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## Committee on the Elimination of Discrimination against Women

### **Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women**

#### **I. Introduction**

1. On 9 December 2010, the Committee on the Elimination of Discrimination against Women (Committee) received information from several organisations<sup>1</sup> (sources) pursuant to article 8 of the Optional Protocol (OP) to the Convention on the Elimination of All Forms of Discrimination against Women (Convention). The sources allege that the United Kingdom of Great Britain and Northern Ireland (UK) has committed grave and systematic violations of rights under the Convention due to restrictive access to abortion for women and girls in Northern Ireland (NI).

2. The UK ratified the Convention on 7 April 1986 and acceded to the OP on 17 December 2004.

#### **II. Submission by the sources of information**

3. The sources submit that in NI, assisting with or procuring an abortion is criminalised, punishable by a maximum sentence of life imprisonment<sup>2</sup> and the availability of abortion is highly restricted. They allege failure of the UK, inter alia, to: (a) establish a comprehensive legal framework to protect and guarantee NI women's right to abortion; (b) ensure that NI women are not exposed to the health risks of unsafe abortion; and, (c) address social, practical and financial obstacles in accessing abortion, which disproportionately affect rural women. The sources allege that the legal framework on abortion discriminates against NI women. Further, accessing abortion is impeded by the prevailing "anti-choice" rhetoric in churches, schools and local politics.

#### **III. Procedural history**

4. On 20 January 2014, the UK submitted its observations on the inquiry submission, indicating that it is lawful to perform an abortion in NI where necessary to preserve the women's life, or where there exists a risk of real and serious adverse effects on the woman's physical or mental health - either long-term or permanent. It stated that although

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<sup>1</sup> The Family Planning Association; Northern Ireland Women's European Platform; Alliance for Choice.

<sup>2</sup> Sections 58 and 59, Offences against the Person Act, 1861; section 25(1), Criminal Justice Act (NI), 1945.

procuring an abortion is criminalised, prosecutions are rare. Further, NI residents can travel to other UK countries, although they are not entitled to National Health Service (NHS) coverage and must pay privately, and internationally to access abortion where it is available on broader grounds. The UK denies any breach of its obligations and asserts that revision of its legislation is not envisaged.

5. In November 2014, the UK submitted information under the Committee's follow-up procedure following the examination of the UK's seventh periodic report.<sup>3</sup> At its sixtieth session (February-March 2015), the Committee considered that the UK had: (a) not implemented its recommendation to decriminalise abortion; and (b) only partially implemented its recommendation to expand grounds for legal abortion following the consultation paper published on 8 October 2014, recommending legislative amendments to allow abortion in cases of "lethal abnormality of the foetus".

6. Between its fifty-seventh and sixty-first sessions, the Committee, upon examining all information received, found the allegations reliable and indicative of grave or systematic violations of Convention rights. It designated Ms. Ruth Halperin-Kaddari and Mr. Niklas Bruun to conduct an inquiry.

7. The UK, on 29 January 2016, agreed that the designated members (DM) visit Belfast and London. The visit took place from 10 to 19 September 2016, during which, the DM and two secretariat members met the NI Minister for Communities, Minister of Justice, Attorney General (AG), and officials from the Department of Health, the NI Human Rights Commission, the Equalities Commission, and the Commission for Children and Young People. They visited a public hospital and a private clinic in Belfast where abortions are performed and interviewed healthcare professionals and management. They interviewed members of the NI Assembly from five political parties, civil society representatives, academics, trade unions and numerous women who sought or procured an abortion. In London, they met representatives of the UK Foreign and Commonwealth Office, Department for Education and Department of Health, and UK NI Office. They met representatives of the Abortion Support Network and the British Pregnancy Advisory Services. The DM obtained information from organisations supplying abortifacients to NI women.

#### **IV. Legal framework on termination of pregnancy in Northern Ireland**

8. Sections 58 and 59 of the Offences against the Person Act, 1861, and section 25(1) of the Criminal Justice Act (NI) 1945 regulate abortion in NI. The latter provision mirrors sections 1 and 2 of the 1929 Infant Life (Preservation) Act in Great Britain, under which it is an offence to intentionally kill a child capable of being born alive before it has a life independent of its mother. It is a defence under the Infant Life (Preservation) Act to show that the death was caused in good faith to preserve the life of the pregnant woman. The Offences against the Person Act 1861, as modified by *R v Bourne*<sup>4</sup> and subsequent NI jurisprudence, extends the grounds for lawful abortion to include, where necessary, to preserve the life of the pregnant woman or where there is a risk of real and serious adverse effects on the woman's physical or mental health, either long-term or permanent. While the NI Court of Appeal recently remarked that the present law on abortion prioritises protecting, to a reasonable extent, the life that women can enjoy independent of the state of health of the foetus<sup>5</sup>, procuring, aiding and abetting abortions in cases of rape, incest, and severe foetal impairment, including fatal foetal abnormality (FFA), remain criminal and carry a maximum penalty of life imprisonment.

9. The 1967 Abortion Act (amended by section 37 of the Human Fertilisation and Embryology Act 1990), permits abortions only in England, Wales and Scotland, *inter alia*,

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<sup>3</sup> CEDAW/C/GBR/CO/7/Add.1.

<sup>4</sup> [1939] 1 KB 687

<sup>5</sup> *AG v Northern Ireland Human Rights Commission* (29 June 2017), para. 79.

in cases where: (a) the pregnancy is under 24 weeks and its continuation involves risk greater than if terminated; (b) it is necessary to prevent grave permanent injury to the physical or mental health of the woman; and (c) a substantial risk exists that the child, if born, would suffer from physical or mental abnormalities and be seriously “handicapped”.

10. Since the 1998 Belfast Agreement, which devolved certain powers to Wales, Scotland and NI, notable developments on abortion in NI have included: (a) NI Assembly’s rejection to extend the 1967 Abortion Act to NI (21 June 2000); (b) launching of a public consultation on draft guidance on abortion for medical practitioners (16 January 2007); (c) issuance (16 July 2008) and withdrawal (30 November 2009) of revised draft guidance on abortion for consultation followed by the release of new guidance (27 July 2010); (e) rejection of an amendment to criminalise the performance of legal abortions at private clinics (12 March 2013); (f) issuance of draft guidance on abortion (8 April 2013); (g) launching of a consultation on amendments to legalise abortion in cases of “lethal foetal abnormality” and sexual crimes, and the regulation of conscientious objection (7 October 2014); (h) rejection of an amendment to restrict the performance of an abortion to NHS establishments except in urgent cases (3 June 2015); (i) NI High Court decision declaring NI’s legal framework on abortion incompatible with article 8 of the European Convention on Human Rights (ECHR) (30 November 2015)<sup>6</sup>; (j) rejection of two motions to amend the Justice Bill to legalise abortion in cases of FFA and sexual crime (11 February 2016); (k) issuance of new guidance on abortion (25 March 2016); and, (l) conviction of a 21-year old woman for self-administering abortifacients (5 April 2016). During the visit, prosecutions were underway concerning women reported by hospital staff following treatment of complications resulting from self-administration of abortifacients, including a mother who purchased abortifacients online for her teenage daughter; and a foreign woman.

