Introduction

1. The Northern Ireland Human Rights Commission (the ‘Commission’), pursuant to Section 69(1) of the Northern Ireland Act 1998, reviews the adequacy and effectiveness of law and practice relating to the protection of human rights. In accordance with this function, the following statutory advice is submitted to the Women and Equalities Committee (the ‘Committee’) in response to its call to submissions for its inquiry into abortion law in Northern Ireland (‘NI’).

2. The Commission is the National Human Rights Institution (‘NHRI’) for Northern Ireland and one of three NHRIs in the United Kingdom (‘UK’). It is accredited with A status before the United Nations and is in full compliance with the United Nations Principles relating to the Status of National Institutions.


4. This is the second submission of the Commission and should be read in conjunction with the Commission’s main report. This submission to the Committee will focus on:

   a. Addressing criminalisation
   b. Addressing access to healthcare
   c. Addressing sexual crime
   d. Comparative analysis of other CoE Member States
   e. The right to information

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1 Principles relating to the Status of National Institutions, Adopted by General Assembly Resolution 48/134 (20 December 1993)
Addressing criminalisation

5. The Commission recognises that the current debate around termination of pregnancy has two main aspects, decriminalisation and access to healthcare services, which are interrelated and considered in turn below.

6. The first aspect of decriminalisation refers to the removal of legislative provisions, which criminalise women and girls for accessing a healthcare service and others, including medical staff, for providing a service. The relevant provisions of the Offences against the Person Act 1861 (‘OAPA’) are recognised by CEDAW as being in breach of the Covenant on the Elimination of all forms of Discrimination against Women. The repeal of, or at least amendment of, this legislation has been recommended by a number of UN Treaty Bodies including the UN Human Rights Committee, CEDAW, Committee on Economic, Social and Cultural Rights and Committee on the Rights of the Child. Most recently in a joint statement, the CEDAW and CRPD Committees confirmed “in order to respect gender equality and disability rights, in accordance with the CEDAW and CRPD Conventions, States parties should decriminalize abortion in all circumstances.”

7. The Commission acknowledges that its litigation in this area was of a narrower focus, namely access to terminations lawfully in circumstances of serious malformation of the foetus (including fatal foetal abnormality), rape and incest. In the UK Supreme Court judgment in this case, the Court highlighted incompatibility with Article 8 ECHR in respect of fatal foetal abnormality and sexual crime. Any legislative attempt to remedy the incompatibility identified in the judgment may seek to amend ss.58 and 59 OAPA, to expressly remove the criminal sanction from these situations.

8. However, the Commission advises that in order to act in full compliance with the international standards, the State Party would need to ensure that sections 58 and 59 of OAPA are repealed in their entirety. This is supported by the CEDAW Inquiry report, which confirms, “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.”

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2 NIHRC, Response to the Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland (Dec 2018) paras 44-56.
3 Joint statement by the Committee on the Rights of Persons with Disabilities (CRPD) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities (29 August 2018) p.2.
4 In the matter of an application by the Northern Ireland Human Rights Commission [2018] UKSC 27.
9. The practical ramifications of addressing the issue of criminalisation, including regulation and process, will be discussed in more detail in the next section.

10. **The Commission recommends that, in the absence of the NI Assembly, that the UK Government introduces legislation to end the criminalisation of women and girls in NI if they seek a termination of pregnancy.**

**Addressing access to healthcare**

11. The current legal position, under the Bourne case, permits a termination where there is a risk of serious and adverse effects on her physical or mental health, which is either long term or permanent. If a termination of pregnancy is requested, the current Department of Health (NI) guidance requires certification by two doctors and in order to support their clinical assessment, health and social care professionals should seek support from the relevant specialists, for example psychiatrists, obstetricians or specialists in genetic conditions. No further detail is provided about how to conduct the clinical assessment or which situations may lead to a lawful termination. A woman may request a second opinion, but does not have a legal right to one.

12. At present, it is unclear to women and girls when they are able to access a termination of pregnancy within the current law. Where a request for a termination of pregnancy is refused, the woman’s options going forward are limited by time. Take for example a woman who receives a diagnosis of a fatal foetal abnormality around the time of the 20-week scan, and disputes whether she meets the Bourne test. She may of course choose to continue with the pregnancy. If she does not want to continue with the pregnancy, she could seek a second opinion or legally challenge the refusal to provide a termination. If on a low income, she would need to apply for legal aid; setting out her personal circumstances in significant detail and relying on a quick turnaround from the Legal Aid Agency. She would also have to be mindful of the fact that if this is unsuccessful, she would then have to arrange to travel to Great Britain within a short window of time. All of this to be done while under significant emotional and physical pressure. This is compounded by other considerations such as cost, accessing

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6 NIHRC, Response to the Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland (Dec 2018) paras 57 and 102.
childcare or support for dependents, time off work or other commitments, the need to travel and repatriation of remains.

13. The CEDAW 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.”

14. Even if the problems with the operation of the Bourne test were resolved, the Commission advises that this would not be sufficient to meet the requirements of access set out by the UN Treaty Bodies.

