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**Response to Government Consultation: A new legal framework
for abortion services in Northern Ireland**

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Who We Are

This submission has been co-authored by students and the lecturer on the Ulster University Transitional Justice Institute taught postgraduate programme LLM Gender, Conflict and Human Rights. The programme focuses on the international legal framework for the protection of women's human rights, in particular the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, or 'the Convention'), and modalities for ensuring effective domestic protection of women's international human rights. Dr Catherine O'Rourke was a co-author of the initial submission to the CEDAW Committee ('the Committee') requesting an inquiry into access to abortion in Northern Ireland.

This submission reflects the views of the named co-authors only and not of any institutions or organisations with whom any of the authors are affiliated.

The Scope of the Submission

This submission focuses on the issue of CEDAW compliance and ensuring that any new framework for abortion services in Northern Ireland is compliant with CEDAW, both in terms of the Committee's specific recommendations to the UK government in its inquiry report, but also in terms of the principles the Committee has established more broadly concerning legal obligations on all state parties under the Convention. The CEDAW Committee has operated since 1982 to monitor state party compliance with the obligations under the Convention, and in this period has developed a substantive body of law detailing state party obligations in the provision of abortion services. Thus, the recommendations in paragraphs 85 and 86 of the CEDAW inquiry report on Northern Ireland can only be fully understood and appreciated in the context of the Committee's broader activities and determinations concerning reproductive rights obligations under the Convention. Moreover, CEDAW belongs to a wider corpus of international human rights law. Consequently, in order to more fully elaborate state party obligations under CEDAW, where relevant and appropriate, we have drawn on other relevant human rights instruments to which the UK is also a state party. Finally, in some instances in which we have identified comparative practice in other jurisdiction of relevance for developing a CEDAW-compliant new legal framework for abortion services, we have included details also.

Question 1: Should the gestational limit for early terminations or pregnancy be: up to 12 weeks, up to 14 weeks, or other?

Under CEDAW specifically, and international human rights law more broadly, there are a number of principles that should underpin legislation and policy on this question. The first principle is that women's equality, dignity, and autonomy must be at the heart of the new legal framework for abortion. The CEDAW Committee has been explicit that the Convention:

Require[s] all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.¹

In order to comply, therefore, with the CEDAW inquiry report recommendations 85 and 86, every aspect of the new legal framework for abortion services in Northern Ireland must comply with this overriding obligation under CEDAW.

The second, related, principle is CEDAW article 2(g) which requires state parties to repeal all national penal provisions which constitute discrimination against women. Under General Recommendation 24, the CEDAW Committee is unequivocal that 'laws that criminalize medical procedures only needed by women punish women who undergo those procedures [and constitute...] barriers to women's access to appropriate health care'.² Thus, the repeal of sections 58 and 59 of the Offences Against the Person Act 1861, in accordance with CEDAW inquiry report recommendation 85(a), is insufficient to ensure complete compliance with CEDAW. Any new legal framework must also eschew criminalization of abortion services that respect women's right to informed consent.

The third principle concerns CEDAW's emphasis on not only *de jure*, but also *de facto* discriminatory laws, policies and practices.³ Thus it is not sufficient for the new legal framework only to establish

¹ CEDAW, General Recommendation No. 24, Article 12 of the Convention (Women and Health) Adopted at the Twentieth Session of the Committee on the Elimination of Discrimination against Women, in 1999, UN Doc. A/54/38/Rev.1, chap. I (hereafter CEDAW, GR24), paragraph 31(e).

² Ibid, paragraph 14.

³ Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979, entered into force 3 September 1981) UNTS 1249 13, article 1, defines discrimination against women as 'any distinction, exclusion or restriction made on the basis of sex

lawful access to abortion services in Northern Ireland; the new legal framework must provide an *enabling framework* by which women and girls throughout Northern Ireland have consistent and effective access to those services. According to the CEDAW Committee:

Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.⁴

Barriers posed by real or perceived lack of confidentiality, stigma, resources, geography (in particular rural location), status as a minor, professional medical discretion or burdensome certification procedures constitute violations of the Convention and must therefore be proactively avoided.

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy? If no, what alternative approach would you suggest?

Experience from other jurisdictions, such as Poland, evidences how such documentation and certification requirements can have a ‘chilling effect’ on both women and medical practitioners.⁵ We further note that CEDAW article 14, paragraph 2 (b), requires States parties to ensure access for rural

which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field’. Further, CEDAW, article 2, obliges state parties to, *inter alia*:

- (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
- (e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
- (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

⁴ CEDAW, GR24, paragraph 22

⁵ *Tysiac v Poland*, European Court of Human Rights Application No. 5410/03, 20 March 2007, paragraph 116.

women to adequate health-care facilities, including information, counselling and services in family planning.⁶ Given the large proportion of rural dwellers in Northern Ireland, we submit that it would be very difficult to require this form of certification whilst also ensuring the equal rights of rural women to abortion services. As such, we recommend against unnecessary certification.

Question 3: Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy be: 21 weeks plus 6 days gestation; 23 weeks plus 6 days gestation, or other?

In line with the information provided in response to Question 1, in order to ensure the fullest possible respect for women's rights to equality, dignity, autonomy, choice and consent as articulated by the CEDAW Committee, the proposed time limits must be as long as possible.

Also, in line with the information provided in response to Question 1, any new legal framework must also eschew the criminalization of abortion services on the basis of gestational time limits, where those abortions would otherwise be lawful.

