Submission to the 72nd Session of the United Nations Committee on the Elimination of Discrimination against Women: List of Issues and Questions in relation to the Eighth Periodic Report of the United Kingdom of Great Britain and Northern Ireland

A submission from the Christian Medical Fellowship (CMF)

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation, representing over 5,000 doctors, 800 medical students and 400 nurses across the UK, including over 250 in Northern Ireland (NI). We are the UK's largest faith-based group of health professionals. A registered charity, we are linked to about 80 similar national bodies in other countries throughout the world.

This response relates to paragraph 19 of the list of issues and questions to the eighth periodic report of the UK. We would like to highlight the following points about the existing law on abortion in Northern Ireland:

1. **The law on abortion in NI protects women from the risks and complications of abortion**

a) **There is no clear evidence of a mental health benefit from abortion compared to birth and some factors increase the risk of negative outcomes post abortion**

The most comprehensive review into the mental health outcomes of induced abortion, carried out in the UK in 2011[1], found the rates of mental health problems for women with an unwanted pregnancy were the same, whether they had an abortion or gave birth. The same review concluded that the most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to the abortion.

The results of this review were re-examined by Fergusson, who confirmed that there is no evidence that abortion reduces the mental health risks of unwanted pregnancy. He found that there were small to moderate increases in risks of some mental health problems post abortion.[2]

A growing body of evidence suggests that women may be at an increased risk of mental health disorders (notably major depression, substance misuse and suicidality) following abortion, even with no previous history of problems. Researchers not associated with vested interest groups have published this evidence.[3] [4]

b) **There is strong evidence of a link between abortion and subsequent preterm birth.**

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[1] 'Induced Abortion and Mental Health: A systematic review of the evidence — full report and consultation table with responses.' Academy of Medical Royal Colleges (AoMRC). December 2011

[2] 2 Fergusson D, Horwood L & Boden J. 'Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence.' *Aust N Z J Psychiatry* 2013;47:1204-1205 bit.ly/W5FPm5

[3] Fergusson D, Horwood L & Boden J. 'Reactions to abortion and subsequent mental health' *British Journal of Psychiatry* 2009;195(5):420-6 bit.ly/1tWeTCM. Fergusson, D, Horwood, L & Boden J. 'Abortion and mental health disorders: Evidence from a 30-year longitudinal study' *British Journal of Psychiatry* 2008;193:444-51

[4] Pedersen W. 'Abortion and depression: A population-based longitudinal study of young women' *Scandinavian Journal of Public* Health 2008;36(4):424-8. 1.usa.gov/1qwNoxc

The risk of a preterm birth in someone who has had a previous abortion is small but real. A 2013 review found that women who had one prior induced abortion were 45% more likely to have premature births by 32 weeks, 71% more likely to have premature births by 28 weeks, and more than twice as likely (117%) to have premature births by 26 weeks.[5] A review published in the American Journal of Obstetrics & Gynecology in 2010, found that terminations in the first and second trimesters are associated with a 'very small but apparently real increase in the risk of subsequent spontaneous preterm birth'.[6]

c) Recent evidence suggests that abortion may increase susceptibility to breast cancer.

A meta-analysis of 36 studies on abortion published in 2014 by Huang et al. concluded that induced abortion is significantly associated with an increased risk of breast cancer – by as much as 44% after one induced abortion and even more as the number of abortions increases.[7] These findings have been dismissed by RCOG, citing Beral's 2004 analysis that abortion does not increase the risk of breast cancer.[8] Further research is needed to clarify the risk.

d) There is a small but real risk of physical complications from abortion.

Government statistics report complications for 278 abortions out of 185,000 in England and Wales in 2012, with twice as many complications from medical abortions as surgical. Complications include haemorrhage, damage to the cervix, uterine perforation and/or sepsis but this only includes those reported up to the time of discharge from the place of termination.[9] Complications such as these will become more of an issue as more medical abortions are carried out in patients' homes.

The RCOG reports[10] that for second trimester medical abortions, surgical intervention rates vary between studies ranging from 2.5% in one study and up to 53% in a UK multicentre study. The same report states that women are more likely to seek medical help for bleeding after medical abortion than after surgical abortion and to report heavier bleeding than they expected from a medical abortion.

