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Abortion and Constitutional Rights in Ireland Since 2018: Assessing the Health (Regulation of Termination of Pregnancy) Act

Aborto e direitos constitucionais na Irlanda desde 2018: Avaliando a Lei de Saúde (Regulamentação da Interrupção da Gravidez)

Aborto y derechos constitucionales en Irlanda desde 2018: Evaluando la Ley de salud (regulación de la interrupción del embarazo)

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ABSTRACT: This article examines Ireland's current abortion legislation from the perspective of Irish constitutional law. First, it explores constitutional difficulties located both in the Act's text and in established interpretations of its provisions. Second, it describes the constitutional rights that apply to abortion in the post-2018 constitutional order; particularly, abortion-seekers' rights to bodily integrity, freedom from degrading treatment, privacy and equality. It argues that in certain cases, the combined effects of legislative time limits and criminal sanctions jeopardise constitutional rights. Third, it applies this analysis to four specific issues: (i) fatal foetal anomaly, (ii) sexual violence, (iii) risk to health, and (iv) abortion in early pregnancy. Finally, it considers recent recommendations for legislative change, evaluating whether these are sufficient to vindicate abortion-seekers' constitutional rights.
KEYWORDS: Ireland; abortion; constitutional law; reproductive rights; law reform.

RESUMO: Este artigo examina a atual legislação sobre aborto da Irlanda sob a perspectiva da lei constitucional irlandesa. Primeiro, ele explora as dificuldades constitucionais localizadas tanto no texto da lei quanto nas interpretações estabelecidas de suas disposições. Em segundo lugar, descreve os direitos constitucionais que se aplicam ao aborto na ordem constitucional pós-2018; particularmente, os direitos das pessoas que buscam o aborto à integridade corporal, à liberdade de tratamento degradante, à privacidade e à igualdade. Argumenta que, em certos casos, os efeitos combinados dos limites de tempo

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legislativos e das sanções penais comprometem os direitos constitucionais. Em terceiro lugar, aplica essa análise a quatro questões específicas: (i) anomalia fetal fatal, (ii) violência sexual, (iii) risco à saúde e (iv) aborto no início da gravidez. Por fim, considera as recentes recomendações de mudança legislativa, avaliando se são suficientes para defender os direitos constitucionais das pessoas que buscam o aborto.
PALAVRAS-CHAVE: Irlanda; aborto; direito constitucional; direitos reprodutivos; reforma legislativa.

RESUMEN: Este artículo examina la actual legislación irlandesa sobre el aborto desde la perspectiva del derecho constitucional irlandés. En primer lugar, explora las dificultades constitucionales localizadas tanto en el texto de la ley como en las interpretaciones establecidas de sus disposiciones. En segundo lugar, describe los derechos constitucionales que se aplican al aborto en el orden constitucional posterior a 2018; en particular, los derechos de las mujeres que solicitan un aborto a la integridad corporal, a no sufrir tratos degradantes, a la intimidad y a la igualdad. Sostiene que, en determinados casos, los efectos combinados de los plazos legislativos y las sanciones penales ponen en peligro los derechos constitucionales. En tercer lugar, aplica este análisis a cuatro cuestiones específicas: (i) anomalía fetal mortal, (ii) violencia sexual, (iii) riesgo para la salud, y (iv) aborto en embarazos precoces. Por último, examina las recientes recomendaciones de cambio legislativo, evaluando si son suficientes para reivindicar los derechos constitucionales de las solicitantes de aborto.
PALAVRAS CLAVE: Irlanda; aborto; derecho constitucional; derechos reproductivos; reforma legislativa.

1. Introduction

For decades, the Eighth Amendment to the Irish Constitution meant that abortion was only available in Ireland as a last resort, where necessary to save the abortion-seeker's life. In 2018, a referendum removed the Amendment, replacing it with a general power to legislate for abortion. This means that the grounds for accessing an abortion in Ireland are contained in legislation, and are not substantively derived from the constitution itself. The Health (Regulation of Termination of Pregnancy) Act 2018 ('the Act') represents the first exercise of that power. The Act requires anyone accessing an abortion in Ireland to meet prescribed grounds. Abortion is available on request provided that no more than 12 weeks have passed since the abortion-seeker's last menstrual period but the Act imposes a mandatory three-day wait between initial consultation and provision of treatment. In later pregnancy, it requires abortion-seekers to produce evidence of exceptional pregnancy-related suffering: risk to life, risk of serious harm to health, or diagnosis of certain fatal foetal anomalies. Abortion-seekers who cannot meet these criteria cannot access an abortion unless those assisting them commit a criminal

offence. The 2018 referendum has not yet enabled a more creative constitutional framing of reproductive rights. In this article, I analyse the Act's constitutional status.

This article is in four parts. First, I argue that constitutional difficulties reside both in the Act's text and in established interpretations of its provisions. Both refusal of care and delayed care under the Act generate constitutional issues, even where an abortion-seeker unable to access care in Ireland manages to do so abroad. Second, I set out the constitutional rights that apply to abortion in the post-2018 constitutional order. The 'right to life of the unborn' under the Eighth Amendment once dominated constitutional discussion of abortion. With the Amendment gone, we can reframe restrictions on abortion access in terms of abortion-seekers' rights to bodily integrity, freedom from degrading treatment, privacy and equality. In certain cases, the combined effects of legislative time limits and criminal sanctions jeopardise constitutional rights. In the next section, applying this argument to four specific issues: (i) fatal foetal anomaly, (ii) sexual violence, (iii) risk to health, and (iv) abortion in early pregnancy. Finally, I consider recommendations for legislative change set out in the February 2023 report of the Independent Review of the Act and evaluate whether these are sufficient to vindicate abortion-seekers' constitutional rights. At the time of writing, it is not clear whether the Oireachtas will act on the Review's recommendations at all.

2. Constitutional Rights and Access to Abortion Care: An Overview

While the Amendment was in force, the 'right to life of the unborn' was seen to trump any competing rights, except where the abortion-seeker's own life was at stake. No court has handed down a judgment on the abortion issue since the Amendment was removed from the Constitution. However, we can identify the basic substance of the post-2018 constitutional position on abortion. Shortly before the referendum, in *M v Minister for Justice & Others* [2018] IESC 14, the Supreme Court confirmed that the foetus had no rights other than those contained in the Amendment. It follows that removing the

Amendment from the Constitution also removed the independent constitutional right to life of the unborn. As such, the state may still pursue its interests in protecting foetal life as a dimension of the common good, but foetal life is no longer a determinative constitutional force. Pregnancy is no longer a firm limit on the enjoyment of constitutional rights but, rather, provides the context in which many people will exercise those rights at key points in their lives.