11. On 14 June 2017, the UK Supreme Court rejected an appeal which challenged England’s failure to extend NHS coverage to NI women seeking a legal abortion in England, citing the need to “afford respect to the democratic decision of the people of Northern Ireland”.<sup>7</sup> However, on 29 June 2017, the UK Minister for Women and Equalities announced that henceforth NHS coverage would extend to NI women accessing abortion in England.<sup>8</sup>

12. On 29 June 2017, the NI Court of Appeal allowed an appeal against an order made by Justice Horner in which he declared sections 58 and 59 of the Offences against the Person Act and section 25 of the Criminal Justice Act incompatible with Article 8 of the ECHR in so far it is an offence to procure an abortion in cases of FFA, rape or incest.<sup>9</sup> While the appeal was allowed, the Chief Justice’s decision instructs the legislature to urgently address “the pressing need to ensure that there is a practical and effective method of implementation of rights of women” regarding access to abortion.<sup>10</sup>

<sup>6</sup> Northern Ireland Human Rights Commission’s Application [2015] NIQB 96.

<sup>7</sup> *R (on the application of A and B) v Secretary of State for Health* [2017] UKSC 41, p. 9.

<sup>8</sup> Letter from Rt. Hon. Justine Greening MP, Minister for Women and Equalities to MPs (29 June 2017).

<sup>9</sup> *Supra*, note 5.

<sup>10</sup> *Ibid.*, para. 85.

## V. Findings of fact

### A. Access to abortion

#### (I) *De facto limitations on access to legal abortions in Northern Ireland*

##### (a) *Institutional and geographical limitations*

13. In 2015-2016, only 46 abortions were performed in NI's public hospitals<sup>11</sup> yet in stark contrast, 724 NI women travelled and procured an abortion in England.<sup>12</sup> The DM learned that accessibility of both medical and surgical abortion is limited from the onset by institutional and geographic factors. All services are concentrated in two facilities located in Belfast: the Royal Maternity Hospital is the only public facility currently performing abortions in very limited cases of FFA; and, the Marie Stopes International Clinic is the only private facility performing medical abortions until 9.4 weeks of gestation exclusively under the mental and/or physical health exception.

##### (b) *Lack of clarity on when an abortion can be performed legally*

14. Health professionals are equally liable to a penalty of life imprisonment for aiding and abetting the procurement of an abortion.<sup>13</sup> A consultation on draft guidance for health professionals on the circumstances in which an abortion can be performed legally was conducted in 2013.<sup>14</sup> Issued by the Department of Health, Social Services and Public Safety (DHSSPS), the stated purpose of the draft guidance was “to guide clinicians on the application of the very strict and narrow criteria that are consistent with the law”.<sup>15</sup>

15. In the Committee's view, the finalised DHSSPS guidance<sup>16</sup> (March 2016) does not clarify the circumstances in which abortions are lawful in NI. Health professionals are responsible for assessing, on a case-by-case basis, whether the woman's clinical circumstances meet the legal test for an abortion.<sup>17</sup> The guidance recommends that two doctors with appropriate skills and expertise undertake the assessment. In practice, no clinicians are designated and no protocol exists to guide the assessment. The DM were informed that the risk of life imprisonment for interpreting the law incorrectly discourages clinicians from making a referral for abortion.

16. The DHSSPS guidance states: “the impact of foetal abnormality on a woman's physical or mental health may be a factor to be taken into account when a health professional makes an assessment of a woman's clinical condition and recommends options for her on going care”.<sup>18</sup> However, it does not clarify whether abortion is an option. The Committee notes that the Chief Medical Officer tasked the Public Health Agency and Health and Social Care Boards and Trusts to “work together to ensure that appropriate arrangements for care and support are in place to allow all eligible women access to termination of pregnancy services”, and to “liaise to develop regional information leaflets

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<sup>11</sup> NI Department of Health, Social Services and Public Safety (DHSSPS), NI Termination of Pregnancy Statistics 2015/2016, p. 2, Table 1. Note: 46 abortions (30 medical; 16 surgical). “Medical abortions” are induced by abortifacient pharmaceutical drugs used until 9 weeks gestation. “Surgical abortions” entails removal of the foetus and placenta from the uterus through vacuum aspiration or dilatation and evacuation.

<sup>12</sup> UK Department of Health, Abortion Statistics, England and Wales: 2016, p. 71 (June 2017).

<sup>13</sup> *Supra*, note 2.

<sup>14</sup> DHSSPS, The Limited Circumstances for a Lawful Termination of Pregnancy in NI: A Guidance Document for Health and Social Care Professionals on Law and Clinical Practice, (April 2013).

<sup>15</sup> *Ibid.*, para. 1.3.

<sup>16</sup> DHSSPS, Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland (March 2016).

<sup>17</sup> *Ibid.* p. 5.

<sup>18</sup> *Ibid.* para 2.9.

on termination of pregnancy”.<sup>19</sup> However, no clear communication strategy exists for health professionals or the public on the circumstances in which legal abortions can be accessed. The Committee finds that the ambiguous NI legal and policy framework does not provide a clear pathway for care of women requiring an abortion.

(c) ***Chilling effect on clinicians***

17. The downward trend<sup>20</sup> of legal abortions performed in NI since 2013 is attributable to the increasing unwillingness of clinicians to make referrals for or to perform an abortion for increased fear of criminal liability. The DM learned that between 2003 and 2008, abortions were available in FFA cases as clinicians interpreted the law favourably using the mental health exception. The subsequent increased scrutiny of abortions by authorities resulted in fewer abortions performed in NHS hospitals. In 2009, the [then] Health Minister launched an investigation into every abortion performed, under the mental health exception, on women with FFA cases. Between 2011 and 2012, the Minister requested medical practitioners to record personal details about the woman and reasons for the abortion.<sup>21</sup>

18. The Royal Colleges of Obstetricians and Gynaecologists, of Midwives, and of Nursing, in NI have described the draft 2013 guidance that was consulted upon as intimidating for both women and healthcare professionals.<sup>22</sup> In their view, the guidance creates uncertainty and fear, resulting in a chilling effect on the performance of abortions. The Committee finds the finalised 2016 guidance perpetuates such intimidation as it states that: “A health and social care professional has a legal duty to refuse to participate in any procedure leading to termination of pregnancy if it would be an offence under the law of NI. Under Section 5 of the Criminal Law Act (NI) 1967, if they know or believe that such an offence has been committed and have information which is likely to be of material assistance in securing the apprehension, prosecution, or conviction of the person who committed it, then they are under a duty to give that information within a reasonable time to the police. Failure to do so without a reasonable excuse is an offence which upon conviction carries a maximum penalty of ten years imprisonment.”<sup>23</sup> The result is the continuing restriction of abortions in NI.

(d) ***Inability to access services due to harassment by anti-abortion protestors***

19. The DM learned that women’s access to legal abortion services in NI is further impeded by the presence and actions of anti-abortion protestors stationed at entrances of public and private health facilities. The DM witnessed that anti-abortion protestors monitored women entering and exiting a facility and displayed large graphic posters of disfigured fetuses. The DM heard testimony of anti-abortion protestors having chased women exiting the facilities, forcing plastic baby dolls into their arms and pro-life literature into their bags, pleading with them “not to murder their babies”. A facility has recruited escorts to shield clients from this aggressive behaviour. Although police are frequently alerted to this situation, they rarely intervene.

20. **In conclusion**, the Committee finds that despite legal provision for abortion in very limited circumstances, de facto limitations render access to abortion virtually impossible. This includes: (a) geographical and institutional limitation of services; (b) ambiguity regarding the circumstances for performing a legal abortion; (c) clinicians’ unwillingness to perform abortions due to intimidating and hostile working environments resulting from threats of prosecution; and, (d) impunity of anti-abortion protestors for assaults perpetrated against women seeking abortion.

<sup>19</sup> NI Chief Medical Officer’s letter to PHA, HSCB and HSC Trusts (25 March 2016).