Further, in CEDAW article 12, which prohibits discrimination against women in accessing healthcare, the Convention includes a broad definition of 'health', to include both physical and mental health throughout the life cycle, and which is tailored to the diverse needs based on disability, age, socioeconomic status and other factors.⁷ The UN Committee on Economic, Social and Cultural Rights, which monitors state compliance with the International Covenant on Civil and Political Rights to which the UK is a state party, has determined that:

Violations of women's sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms

⁶ CEDAW, GR24, paragraph 28.

⁷ Ibid, paragraph 12.

of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.⁸

We therefore submit that, in order to ensure CEDAW compliance, a broad definition of health must be applied, with a low threshold for potential risk of injury.

Question 4: Should abortion without time limit be available for fetal abnormality where there is substantial risk that: the fetus would die in utero (in the womb) or shortly after birth; the fetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life, or other?

In recommendation 85(b)(iii) of the CEDAW inquiry report, the Committee required that provision for abortion on grounds of severe foetal impairment, including FFA, avoid 'perpetuating stereotypes toward persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term'. Consequently, in addressing this question, the submission draws also on the UN Convention on the Rights of Persons with Disabilities (CRPD),⁹ and the UN Convention on the Rights of the Child (CRC), two international human rights treaties also ratified by the UK.

We note that the CRPD frames disability as an evolving concept which intersects persons with impairments and their societal environment. Further, it makes no explicit reference to abortion or pregnancy in the treaty text. However, in its work, the CRPD Committee has outlined a number of issues of relevance, in particular:

⁸ UN Committee on Economic, Social and Cultural Rights (article 12) 'General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights', paragraph 18.

⁹ Convention on the Rights of Persons with Disabilities (adopted 24 January 2007, entered into force 3 May 2008) A RES 61 106; Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) TS 1577;

1. The CRPD Committee states that 'laws which explicitly allow for abortion on the grounds of impairment violate the Convention on the Rights of Persons with Disabilities'.¹⁰
2. The CRPD Committee views even FFA as a decision that is grounded in impairment. They highlight that the pre-natal assessment of impairment as non-exact and the assessment perpetuates stereotyping disability as 'incompatible with a good life'.¹¹

In light of this position of the CRPD Committee, in interpreting state party obligations under CRPD, we submit that the only feasible means for implementing recommendation 85(b)(iii) of the CEDAW inquiry report is to ensure a broad right of access to abortion services, in conjunction with an increase in practical and emotional support for parents with children with disabilities, as well as a move towards representation and normalisation of safe and accessible abortion services for women with disabilities. We further note that CRPD, article 25 obliges state parties to ensure the sexual and reproductive health of people with disabilities. We therefore further conclude that, in order for the new legal framework to comply with recommendation 85(b)(iii), the rights of women and girls with disabilities to make informed decisions about their own sexual and reproductive health must be protected and enforced.

Comparative Practice in Other Jurisdictions

In the Republic of Ireland, abortion is currently permitted in situations in which two medical practitioners are in agreement that a condition will lead to the death of the fetus within 28 days of birth.¹²

¹⁰ Committee on the Rights of Persons with Disabilities, 'Comments on the draft General Comment No 36 of the Human Rights Committee on article 6 of the International Covenant of Civil and Political Rights'. Concluding Observations: Japan (2014), para. 13. Cf. Communication 684/1996 R.S. v Trinidad and Tobago, Views adopted on 2 April 2002, para. 7.2

¹¹ Ibid

¹² Health (Regulation of Termination of Pregnancy) Act 2018 (Republic of Ireland).

Question 5: Do you agree that provision should be made for abortions without gestational time limit where: there is a risk to the life of the woman or girl greater than if the pregnancy were terminated? If termination is necessary to prevent grave and/or permanent injury to the physical or mental health of the pregnant woman or girl? Or other?

CEDAW article 12, which prohibits discrimination against women in accessing healthcare, adopts a broad definition of ‘health’, to include both physical and mental health throughout the life cycle, and which is tailored to the diverse needs of women and girls based on (dis)ability, age, socioeconomic status and other factors.¹³ Further, the UN Committee on Economic, Social and Cultural Rights, which monitors state compliance with the International Covenant on Economic, Social and Cultural Rights to which the UK is a state party, has determined that:

Violations of women’s sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.¹⁴

We therefore submit that, in order to ensure CEDAW compliance, a broad definition of health must be applied, with an understanding of the fundamental interconnection of health and life, and with low threshold for potential risk to life. We further submit that, in line with principles enumerated in response to question 1, any mechanism for decision-making on this question must ensure that the pregnant woman’s dignity, autonomy, choice and informed consent is central.

¹³ CEDAW, GR24, paragraph 12.

¹⁴ UN Committee on Economic, Social and Cultural Rights (article 12) ‘General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights’, paragraph 18.

Question 6: Do you agree that a medical practitioner or another registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body’s requirements and guidelines?

‘Safe abortion’ is an essential human right that should be respected, protected and fulfilled. As a positive right, states must ensure access to the highest attainable standard of abortion services,¹⁵ which means guaranteeing trained personnel¹⁶ and a space with the appropriate conditions for performing it are available.¹⁷

CEDAW and CESCR, through their general comments and recommendations, affirm the right (of women) to ‘the highest attainable standard of health’,¹⁸ and more specifically, ‘sexual and reproductive health’.¹⁹ Thus, whilst no human rights treaty provision specifies ‘who’ can perform an abortion, nor ‘where’, general principles are established which provide an important and useful framework for the new legal framework in Northern Ireland.