Abortion-seekers' constitutional rights may be breached if they cannot access timely abortion care under the Act. I outline four broad kinds of breach here, discussing them more concretely in the article's next section. First, we can imagine direct challenges to the constitutionality of certain provisions of the Act. The Act clearly prohibits abortion in most circumstances, particularly after the first trimester of pregnancy, and some of these prohibitions may not pass constitutional muster. Second, we can imagine a medical negligence case where a woman is entitled to access an abortion under the Act, but her doctor fails to appreciate that the relevant standard of care in her case requires offering the opportunity to terminate the pregnancy. While the primary claim would be in medical negligence, constitutional arguments may also arise. Healthcare practitioners and public bodies such as the Health Services Executive are obliged to protect constitutional rights (*Kearney v McQuillan* [2010] 3 IR 576). In the third kind of case, an abortion-seeker is deliberately refused care which she is entitled to access under the Act. Such cases may arise around conscientious objection. However, we should also anticipate refusals arising from restrictive interpretations or applications of the Act's provisions. In such cases, healthcare personnel may believe that, even if it would otherwise be negligent to withhold abortion care, it would not be legal to provide it. Pro-choice doctors at all levels of Ireland's health service enabled the rollout of abortion provision, including by producing guidance on statutory interpretation, and adapting their practice to provide the best possible care within the limitations of the law (DUFFY et al., 2023, p. 57). However, refusals of legal abortion are a documented problem. These are often framed as a symptom of criminalisation's 'chilling effects' (MULLALLY et al., 2020).

Chilling effects raise clear constitutional issues. We can imagine a case where an abortion-seeker contests their medical team's interpretation of a provision of the Act, requiring the court to clarify how the Act should be interpreted. Constitutional rights must be 'taken seriously' so that they have 'life and reality' in practice. This means that legislation must be interpreted to give effect to those rights (*Buckley v Attorney General* [1950] IR 67). It is also worth noting that while the Amendment was in force, Irish courts affirmed that uncertainty in the abortion law, and consequent confusion among medical practitioners, could undermine the secure enjoyment of constitutional rights (*AG v X* [1992] IESC 1 per McCarthy J *obiter*; *PP v HSE* [2014] IEHC 622). While the courts cannot compel the Oireachtas to amend constitutionally sound legislation, they can highlight flaws and guide interpretation. For instance, where two interpretations of a legislative provision are available, and one is constitutional but the other is not, a court will presume that the Oireachtas intended the constitutional interpretation (*McDonald v Bord na gCon* [1965] IR 217).

Finally, even if care is not refused outright, it may be delayed so that an abortion-seeker falls outside one of the Act's time limits. For instance, a doctor cannot treat a patient under s 12 (access in early pregnancy) after 12 weeks LMP. Delays may arise for many reasons, including a delay in assessing the abortion-seeker's entitlement to access an abortion under the Act, or a failure to transfer care to a different healthcare provider following an assertion of conscientious objection. The Act does not guarantee prompt access to care. It does not say how long an abortion-seeker may wait for care after they have requested an abortion. This is a problem because abortion is always time-sensitive, and so delay can be harmful even if the person affected eventually accesses care. Delay may mean that they may suffer uncertainty, additional trauma or avoidable additional risk to life or health. Delay often means that they cannot access a legal abortion in Ireland at all. This is because the Act partially criminalises abortion by reference to fixed deadlines. If the abortion-seeker misses a statutory deadline, no doctor can treat her without risking prosecution. She can only lawfully be treated in Ireland if she comes within another

statutory ground for abortion access; for instance, the risk to health and life ground under s 9. Of course, even where this is possible, proving eligibility is likely to require the abortion-seeker to suffer a serious and unavoidable deterioration in their health, and associated infringements of constitutional rights. Certainly, anyone unable to access a timely abortion in Ireland may seek one abroad but, as discussed further below, while travel is a safety net, it does not cure breaches of constitutional rights.

The Eighth Amendment's demise fundamentally alters the constitutional position around abortion provision. The Amendment concealed and minimised a range of potential harms which are more visible under the new legislation. In the next section, I examine the substance of the key constitutional rights at issue when abortion care is delayed or denied.

3. Constitutional Rights of Abortion-seekers After the Eighth Amendment

In this section, I survey relevant Irish case law on the rights to bodily integrity and freedom from inhuman and degrading treatment, the right to privacy and the right to equality. I focus on these rights, rather than on the abortion-seeker's right to life, which was already recognised, albeit in a very limited way, under the Amendment. I also briefly consider the rights of conscientious objectors. The Irish courts have considered very few cases directly engaging the constitutional rights of abortion-seekers and so, in this section, it is necessary to draw analogies between abortion-seekers' experiences and the experiences of others litigating equivalent claims before the Irish courts; often patients seeking medical treatment, but also prisoners, asylum-seekers and children in state detention. This discussion establishes the framework for constitutional analysis of the 'grounds' for abortion under the Act.

3.1 Bodily Integrity and Freedom from Inhuman and Degrading Treatment

The right to bodily integrity in Irish constitutional law is not a holistic right to health. Instead, it is a robust right not to have one's health endangered by the state, and to be protected from unjustified bodily interference and restraint. It protects against unwanted medical interventions such as force-feeding (*Governor of a Prison v GDC* [2020] IEHC 34) or unwanted blood transfusion (*JM v Board of Management of St Vincent's Hospital* [2003] 1 IR 321) and is the basis for informed consent safeguards. For instance, in *HSE v B* [2016] IEHC 605 [17], the High Court held that it would violate the rights to bodily integrity and dignity to submit a woman to a C–section against her will. Denial of abortion care may precipitate other unwanted interventions, to facilitate ongoing pregnancy or birth. These, in turn, may jeopardise the abortion-seeker's bodily integrity. 'Bodily integrity' entails more than physical protection. As Hogan J explains in *Kinsella v Mountjoy* [2011] IEHC 235, it encompasses 'not simply the integrity of the human body, but also the integrity of the human mind and personality'. In considering this right in the context of abortion, a court should consider whether the abortion-seeker suffers extreme mental distress as a result of denied or delayed care (*Sullivan v Boylan* [2012] IEHC 389 *per*. Hogan J). The right to bodily integrity can apply when healthcare is criminalised or knowingly withheld (*State (C) v Frawley* [1976] IR 365, 372). It may also encompass a right to help in accessing medical treatment (*McGee v AG* [1973] IR 284 *per* Walsh J *obiter*). For instance, a right to positive assistance has been recognised in some cases involving prisoners, since they cannot arrange medical care on their own. While abortion-seekers in Ireland are not typically imprisoned or detained, the legislative framework means that they can do little, on their own, to address delays in access to care; they are dependent on the actions of others (*MEO v Minister for Justice* [2011] IEHC 545). In such circumstances, delays in access to medical care can violate the right to bodily integrity (*Barry v Governor of the Midlands Prison* [2019] IEHC 594 [67]). The point is not only that delays cause physical conditions to worsen but that they exacerbate mental distress (*NHV v Minister for Justice* [2016] IECA 86 [118]).