<sup>20</sup> Supra, note 11, p. 2, Table 1.

<sup>21</sup> NI Health Minister Edwin Poots’ written Statement to NI Assembly (22 August 2012).

<sup>22</sup> Responses to the DHSSPS on draft guidance (July 2013).

<sup>23</sup> Supra, note 16 para. 9.4. See also supra, note 5, paras 61 and 62.

## (II) *The reality of illegal abortions in Northern Ireland*

21. Since 2000, the NI Police Service (PSNI) has investigated over 30 cases of individuals suspected of procuring an abortion.<sup>24</sup> Between 2006 and 2015, the PSNI made 11 arrests related to illegal abortion.<sup>25</sup> Between 2011 and 2016, five people were questioned and arrested for possession of abortifacients; two were convicted.<sup>26</sup>

22. Information reveals a rise in the self-administration of medical abortions, which is criminal, by women unable to travel outside NI and whose pregnancies are below nine weeks' gestation. This upward trend is attributed to the presence of non-profit organisations providing early medical abortions outside the formal healthcare system through online telemedicine since 2006. Although no official data exist on the extent of the phenomenon in NI, an online supplier of abortifacients provided the DM with information on procurers, including NI women. These women represent a wide age-range including under 20s and over 45s, with most in their early 30s identified as married, cohabiting, or single.

23. The finalised 2016 guidance addresses the use of abortifacients purchased from the Internet and states that, "*their use to secure a miscarriage in NI is likely to be an offence under the Offences Against the Person Act.*"<sup>27</sup> The guidance obligates health professionals to provide appropriate treatment to women suspected of having self-administered abortifacients. It further states: "*Health and social care professionals working in clinical situations need to be assured that procedures they are involved in are lawful. [They] must balance the need for confidentiality of patients with **the obligation to report unlawful terminations of pregnancy to the police** and the need to protect others from serious harm. [Emphasis added]*"<sup>28</sup> The DM received testimony that to avoid having to report women presenting with post-abortion complications to PSNI, the women are neither asked, nor encouraged to reveal, if they had ingested abortifacients. Healthcare professionals stated that the "don't ask, don't tell" practice is untenable as it presents a barrier to providing appropriate medical care.

24. The Committee acknowledges the significant health risks associated with ingesting counterfeit abortifacients from unverifiable Internet sources and notes that the only dedicated assistance for women who have self-administered abortifacients is the telephone helpline of the British Pregnancy Advisory Service, an NGO in Great Britain. It is, therefore, concerning that the guidance, in effect, discourages women from seeking care for post-administration complications, fearing criminal sanction.

## (III) *Travelling out of Northern Ireland for abortion*

### (a) *Accessing abortion services in England*

25. Between 1970 and 2015, a total of 61,314 abortions in England were performed on NI residents.<sup>29</sup> Annually, approximately 16 percent of all abortions performed on non-residents of England and Wales are provided to NI women.<sup>30</sup> In 2016, five were performed on girls under 16 years, and 19 were performed on girls between 16 and 17 years.<sup>31</sup> The majority of procedures occurred between three to nine weeks of gestation, with only three

<sup>24</sup> F. Bloomer et al., Report, 'Moving Forward From Judicial Review on Abortion in Situations of Fatal Foetal Abnormality and Sexual Crime: The Experience of Health Professionals' (July 2016), Reproductive Health Law and Policy Advisory Group (p. 8).

<sup>25</sup> Freedom of Information Request no. F-2015-02701, 'Charges Relating to Arrests Relating to Abortion'.

<sup>26</sup> Freedom of Information Request no. F-2016-01040, 'Abortion Pills'.

<sup>27</sup> Supra, note 16 paras. 6.5 – 6.8.

<sup>28</sup> Ibid, (pp. 20; paras. 6.1, 6.4).

<sup>29</sup> Bloomer, Fiona, et al, Northern Ireland Overview Of Monitoring Data On Abortions. Reproductive Health Law and Policy Advisory Group Report, (June 2017),

<sup>30</sup> Supra, note 7 para. 53.

<sup>31</sup> Supra, note 12 p. 76, Table 12c.

percent of abortions performed at 20 weeks or later.<sup>32</sup> This phenomenon is acknowledged by authorities both in NI and England through the collection of official statistics. Interviewees attested that these statistics present an underestimate due to the lack of traceability of all women undergoing an abortion extraterritorially (some may not indicate their NI address to the service provider, while others may travel internationally). The number of abortions to non-residents of England and Wales has fallen each year since 2003.<sup>33</sup> The Committee has drawn a link between these figures and the rising usage of abortifacients in NI.<sup>34</sup>

26. Until recently, the NHS covered abortion costs only for residents of England, Scotland and Wales, excluding women from NI,<sup>35</sup> who were required to pay approximately £600 to £2,000, including travel and accommodation costs, for abortion services in Great Britain. The financial and logistical difficulties of travelling compelled some NI women to obtain abortions late in their pregnancy at greater risk to their physical and mental health or be forced to carry them to term. Some under-privileged women received limited financial support from the Abortion Support Network, a non-governmental organisation based in England. From 29 June 2017, NI women seeking a legal abortion in England can benefit from NHS coverage. However, the Committee notes this benefit is not guaranteed by law.

27. Testimonies revealed that the stress of undergoing an abortion outside NI is compounded by logistical arrangements and the secrecy within which these must be made; ultimately impacting women's mental health. Logistical arrangements include: determining a clinic that offers the correct procedure and availability within the necessary timeframe; procuring transportation tickets and hotel reservations, including any transfers; arranging care for any children at home; requesting leave from work; and dealing with unforeseen complications, including an extended stay. For women and girls who do not possess a driver's licence or passport, securing photographic identification for travel within the tight timeline in which an abortion can be performed is a challenge.

28. The secrecy further entails women taking serious decisions about their health without qualified medical advice. Before the issuance of the 2013 draft guidance, NI women benefitted from medical supervision over their abortion in England. The DM learned about the practice of extra-contractual referral to England in FFA cases for the procedure conducted in the second or third trimester of pregnancy requiring the administration of an injection into the foetus prior to the abortion<sup>36</sup>. In such cases, physicians in NI and England would ensure seamless care during the procedure in England and the delayed expulsion of the foetus in NI. This practice has ceased since 2013 due to uncertainty regarding complicity in a crime.

29. Noting the heavy financial, emotional and logistical burden, the Committee considers that such travel is not a viable solution for women.

**(b) *Post-abortion care for abortions performed outside Northern Ireland***

30. The DM learned from NI women who had undergone an abortion outside NI about the post-procedure mental anguish they experienced. These women are discharged on the day of the procedure and often, to economise, immediately return to NI despite their vulnerable physical and mental state. Once returned, women described fearing community stigma and possible prosecution, and hence remained secretive about the abortion, including from their doctors. In addition to descriptions of feeling "dirty", "shameful", "pressured to just get on with it", these women described how the culture of silence impacted their health. There is no systematic sharing of medical records between the abortion facilities outside NI and doctors in NI, nor do many women wish their "abortion

<sup>32</sup> Ibid.

<sup>33</sup> Supra, note 7 para. 2.56. Between 2003 and 2016, the number of non-residents of England and Wales procuring an abortion in England decreased from 9,078 to 4,810.

<sup>34</sup> Guttmacher Policy Review, Summer 2015, Vol. 18, No. 3.

<sup>35</sup> Supra, note 7 and 8.

<sup>36</sup> Royal College of Obstetricians and Gynaecologists, 'Termination of Pregnancy for Foetal Abnormality in England, Scotland and Wales' (May 2010), pp.29-31.

record” transferred. Hence, in cases where women suffer post-procedure complications, lack of any acknowledgement that an abortion took place is a barrier to seeking and receiving appropriate medical care.