We note that NICE Guidelines recommend against restricting the provision of abortion services to doctors, and recommend also the use of midwives and nurses.²⁰ Further, human rights obligations as interpreted by CEDAW and CESCR Committees stipulate that services are applied by ‘trained²¹

¹⁵ CEDAW, article 12; CEDAW, GR24, paragraph 2; CEDAW, General Recommendation No. 19, paragraph 7 (g); ICESCR, article 12; CESCR, General Comment No. 22, paragraph 11.

¹⁶ CESCR, General Comment No. 22, paragraph 13.

¹⁷ CEDAW, GR24, Recommendations government action (e).

¹⁸ CEDAW, article 12; CEDAW, GR24, paragraph 2; CEDAW, General Recommendation No. 19, paragraph 7 (g); ICESCR, article 12.

¹⁹ CESCR, General Comment No. 22, paragraph 11.

²⁰ NICE guidelines recommend the use of nursing and midwifery staff (September 2019) and not just doctors; this is also recommended in World Health Organization Guidance.

²¹ ‘Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women’s health and human rights’, CEDAW, GR24, Recommendations government action (f). ‘Training health care providers’ regarding safe abortion, CESCR, General Comment No. 22, paragraph 28.

medical and professional personnel and skilled providers'.²² Furthermore, international human rights law requires an 'adequate number of health-care providers', in addition to requiring that health-care providers who 'refuse to perform [abortion] services' ensure 'that women are referred to alternative health providers'.²³

Where an abortion is permitted, although international human rights law does not specify an explicit place (e.g. hospital, clinic or GP²⁴), it can be identified as a space where the services are 'consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice'.²⁵ It is also specified the need of safe abortion, which also emphasises on the quality of the services²⁶ and the idea to put women at the centre.²⁷ Moreover, the intersectionality perspective must be considered, taking into account the needs of particular groups such as persons with disabilities²⁸ or the geographical barriers, for instance of rural women.²⁹ Finally, the quality of the service must be ensured, without any distinction due to the facilities characteristic as public or

²² CESCR, General Comment No. 22, paragraph 13.

²³ CEDAW, GR24 paragraph 11. Also, the 'Termination of Pregnancy bill 2018' part 2 'Registered health practitioner with conscientious objection' mentions the responsibility of addressing to a 'another registered practitioner that does not have conscientious objection to the performance of the termination'. Available at < <https://www.legislation.qld.gov.au/view/pdf/bill.first/bill-2018-089?>>.

²⁴ A debate about how ideal services could be in NI can be found in G Horgan A M Gray and L Morgan, 'Developing Policy for a Full Reproductive Health Service in NI' (2019) ARK Policy Brief 7

²⁵ CEDAW, GR24, Recommendations government action (e).

²⁶ CESCR, General Comment No. 22, paragraph 28.

²⁷ 'Perspective of women needs', CEDAW, GR24, paragraph 11

²⁸ CESCR, General Comment No. 22, paragraph 24. Convention on the Rights of Persons with Disabilities, article 25.

²⁹ CEDAW, article 14, CEDAW, General Recommendation No.34; CESCR, General Comment No. 22, paragraph 46.

private³⁰-even though it is important to put emphasis on 'safe abortion' as a matter of public health globally.³¹

'Who' and 'where' abortion should be answered considering women human rights interdependence. The right to sexual and reproductive health is linked with the right to life,³² liberty and security of person and freedom from torture and other cruel, inhuman or degrading treatment.³³ In conclusion, the medical practice of abortion can be safe and reliable 'when performed by skilled health care providers in sanitary conditions'.³⁴

Question 7: Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortions procedures can take place and be able to be developed within Northern Ireland?

Yes, for the principles enumerated in response to question 6.

Question 8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?

The principles enumerated in response to question 6 should also frame legislation in this area.

³⁰ CESCR, General Comment No. 22, paragraph 42.

³¹ SRHM, 'Safe Abortion' (2019), <<http://www.srhm.org/safe-abortion/>>; WHO, 'Safe Abortion: technical and policy guidance for health systems' (2edn World Health Organization 2012) 17.

³² *Alyne da Silva Pimenez v. Brazil*, CEDAW Committee Communication No. 17/2008, 10 August 2011; Human Rights Committee, General Comment No. 36 (Article 6 of the ICCPR).

³³ *Karen Noelia Llantoy Huaman v. Peru*, Human Rights Committee Communication No. 1153/2003, 24 October 2005, UN Doc. CCPR/C/85/D/1153/2003.

³⁴ 'Abortions are one of the safest medical procedures available (while taken) by a trained health-care provider in sanitary conditions.' Amnesty International, 'Key Facts on Abortion' (2018) <<https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/abortion-facts/>>

Question 9: Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland? Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation? Or other?

We endorse the principles enumerated in response to question 1 to frame the answer to this question.

Questions 10: Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services? Or other?

We endorse the principles enumerated in response to question 1 to frame the answer to this question.

Question 11: Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the UK, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administration or managerial tasks?

Yes, subject to compliance with the obligations under CEDAW and the European Convention on Human Rights, as detailed in response to question 12.

Question 12: Do you think that further objections or clarification regarding conscientious objection is required in the regulations? If yes, what additional measures?

Conscientious objection (CO) has been defined as ‘the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs’.³⁵

³⁵ Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield, ‘Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study’ (2017) [Available at <https://www.ncbi.nlm.nih.gov/pubmed/28630541>] page 56.