Although travel abroad may secure access to abortion care, it may also expose an abortion-seeker to other violations of the right to bodily integrity. Travel disrupts continuity of care (ABORTION RIGHTS CAMPAIGN, 2022, p. 25). Treatment is delayed while the abortion-seeker makes travel arrangements and navigates a foreign healthcare system (KENNEDY, 2021, p. 56). In certain cases, for instance, where the abortion-seeker is ill and travel is demanding, the enforced journey may jeopardise their constitutional rights. The issues here resonate with those in *Aslam v Minister for Justice* [2011] IEHC 512, where the High Court recognised that mandatory transfer of a heavily pregnant asylum-seeker by sea or air, risking early labour, could compromise her bodily integrity. Equivalent violations are possible in the case of a gravely ill person denied an abortion on health grounds in Ireland, or a person denied an Irish abortion who is at risk of losing a pregnancy following a fatal foetal anomaly diagnosis. It is irrelevant that some help is available from private charities such as the Abortion Support Network; the state cannot delegate its responsibilities to them. In later pregnancy, a delay may mean that even if the abortion-seeker travels to another jurisdiction, they can only access more expensive and burdensome forms of abortion care. Protracted delays may also mean that the abortion-seeker denied an abortion at home struggle to access one abroad. For example, people travelling to England will need to reckon with the 24-week time limit for terminating a pregnancy on health grounds under the Abortion Act 1967. As Hogan J observed in *A v MJELR* [2011] IEHC 397, it is not enough that an opportunity to vindicate a constitutional right is available abroad in principle; it must also be genuinely accessible in practice.

Violations of the right to bodily integrity can amount to inhuman and degrading treatment, provided that the individual experiences a minimum level of severity of risk to health, or of distress or humiliation (*Barry v Midlands Health* [2019] IEHC 594). Arguably, any degrading effects of the Act are indirectly rather than deliberately imposed, and older Irish cases suggested that inhuman and degrading treatment must be inflicted with the deliberate intention to punish the sufferer by taking advantage of their vulnerability. It must be 'evil in its purposes' as well as 'evil in its consequences' (*Mulligan v Governor of*

Portlaoise [2010] IEHC 269). More recent case law, however, imposes no such requirement. Thus, the Constitution may recognise that an abortion-seeker may be subjected to degrading treatment where she requests abortion care to avoid a serious risk to health, even if her medical team denies or delays abortion care on the basis of a good-faith medical judgment, or a reasonable but erroneous interpretation of the Act.

These protections necessarily intersect with concerns for vulnerability and marginalisation. In a 'humane society', the duty to protect the right to freedom from degrading treatment, as Hogan J observes in *Connolly*, is 'most acute in the case of those who are vulnerable, marginalised and stigmatised' (*Connolly v Governor of Wheatfield Prison* [2013] IEHC 334). Where a vulnerable person, such as a child, a refugee, a person living in poverty, or an individual who is under the care and control of the state requires abortion access, the constitutional claim to protection from degrading treatment is even stronger (*SF v Director of Oberstown Children Detention Centre* [2017] IEHC 829). An abortion-seeker's underlying health conditions may impose additional obligations on the state, particularly where these are potentially life-threatening. In recognising a right to access contraception in *McGee v AG* [1973] IR 284, 315 Walsh J insisted that, where pregnancy placed a woman's health at extraordinary risk, she would have 'a right to be assisted in her efforts to avoid putting her life in jeopardy'. The state would then have 'a positive obligation to ensure by its laws as far as is possible' that the means of preserving her life were made available to her.

3.2 Privacy

The constitutional right to privacy includes a right to autonomy or self-determination (*Simpson v Mountjoy* [2020] IESC 52 [10] *per* O'Donnell J.). In particular, it includes a right to make informed decisions about one's own health (*Kearney v McQuillan* [2010] 3 IR 576 per. MacMenamin J). By definition, any restriction on abortion access engages this right, because sexuality and reproduction are core and intimate dimensions

of private life. In *McGee v AG*, the Supreme Court recognised that the decision to limit the size of one's family fell within the constitutional right to marital privacy. In that case, the Supreme Court was clear that the right applied irrespective of the individual's state of health; suffering is not a qualifying condition for privacy. Since *McGee* the courts have confirmed that the right to privacy applies to personal as well as marital life (*Kennedy v. Ireland* [1998] 1 ILRM 472). The Amendment was inserted into the Constitution as a deliberate check on the privacy rights enumerated in *McGee* (*M v Minister for Justice* [2018] IESC 14 [10.10]). We can reasonably assume that these rights are restored now that the Amendment has been repealed.

The constitutional right to freedom of conscience may buttress the right to privacy here. The Irish case law on this right is limited and has generally associated freedom of conscience with freedom of religion (*McGee v Attorney General* [1974] IR 284, 291–92, 303, 326.). However, freedom of individual philosophical and moral conscience is also arguably part of the constitutional fabric (*AM v Refugee Appeals Tribunal* [2014] IEHC 388 [32]–[33]). In addition, the parental rights protected under the Constitution may strengthen the argument from individual privacy. For example, following severe foetal anomaly diagnoses, abortion-seekers and their families make serious and weighty decisions in the interests of their whole families, any existing children, and the fatally compromised foetus, and these may legitimately include a decision to terminate the pregnancy.