31. The Committee notes the confirmation provided by the NI Chief Nursing Officer that “*in relation to a procedure which has been performed within the law in Great Britain, our legal advice states that a midwife assisting with the completion of such a termination in NI would not be considered to be an accessory in a criminal act.*”<sup>37</sup> Nonetheless, the DM heard testimony that health professionals fear prosecution for failing to report women seeking after-care because they lack knowledge about the legality of the abortion. Furthermore, the 2016 guidance confirms: “*[r]egardless of where a termination of pregnancy has been carried out, where necessary, support must be provided for individuals through after care services including counselling and other psychological support services. It is the responsibility of Health and Social Care Trusts to provide access to after care support for all women where it has been assessed to be required.*”<sup>38</sup> The Committee notes that no structures exist to support women following an abortion (i.e. bereavement services) and no official statistics are collected on the number of women who have accessed post-abortion healthcare or support.<sup>39</sup>

(c) ***Repatriation of foetal remains***

32. A significant source of stress for women who have undergone an abortion outside NI is the transportation of foetal remains to NI for reasons, including emotional (bereavement), religious (burial), medical (DNA testing for recurrence risk of genetic abnormalities), and as prosecutorial evidence in rape cases. The DM learned that NI residents face difficulties in obtaining DNA analyses in England to establish genetic abnormalities in cases of FFA. Thus, they are forced to return with foetal remains to conduct thorough tissue testing to determine risk factors for future pregnancies. Testimonies revealed that the absence of any established protocols regarding the transfer of foetal remains has resulted in women resorting to undignified transporting practices, including in cooler boxes or hand luggage, at the mercy of airline personnel. Furthermore, no protocol on the reception of foetal remains by NI mortuaries exists. This situation recently led to the resignation of one of the only two NI paediatric pathologists.

**B. Criminalisation of abortion and its effect on women who find themselves in untenable or unplanned pregnancies**

33. All women interviewed by the DM who were denied access to safe abortion in NI conveyed the extreme vulnerability, physical and psychological stress, mental anguish, desperation and isolation they experienced in seeking appropriate medical treatment to terminate their pregnancy.

(a) ***Women in situations of poverty***

34. The Committee notes that the criminalisation of abortion has a particularly adverse impact on women in situations of poverty. In comparison to the rest of the UK, NI experiences: (a) the highest fertility rate; (b) the highest and most persistent levels of child poverty; (c) a higher proportion of single-earner households; (d) lower wage rates; (e) the lowest living standards; (f) the highest childcare costs outside of London; and (g) a higher prevalence of poor mental health. The Committee draws the link between the low control that NI women have over their fertility and the disproportionate risk of poverty faced by large families.

<sup>37</sup> Chief Nursing Officer’s letter on “foeticide” (19 March 2009).

<sup>38</sup> *Supra*, note 16 paras. 1.7; 5.15-16. Also: All questions, asked by Clare Bailey to all Ministers, during the 2016-2017 session, containing abortion.

<sup>39</sup> NI Assembly, All questions, asked by Steven Agnew to all Ministers, during the 2016-2017 session, containing abortion.

35. The Committee notes the views of Justice Horner on the direct correlation between the adverse effects of the criminalisation of abortion and worsening socio-economic status.<sup>40</sup> Notwithstanding the very recent commendable extension of NHS coverage to NI women accessing abortion in England, the Committee finds that poor women, girls and other women in vulnerable situations are particularly disadvantaged owing to barriers faced in travel to access abortion outside NI. Those wishing to continue their pregnancy do not receive any State support for raising an unplanned child, thereby driving them into deeper poverty. This is exacerbated by recent changes to the distribution of welfare benefits in the UK capping the ceiling for new beneficiaries to a maximum of two children per family.

**(b) *Pregnancies resulting from rape and incest***

36. There is no exception allowing abortions in cases of rape or incest, not even when the victims are children. The DM heard testimonies about the experience of a 12 year old girl who travelled to Manchester for an abortion after becoming pregnant following repeated acts of rape by her uncle. She was accompanied by the PSNI solely to collect conception tissue in order to determine the DNA of the accused. The DM could not uncover who financed the girls' travel and procedure and if she received follow up health care. A former social worker recounted that sometimes social workers arrange abortions outside NI for pregnant adolescents under their care.

37. Information revealed the link between the country's recent violent history and the very high rates of sexual abuse experienced by both women and men across NI with estimates that one in four residents suffers sexual abuse in their lifetime.<sup>41</sup> Statistics show that victims of sexual abuse range from infants to 90 year olds, with children consistently forming the majority of victims (61 percent in 2013/14).<sup>42</sup> In 2014/2015, PSNI recorded: 28,287 domestic abuse incidents; 2,734 sexual offences, and 737 offences of rape<sup>43</sup> Moreover, the recorded number of sexual offences involving children under 16 has dramatically increased over the past decade.<sup>44</sup>

38. The DM learned that the criminalisation of abortion places female victims of rape or incest at risk of being treated as criminals themselves and has contributed to the underreporting of rape, fearing prosecution and conviction. No data exists on the number of pregnancies resulting from rape or incest or of victims seeking an abortion. However, the fact that these crimes can and do result in pregnancies is recognised by the NI Criminal Justice Compensation Scheme, which awards a victim the amount of £5,500 where a pregnancy is directly attributable to a sexual offence irrespective of the victim's age. According to NI authorities, four awards were made between 2011 and 2016<sup>45</sup>. It is unknown whether State-provided support exists for rape or incest victims who do not wish to continue the pregnancy. This includes psycho-social services during and after pregnancy; facilitating adoption where requested; and financing for raising an unplanned child.

**(c) *Pregnancies involving a fatal foetal abnormality***<sup>46</sup>

39. Exceptions allowing abortions are also not available in FFA cases.<sup>47</sup> Numerous women upon receiving a diagnosis of FFA recounted their extreme anxiety in having to deal both with the shock of a pregnancy not going as planned and being denied information

<sup>40</sup> Supra, note 6 para. 154.

<sup>41</sup> NI Assembly, Research and Information Service Research Paper, *Rape Statistics* (25 February 2015), p. 19.

<sup>42</sup> Ibid. at p. 30.

<sup>43</sup> DHSSPS and DoJ, *Stopping domestic sexual violence and abuse in NI: A seven year strategy* (March 2016) pp.22-23

<sup>44</sup> PSNI, *Trends in Police Recorded Crime in Northern Ireland 1998/99 to 2014/15* (06 August 2015) (p. 17)

<sup>45</sup> Email from NI authorities to CEDAW Secretariat (25 January 2017).

<sup>46</sup> Terms to describe fatal foetal impairment include, "life limiting abnormality" and "lethal foetal abnormality". Justice Horner notes the implicit value judgment in whatever term chosen ([2015] NIQB 96 (paras. 5, 148)).

<sup>47</sup> Supra, note 2, para. 2.9.

on the options available to ensure their best health, including on legal choices for abortion that exist outside NI and the right to post-abortion care upon return.

40. Most women learn late in their pregnancy (18-20 weeks) of FFA, due to the unavailability of publicly funded foetal anomaly tests in NI both prior to and during the second trimester of pregnancy, in contrast to what is offered under the NHS in the rest of the UK. The DM noted that, in comparison to the rest of the UK, a greater proportion of foetuses with severe congenital anomalies are carried to term, dying shortly after birth.<sup>48</sup> The Committee draws the link between the unavailability of abortions in FFA cases and the high stillbirth rate in NI, noting the Belfast Trust experiences the highest rates in the UK.

