 2009, the IFPA faced the same challenges and turned away 3,000 medical card users who sought family planning (Irish Family Planning Association, 2009, p. 6). Again in 2010, 2011, 2012 and 2013 the IFPA validated the impact of the recession and consequent austerity measures on women by reporting a fall off in private clients and documenting the organization's inability to meet the increase demand for services from medical card clients. Their 2010 Annual Report states, "Women simply cannot afford to pay for sexual and reproductive health services" (p. 1) and they urge that, "The Government must act now and provide adequate resources for family planning services or risk a reversal of the many social and economic benefits women living in Ireland have enjoyed thanks to access to modern family planning methods" (p. 1).

By 2012 the IFPA had experienced an HSE funding reduction by almost 25% (Irish Family Planning Association, 2012a, p. 2) and had been handling significant cuts to their own budget as they dealt with the ramifications of four years of economic crisis' financial strain on women. Interestingly, by 2012, the documents show a significant shift in the discourse of the IFPA's annual reports. The organization began to explicitly and directly link the vulnerability of poor women and their ability to access reproductive health services to an obligation of the State to protect them based on human rights principles. The IFPA stated that reduction in funding was "severely limiting our ability to respond to the sexual and reproductive health needs of medical card clients, including many women and girls who are low-income or living in poverty" (2012a, p. 2) and they urged that "onus remains on the Irish Government to provide adequate resources for family planning services

for all people in Ireland” (2012a, p. 2). Again, the IFPA promoted women’s sexual and reproductive rights by invoking an international human rights system that sees it as the duty of States to respect, protect and fulfill rights (UN Women, 2015).

Furthermore, in their submissions since the economic downturn, the IFPA called on the State to be held responsible for the provision of health care services and protection of women in Ireland; in particular the protection of groups of women who are most vulnerable. For example, in specific relation to abortion law, the IFPA stated in their 2008 submission to the UN Human Rights Committee:

In an Irish context, women who can afford to travel and/or have legal permission to do so, dependent on their immigration status, for example, can exercise the option of travel to another State in order to access safe abortion services. (p. 6)

In their 2011 submission to the UN Committee Against Torture, the IFPA stated,

The criminalisation of abortion disproportionately impacts vulnerable and disadvantaged women and girls who cannot raise the necessary funds to travel abroad or who cannot leave the jurisdiction because of immigration restrictions as well as young women in the care of the State. (p. 2)

Again in their 2011 Universal Periodic Review, the IFPA stated:

The restrictions on abortion disproportionately impacts women living in poverty. Although abortion is severely restricted within Ireland, the State repeatedly acknowledges that abortion is readily accessed by thousands of women each year who pay to travel abroad. For women living in poverty, raising the necessary funds for flights, hotel, transportation to and from the airport and the private procedure is impossible. Women who do not have the means to travel are forced to continue the pregnancy against their will or seek out illegal and unsafe methods of abortion, creating a risk to her health and wellbeing. (p. 3)

How much more intensified are the burdens placed on women to realize their sexual and reproductive rights in times of economic crisis, especially among those most vulnerable?

By exposing multiple barriers that poor and immigrant women face in accessing sexual and reproductive health care, the IFPA drew attention to the intersection of needs of various groups of women in Ireland. For example, for asylum-seeking women in Ireland, immigration status and economic dependence limit their ability to negotiate reproductive health decisions freely. In an attempt to address the needs of their asylum seeking clients, whose situation can be particularly dire, the IFPA worked together with Akina Dada wa Africa-AkiDwa (Swahili for sisterhood), a network of migrant women living in Ireland (for more information see <http://akidwa.ie>), to develop a program that would inform women seeking asylum of available services and encourage them to feel empowered to access those services. Furthermore, the program aimed to raise awareness of the experiences of and barriers to care that asylum seekers face; experiences that are rooted in the multiple and intersecting needs that arise from being an asylum seeker (Irish Family Planning Association, 2010b).

In 2010, as part of their efforts to promote basic human rights in regard to reproductive and sexual health, the IFPA helped to publish the *Sexual Health and Asylum Report*. The handbook focuses on the work of a grass-roots program called the Majira program, a collaboration between the IFPA and AkiDwA. Together in 2009 and 2010, the participants produced a handbook to help service providers understand the multiple and overlapping barriers that asylum-seeking women face in making and carrying out their reproductive health decisions. In the handbook, common issues that affect asylum-seeking women were identified and addressed. These include awareness of SRH services; unfamiliar health system; communication; interpreting; informed consent; privacy; confidentiality; assumptions; poverty; sex of health care provider; child care; transportation; support networks; limitations on health consultations; LGBT stigma; awareness of laws and regulations; female genital mutilation; gender-based violence; and sexual exploitation/prostitution (Irish Family Planning Association, 2010b). In addition, arenas in which these issues play out are discussed, such as family planning and contraception, cervical cancer screening, sexually transmitted infections, crisis pregnancy and post-abortion care.