This right is protected under international³⁶ and domestic legal frameworks³⁷. In the context of health care provision, the CO rights can act as a barrier to sexual and reproductive rights which are also protected under international legal instruments. In the UK, the elaborated standard for interpreting CO rights establishes that CO rights are qualified rights: whilst the right itself is absolute and requires protection by law, but its manifestation can be limited to prevent infringement on the rights of others.³⁸ Consequently, legal frameworks must have adequate regulations that respects

³⁶ European Convention on Human Rights, article 9; see also Amnesty International and Human Rights Watch ‘Comprehensive Approach to Regulating Conscientious Objection in the Health Care Field Needed’ https://www.hrw.org/sites/default/files/related_material/Statement%20by%20Amnesty%20International%20and%20Human%20Rights%20Watch%20%20Comprehensive%20approach%20to%20regulating%20conscientious%20objection.pdf.

The right to freedom of conscience is recognized in multiple international treaties. See e.g. Article 18 of the International Covenant on Civil and Political Rights (ICCPR), and Article 5 (d)(vii) (recognizing the right of nondiscrimination in the enjoyment of the right to freedom of conscience) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). The right of conscientious objection as a derivative of the right to freedom of conscience has been recognized by the Human Rights Committee, most often in reference to military service. UN Human Rights Committee, General Comment 22, Article 18: The Right to Freedom of Thought, Conscience and Religion, A/48/40 vol. I (1993) 208, paras. 11’

³⁷ UK based protection of CO - The Abortion Act of 1967 (England, Scotland and Wales) Section 4(1); Human Fertilisation and Embryology Act 1990, Section 38; Nursing and Midwifery Council, ‘The Code of Professional standards of practice and behaviour for nurses, midwives and nursing associate’ Paragraph 4.4; Guidance General Medical Council (GMC) 2013 Paragraph 52, 54, 57, 59

³⁸ *Janaway v Salford Health Authority* (1988) (a secretary refused to type a letter which referred a patient to a consultant in regards termination of the client’s pregnancy on grounds of CO) *Greater Glasgow Health Board v Doogan* (Two midwives responsible for providing clinical leadership and operational management for delivery of the midwifery service within labour ward and obstetric

health/medical practitioners rights to CO at the same time ensuring that those rights do not serve as a barrier to women's full enjoyment and exercise of sexual and reproductive rights.³⁹

Conscientious Objection under CEDAW

International legal instruments and bodies have a clear position that the manifestation of CO rights is limited, and states have obligations to regulate its exercise. For example, the Committee on the Rights of the Child, in its interpretation of the Convention on the Rights of the Child to which the UK is a state party, has determined that states should ensure that 'adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections'.⁴⁰ The CEDAW Committee, in its engagement with state parties to the Convention, has elaborated the following set of legal obligations on states regarding conscientious objection:

1. A referral system must be put in place to ensure women access to alternative services where CO rights are exercised.⁴¹ Here the interpretation of limitations of CO set in *Janaway v Salford Health Authority* and is a relevant guide for states in designing referral regulations as it relates to medical practitioners' duty of referral. The UK courts have limited practitioners exercise of CO as it relates to referral;
2. States are obligated to ensure that women are provided with information on available alternatives;⁴²

theatre refused to delegate , supervise or support staff on the labour ward directly involved with abortions on grounds of CO).

³⁹ See Amnesty International and Human Rights Watch statement on 'Comprehensive Approach to Regulating Conscientious Objection in the Health Care Field Needed'.

⁴⁰ Information Series on SRHR available here: https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf
General Comment 15, para. 69.

⁴¹ CEDAW, General Recommendation No. 24 Paragraph 11; CEDAW Committee, Concluding Observations: Slovakia, para. 43, UN Doc. A/63/38 (2008)

⁴² CEDAW Committee, Concluding Observations: Hungary, para. 31, UN Doc. CEDAW/C/HUN/CO/7-8 (2013)

3. That state must ensure conscientious objection remains a personal decision rather than an institutional practice;⁴³
4. The state must guarantee access to abortion in public hospitals.⁴⁴ States are obligated to ensure that adequate services are available for referral and that non-objecting providers are available to carry out services.
5. States should provide appropriate systems and mechanisms for patients' timely referral to other health care providers in cases of conscientious objection.⁴⁵
6. Regulations on CO should clearly define CO and its corresponding legal obligations guided by principles of transparency and accountability which ensures redress to women that may be affected adversely when CO rights are exercised.⁴⁶

⁴³ CEDAW Committee, Concluding Observations: Hungary, para. 31, UN Doc. CEDAW/C/HUN/CO/7-8 (2013)

⁴⁴ CEDAW Committee, Concluding Observations: Croatia, para. 117, UN Doc. A/53/38/Rev.1 (1998); Italy, para. 360, UN Doc. A/52/38/Rev.1 (1997)

⁴⁵ Concluding Observations: Poland, para. 28, UN Doc. E/C.12/POL/CO/5 (2009)

⁴⁶The UN CESCR has emphasized transparency and accountability, noting that that it is 'important to undertake preventive, promotive and remedial action to shield women from the impact of [...] norms that deny them their full reproductive rights'. The Committee highlighted the importance of effective judicial or other appropriate remedies for violations of the right to health. (United Nations Committee on Economic, Social and Cultural Rights, General Comment General Comment 14, The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/2000/4, paragraphs 21 and 59, available at: <http://daccess-ddsny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement>); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover – Mission to Poland, 20 May 2010, UN Doc. A/HRC/14/20/Add.3, paragraph 3, available at: <http://daccess-ddsny.un.org/doc/UNDOC/GEN/G10/134/03/PDF/G1013403.pdf?OpenElement>.