41. Testimonies abound that the late diagnosis of FFA and lack of counselling on options for legal abortion results in delayed treatment with ensuing physical and psychological trauma for the women, some describing it as torture. These women face severe stress in arranging all logistics within the allowed time limit to procure a legal abortion outside NI, which, in England, is 24 weeks and 6 days.<sup>49</sup> The more advanced the pregnancy, the more difficult travelling becomes, the more complex and costly the abortion, and the higher the risk of post-abortion complications.

42. **In summary**, the Committee finds that the NI legal and policy framework criminalising abortion deprives women of any real choice in influencing circumstances affecting their mental and physical health. Being forced to either continue a pregnancy, particularly in grievous situations of FFA, rape and incest, as well as for children and poor women, or to travel to receive intimate care in unfamiliar surroundings in the absence of support networks, do not represent reasonable or acceptable options. Both avenues entail significant physical and psychological suffering. The Committee notes the recent UK Supreme Court judgment which accepts as evidence facts closely mirroring the Committee's findings, and upon which the Court concluded that, "it remains easy to understand why the plight of women who find themselves in unwanted pregnancy [in NI] is deeply unenviable".<sup>50</sup>

## C. Inadequacy of Family Planning Support

### (a) *Sexual health education and information*

43. The DM observe that NI youth are denied the education necessary to enjoy their sexual and reproductive health and rights. Most NI children attend single denominational schools, either Catholic or Protestant. Church representatives play active roles in school management boards with the result that 'Relationship and Sexuality Education' (RSE), although a recommended part of the primary and post-primary statutory curriculum of the Department of Education, is under-developed or non-existent owing to the school's discretion to implement curriculum contents according to its values and ethos.<sup>51</sup> Where RSE is delivered, it is frequently provided by third parties based on anti-abortion and abstinence ethos.<sup>52</sup>

44. The Committee notes that access to abortion services and contraceptives are not statutory requirements of the advisory curriculum<sup>53</sup>. Data show that the use of contraception

<sup>48</sup> Supra, note 27 pp. 5-6; See also, Belfast Telegraph, 'Belfast has worst stillbirth rate in UK – Medics say abortion laws skew figures' (16 February 2016).

<sup>49</sup> Section 1(1)(a), Abortion Act 1967 (UK).

<sup>50</sup> Supra, note 7, paras. 5 and 6.

<sup>51</sup> Dept. of Education Circular 2013/16 'Relationships and Sexuality Education Policy in Schools' (25 June 2013); Council for Catholic Maintained Schools Circular 2007/12 (14 March 2007); Dept. of Education Circular 2015/22 'Relationships and Sexuality Education (RSE) Guidance' (26 August 2015).

<sup>52</sup> Education and Training Inspectorate, 'Report of an Evaluation of Relationship and Sexuality Education in Post-Primary Schools' (Jan 2011).

<sup>53</sup> Council for the Curriculum, Examinations, and Assessment, Northern Ireland Curriculum, Relationship and Sexuality Education Guidance –An Update for Post-Primary Schools (2015) (pp. 19 and 37).

by NI youth is lower and their rates of sexually transmitted infections are higher in comparison to their peers in other parts of the UK<sup>54</sup>. Further, the prevalence of unplanned teenage pregnancies in NI is higher in comparison to other European Union countries and six times higher in deprived areas of NI. These factors point to State negligence in pregnancy prevention through failure to implement its recommended curriculum on RSE and ensure age-appropriate, culturally sensitive, comprehensive and scientifically accurate sexuality education.

**(b) Access to reproductive health services and contraceptives**

45. The Committee notes the centralised and limited availability of facilities in NI providing information, counselling and services in family planning, and particularly about options to access legal abortions in or outside NI. Furthermore, medical professionals are neither trained nor encouraged to provide information on abortion options and rely on this information being provided by non-governmental entities.

46. Women attested to difficulties in obtaining modern forms of contraception, *inter alia*, emergency (morning-after pill), oral, long term (intrauterine) and permanent (sterilisation). Testimonies revealed that women were refused sterilisation if deemed too young or unmarried, including pharmacists' reluctance to dispense or provide information about emergency contraception.<sup>55</sup>

47. The Committee concludes that NI women and girls are frustrated in their efforts to access the information and services necessary to enjoy their sexual and reproductive health and rights. In the context of a restrictive abortion regime, this leaves women without options to determine the number and spacing of their children.

**D. Social Context of Abortions in Northern Ireland**

48. The Committee acknowledges the interconnectedness between the level of access to legal abortion and the socio-political and religious context of NI, particularly the religious characterisation of abortion as a sin. It recognises that this context informs the positions taken by political parties<sup>56</sup> on amending legislation criminalising abortion, including the often cited argument that it could destabilise the peace process or lead to "abortion on demand".

49. Interviews with NI State and non-State actors reveal a lack of political will to change the *status quo*, epitomised by the NI Assembly's rejection, in May 2016, of legislative amendments allowing abortion in limited cases of FFA and sex crimes.<sup>57</sup> The Committee also notes attempts by NI authorities to further narrow access to legal abortion through threats to close NI's sole private abortion provider.

50. The Committee finds that statements by authorities reinforce the characterisation of abortion as a strictly moral issue rather than a health and human rights one. It highlights the AG's statement, who drew a parallel between abortions in FFA cases and "putting a bullet in the back of the head of the child two days after it's born"<sup>58</sup>. It further notes a Parliamentarian's statement that "the most dangerous place for a child is in its mother's womb".<sup>59</sup> Other statements made by politicians and government officials, including the characterisation of a woman's primary role as a mother<sup>60</sup>, have reinforced gender

<sup>54</sup> Family Planning Association, 'Teenagers: sexual health and behaviour' (January 2011); The Belfast Telegraph, 'Call for better NI sex education as STIs rise' (12 Sept 2016).

<sup>55</sup> No pharmacist-wide protocol exists to guide the dispensation of emergency contraception in a confidential and gender-sensitive manner.

<sup>56</sup> Letter to UK Members of Parliament from four NI political parties (May 2008).

<sup>57</sup> Official Report (Hansard), 10 February 2016, Vol 112, No. 5.

<sup>58</sup> Comments made by Mr. Larkin, then a QC, during a panel discussion on the BBC's Sunday Sequence programme (May 2008).

<sup>59</sup> Mr. Jonathan Bell, MLA, 12 March 2013.

<sup>60</sup> F. Bloomer and K. O'Dowd, 'Restricted access to abortion in the Republic of Ireland and Northern

stereotypes steeped in patriarchy, thereby contributing to the belief that it is acceptable to deny women reproductive choice.

51. Moral characterisations of abortion reinforce the stigma associated with the procedure. This perpetuates a culture of silence on the effect of its criminalisation and facilitates wilful blindness to the reality faced by NI women. The Committee, therefore, finds that the inadequacy of State-provided family planning support as driven by socio-religious considerations, coupled with a political culture which circumscribes the role of women, places NI women and girls in a double jeopardy effectively depriving them of any control over their fertility.

## **VI. Legal findings**

### **A. Human rights obligations of decentralised systems**

52. The UK operates a decentralised system of government. Under the Sewel Convention, the Westminster government (Westminster) will not normally invite the UK Parliament, which retains the right to legislate on all matters, to legislate on devolved matters except upon the devolved legislature's agreement. For NI, the Belfast Agreement and the subsequent Northern Ireland Act 1998 (as amended) form the constitutional structure.