An expansive account of the relationship between privacy and self-determination would recognise that the Constitution protects individuals' rights to determine the long-term shape of their lives, and to access the available resources necessary for full citizenship. The Act does not fully recognise the abortion-seeker's moral capacity but subordinates their moral judgment to the determinative judgment of others in one of the most intimate possible areas of personal life. The statutory criteria for access to abortion may be, as the Canadian Supreme Court once put it, 'entirely unrelated to [the abortion-seeker's] own priorities and aspirations' (*R v Morgentaler* [1988] 1 SCR 30). From this

perspective, the statutory three-day waiting period under s 12 of the Act may be an especially egregious violation of the right to privacy, since it bears no connection to individual abortion-seekers' circumstances or aspirations (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 41).

3.3 Proportionality

No provision or operation of the Act is illegitimate merely because it infringes a constitutional right. What matters is that the infringement is disproportionate. The courts will generally defer to the Oireachtas' assessment of proportionality (*O'Doherty and Waters v Minister for Health* [2022] IESC 32 [62]–[65]). However, any infringement of constitutional rights through restriction and criminalisation of abortion access should be proportionate to the public policy goal sought to be achieved. The more serious the breach, the greater the justification required (*Meadows v Minister for Justice* [2010] 2 IR 701). As already discussed, with the Amendment gone, the Oireachtas remains entitled to pursue a policy goal of protecting foetal life, as a dimension of the common good. Other relevant policy goals include the imperative to promote safe abortion for those entitled to it, and to deter harmful practices. Whatever policy goals are invoked, the means selected to achieve them – a combination of time limits and criminal penalties – are subject to serious scrutiny.

It is doubtful that criminalisation of abortion is rationally connected to the Oireachtas' policy objectives. Arguably, it is irrational to seek to prevent abortion by criminalising it, because criminalisation does not achieve the policy goal of protecting foetal life by substantially reducing the number of abortions taking place within Ireland or accessed by Irish residents. It is not merely that criminalisation achieves any retributive, deterrent or public-order goal at the expense of individual rights, but that it does not achieve them at all (DE LONDRAS et al., 2022). People still access abortion despite criminalisation, just as they did under the Amendment, but later in pregnancy and under

more burdensome circumstances. These restrictions may be inspired by another policy goal; that of ensuring that where abortions happen, and especially where they happen in late pregnancy, they are done safely and by professionals. However, it is not clear that criminalising doctors generates safety benefits that are not already secured by the wider medical law. On the other hand, criminalisation, combined with strict time limits, undermines the policy goal of ensuring that those legally entitled to abortion care can access it safely. At the time the Act was passed, the Oireachtas emphasised 'legal certainty' as a key objective of new abortion law; it recognised that well-drafted abortion law can confer a sense of security both on abortion-seekers and on their doctors. In practice, however, criminalisation of abortion under the Act has amplified ambiguity in the law, generating 'chilling effects', (ABORTION RIGHTS CAMPAIGN, 2022, p. 12) encompassing both burdensome over-compliance with the law and refusal to provide care, at all, or to the full extent permitted by law. In addition, the Act imposes arbitrary time limits, which are unrelated to any therapeutic considerations and compound the unfairness of criminalisation.

We should also ask whether the current criminalisation of abortion impacts as little as possible on abortion-seekers' constitutional rights. In other words, any infringement on those rights must be tailored to achieving the policy objectives of protecting foetal life and deterring unsafe abortion. Certainly, the Oireachtas is free to draw on alternative less punitive social measures to protect foetal life by encouraging continued pregnancy. However, the Constitution allows the Oireachtas significant latitude in selecting means to achieve its policy ends. Criminalisation of abortion, in itself, is probably legitimately within the Oireachtas' toolkit. The more serious difficulty is that the Act appears overwhelmingly concerned to restrict access to abortion and offers little 'balance' between individual rights and public-policy goals. There are three key points here. First, the time limits imposed under the Act make no exceptions for individuals who may find it more difficult to navigate the abortion care system. The Act offers abortion-seekers no countervailing guarantee of prompt access to care, or of

effective help for those refused a lawful abortion. Second, the law does not criminalise only those abortions that are inherently unsafe, performed by unqualified people or done without the abortion-seeker's consent. Third, an abortion-seeker who falls short of the legislative criteria in some a minor way – for instance, by missing the 12-week deadline under s 12 by just one day – can be denied abortion access with all of the severe personal and health consequences that that entails, and with no other effective means of vindicating affected constitutional rights (*Murphy v Independent Radio and Television Commission* [1999] 1 IR 2 [48]). Legislators might argue that extensive prohibitions avoid the need to involve state agents in determining which abortions are acceptable and which are not. This argument is weakened by a range of provisions in the Act which require doctors to do precisely that; for instance by evaluating the severity of risks to health (s 9), or the likelihood that a foetus will die within 28 days of birth (s 11).

3.4 Equality

The Act only applies to 'women'. We might argue that certain restrictions on access to abortion violate rights to gender equality because no form of cisgender men's healthcare is subject to the kinds of criminal restrictions habitually applied to abortion. Some of the Act's provisions, such as the mandatory three-day waiting period under s 12, draw on stereotypes of women as inherently indecisive or irrational. Irish constitutional equality jurisprudence is underdeveloped, especially as regards substantive equality, and the courts avoid discussing it where other constitutional approaches are available (*Murtagh Properties v Cleary* [1972] IR 330). In theory, of course, abortion engages the constitutional right to equality because reproductive self-determination 'relates to [individuals'] essential attributes as persons' (*Quinn's Supermarket v Attorney General* [1972] IR 1). Discrimination claims based on sex or gender are subject to especially strict scrutiny (*Re Employment Equality Bill 1996* [1997] 2 IR 321). However, the Constitution in Article 40.1 expressly permits the Oireachtas to 'have due regard to differences of

capacity, physical and moral, and of social function'. This means that the Oireachtas enjoys wide discretion to distinguish between people based on sex or gender, provided that the distinctions imposed are not 'invidious, arbitrary or capricious'. Differences in reproductive capacity may be assumed to produce unavoidable and natural differences in social function. For example, in *MD v Ireland* the Supreme Court was persuaded that such differences could justify disparate approaches under criminal law; the state could be justified in criminalising boys, but not girls, who engaged in underage sexual intercourse because girls could get pregnant and boys could not (*MD v Ireland* [2012] IESC 10). It may follow, therefore, that the Oireachtas is justified in applying exceptional criminal regulation to abortion, despite the consequences for gender equality, because it is impossible to address abortion without exposing people who have the biological capacity to become pregnant to distinctive burdens. However, it should be possible to distinguish between the criminalisation of abortion in general, and the more fine-grained regulation of abortion practice. For instance, an equality argument in a case focusing on the criminal regulation of abortion with pills in early pregnancy might have a greater chances of success, since it is more difficult to distinguish the practices of prescribing, dispensing and taking 'abortion pills' (mifepristone and misoprostol) from those applied to other medications which might be used by both men and women (ERDMAN; JELINSKA; YANOW, 2018).