7. The exercise of CO rights must be adequately documented to support transparency and accountability;⁴⁷
8. Where a patient's life or health is in danger, providers have an obligation to provide treatment, irrespective of conscientious objection.⁴⁸

Conscientious Objection to Abortion under the European Convention on Human Rights

Given the significance of the jurisprudence of the European Court of Human Rights in the UK legal system, we further note that the Court has repeatedly found the unregulated practice of conscientious objection to be a violation of the Convention. In *P and S v. Poland*, a minor became pregnant as a result of rape. In keeping with Poland's 1993 Abortion Act which provides the possibility of lawful abortion in certain narrowly defined situations such as if pregnancy is a result of a crime/rape the minor had right to a legal abortion. But in this case the minor faced many obstacles in accessing a legal abortion some of which included doctor's refusal to perform the abortion on grounds of CO. The key issues pertinent to CO before the court stemmed from the applicants submission to the court that the absence of a comprehensive legal framework governing the practice of conscientious objection and ensuring access to lawful termination of pregnancy in medical facilities had allowed the doctors to deny the minor her right to terminate her pregnancy in a respectful, dignified and timely manner.⁴⁹ The facts show that after the minor had reported the rape incident at a public health centre in the area where she lived in April of 2008 to a time in May 2008 when the District Prosecutor officially certified that in keeping with the abortion act the minor's pregnancy had resulted from unlawful sexual intercourse,⁵⁰ the minor's mother immediately requested the local hospital for referral for a legal abortion in keeping with the abortion act. The doctors refused on grounds of CO, without the mother's consent the minor was referred to a priest for counselling to change her mind about the abortion, the hospital provided inaccurate information about the requirements of a legal abortion and refused to refer to an adequate service provider. Another hospital was contacted but also

⁴⁷ Ibid, paragraph 52.

⁴⁸ Ibid, paragraph 50.

⁴⁹ *P. and S. v. Poland*, European Court of Human Rights Application no. 57375/08, paragraph 93.

⁵⁰ Ibid, paragraphs 5-10.

could not perform the abortion. And finally, in June 2008 through the Ministry of Health the abortion was administered in a town 500 kilometres away from the minor's home town.⁵¹ Given that the abortion was administered, Poland claimed the legal conditions for a lawful abortion existed and the abortion was obtained hence the state fulfilled its obligations to Article 8 of the ECHR. Poland further argued that the doctors in exercise of their statutory CO rights provided for under Article 39 of the Doctor and Dentist Professions Act rightfully refused to perform the abortion but failed to refer in keeping with the act however, that error was a non-issue because eventually the abortion was obtained within the timeframe provided in the act.⁵²

The Principles established by the European Court of Human Rights to regulate Conscientious Objection:

1. **State has an obligation to Regulate CO:** The court restated its judgment in *R.R. v. Poland* that once a state adopts laws allowing abortion, it is under obligation to design regulations that do not limit abortion.⁵³ Further on CO, restating its interpretation of the word 'practice' used in Article 9 § 1 of the ECHR the court states that the word practice does not denote that each and every act or form of behaviour motivated or inspired by a religion or a belief qualifies for absolute protection; that to regulate what practice mean in the health system Poland is obliged to organise its health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.⁵⁴
2. **Obligation to mandate health practitioners to document refusal of CO and to refer patients to competent service providers:** Mechanism to regulate CO should include elements allowing the right to conscientious objection to be reconciled with the patient's interests, by making it mandatory for such refusals to be made in writing and included in the patient's medical record

⁵¹ Ibid, paragraphs 11- 41.

⁵² Ibid, paragraph 92.

⁵³ Ibid, paragraph 110.

⁵⁴ Ibid, paragraph 106.

and, above all, by imposing on the doctor an obligation to refer the patient to another physician competent to carry out the same service.⁵⁵

3. **Obligation to provide Information and act in a timely manner:** The events surrounding the determination of the first applicant's access to legal abortion were marred by procrastination, confusion and procedural gaps.⁵⁶ Effective access to reliable information on the conditions for the availability of lawful abortion, and the relevant procedures to be followed, is directly relevant for the exercise of personal autonomy. It reiterates that the notion of private life within the meaning of Article 8 applies both to decisions to become and not to become a parent (*Evans v. the United Kingdom* [GC], no. 6339/05, § 71, ECHR 2007-I; *R.R. v. Poland*, cited above, § 180). The nature of the issues involved in a woman's decision to terminate a pregnancy or not is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are taken in good time.⁵⁷

Comparative Practice in Other Jurisdictions

Portugal: Portugal's 2007 abortion laws is a good example as it limits the negative impact of 'conscientious objection' on women. The law allows CO only those directly involved in providing abortion care; the provider who refuses must submit a written statement to their hospital director clarifying why they object and confirming their agreement to provide an abortion if necessary to save the woman's life; must inform the patient and refer the patient to a non-objecting abortion provider; the national public health system in Portugal provides abortion services, and all gynaecological departments must have at least one doctor willing to perform abortion. These regulations have improved women's access to abortion services though there are still gaps where in health worker may ignore the regulations.⁵⁸

⁵⁵ Ibid, paragraph 107.

⁵⁶ Ibid, paragraph 108.

⁵⁷ Ibid, paragraph 111.

⁵⁸ See International Women Health Coalition report on CO , 'Unconscionable: When Providers Deny Abortion Care' available here <https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/>

Sweden, Iceland and Finland⁵⁹ prohibit CO under any circumstances the refusal to treat patients, including the use of ‘conscientious objection’ in reproductive health care.