53. The UK argues that following the devolution of health and criminal law to NI, Westminster cannot amend NI's criminal law, including revising abortion laws. The Committee recalls that under international law of State responsibility, all acts of State organs are attributable to the State. The Vienna Convention on the Law of Treaties provides in article 27 that a party to a treaty may not invoke the provisions of its internal law as a justification for its failure to perform it. Moreover, the Committee's General Recommendation (GR) No. 28 (2010) on the core obligations of States parties reiterates that the delegation of government powers "does not negate the direct responsibility of the State party's national or federal Government to fulfil its obligations to all women within its jurisdiction".<sup>61</sup> Thus, the UK cannot invoke its internal arrangements (the Belfast Agreement) to justify its failure to revise NI laws that violate the CEDAW Convention.

### **B. State party's obligations with respect to women's sexual and reproductive health and rights under CEDAW Convention**

54. Article 12, complemented by article 16(1)(e), guarantee women the right to health, including sexual and reproductive health. They require States parties to eliminate discrimination against women in the provision of health care and ensure access to services, including family planning and the right to freely and responsibly decide on the number and spacing of children. Article 12, read with articles 1, 2, 5, 14 and 16(1)(e), constitutes the legal underpinnings of the Committee's jurisprudence in this area.

55. Article 2(c), (d), (f) and (g) obligates States parties to establish legal protection of the rights of women on an equal basis with men and refrain from engaging in acts or practices discriminatory to women, and to take appropriate measures, including legislation, to modify or abolish existing laws, particularly penal laws, discriminatory to women. Article 2, read with article 1, requires States parties to take appropriate measures to eliminate any restriction having the effect or purpose of impairing or nullifying the enjoyment or exercise by women of human rights in all fields. Article 2(g) requires States parties to, "repeal all national penal provisions that constitute discrimination against women". Article 5 addresses gender stereotypes including social and cultural patterns of conduct. Read with articles 12 and 16, it requires States parties to eliminate gender

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Ireland: exploring abortion tourism and barriers to legal reform' (2014) (p. 3).

<sup>61</sup> Para. 39.

stereotypes that impede equality in the health sector and negatively impact women's capacity to make free and informed choices about their health care, sexuality and reproduction.

56. GR No. 24 (1999) on women and health states: "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures are barriers to women's access to health care."<sup>62</sup> Since abortion is a service which only women require, the Committee found a violation when access was unduly restricted. In *L.C. v Peru*,<sup>63</sup> the Committee recommended that the State party, "review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse" having observed that the "failure of the State party to protect women's reproductive rights and establish legislation to recognize abortion on the grounds of sexual abuse and rape are facts that contributed to L.C.'s situation".<sup>64</sup>

57. In *Pimentel v Brazil*<sup>65</sup> and GR No. 24 (1999), the Committee outlined that States parties should ensure women's right to safe motherhood and obstetric services.<sup>66</sup> Safe motherhood encompasses a series of practices and protocols designed to ensure high-quality services to achieve optimal health for both the pregnant woman and the fetus. This cannot be guaranteed if women are denied information and access to health services, and are compelled to carry pregnancies to full term where it poses a threat to their health. Optimal health for pregnant women cannot be attained if access to abortion is denied when it is the safest option to address threats to their physical or mental health.

58. Based on its expertise in interpreting articles 12(1) and 16(1)(e), GR No. 24 (1999) read with article 2(b), (d), (e) and (f), clarified by GR No. 28 (2010) and article 5, clarified by GRs No. 19 (1992) and 35 (2017) on violence against women and gender-based violence against women, the Committee systematically recommends the decriminalisation of abortion in all cases. States parties are obligated not to penalise women resorting to, or those providing such services.<sup>67</sup>

59. Criminal regulation of abortion serves no known deterrent value. When faced with restricted access women often engage in clandestine abortions including self-administering abortifacients, at risk to their life and health. Additionally, criminalisation has a stigmatising impact on women, and deprives women of their privacy, self-determination and autonomy of decision, offending women's equal status, constituting discrimination.<sup>68</sup>

60. The Committee interprets articles 12 and 16, clarified by GR Nos. 24 and 28, read with articles 2 and 5, to require State parties to legalise abortion, at least in cases of rape, incest, threats to the life and/or health (physical or mental) of the woman, or severe foetal impairment. This positive obligation entails providing access to health care services, including ensuring the provision of accessible and safe (medically-approved) legal abortions. The Committee consistently discourages the use of abortion as a means of family planning.<sup>69</sup> In this regard, the Committee has emphasised the need for providing contraceptives including guidance on scientifically-sound contraceptive methods to avoid unwanted pregnancies.<sup>70</sup> In the Philippines inquiry, it observed that "*distinctive health features that differ for women in comparison to men include biological factors such as women's reproductive functions. Given that such factors have a bearing on women's reproductive health needs, the Committee considers that substantive equality requires that States parties attend to the risk factors that predominantly affect women. Given that only*

<sup>62</sup> Paras. 14 and 31(c).

<sup>63</sup> Communication No. 22/2009.

<sup>64</sup> Para. 8.18.

<sup>65</sup> Communication No. 17/2008.

<sup>66</sup> Para. 27.

<sup>67</sup> Concluding Observations (COBs): Ireland, 1 July 1999, A/54/38, para. 185; Jordan, 27 January 2000, A/55/38, para. 180; United Kingdom, 1 July 1999, A/55/38, para. 309.

<sup>68</sup> Committee's statement: "Sexual and reproductive health and rights: Beyond 2014 ICPD review".

<sup>69</sup> COBs: Azerbaijan, (1998), A/53/38, para. 66; Burundi, (2001), A/56/38, para. 62.

<sup>70</sup> COBs: Burundi, (2001), A/56/38, para. 62; Former Yugoslav Republic of Macedonia, (2006), CEDAW/C/MKD/CO/3, para. 31.

women can become pregnant, lack of access to contraceptives is therefore bound to affect their health disproportionately”.<sup>71</sup>

61. Post-abortion medical services, regardless of whether abortion is legal, should always be available. In the Philippines inquiry, the Committee emphasised the need to provide high-quality post-abortion care in all public health facilities, especially where complications arise from unsafe abortions.<sup>72</sup>

62. In cases of severe foetal impairment, the Committee aligns itself with the Committee on the Rights of Persons with Disabilities in the condemnation of sex-selective and disability-selective abortions, both stemming from the need to combat negative stereotypes and prejudices towards women and persons with disabilities. While the Committee consistently recommends that abortion on the ground of severe foetal impairment be available to facilitate reproductive choice and autonomy, States parties are obligated to ensure that women’s decisions to terminate pregnancies on this ground do not perpetuate stereotypes towards persons with disabilities. Such measures should include the provision of appropriate social and financial support for women who choose to carry such pregnancies to term.

63. Rural, migrant, asylum-seeking, refugee women and women in situations of conflict and poverty face additional barriers in accessing healthcare. In GR No. 30 (2013) on women in conflict prevention, conflict and post-conflict situations, the Committee recommends that States parties, “[E]nsure that sexual and reproductive health care includes...safe abortion services; post-abortion care.”<sup>73</sup> In GR No. 34 (2016) on the rights of rural women, it observes that “[a]ccess to health care, including sexual and reproductive health care, is often extremely limited for rural women”.<sup>74</sup> It recommends that States parties provide “[a]dequate financing of health care systems in rural areas, particularly with regard to sexual and reproductive health and rights”.<sup>75</sup>

## **C. Violations of rights under the Convention**

### ***(I) Criminalization of abortion and impeded access to sexual and reproductive health services***

#### ***(a) Ramifications of criminal sanctions***

64. The criminalisation of abortion and its availability on limited grounds compels women to (a) travel outside NI to procure a legal abortion; (b) to carry their pregnancy to term if they cannot travel; and (c) procure an illegal abortion in NI, risking serious health consequences. This scenario creates a socio-economic bifurcation in access to sexual and reproductive health services and carries substantial psychosocial ramifications. It further deepens the socio-economic divide as women who cannot terminate an unwanted pregnancy face long-term adverse economic consequences, linked to both bearing and raising a child, particularly in light of the capped welfare benefit scheme for families. Although the maximum penalty of life imprisonment has never been imposed, conviction under lighter penalties has serious ramifications on all aspects of a woman’s life.