Besides basic issues of gender inequality, the Act generates well-documented problems of abortion access for minoritised groups, including disabled people, migrants, people living in poverty, people at risk of domestic violence, and adolescents (ABORTION RIGHTS CAMPAIGN, 2021, p. 11–14). Even if the legislation does not exclude these groups by name, in practice, abortion is not equally accessible to them. The legislative time limits are punitive. They assume an abortion-seeker who has a strong awareness of their body so that they realise they are pregnant in good time; are aware that they are eligible for an abortion; know how to access it or can find out quickly; have the resources to travel repeatedly for care if necessary and do not require much help to organise appointments,

interact with doctors, or make and implement healthcare decisions. In theory, the Constitution may require state agents to ensure that people who may lack any of these characteristics – teenagers, some disabled people, newcomers to Ireland or people living in poverty – receive accommodations when accessing legally available healthcare. Case law on equitable access to public services is limited and concentrates on the narrow question of access to the courts. Certainly, while the Amendment was in force, state agencies provided limited assistance with abortion travel for migrants and children in state care, but it is not clear that this support mandated by the Constitution (*A and B v Eastern Health Board* [1997] IEHC 176), or indeed, that it was sufficient to vindicate affected people's rights (FLETCHER, 2013).

The Act's time limits pose a different equality problem. Arguably, equality requires not that people are helped to meet unfair criteria, but that those criteria are changed, so that barriers to abortion access are lowered or eliminated. For example, some people burdened by the provisions for access to abortion in early pregnancy under s 12 could be accommodated by a more expansive interpretation of s 9 (the health ground). Others would be better served if doctors could suspend the three-day wait requirement under s 12 in appropriate cases or extend that section's 12-week time limit, or if both provisions were removed from the Act altogether. The Constitution allows the Oireachtas to make special provision for minoritized groups in its legislation. For example, the Oireachtas could extend the 12-week time limit under s 12 to facilitate abortion access by minors because they may take longer to realise that they are pregnant and to disclose their pregnancies to others. However, the constitutional jurisprudence on indirect discrimination is underdeveloped, and it is not clear that the Constitution actually requires the Oireachtas to change the law to ensure equality of access to legally available services (*Fleming v Ireland* [2013] IESC 19 [136]).

Fleming v Ireland [2013] IESC 19 is a case in point. Marie Fleming argued that the criminal law on assisted suicide discriminated against her. Her health had deteriorated so that it was impossible for her to end her life on her own, and the law criminalised

anyone who would help her. The Supreme Court held that the law did not violate her right to freedom from discrimination simply because it made no exception for people in her position. The law did not directly discriminate against disabled people. It was addressed, not to Ms Fleming, but to her potential assistant. The Court even suggested that it was not the law but Ms Fleming's disability that caused her difficulty, and that she could have escaped the strictures of the law if she had acted to take her own life while she was still well enough to do so. As with the law challenged in *Fleming*, the abortion legislation does not directly discriminate against any category of abortion-seeker and the criminal dimension of the law is addressed, not to abortion-seekers, but to those who would assist them. That said, perhaps *Fleming* would have been decided differently if the Supreme Court had accepted that the law in that case had some impact on one of Ms Fleming's fundamental rights. The Court held that the disputed law in *Fleming* was intended to protect the constitutional right to life and that there was no constitutional basis on which to assert a state-sanctioned right to die. A court could approach the abortion law differently. Unlike assisted suicide, the abortion legislation already permits abortion in some circumstances and there is now a clear constitutional basis – in the rights to privacy and bodily integrity as discussed above – for a claim to access abortion in a range of circumstances not currently provided for by statute. The abortion-seeker's case may be strongest where their health or life is at risk; here, their equality claim would intersect with the state's duty to safeguard life and preserve citizens from violations of their bodily integrity. Following *Fleming*, however, it might be argued that a person denied an abortion has not been disadvantaged by the law, since, theoretically at least, they could have sought an abortion earlier in pregnancy. On this argument, any harm suffered would be attributable to the progressing pregnancy and not to the law itself, just as Ms. Fleming's suffering was attributed to her disability. That argument would be weaker in a case where an abortion-seeker only came to need an abortion in later pregnancy, following a health crisis or a diagnosis of fatal foetal anomaly.

3.5 The Rights of Those Who Object to Abortion

A doctor may refuse to treat an abortion-seeker, not because he believes the law forbids him to provide care a given case, but because he opposes abortion. In s 22, the Act acknowledges the rights of such 'conscientious objectors'. The Act provides that while a healthcare practitioner cannot be compelled to participate in a non-emergency abortion, they are obliged to make alternative arrangements for that patient's care (s 22(3)). This limitation on the objector's freedom of conscience is proportionate; necessary to give 'life and reality' to the countervailing rights of the abortion-seeker (*Article 26 and the Employment Equality Bill* [1997] IESC 6.). Arguably, indeed, the statutory restriction here does not go far enough, because s 22 contains no direct enforcement mechanism; a doctor who refuses to promptly transfer care to a willing colleague is not punished (O'SHEA, 2023, p. 14). Objectors may also obstruct lawful access to abortion in other ways – for instance, through persuasion or conservative interpretation of the legislation or refusal to co-operate with colleagues –without disclosing their motivations.

4. Specific Issues in the Constitutional Law of Abortion

In this section, I use the constitutional arguments set out above to analyse the statutory 'grounds' for abortion access under the Act. I explore specific potential breaches of constitutional rights arising under each ground.

4.1 Fatal Foetal Anomaly

Section 11 of the Act regulates fatal anomaly cases using a familiar combination of criminalisation and time limits. In this instance, however, the time limit relates to the foetus' prognosis rather than to the duration of the pregnancy. The Act requires two

doctors to certify that the foetus is likely to die before, or within 28 days of, birth. If they cannot make that prediction in good faith, they cannot lawfully offer the abortion-seeker an abortion in Ireland. Many women continue to leave Ireland to access abortion following fatal foetal abnormality diagnoses because doctors caring for them cannot adequately determine when the baby, if born alive, will die (O'SHEA, 2023, p. 67).