England, Norway, and Portugal: A 2017 case study of regulation of Conscientious Objection to Abortion found that the England, Norway, and Portugal CO regulations shows the possibilities of balancing CO rights with ensuring women rights to abortion/reproductive rights. The report⁶⁰ identified three primary factors ‘necessary for a functional health system that guarantees access to abortion while still permitting CO’ namely: *clarity* about who can object and to which components of care, ready access by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services. The report also noted that social attitudes remain a barrier even in countries that have functional CO regulations.

Question 13: Do you agree that there should be provision for power which allow for an exclusion or safe zone to be put in place?

Yes.

Definitions

1. Buffer, bubble, safe or exclusion zones have been defined as designated ‘protest-free zones’ that surround abortion clinics. Such exclusion zones are designed to ensure that those accessing or providing abortions are free from harassment, violence and intimidation from anti-choice protestors. These protest-free zones are also aimed at preventing abortion clinics from being vandalised and obstructed.

⁵⁹ Ibid

⁶⁰ Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield, ‘Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study’ (2017), available at <https://www.ncbi.nlm.nih.gov/pubmed/28630541>.

2. As noted by the National Abortion Federation (NAF), ‘Buffer zone laws limit how close demonstrators are allowed to be from a facility by requiring that protests occur at a specific distance from a facility. They are a proven way to balance the importance of safe access to reproductive health care facilities with the free speech rights of anti-choice individuals to distribute literature or engage in conversations with consenting parties’.⁶¹
3. Jennifer Toussaint notes two types of buffer zones in the context of injunctions ruled by the Supreme Court in the US: ‘Floating buffer zones’ and ‘fixed buffer zones’.⁶² The term ‘floating buffer zones’ usually refer to protections around moving objects, such as cars and people heading towards abortion clinics, while the term ‘fixed buffer zones’ usually refers to the static area around an abortion clinic itself.

The Northern Ireland Context

The CEDAW inquiry report on abortion access in Northern Ireland addresses the issue of harassment and intimidation from anti-choice protesters. In paragraph 19, it is noted that, ‘The designated members learned that women’s access to legal abortion services in Northern Ireland was further impeded by the presence and actions of anti-abortion protesters stationed at entrances to public and private health facilities. The designated members witnessed protesters monitoring women entering and leaving a facility and displaying large, graphic posters of disfigured fetuses. The designated members heard testimony of protesters having chased women leaving the facilities, forcing plastic baby dolls into their arms and pro-life literature into their bags and pleading with them ‘not to murder their babies’. One facility has recruited escorts to shield clients from such aggressive behaviour. Although the police are frequently alerted to the situation, they rarely intervene.’⁶³

⁶¹ National Abortion Federation, ‘Buffer Zones’ <<https://prochoice.org/education-and-advocacy/violence/buffer-zones/>> accessed 2 December 2019.

⁶² Jennifer N Toussaint, ‘Abortion Protesting’ (2007) 8 Geo J Gender & L 129.

⁶³ CEDAW Committee, ‘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 Discrimination against Women’ (2018) CEDAW/C/OP.8/GBR/1, paragraph 19.

Clinic chaperones at the Marie Stopes clinic in Belfast have also reported being called ‘child killers’ and ‘Satanists’ by protestors as they attempt to block clients entering clinics and play sounds of crying babies over loudspeakers.⁶⁴

The UK Context

Ealing Safe Zone Court of Appeal Judgment: On 21 August 2019, the Court of Appeal upheld Ealing Council’s safe zone outside the Marie Stopes West London Centre in Ealing. A joint statement from the British Pregnancy Advisory Service (Bpas), Marie Stopes UK and Sister Supporter said this judgement makes ‘clear that harassing and intimidating activities and behaviours towards women outside an abortion clinic are not acceptable’.⁶⁵

Coalitions of charities are continuing to urge for safe zones across the country. In an October 2019 press release, Bpas said, ‘A coalition of charities and medical bodies has today written to the Home Secretary Priti Patel to urge her to reconsider the case for buffer zones, amid serious concerns about the process that led her predecessor to reject them. In September 2018, the then-Home Secretary Sajid

⁶⁴ Cafolla (n 3).

⁶⁵ Marie Stopes UK, ‘Joint Statement - Clinics and Campaigners Welcome the Court of Appeal Judgment on Ealing Council’s Abortion Clinic Safe Zone’ (2019) <<https://www.mariestopes.org.uk/news/ealing-safe-zone-court-of-appeal-judgment/>> accessed 4 December 2019.

Javid dismissed calls for buffer zones around abortion clinics following a public consultation'.⁶⁶ FOI documents released in October address this issue.⁶⁷

Back off campaign: In response to the continued harassment of women and abortion clinic staff in the UK, a campaign was established called 'Back Off'. The campaigners believe the UK needs 'specific legislation to ensure women can access pregnancy advice and abortion centres free from interference and intimidation, as has been enacted in other countries. We propose the establishment of 'buffer' or 'access' zones around registered pregnancy advisory bureaux and clinics, in which anti-abortion activity cannot take place. This would stop activity taking place directly outside centres, ensure women are not approached unsolicited, and prevent other activities designed to cause distress – e.g. filming and strewing the pathway with pictures or models of foetuses.⁶⁸

Comparative Practice in Other Jurisdictions

South Africa: *The Choice on Termination of Pregnancy Act 1996*. Referred to by the Guttmacher Institute, a sexual and reproductive rights organisation, as 'one of the most liberal abortion laws in the world,'⁶⁹ this piece of legislation stipulates in Section 10 on Offences that, 'Any person who prevents the lawful termination of a pregnancy, or who obstructs access to a facility for the

⁶⁶ British Pregnancy Advisory Service, 'Charities call for urgent review of decision to reject buffer zones after evidence of women's experience outside abortion clinics suppressed in flawed consultation' (2019) <<https://www.bpas.org/about-our-charity/press-office/press-releases/charities-call-for-urgent-review-of-decision-to-reject-buffer-zones-after-evidence-of-women-s-experience-outside-abortion-clinics-suppressed-in-flawed-consultation/>> accessed 4 December 2019.