65. Recalling GRs Nos. 19 (1992) and 35 (2017) on violence against women and gender-based violence against women respectively, discrimination against women includes gender-based violence, defined as: “violence which is directed against a woman because she is a woman or that affects women disproportionately.” A restriction affecting only women from exercising reproductive choice, and resulting in women being forced to carry almost every pregnancy to full term, involves mental or physical suffering constituting

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<sup>71</sup> Inquiry on the Philippines, CEDAW/C/OP.8/PHL/1, para. 111.

<sup>72</sup> Ibid, para. 52(e).

<sup>73</sup> Para. 52(c).

<sup>74</sup> Para. 37.

<sup>75</sup> Para. 39(b).

violence against women and potentially amounting to torture or cruel, inhuman and degrading treatment<sup>76</sup>, in violation of articles 2 and 5, read with article 1. It affronts women's freedom of choice and autonomy, and their right to self-determination. The mental anguish suffered is exacerbated when women are forced to carry to term a non-viable foetus (FFA) or where the pregnancy results from rape or incest. Forced continuation of pregnancy in these scenarios is unjustifiable State-sanctioned coercion.

66 In defining discrimination, the Convention deliberately adopts a dual "effect" and "purpose" approach in order to capture acts that might have a discriminatory effect even when not purposeful. Criminalising provision of abortion by medical professionals in effect hinders women's access to sexual and reproductive health services.

**(b) *De facto unavailability of abortion under the physical or mental health exceptions due to restrictive interpretation, intimidation and ambiguity***

67. The Committee considers that the *Bourne* criteria are narrowly construed by authorities and heavily constricted by the qualifications of "long-term or permanent". Consequently these criteria are hardly met in practice. Furthermore, it finds that the State-issued guidance on legal abortion has a chilling effect on healthcare professionals as it is unclear when an abortion performed under the physical or mental health grounds is legal. Consequently, they decline service provision to avoid criminal sanctions. Women who should qualify for a legal abortion under these exceptions are compelled to carry pregnancies to term.

**(c) *Legitimate interests of the State in potential life of the unborn***

68. NI authorities argued that NI recognises a right to life of the unborn through its criminal law on abortion. The Committee notes the NI Court of Appeal's holding that "*Bourne* determined [...] that the foetus enjoyed protection under the criminal law subject to the qualification that the mother had a superior right. The foetus did not, therefore, have a right to life comparable to that of those who had been born."<sup>77</sup> Under international law, analyses of major international human rights treaties on the right to life confirm that it does not extend to foetuses.<sup>78</sup> While the Committee acknowledges that the State may have a legitimate interest in "pre-natal life", criminalising abortion does not further this purpose. World Health Organisation data indicates: (a) a direct correlation between restrictive abortion laws and high rates of unsafe abortions, leading to high mortality and morbidity; and, (b) that bans or very restrictive abortion laws have no deterrent effect<sup>79</sup>.

**(d) *Rural women and women in situations of poverty and/or other forms of vulnerability***

69. The limited availability of sexual and reproductive services, particularly publicly-funded legal abortions in NI, limits options available to rural, migrant, asylum-seeking, refugee women and women in situations of poverty to access safe abortion services. In light

<sup>76</sup> The Human Rights Committee and the Committee against Torture have found that denial of access to abortion services can result in cruel, inhuman and degrading treatment. See *Whelan v Ireland*, Communication No. 2425/2014; *Mellet v. Ireland*, Communication No. 2324/2013; *K.L. v. Peru*, Communication No. 1153/2003; *L.M.R. v. Argentina*, Communication No. 1608/2007; and Peru, CAT/C/PER/CO/5-6 (2013) para. 15; Ireland, CAT/C/IRL/CO 1 (2011), para. 26. GR. No. 35 (2017) gender-based violence against women; See also supra note 5, paras- 60-62.

<sup>77</sup> Supra, note 7, para. 52.

<sup>78</sup> Article 3 of the UDHR limits the right to life to those who have been 'born'. Historical records indicate that the term 'born' was intentionally used to exclude the foetus or any other antenatal application of human rights as confirmed by the refusal to amend the text to remove the term and protect the right to life from conception (GA OR 3rd Comm., A/PV/99 (1948) at 110-124). The ICCPR equally rejects the proposition that the right to life protected under article 6(1) applies before birth. The *travaux préparatoires* indicate that a proposed amendment, later rejected, stated: "the right to life is inherent in the human person from the moment of conception, this right shall be protected by law" (UN GAOR Annex, 12th Session, Agenda Item 33, at 96, UN Doc. A/C.3/L.654 and UN GAOR, 12th Session, Agenda Item 33, at 113 UN Doc. A/3764, 1957).

<sup>79</sup> WHO, Safe abortion: technical and policy guidance for health systems (2012).

of the multiple barriers faced by these women to access abortion both in and outside NI, the Committee notes their susceptibility to unsafe abortion.

(e) **Harassment by anti-abortion protestors**

70. In violation of their right to seek sexual and reproductive health services and information, women are subjected to harassment by anti-abortion protestors emboldened by lack of prosecution.

(f) **Post abortion care**

71. NI authorities claim that post-abortion care is available irrespective of whether abortions were procured legally or illegally and no legal repercussions flow from women seeking post-abortion care in any circumstance. Investigations revealed that post-abortion care is unavailable for women procuring abortions legally outside NI or illegally in NI. Fear of community stigma and criminal prosecution prevent women from seeking care. Healthcare professionals, being legally obligated to report suspected crimes, may report women who procure legal abortions outside NI, as they cannot ascertain legality in the absence of shared medical records with abortion providers outside NI.

(g) **Findings**

72. The Committee finds that the State party is in violation of Convention articles:

(a) 1 and 2 read with articles 5, 12 and 16 for perpetrating acts of gender-based violence against women through its deliberate maintenance of criminal laws disproportionately affecting women and girls, subjecting them to severe physical and mental anguish that may amount to cruel, inhuman and degrading treatment;

(b) 12 for failing to respect women's right to health by obstructing their access to health services including through laws criminalising abortion, which punish women and those assisting them, and rendering access to post-abortion care, irrespective of the legality of the abortion, inaccessible as clinicians fear prosecution;

(c) 2, 12, and 16 for denying women the right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights;

(d) 2, 12, 14(2)(b) and 16(1)(e), read with article 1 for dereliction of its public health duties. The concentration of sexual and reproductive services in Belfast and the exportation of abortion to England seriously impacts disadvantaged groups unable to travel for socioeconomic reasons, exacerbating multiple forms of discrimination already suffered by rural, migrant, asylum-seeking, refugee women and women in situations of poverty; and

(e) 10 and 12 for failing to protect women from harassment by anti-abortion protestors when seeking sexual and reproductive health services and information.