Denial of abortion access following a fatal foetal anomaly diagnosis can breach the constitutional right to freedom from degrading treatment. Arguments to this effect have succeeded in other legal forums. In *Mellet* (UN Doc No CCPR/C/116/D/2324/2013 (2016)) and *Whelan* (UN Doc No CCPR/C/119/D/2425/2014 (2017)) the UN Human Rights Committee identified Ireland's pre-2018 abortion law with the infliction of 'intense mental and physical suffering' and 'a high level of mental anguish' on abortion-seekers required to leave Ireland to end a pregnancy abroad following a fatal foetal anomaly diagnosis. Although Ireland's abortion law no longer directly criminalises women, most of salient features of *Mellet* and *Whelan* continue under the Act. They include ruptures in continuity of healthcare, the requirement to navigate an unfamiliar health service, and the requirement to seek care abroad without the support of trusted doctors, family, and friends (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 68). Women denied care in Ireland after a foetal anomaly diagnosis describe depending on charitable support to fund treatment and travel, (CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 172) separation from family and friends, (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 68; CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 173) and difficulty in repatriating their babies' remains. These issues can all have a serious impact on a family's ability to frame and grieve their loss (CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 177). In the UK Supeme Court's judgement in *NIHRC's Application* ([2018] UKSC 27 [237]–[238]) Kerr LJ, dissenting, held that an abortion-seeker is 'plainly humiliated' if she is required, against her wishes, to carry a foetus who is doomed to die. Kerr LJ confirmed that this distress is exacerbated, not eased, if the only way to end the pregnancy is to travel to a foreign jurisdiction without the support of friends and family. Some women who travelled for

abortion care after 2018 reported a sense of stigma or shame associated with being told that they did not qualify for care in Ireland (CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 173). People receiving a fatal diagnosis at or after 20 weeks are under significant time pressure They may need to withdraw from assessment under Irish law and travel sooner rather than later, in an effort to obtain care in the UK before 24 weeks when it is more accessible, less expensive and less burdensome (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 26; CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 149).

The 28-day provision in s 11 is arbitrary because it does not reflect any substantive difference either in outcomes for the foetus or in affected abortion-seekers' experiences. It is not a meaningful tool for distinguishing between fatal and 'severe' anomaly (POWER; MEANEY; O'DONOGHUE, 2020). From the abortion-seeker's perspective, the distress associated with denial of abortion care or with travel abroad is not materially different whether doctors predict the foetus will die within a month of birth, or weeks later. In addition, the 28-day limit in s 11 cannot always be justified as necessary to protect foetal life in the later stages of pregnancy. Even under the Amendment, the courts recognised that the duty to protect foetal life was weaker where nothing could practicably be done to ensure that the foetus was born alive. This was illustrated in *PP v HSE* [2014] IEHC 622 where the High Court held that it was not permissible to expose a brain-dead pregnant woman's body to futile and 'grotesque' medical interventions in an effort to keep the foetus alive as long as possible. With the Amendment repealed, the state's legitimate interest in foetal life is more narrowly drawn. It is not obvious that it can justify wide-ranging restrictions on abortion access following a fatal anomaly diagnosis, even where there is a slim chance that the foetus will survive for more than a month after birth.

Besides challenging the constitutionality of the 28-day limit, an individual denied an abortion on fatal foetal anomaly grounds might argue that s 11 should be interpreted more expansively to guarantee abortion-seekers' relevant rights. This section imposes a significant interpretive burden on doctors willing to provide care (CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 33). It requires two doctors to certify that they are of the

reasonable opinion formed in good faith that there is 'present a condition affecting the foetus that is likely to lead to the death of the foetus' either before or within 28 days of birth. Prospective quality of life is irrelevant. The legislation does not specify the degree of likelihood of death, but there is some evidence that in practice many doctors will require something approaching certainty before certifying that a patient is eligible for abortion under s 11. Available evidence suggests(ABORTION RIGHTS CAMPAIGN, 2021, p. 7) that s 11 is not always interpreted consistently across hospitals. Although the Act provides that only two doctors need to decide together, it is common for larger multi-disciplinary teams to decide these cases on a group consensus basis. These behaviours suggest a strict working interpretation of what certifying doctors are required to do in order to demonstrate the 'reasonableness' of their decision (MISHTAL et al., 2021, p. 30). This is an example of a 'chilling effect' under the law because doctors engage in over-compliance in order to avoid criminalisation (DUFFY et al., 2023, p. 58). This 'chilling effect' also imposes resource burdens because foetal medicine units are seen to require access to a range of additional expertise and testing facilities in order comply with the Act. In practice, an abortion-seeker who is legally entitled to an abortion in Ireland on fatal foetal anomaly grounds may be denied that abortion, and suffer associated breaches of constitutional rights, even where two appropriate doctors are available and willing to certify based on their reasonable good faith opinions.

4.2 Sexual Violence

The Act does not include a specific 'sexual violence' provision. The Oireachtas assumed that a person who has been raped would access an abortion 'on request' before 12 weeks LMP under s 12 (ABORTION RIGHTS CAMPAIGN, 2022, p. 18). A person who cannot access an abortion even though she is pregnant because of rape is undoubtedly exposed to degrading treatment. This principle is well established under international human rights law (*Mellet v Ireland*, UN Doc No CCPR/C/116/D/2324/2013 (2016); *Whelan*

v Ireland, UN Doc No CCPR/C/119/D/2425/2014 (2017)). The basis for an equivalent position is also visible in Irish constitutional law. In *DPP v Tiernan* [1988] IR 250 Finlay CJ wrote that rape was a 'gross attack upon the human dignity and the bodily integrity of a woman and a violation of her human and constitutional rights', including because rape could impose the possibility of a distressing pregnancy and birth on the victim. Finlay CJ recognised that a deeply unwanted pregnancy continued the original violation of the rape. In addition, the Oireachtas has a legitimate interest in ensuring that victims of sexual crime can access abortion without undue procedural burdens. In practice, the Act prevents that interest from being achieved. At a minimum, the legislation should allow for extension of the s 12 time limit in cases where a pregnancy is related to rape or other sexual coercion.