15. Once decriminalisation is achieved, there is no legal basis to prevent women and girls accessing, or healthcare professionals performing, terminations of pregnancy in NI. Therefore, there will be the need for further regulation to support clinicians in their decision-making and to provide advice to women and girls on their options regarding termination of pregnancy. The present guidance for healthcare professionals, which relies on OAPA, will not be sufficient to do this.

16. A regulatory framework could take the form of specific legislation on termination of pregnancy, for example the Abortion Act 1967 in Great Britain and the Regulation of Termination of Pregnancy Bill in Ireland. This would need to set out the particular circumstances in which termination of pregnancy is accessible, including any gestational limits or provisions for conscientious objection. It would also need to be supported by further clinical guidance from the Department of Health, and/ or the Royal Colleges, to provide further guidance to clinicians to support their clinical judgments.

17. Existing legislation and policy would also need to be considered in this context. For example, dealing with other criminal sanctions, issues around informed consent and the regulation of medical services provision.

18. In order to comply with the international standards, any further regulation for access to termination would have to permit the following circumstances:
   a. Threat to the pregnant woman’s physical or mental health, without conditionality of ‘long-term or permanent’ effects;
   b. Rape and incest; and,
   c. Severe foetal impairment, including fatal foetal abnormality.

11 CEDAW, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the
19. The CEDAW-CRPD statement also recognises that a “human rights based approach to sexual and reproductive health acknowledges that women’s decisions on their own bodies are personal and private and places the autonomy of the woman at the centre of policy and law-making related to sexual and reproductive health services”.\(^\text{12}\)

20. A process for achieving access on medical grounds would also have to be agreed, including, a right to conscientious objection on the part of healthcare professionals. Further guidance from clinicians would be required in this scenario, as a legal framework will not identify the precise nature of the conditions, which may fall within its scope.

21. Any procedure for accessing a termination on the grounds of sexual crime is likely to be time sensitive and may or may not include contact with the criminal justice system. This will be developed in the next section. Often, the difficulties associated with such a procedure can be circumvented by permitting open access at an early stage of pregnancy, as recently outlined in legislation being implemented in Ireland.

22. The Commission recommends that, following a change in the criminal law and in line with international human rights standards, the Department of Health (NI) ensure that women and girls have access to termination of pregnancy in at least circumstances of a threat to physical or mental health, serious (including fatal) foetal abnormality, rape or incest. The Commission also recommends that women and girls have access to appropriate aftercare services.\(^\text{13}\)

23. The Commission recommends that the current guidance from the Department of Health (NI) is reviewed to ensure that it provides sufficient direction for healthcare professionals to provide termination of pregnancy within the present legal framework.

24. The Commission recommends that appropriate information is provided to women and girls in respect of their options relating to sexual and reproductive health. This includes the current pathway available to access a lawful termination of pregnancy in Great Britain.

\(^\text{12}\) Joint statement by the Committee on the Rights of Persons with Disabilities (CRPD) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities (29 August 2018) p.1.
\(^\text{13}\) NIHRC, Response to the Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland (Dec 2018) paras 69, 81 and 103.
Addressing sexual crime

25. The current legal position in NI does not automatically permit access to termination on the basis of a sexual crime.

26. In the Commission’s case, the UK Supreme Court identified that failure to provide access, in situations of rape and incest, was in breach of Article 8 ECHR.¹⁴ Therefore, in order to remedy this identified incompatibility, express provision could be made by amendment to ss. 58 and 59 OAPA.

27. However, the Commission recognises that a procedure to deal with this scenario is likely to be difficult and potentially controversial. It notes that the DoJ also identified a number of difficult issues to be considered in addressing sexual crime in the context of termination.¹⁵ As a consequence, in its consultation exercise, it only sought views rather than a specific recommendation or proposal for change.¹⁶

28. An additional difficulty arises in NI in respect of sexual crimes. The Criminal Law Act (Northern Ireland) 1967 creates a duty to report a relevant offence. The Attorney General for NI has produced human rights guidance for the Public Prosecution Service NI on Section 5 in the context of disclosures of rape made in the claims for social security.¹⁷ There is no specific guidance from the Attorney General in respect of access to termination. The Department of Health guidance for healthcare professionals, states that, “health and social care professionals will need to balance the interests of their patient against the public interest in reporting certain information to the police.”¹⁸

29. In the recent review of the law and procedures in serious sexual offences in NI, Sir John Gillen has recommended in his preliminary report that section 5 be repealed, save in cases where an individual with knowledge of a relevant offences concerning a child or vulnerable adult would be obliged to report it to the police.¹⁹

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¹⁴ In the matter of an application by the Northern Ireland Human Rights Commission [2018] UKSC 27, para 2.
¹⁷ AGNI, Human Rights Guidance for the Public Prosecution Service: The Application of Section 5 of the Criminal Law Act (NI) 1976 to rape victims and those to whom they make disclosure in connection with a claim for social security, child tax credit or anonymous registration on the electoral roll (20 April 2018).
¹⁸ DH, Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland (March 2016) para 6.4.
30. Some countries, most recently for example Ireland, have taken a more open approach to access to termination at the early stages of pregnancy. This is one practical way in which any difficulties surrounding a process for permitting access on grounds of sexual crime can be circumvented. It must be noted that while early access may remove difficulties associated with women having to disclose a crime, it may not resolve every situation. For example, where a child becomes pregnant as a result of a sexual crime, the existence of the pregnancy may not come to light or the child may not be able to access support or advice within this early period.