**(II) Gender stereotypes**

73. Information obtained revealed:

(a) Prevalence of discriminatory gender stereotypes on women's role as mothers as rooted in culture and religion;

(b) Politicians' statements that vilify women and foment negative stereotypes regarding reproduction;

(c) The societal ostracisation and religious condemnation of women who undergo an abortion breeds fear and hinders access to sexual and reproductive health services and information; and

(d) Non-existence of policy to counter existing negative stereotypes, which condone a culture of silence and stigma; and that healthcare facilities are suffused with negative stereotypes regarding women primarily as mothers, impeding the provision of

evidence-based and scientifically sound information and service on pregnancy prevention and termination.

### *Findings*

74. The Committee finds that the failure to combat stereotypes depicting women primarily as mothers exacerbates discrimination against women and violates article 5, read with articles 1 and 2, of the Convention.

## **(III) Access to sexual health education**

75. The provision of age-appropriate, culturally sensitive, comprehensive, and scientifically accurate sexuality education and information is critical to the realisation of women's right to health. Schools' discretion to deliver the RSE curriculum results in poor quality sexuality education for youth and anti-abortion and abstinence ethos indoctrination.

### *Findings*

76. The Committee finds that the State party has failed to prioritise the prevention of unplanned pregnancy through the provision of quality sexuality education. Its lack of oversight on schools' discretion to deliver the RSE curriculum to ensure that it is evidence-based and includes contraceptive use, safe abortion and post-abortion care, violates article 10(h) of the Convention.

## **D. Principal findings of violations under the Convention**

77. In light of the above, the Committee finds that the State party has violated Convention articles: 12 read alone; 12 read with 2 (c), (d), (f), (g), 5 and 10(h); 10(h) read with 16(1)(e); 14(2)(b) read alone; and 16(1)(e) read alone. These articles should be read together with the Committee's GR Nos: 19 (1992); and 35 (2017) on violence against women and gender-based violence against women; 21 (1994) on equality in marriage and family relations; 24 on women and health; 26 (2008) on women migrant workers; 28 (2010) on core obligations of States parties; 32 (2014) on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women; 33 (2015) on access to justice; and, 34 (2016) on the rights of rural women.

## **E. Grave or systematic nature of the violations**

78. Pursuant to article 8 of the OP and Rule 83 of its Rules of Procedure, the Committee must assess if the violations of rights are grave or systematic.

79. The Committee considers violations to be "grave" if they are likely to produce substantial harm to victims. A determination regarding the gravity of violations must take into account the scale, prevalence, nature and impact of the violations found.<sup>80</sup>

80. The term "systematic" refers to the organised nature of the acts leading to the violations and the improbability of their random occurrence.<sup>81</sup> The Committee has stressed that a "systematic denial of equal rights for women can take place either deliberately, namely with the State party's intent of committing those acts or as a result of discriminatory laws or policies, with or without such purpose".<sup>82</sup>

81. The Committee assesses the gravity of the violations in NI in light of the suffering experienced by women and girls who carry pregnancies to full term against their will due to the current restrictive legal regime on abortion. It notes the great harm and suffering resulting from the physical and mental anguish of carrying an unwanted pregnancy to full

<sup>80</sup> Supra, note 76, para. 47; Canada Inquiry, CEDAW/C/OP.8/CAN/1, para. 213.

<sup>81</sup> Supra, note 76, para. 48; Mexico inquiry, CEDAW/C/2005/OP.8/MEXICO, para. 261.

<sup>82</sup> Supra, note 76, para. 48.

term, especially in cases of rape, incest and severe foetal impairment, particularly FFA.<sup>83</sup> The situation gives NI women three deplorable options: (a) undergo a torturous experience of being compelled to carry a pregnancy to full term; (b) engage in illegal abortion and risk imprisonment and stigmatisation; or, (c) undertake a highly stressful journey outside NI to access a legal abortion. Women are thus torn between complying with discriminatory laws that unduly restrict abortion or risk prosecution and imprisonment.

82. The systematic nature of the violations stems from the deliberate retention of criminal laws and State policy disproportionately restricting access to sexual and reproductive rights, in general, and highly restrictive abortion provision, in particular. Westminster and NI authorities acknowledge the magnitude of the phenomenon and choose to export it to England where NI women travel to access abortions. The UK's observations and interviews with NI authorities clarify the deliberate intention neither to decriminalise abortion nor to expand the grounds for legal abortion. Availability of abortion in other parts of the State party does not absolve it of its responsibility under the Convention to ensure accessibility in NI.

83. The Committee finds that the State party is responsible for:

(a) Grave violations of rights under the Convention considering that the State party's criminal law compels women in cases of severe foetal impairment, including FFA, and victims of rape or incest to carry pregnancies to full term, thereby subjecting them to severe physical and mental anguish, constituting gender-based violence against women; and

(b) Systematic violations of rights under the Convention considering that the State party deliberately criminalises abortion and pursues a highly restrictive policy on accessing abortion, thereby compelling women to:

- (i) Carry pregnancies to full term;
- (ii) Travel outside NI to undergo legal abortion; or
- (iii) Self-administer abortifacients.

## VII. Recommendations

84. In the light of the above findings and in line with relevant recommendations addressed to the State party by other United Nations bodies, the Committee refers to its previous concluding observations<sup>84</sup> and recommends the following to the State party, focusing on NI.

### A. Legal and institutional framework

85. The Committee recommends that the State party urgently:

(a) **Repeal sections 58 and 59 of the Offences against the Person Act, 1861 so that no criminal charges can be brought against women and girls who undergo abortion or against qualified health care professionals and all others who provide and assist in the abortion;**

(b) **Adopt legislation to provide for expanded grounds to legalise abortion at least in the following cases:**

- (i) **Threat to the pregnant woman's physical or mental health without conditionality of "long-term or permanent" effects;**
- (ii) **Rape and incest; and**

<sup>83</sup> *Mellet v. Ireland*, Human Rights Committee, Communication No. 2324/2013.

<sup>84</sup> CEDAW/C/GBR/CO/7 (2013), paras. 50 and 51

(iii) Severe foetal impairment, including FFA, without perpetuating stereotypes towards persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term.

(c) Introduce, as an interim measure, a moratorium on the application of criminal laws concerning abortion, and cease all related arrests, investigations and criminal prosecutions, including of women seeking post-abortion care and healthcare professionals;

(d) Adopt evidence-based protocols for healthcare professionals on providing legal abortions particularly on the grounds of physical and mental health; and ensure continuous training on these protocols;

(e) Establish a mechanism to advance women's rights, including through monitoring authorities' compliance with international standards concerning access to sexual and reproductive health including access to safe abortions; and ensure enhanced coordination between this mechanism with the Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland Human Rights Commission; and

(f) Strengthen existing data collection and sharing systems between the DHSSPS and the PSNI to address the phenomenon of self-induced abortions.

## **B. Sexual and reproductive health rights and services**

86. The Committee recommends that the State party:

(a) Provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, including on all methods of contraception and access to abortion;

(b) Ensure accessibility and affordability of sexual and reproductive health services and products, including on safe and modern contraception, including oral and emergency, long term or permanent and adopt a protocol to facilitate access at pharmacies, clinics and hospitals;

(c) Provide women with access to high quality abortion and post-abortion care in all public health facilities, and adopt guidance on doctor-patient confidentiality in this area;

(d) Make age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health and rights a compulsory curriculum component for adolescents, covering early pregnancy prevention and access to abortion, and monitor its implementation;

(e) Intensify awareness-raising campaigns on sexual and reproductive health rights and services, including on access to modern contraception;

(f) Adopt a strategy to combat gender-based stereotypes regarding women's primary role as mothers; and

(g) Protect women from harassment by anti-abortion protestors by investigating complaints, prosecuting and punishing perpetrators.