⁶⁷ Abortion Clinic Protest Review: Executive Summary <<https://images.back-off.org/wp-content/uploads/2019/10/07113420/Home-Office-response-ANNEX-B-FOI-50345-Evidence-pack.pdf>> accessed 4 December 2019.

⁶⁸ Back Off campaign, 'The campaign' <<https://back-off.org/the-campaign/>> accessed 4 December 2019.

⁶⁹ Frances A. Althaus, 'Work in Progress: The Expansion of Access to Abortion Services in South Africa Following Legalization' (2000) <<https://www.guttmacher.org/journals/ipsrh/2000/06/work-progress-expansion-access-abortion-services-south-africa-following>> accessed 2 December 2019.

termination of a pregnancy shall be guilty of an offence. Such persons will be liable on conviction to a fine or to imprisonment for a period not exceeding 10 years'.⁷⁰

The US: *The Freedom of Access to Clinic Entrances (FACE) Act*. 'Passed by the United States Congress and signed into law by President Bill Clinton in May 1994, [the act] makes it a crime to intentionally use force, the threat of force, or physical obstruction to injure, intimidate, interfere with, or attempt to injure, intimidate, or interfere with someone obtaining or providing reproductive health care services. FACE also includes penalties for anyone who intentionally damages or destroys a facility that provides reproductive health care services. Many states have enacted their own versions of FACE or similar statutes, allowing prosecutors to bring criminal or civil charges under state law, and giving providers broader opportunities for enforcement of the law.'⁷¹

Australia: *Safe Zone Legislation*. Legislation providing for safe access zones around clinics which provide abortion services has been introduced in six Australian jurisdictions, namely: Tasmania, the Australian Capital Territory, Victoria, the Northern Territory, New South Wales and most recently Queensland.⁷² Sifric and Penovic note that after their research was published before abortion was decriminalised in Queensland, with safe zone legislation also being introduced in the state.

(i) *Tasmania:* Tasmania was the first Australian state to introduce such legislation within the Reproductive Health (Access to Terminations) Act.⁷³ Sifric and Penovic note that, 'The Tasmanian legislation prevents protesters from engaging in prohibited behaviour within 150 metres of a clinic at

⁷⁰ 'Choice on Termination of Pregnancy Act 1996: Republic of South Africa' (1997) 5 *Reproductive Health Matters* 116 <<https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2897%2990013-6?needAccess=true>> accessed 4 December 2019.

⁷¹ National Abortion Federation (n 1) 1.

⁷² Ronli Sifris and Tania Penovic 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2017) 44 *Monash University Law Review* 317. <https://www.monash.edu/__data/assets/pdf_file/0006/1730463/01_Sifris-and-Penovic.pdf> accessed 4 December 2019.

⁷³ Reproductive Health (Access to Terminations) Act 2013 (Tas) ss 9(1)–(2).

which terminations are provided. Prohibited behaviour includes harassment, intimidation or obstruction of a person; visible anti-abortion protesting; footpath interference and recording a person entering premises at which terminations are provided. The penalty for engaging in prohibited behaviour within an access zone is a '[f]ine not exceeding 75 penalty units or imprisonment for a term not exceeding 12 months, or both. In July 2016, John Graham Preston became the first protester to be convicted of violating the safe access zone provisions; he was fined \$3,000 for protesting outside a Hobart clinic'.⁷⁴

(ii) *Australian Capital Territory*: 'The ACT passed legislation in 2015 which amends the Health Act 1993 (ACT) so as to introduce safe access zones. Like the Tasmanian legislation, the ACT provisions prohibit conduct including the harassment, intimidation and recording of women entering an 'approved medical facility', and prevent anti-abortion protesting from taking place within the safe access zone. Unlike the Tasmanian legislation, the ACT law does not provide for a specific geographical zone but rather provides a minimum zone of 50 metres and leaves the maximum to the discretion of the Minister.'⁷⁵

(iii) *Victoria*: 'In November 2015, soon after the passage of the ACT legislation, Victoria passed the Public Health and Wellbeing Amendment (Safe Access Zones) Act which amends the Public Health and Wellbeing Act 2008 (Vic) so as to provide for safe access zones around a clinic at which abortion services are provided.'⁷⁶ The Victorian government in Australia said in 2018 that buffer zones around abortion clinics do not breach Australians' right to free speech because anti-abortion protestors are not engaged in public debate when they demonstrate outside of clinics. Rather, their aim is to target vulnerable women for their healthcare choices and harassing staff at their place of work. The Victorian government made this statement in the aforementioned Attorney General submission to the Australian High Court.⁷⁷ This submission came after Australian anti-choice protestor and religious

⁷⁴ Sifris and Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2017) 44 Monash University Law Review 317, 318.

⁷⁵ Ibid.

⁷⁶ Ibid, 319.