In order to fully disclose the labyrinth of regulations that asylum-seeking women must navigate to access abortion services outside the Irish state, the IFPA report (2010b) states:

Women must apply for a re-entry visa from the Department of Justice and Law Reform and a visa from the country to which they will be travelling. Both visas cost approximately 60 Euro each and processing times can take up to 15 working days, depending on which country the woman will be travelling. Furthermore, documentation from the abortion clinic abroad and the crisis pregnancy service attended in Ireland is required to support the visa applications. While the bureaucratic and administrative hurdles are enormous, the cost of visas, flights, accommodations and the termination procedure is impossible for most [asylum seeking] women. (p. 23)

The report here is drawing attention to the need for what Correa and Petchesky (1994) call “enabling conditions;” the conditions that aid in a reconstruction of human rights that acknowledges gender, class, cultural and other differences and recognizes social needs. Enabling conditions involve social welfare, personal security and political freedom (p. 107) and must be present for sexual and reproductive rights to be realized. In the case outlined above, asylum-seeking women need accurate information about reproductive and sexual health services, freedom from violence, financial means to travel, legal means to exit and enter the country and emotional and social support. To sum up this point, in their 2012 publication *New Expert Group Must Vindicate Right to Abortion* Niall Behan, on behalf of the IFPA states:

No woman in a life-threatening situation should be forced to endure the uncertainty, humiliation and distress that these women face. It is in the hands of the expert group to ensure that this never happens again. Time is of the essence. Every day the State fails to reform its restrictive abortion laws, it is violating the judgment of the Supreme Court and the European Court of Human Rights and showing a callous disregard for women’s human rights (p. 2).

Conclusion

At their most basic level, human rights “are held by all human beings, irrespective of any rights or duties that an individual may (or may not) have as citizens, members of families, workers, or parts of any public or private organization or association” (Luna, 2009, p. 345). Framing sexual and reproductive health as a human right carries the potential to hold States responsible to respond to violations of women’s bodily integrity that occur in realms that traditionally have been seen as private, or as part of the domestic sphere (2009, p. 349). In addition, using a human rights structure when discussing sexual and reproductive health links the struggle of women in a particular social or geographic location to similar, though maybe not identical, struggles of women in a variety of social and geographic locations based on a universal and internationally agreed upon framework; potentially creating transnational solidarities (2009, p. 354). Situating sexual and reproductive health within the context of human rights calls on government bodies not only to recognize sexual and reproductive health matters as legitimate but also to protect women’s sexual and reproductive health through funding services (Berer, 2004) and protect against the erosion of access to public services.

Through various documents, such as annual reports and submissions to UN bodies, the IFPA called on the State to be accountable for the provision of health care services and protection of women in Ireland. Such an approach is deeply meaningful in light of the intersection of needs and obstacles that the most vulnerable groups of women face in realizing their sexual and reproductive health. In addition, using a human rights structure when discussing sexual and reproductive health links the struggle of women in a particular social or geographic location to similar struggles of women in other parts of the world thereby creating transnational solidarities.

Of course, efforts to move towards these goals will vary based on social and geographic location as well as varying cultural contexts. Although critiques of human rights discourses have been well documented, such as vague language, an overemphasis on individualism and a presumption of universality, as women’s health advocates invoke human rights frameworks in advocating for sexual and reproductive rights, an understanding and respect for the differences between women based on religion, culture, sexual identity or medical circumstance must be kept in mind both within as well as between countries. Certainly, women’s experiences worldwide cannot be homogenized. A universalizing in rights language must account for and recognize that “different rights have different meanings and values across culture, nation, religion, etc.” (Correa & Petchesky, 1994, p. 117).

With this in mind, moral and political value in human rights remains in that it provides a pro-active strategy and inspiration for advancing sexual and reproductive rights (Sistersong, 2005, p. 3) in terms of change in policy, social norms, social practices as well as emphasizing the need for women to have both the power and resources to make and carry out informed decisions about their sexual and reproductive lives. When organizations like the IFPA act based on a deep commitment to human rights, they pose a major threat to maintaining a social hierarchy that benefits political elites (Luna, 2009, p. 345) and can create a transformation in the lived realities of women around the globe.

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