4.3 Risks to Health

Abortion should be available in Ireland in cases where a continuing pregnancy places a woman's health at risk of serious harm, but in practice this ground is rarely used, and researchers have struggled to access women who have attempted to avail of it (CONLON; ANTOSIK-PARSONS; BUTLER, 2022, p. 126). Section 9 requires two doctors to certify that they are of the reasonable opinion formed in good faith that the abortion-seeker is a risk of 'serious harm' to their health, that the foetus has not reached viability and that it is 'appropriate to terminate the pregnancy in order to avert the risk'. 'Serious harm' to health is not defined. Neither is 'appropriate'. Although it is not clear that 'serious' means 'permanent' or 'life-threatening', so few abortions are performed under s 9 as to suggest that it is being interpreted in this way (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 56). For instance, the number of abortions provided in Ireland on grounds of risk to life or health after 12 weeks in 2022 was very low – 26 (KENNEDY, 2021, p. 29). An equivalent number of abortions were provided on grounds of risk to life in the years before the Amendment was repealed (ABORTION RIGHTS CAMPAIGN, 2022, p. 18).

Government statistics do not distinguish between s 9 abortions performed on grounds of risk to life, and those performed on grounds of risk to health (DEPARTMENT OF HEALTH, 2023). They cannot indicate whether abortion is accessible when serious health risks materialise after 12 weeks LMP, or whether abortion-seekers are required to wait until it is clear that continuing pregnancy will pose a risk to life. It may be that low numbers of terminations under s 9 reflect the availability of abortion on request in earlier pregnancy. However, these statistics nevertheless suggest that s 9 is not available as a safety net where abortion is sought after 12 weeks LMP and the abortion-seeker's health is foreseeably at risk, but their life is not. This would also mean that s 9 abortions are not available after 12 weeks LMP in cases of rape or in cases of foetal abnormality not deemed to meet the restrictive test in s 11, even where the abortion-seeker's mental health is at risk of serious harm. As with s 11 it is likely that the risk of arrest and prosecution has had a 'chilling effect' on interpretation of the legislation within the healthcare system. There is some suggestion that risk to life and risk to health are being conflated in practice(O'SHEA, 2023, p. 8) or even that some doctors may not understand how the law in this area has changed (DUFFY et al., 2023, p. 74).

Section 9 should also be understood as reinforcing the 12-week time limit under s 12. After 12 weeks LMP, most abortion-seekers requiring an abortion in Ireland are abandoned by the law, regardless of their circumstances. Alternatively, s 9 forces those whose health is already at clear risk to wait until their life is in jeopardy or until they are exposed to avoidable permanent or long-term health consequences. If that is the case, then s 9 of the Act mirrors the old position under the Amendment, whereby people were denied an abortion in earlier pregnancy, even if a risk to life was foreseeable, and required to wait until they were almost at death's door. As such, severe violations of the rights to bodily integrity and freedom from inhuman and degrading treatment may flow from the narrow application of s 9.

4.4 Abortion in Early Pregnancy

Two time-based restrictions govern abortion in early pregnancy. The first is the rigid 12-week LMP limit under s 12. 'LMP' indicates that the time limit is counted from the abortion-seeker's last menstrual period, rather than from an estimated date of conception (s 12(5)). Foetal age is two weeks behind the gestational age calculated using LMP. This time limit is strict (12 weeks + 0 days). The time limit is entirely arbitrary; it has no rational connection to medical practice. It applies even to cases of failed early medical abortion (ABORTION RIGHTS CAMPAIGN, 2021, p. 6). Early medical abortion has a 2 per cent failure rate and access to early surgical abortion in Ireland is very limited (ABORTION RIGHTS CAMPAIGN, 2022, p. 30). If an abortion-seeker is treated under s 12 before the 12-week period has elapsed, and the abortion fails, the deadline cannot be extended, (DUFFY et al., 2023, p. 57) even though the failed abortion is not the abortion-seeker's fault (KENNEDY, 2021, p. 20). Those refused care in early pregnancy are likely to face further suffering. A woman refused care at a few days past the 12-week limit may take weeks to arrange treatment abroad, if she can even travel at all. So, a refusal in Ireland at 12 weeks may become a more difficult and expensive termination at 20 weeks elsewhere(DONNELLY; MURRAY, 2023, p. 13) or a continued unwanted pregnancy at home.

Since the time limit triggers potential criminal penalties, it also produces chilling effects. For instance, abortion-seekers considered to be close to 10 weeks LMP are often referred for ultrasounds even though this is not required by law and can impose additional delays (ABORTION RIGHTS CAMPAIGN; GRIMES, 2021, p. 38). In addition, as a matter of policy, from 10 weeks LMP, abortion-seekers are only treated in hospital rather than in the community. This generates obvious burdens for primary care providers, who may need to work under pressure to ensure a hospital appointment for a person approaching the 12-week limit (KENNEDY, 2021, p. 38).

Section 12 also imposes a three-day wait requirement. This waiting period is unique to abortion care. It has no therapeutic justification and reflects a paternalistic impulse to ensure that women seeking abortion on request have properly considered their decision (O'SHEA, 2023, p. 86). It directly engages the right to privacy because it is rooted in the assumption that abortion-seekers are unreliable decision-makers. It is also inappropriate given the time-sensitivity of early access to medical abortion (ABORTION RIGHTS CAMPAIGN, 2022, p. 13). It leads to delays in abortion access, which may expose abortion-seekers to unnecessary risk. The mandatory waiting period necessitates two doctors' appointments, compounding existing burdens on those – for instance, teenagers, homeless people or disabled people – who may already struggle to keep multiple appointments (O'SHEA, 2023, p. 17). A three-day delay may also mean that they cannot access an abortion in Ireland within 12 weeks and will face further delays until they can arrange and pay for travel and treatment abroad.