An Australian review of 7,000 abortions found that: *'Following mid trimester medical abortion, emergency department presentation and subsequent admission were frequent. Manual removal of*

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[5] Hardy G, Benjamin A, Abenhaim H. 'Effect of induced abortions on early preterm births and adverse perinatal outcomes'. *J Obstet Gynaecol Can* 2013;35(2):138-143 bit.ly/1nsj5UU

[6] Iams J, Berghella V. 'Care for women with prior preterm birth' *American Journal of Obstetrics & Gynecology* 2010;203(3):89-100 1.usa.gov/Y7WEib

[7] Huang Y et al. 'A meta-analysis of the association between induced abortion and breast cancer risk among Chinese females.' *Cancer Causes Control* 2014;25(2):227-36

[8] Beral V et al. 'A collaborative reanalysis of data from 53 studies, including 83,000 women from 16 countries'. *Lancet* 2004;363:1007-16 1.usa.gov/Ol3BXE

[9] 187 reported complications were after medical abortion and 91 after surgical abortion. Abortion statistics, England and Wales: 2012. April 2014. Department of Health. NHS Choices state that after an abortion, the main risk is infection in the womb. bit.ly/1rbtBVi

[10] 'The Care of Women Requesting Induced Abortion: RCOG Evidence-based Clinical Guideline Number 7'. RCOG 2011:37 bit.ly/1gknzMHf

the placenta and the high rate of unplanned surgical intervention (rate of 32%) in these cases impose additional costs as well as placing demand on operating theatre resources.'[11]

It is already of concern to us that women may not always be fully informed of the risks of abortion, even small, and may not have access to unbiased information about the abortion procedure and its consequences, which may impact on their health after the abortion.

In the light of the peer-reviewed risks and complications, it is not surprising that some doctors conclude it is not in their patients' best interests to refer for abortion simply 'on demand'.

2. The abortion law in NI has made a significant difference to the number of abortions

According to research conducted by *'Both Lives Matter'* in 2017, an estimated 100,000 individuals are alive in NI today who would not have been had NI adopted the Abortion Act in 1967 as did the rest of the UK. This figure was independently verified by the Advertising Standards Authority following the investigation of a complaint made to them.[12] Claims that the law has made no difference to the number of women from NI having abortions are not evidence-based.

3. The abortion law in NI protects unborn disabled children from discrimination, including those with life limiting conditions

No person, least of all a healthcare professional, should fail to be moved by compassion in response to cases where an unborn child is diagnosed with a life limiting condition. It is, however, our view that the most compassionate response is not to legalise abortion in these cases for three reasons:

1. The child's right to life and dignity

Impaired and dependent upon the mother as he or she may be, the unborn child is a genetically and physically distinct human individual. To make decisions to end the life of another human individual solely on the basis of his/her abilities is discriminatory for disabled people. This is already a concern in Great Britain where, between 2002 and 2010, there were 17,983 abortions of disabled babies, the overwhelming majority for conditions that are compatible with life outside the womb. 1,189 babies were aborted after 24 weeks, the accepted age of viability. Around 90% of babies identified before birth as having Down's Syndrome are aborted in GB. In NI, 90% were born in 2016. [13] [14] Lord Shinkwin has recently described Northern Ireland as 'the safest place in our United Kingdom to be diagnosed with a disability before birth.'[15]

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[11] Mulligan E, Messenger H. 'Mifepristone in South Australia: The first 1343 tablets'. *Australian Family Physician* May 2011; 40(5)

[12] https://www.asa.org.uk/rulings/both-lives-matter-a17-370344.html

[13] The National Down Syndrome Cytogenetic Register for England and Wales: 2012 Annual Report http://www.binocar.org/content/annrep2012_FINAL.pdf (Accessed 04/12/2018)

[14] See http://www.publichealth.hscni.net/sites/default/files/Core%20Tables%202016%20-%20final%20-%208%20Dec%202017_0.pdf and https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714541/2017_Tables_-_Abortion_Statistics.ods

[15] Lord Shinkwin speaking in the House of Lords on 1/11/2018

Further, the Committee of the UN Convention on the Rights of Persons with Disabilities has consistently criticised abortion practice that distinguishes between unborn children on the basis of disability. Most recently it recommended that the law in Great Britain be changed so as not to legalise selective abortions on the ground of foetal deficiency (CRPD/C/GBR/CO/1, August 2017). The CEDAW Committee's recommendation that the law in NI be changed to permit abortion on the basis of serious and fatal foetal abnormality contravenes this UN recommendation and would introduce a discriminatory regime in NI.

2. The mother's well-being and dignity

We must recognise the risks of abortion to the mother outlined in this submission. Maternal instincts are not maximised by abortion. The maternal instinct is to nurture and protect her child for as long as possible. Allowing the mother to see and hold her baby, to care and to 'say goodbye' is important in the grief process and reduces the risks of subsequent adverse mental health. Priority should be put into provision of excellent support in place for mothers in these circumstances, including bereavement midwives, which are already available in all NI HSC Trusts, and ideally other perinatal palliative care provision (such as rooms with greater privacy).

3. Professional integrity

In line with the historic codes of medical ethics, we believe that the efforts of healthcare professionals should not be put into ending human life, but maximising, enhancing and prolonging it. It is a major shift when medical professionals are expected to actively end lives and this change should not be made lightly.