⁷⁷ High Court of Australia, Melbourne Registry <http://www.hcourt.gov.au/assets/cases/06-Melbourne/m46-2018/Clubb-Edwards_AGVic.pdf> accessed 4 December 2019.

picketeer Kathy Clubb was fined \$5,000 for approaching a couple in a safe zone outside the East Melbourne Clinic.⁷⁸

(iv) *Northern Territory*: 'The NT passed legislation in March 2017 which introduced safe access zones, decriminalised surgical abortions and legalised medical abortion. Like the Victorian and Tasmanian legislation, the safe access zone extends to the area 'within 150 metres outside the boundary'¹⁸ of premises providing termination and the penalty for engaging in prohibited conduct within the zone is '100 penalty units or imprisonment for 12 months.'⁷⁹

(v) *New South Wales*: 'The Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018 (NSW) was enacted and commenced in June 2018. Like the Tasmanian, Victorian and NT legislation, it creates safe access zones of 150 metres around clinics at which abortions are provided and prohibits specified conduct within the radius of the zones.'⁸⁰ (vi) *Queensland*: Abortion was recently decriminalised in Queensland, which saw the enactment of the Termination of Pregnancy Act 2018.⁸¹ The law stipulates provisions on prohibited conduct in safe access zones in Division 2 Section 15 and 16. In Section 16, for example, it addresses restrictions on recording persons in or near termination centres and notes the penalty if such provisions are violated.

Canada: Three provinces/territories in Canada have enacted local-level legislation pertaining to abortion buffer zones so far: (i) *British Columbia*: The Access to Abortion Services Act was enacted in September 1995 and aims to restrict protest activity outside abortion clinics in the province. The law addresses injunctions, arrests, offences and sentencing, recording outside clinics and activities

⁷⁸ Paul Karp, 'Safe zones' around abortion clinics don't threaten free speech, Victoria says' (2018) <<https://www.theguardian.com/world/2018/may/18/safe-zones-around-abortion-clinics-dont-threaten-free-speech-victoria-says>> accessed 4 December 2019.

⁷⁹ Ibid, 320.

⁸⁰ Ibid.

⁸¹ Termination of Pregnancy Act 2018 (QSL) s 15 -16. <<https://www.legislation.qld.gov.au/view/pdf/asmade/act-2018-023>> accessed 4 December 2019.

restricted in safe zones.⁸² (ii) Ontario has a 50-metre fixed buffer zone for clinics that perform abortions in the province. The Safe Access to Abortion Services Act, 2017 stipulates provisions on what is prohibited outside abortion clinics in Ontario.⁸³ (iii) *Alberta*: In April 2015, the province of Alberta introduced a bill for no-go zones around abortion clinics.

CEDAW Committee:

In addition to its recommendations in the CEDAW inquiry report on Northern Ireland, in its concluding observations to Australia, the CEDAW Committee recommends to the State party in 50(a) that it should:

Implement the recommendation made by the Children’s Commissioner in 2017 to review state and territory laws, policies and practices to guarantee access to legal and prescribed abortion services and to raise awareness of sexual and reproductive health rights among women and girls, parents, teachers, medical professionals and the general public and *create safe zones around abortion clinics*.⁸⁴

Thus, it is the Committee’s position that such safe zones are required in order to guarantee effective access to abortion services.

⁸² Access to Abortion Services [RSBC 1996] <http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96001_01> accessed 4 December 2019.

⁸³ Safe Access to Abortion Services Act, 2017 < <https://www.ontario.ca/laws/statute/17s19>> accessed 4 December 2019.

⁸⁴ UN Committee on the Elimination of Discrimination against Women, ‘Concluding Observations Australia’ (2018) CEDAW/C/AUS/CO/8 paragraph 50(a).

Question 14: Do you consider that there should also be a power to designate a separate zone where protest can take place under certain conditions? If no, what alternative approach do you suggest?

We note that freedom of assembly rights as guaranteed under the European Convention on Human Rights article 11 are not unqualified rights and can be restricted in order to, *inter alia*, to protect the rights and freedoms of others. As articulated in response to question 1, the new legal framework for abortion services in Northern Ireland must pursue to primary aim of protecting and ensuring the right of women to effective access to lawful abortion services. These principles apply likewise to the regulation of public space surrounding places where abortion services are provided.

Question 15: Have you any other comments you wish to make about the proposed new legal framework for abortion services in Northern Ireland?

CEDAW article 5 requires state parties to adopt measures to challenge discriminatory social and cultural patterns. In its broader activities under article 5, the Committee consistently draws attention to how discriminatory attitudes and stereotypes that regard women primarily as mothers underpin discriminatory laws, policies and practices in the denial of women's rights to health, including reproductive health. More specifically, the CEDAW inquiry report on Northern Ireland in paragraph 73 details how gender stereotypes across social, political and economic life 'condone a culture of silence and stigma' that prevent women's access to rights guaranteed under CEDAW. The new legal framework, in order to be effective, must address not only legal and technical aspects of the provision of abortion services, but also commit to a process of public and professional education to challenge such discriminatory gender stereotypes. It is certain that the CEDAW Committee will raise this issue – and concerns about non-compliance – in further dealings with the UK Government.

We further note that, in order to guarantee effective access to abortion services, the new legal framework will also require changes to legislation in cognate areas. Specifically, we note that abortion is also a workplace issue that will have implications for, for example, work absence and sick leave. CEDAW article 11 prohibits discrimination against women in employment, including the

- (e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

These CEDAW provisions establish essential requirements for effective access to abortion in Northern Ireland.