The s 9 health ground is interpreted so restrictively that s 12 is the only legal route to abortion for a range of abortion-seekers in extremely demanding circumstances. As such, delays or denials of care after 12 weeks may lead to breaches of the right to freedom from degrading treatment. Even outside of such cases, it is possible that the time-based criminal provisions under s 12 are unconstitutional as unjustified breaches of the right to privacy. In *McGee*, the Supreme Court found that a law criminalising the importation of contraceptives was unconstitutional as a breach of the right to marital privacy. Today, the same right – to assert sexual and reproductive self-determination by pursuing what Henchy J. called an 'informed and conscientious wish' to use a safe medication or device – can be asserted outside of marriage. There are strong parallels between the contraceptives at the centre of *McGee* and the pills used for early medical abortion. Sale and importation of contraception were criminalised at the time of the *McGee* decision but its use was not. Similarly, in Ireland today, it is a crime to assist someone else to have an abortion outside the terms of the Act, but it is not illegal to use pills to self-induce abortion (s. 23(3)), even if it may be difficult to acquire them in

practice. Unlike in *McGee*, abortion-seekers who have abortions are not criminalised, but their doctors are. In some ways, this worsens their situation by comparison with Mrs McGee. Mrs McGee made her decision with her doctor's help, but a woman who needs an abortion after 12 weeks LMP is denied access to meaningful medical help by s 23 of the Act which criminalises that assistance in most circumstances. In addition, by criminalising doctors, the Act arguably exposes women to some of the same harms of criminalisation considered in *McGee*. For example, if a doctor were prosecuted for performing an illegal abortion, the abortion-seeker's private life would also be affected by the associated police investigation, and potentially by court proceedings, even if she did not desire the prosecution and even if the case were never made public. If an abortion-seeker accesses abortion illegally – for instance, using pills – she is vulnerable to many of the burdens typical of the pre-2018 abortion experience: secrecy, fear, and concern for those assisting her (DE LONDRAS, 2020, p. 44).

Over fifty years ago, the *McGee* Court was clear that rights to access contraception did not extend in the same way to ending a pregnancy. However, a resounding majority vote in the 2018 referendum has since clarified that abortion is constitutionally permissible in principle. It may be that the state is entitled in principle to restrict access to abortion later in a viable pregnancy. It is less likely that early pregnancy is sacrosanct. In the right case, a court might be persuaded that early medical abortion at 14 weeks LMP, for example, falls within the zone of privacy protected by the Constitution. The strength of such a case would depend on the court's interpretation of other elements of the Act: for example, a 12-week LMP time limit may seem more reasonable if there are meaningful routes to access after 12 weeks, such as under the s 9 health ground.

5. Conclusion: Prospects for Change?

This article has argued that the Irish approach to abortion continues to present serious constitutional problems, although they are more complex and varied than was once the case. Not all require substantive constitutional solutions. Some issues identified in this article can be solved, at least temporarily, without amending the Act. Improved ministerial or clinical guidance would suffice in some instances. This was made clear at the height of the COVID–19 crisis when the government facilitated telemedicine services by clarifying that the 'having examined' provision in s 12 did not require in-person physical examination (SPILLANE et al., 2021). Similar guidance could clarify, for instance, that s 11 does not require a certifying doctor to be certain that the foetus will die before or within 28 days of birth, but only that they are more likely to die than not. Guidance could also clarify that 'serious harm' to health under s 9 does not equate to permanent, life-threatening or disabling harm. The Independent Review made recommendations to this effect (O'SHEA, 2023, p. 21, 67).

However, other problems cannot be solved using guidance alone. The Independent Review fell short of recommending that abortion care should be fully decriminalised, or relevant criminal offences radically narrowed. It is not clear that guidance alone could undo the 'chilling' impact of criminalisation. The legislation should also be amended to ensure accountability where abortion-seekers' statutory entitlements are not fulfilled. At present, the Act offers little procedural certainty for abortion-seekers. No statutory remedy is available to an individual who could show that they were entitled in principle to a s 9 or s 11 abortion but were prevented from accessing it because they were not informed of their right to a review, received a substandard review, or were blocked by an uncooperative conscientious objector. In these cases – reviews and transfers following conscientious objection – the Oireachtas inserted specific, albeit weak, protections into the Act, but it is difficult to impose accountability for non-compliance. Given the real risk of breach of the right to bodily integrity or freedom from inhuman and degrading treatment arising from delay, the Oireachtas should amend

the Act to include clear and enforceable statutory entitlements to timely and effective care.

Arbitrary time limits, including the 12-week limit for abortion access in early pregnancy, should be revisited or removed. The Independent Review advised reframing the three-day waiting period under s 12 as a statutory entitlement, which individuals could exercise or not. The Review also suggested extending the 12-week time limit in exceptional circumstances, where an abortion-seeker 'times out' before care has been provided or completed (O'SHEA, 2023, p. 25). This would cover failed treatment, delays caused by the three-day wait if retained, or delays within the healthcare system. As drafted, however, it would not address obstacles to accessing timely care associated with structural inequalities (CHAKRAVARTY et al., 2023). More extensive amendments are necessary. The time limit could be removed or extended, or the Oireachtas could make statutory exceptions for categories of individual who are more likely to suffer severely where time limits are enforced.

As de Londras has written, (DE LONDRAS, 2020, p. 42) the Act betrays uncertainty about abortion-seekers' legal status. They are no longer criminalised as they once were, but the Oireachtas has not clarified their status as rights-bearers or explored their post-2018 position within the Constitution. Given the Act's restrictions and silences, we can assume either that the Oireachtas assumes that abortion-seekers have no significant constitutional rights at all (DE LONDRAS, 2020, p. 45) or, perhaps, that the Oireachtas is leaving it to other constitutional actors, including litigants and judges, to figure out what they might be. It may be that Irish feminist activists will need to adopt tactics familiar from Latin American reproductive rights movements, and engage more directly in strategic litigation around delayed and denied abortion care (ERDMAN; BERGALLO, 2024).

At the same time, this article, in staying as close as possible to a plausibly mainstream approach to Irish constitutional interpretation, suggests a need for careful reflection around routes to engagement with the courts. The point of this article is to show how under-developed Ireland's resources for constitutionalisation of abortion access

rights still are. Consider Anna Śledzińska-Simon's recent work in which she identifies four frameworks for the constitutional recognition of rights to access abortion (ŚLEDZIŃSKA-SIMON, 2023); a negative approach emphasising freedom from state interference; a positive approach which draws on the principle of equality and a commitment to transformative constitutionalism; a social rights approach emphasising the state's positive obligations to secure access to healthcare and an approach which combines elements of all three. This article suggests that Ireland's existing constitutional framework - which offers limited protection for privacy and bodily integrity, while paying only scant attention to equality - may support only a limited 'negative' approach to abortion rights. It is difficult to imagine a transformative reproductive rights campaigns which remains within existing Irish legislative and constitutional structures.

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