Additionally, medical science is not infallible and prenatal diagnosis will never be fool proof. Individual cases of children predicted to die soon after birth who have lived long lives and have brought joy to others are testimony to our limitations. There are some benefits from prenatal diagnosis – preparing families and developing therapies if possible – but it should never be used to make judgements about what kinds of lives are worth living.

4. The people of NI should have the right to decide the law through their elected Assembly

It is a principle of democracy that those who are subject to laws should have the power to shape those laws through their elected representatives. Constitutionally in the UK, this a matter that should be decided by the NI Assembly, a point made repeatedly by the British Government and politicians of all political stripe in the Westminster parliament.[16]

Devolution was a key part of the Belfast (Good Friday) Agreement supported in a referendum in May 1998. Indeed, many people in NI do not wish for Westminster to legislate on the issue of abortion. In recent ComRes polling it was found that 64% of people in Northern Ireland, 66% of women and 70% of women between 18-34 believe it would be wrong for Westminster to legislate on this issue.[17]

[16] Official Report, 5 June 2018; Vol. 642, c. 220, Official Report, 9 May 2018; Vol. 640, c. 661 and Official Report, 24 October 2018; Vol. 648, c. 385

[17] Northern Ireland Abortion Poll, Comres, 21st October 2018. ComRes surveyed 1,013 adults in Northern Ireland online between 8th and 15th October 2018. Data were weighted to be representative of all Northern

5. The abortion law in NI is not incompatible with human rights legislation

In paragraph 19, the Committee makes a reference to the judgement of the Supreme Court delivered on 7 June 2018.[18] The Supreme Court held that the Northern Ireland Human Rights Commission had no standing to bring the case and therefore no declaration of incompatibility was made. In non-binding comments, a majority of the court considered that the law which prevents abortion in cases of fatal foetal abnormality and pregnancies caused by rape or incest was disproportionate and incompatible with Article 8 ECHR rights, but not for cases described as 'serious foetal abnormality'. They did *not* suggest that there is a need to repeal sections 58 and 59 of the Offences Against the Person Act 1861. Indeed, doing so would have been contrary to their position regarding serious foetal abnormality.

The Committee's recommendations that the UK 'repeal sections 58 and 59 of the Offences against the Person Act of 1861' and adopt legislation to provide for expanded grounds to legalise abortion where there is a 'threat to the pregnant woman's physical or mental health, without conditionality of "long-term or permanent" effects' and 'severe foetal impairment' would therefore go far beyond the judgement of the UK Supreme Court.

It would be an entirely disproportionate response for the UK to repeal sections 58 and 59 of the Offences against the Person Act of 1861 (OAPA 1861) to amend the law on abortion in NI. This would introduce in NI a more radical abortion regime than the rest of the UK. It would remove all protection of the unborn child up to 28 weeks gestation and would eliminate essential protection for women under s. 58 OAPA 1861 from third parties who intend to procure their miscarriage.

Furthermore, it must be noted that this recommendation is based on a misreading of CEDAW. The text of CEDAW does not mention abortion. There is nothing in the text which requires a state party to allow abortion on specified grounds or to decriminalise abortion. The International Court of Justice, the only body with the jurisdiction to interpret CEDAW, has not interpreted CEDAW in any way that departs from the plain text of the Convention. To interpret CEDAW as requiring a right to abortion or the decriminalisation of abortion is to distort its plain meaning.

6. The law on abortion in NI protects freedom of conscience for health professionals

Freedom of conscience is a right enshrined in Article 9 of the European Convention on Human Rights (ECHR). Similarly, discrimination on the grounds of religion and belief is prohibited under the terms of the 2010 UK Equality Act.

Section 4 of the 1967 Abortion Act specifically protects conscience rights for registered medical practitioners but if ss. 58 and 59 OAPA 1861 were to be repealed, as the Committee suggests, it is highly likely that current conscience protections would be restricted.

Contraction of the scope for conscientious objection by nurses and midwives has already resulted from the 2014 Supreme Court ruling in *Greater Glasgow Health Board v Doogan*[19] where the court

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Irish adults by gender, age and religion. ComRes is a member of the British Polling Council and abides by its rules.

[18] [2018] UKSC 27, https://www.supremecourt.uk/cases/uksc-2017-0131.html

[19] https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf

held that only direct involvement in the abortion procedure would constitute grounds for objection. Indirect involvement such as related supervisory or managerial tasks would not constitute grounds.

For many healthcare professionals, indirect tasks such as signing an authorisation form, clerking a patient for anaesthetic, providing preoperative care, prescribing or referring to another healthcare professional involves complicity with abortion that compromises their integrity.

Legislation should not force someone to have to choose between their job and their conscience. As it stands, the law on abortion in NI protects freedom of conscience for medical professionals. Altering or repealing the law in NI would be highly likely to have detrimental consequences for those with a conscientious objection. This is an issue that concerns our members and also people of other faiths and none.

Christian Medical Fellowship

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