31. The international human rights standards do not require full open access to terminations of pregnancy; however, access must be provided in respect of sexual crime. As human rights standards identified the minimum level of protection, the State is entitled to raise the bar higher.

32. The Commission also recommends that, following a change in the criminal law and in line with international human rights standards, the Department of Health (NI) ensure that women and girls have access to termination of pregnancy in, at least circumstances of a threat to physical or mental health, serious (including fatal) foetal abnormality, rape or incest. In addition, women and girls should have access to appropriate aftercare services.

Comparative analysis

33. This section looks at the 47 Member States of the Council of Europe and their legal position regarding termination of pregnancy. Of these, 41 states permit a general right of access (subject to some practical restrictions such as a three day waiting period).

34. In respect of the remaining six states, the position differs across each. In Malta, Andorra and San Marino termination of pregnancy is

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20 Albania; Andorra; Armenia; Austria; Azerbaijan; Belgium; Bosnia and Herzegovina; Bulgaria; Croatia; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Georgia; Germany; Greece; Hungary; Iceland; Ireland; Italy; Latvia; Liechtenstein; Lithuania; Luxembourg; Macedonia; Malta; Moldova; Monaco; Montenegro; Norway; Netherlands; Poland; Portugal; Romania; Russia; Saint Marino; Serbia; Slovakia; Slovenia; Spain; Sweden; Switzerland; Turkey; Ukraine; United Kingdom.

21 Albania 12 weeks; Armenia 12 weeks; Austria 12 weeks; Azerbaijan 12 weeks; Belgium 12 weeks; Bosnia and Herzegovina 10 weeks; Bulgaria 12 weeks; Croatia 10 weeks; Cyprus No limit; Czech Republic 12 weeks; Denmark 12 weeks; Estonia 11 weeks; Finland 12 weeks; France 12 weeks; Germany 12 weeks; Georgia 12 weeks; Greece 12 weeks; Hungary 12 weeks; Iceland 16 weeks; Ireland, 12 weeks; Italy 90 days; Latvia 12 weeks; Lithuania 12 weeks; Luxembourg 12 weeks; Macedonia 10 weeks; Moldova 12 weeks; Montenegro 10 weeks; Netherlands 24 weeks; Norway 12 weeks; Portugal 10 weeks; Romania 14 weeks; Russia 12 weeks; Serbia 10 weeks; Slovakia 12 weeks; Slovenia 10 weeks; Spain 14 weeks; Sweden 18 weeks; Switzerland 12 weeks; Turkey 10 weeks; Ukraine 12 weeks; United Kingdom (except Northern Ireland) 24 weeks.

22 Note that Ireland has just passed the Health (Regulation of Termination of Pregnancy) Act 2018 and so is
not lawful, but the defence of necessity has been used in the latter two countries where needed to save the life of the pregnant woman. Termination is only lawful in Liechtenstein in order to save the life of the pregnant woman. In Monaco and Poland, termination is lawful only to save the life of the pregnant woman and in cases of foetal abnormality and rape.

**Serious, severe and fatal abnormalities**

35. There are 31 Member States, which legislate for some form of foetal abnormality\(^{23}\) and a number of others provide access implicitly under other grounds such as risk to the woman’s health.\(^{24}\) The provisions legalising terminations on grounds of foetal abnormality differ in three main respects: (i) the language used, (ii) the process of attestation, and (iii) the gestational time limits imposed.

36. Some states provide separate provisions dealing with ‘fatal’ foetal impairments and ‘serious’ foetal impairments.\(^{25}\) However, the majority of States encompass both forms of impairment under one provision, prescribing ‘serious’ or severe’, implicitly covering fatal foetal abnormalities as well.

37. The language used to describe impairments includes ‘incurable malformation of the foetus’, ‘incurable problem with the development of the foetus’, ‘serious or incurable disease or malformation’, ‘serious physical or mental disabilities’, ‘serious foetal defects’ or ‘severe abnormality’. To the Commission’s understanding, none of the legal instruments specifies which forms of conditions would fall within the scope of the definition; this is left to clinical judgment.

38. The gestational limits also vary significantly across Member States. The majority of States, which expressly provide for termination of pregnancy in situations of serious or fatal foetal abnormality, do not specify a gestational time limit in law.\(^{26}\) Where gestational time limits are specified in law, for a serious foetal abnormality, this can range from 20 to 24 weeks\(^{27}\); with Norway and Poland permitting up to the point of viability. For fatal foetal abnormalities, where those are set down in law, gestational limits vary up to a maximum of 22 weeks.\(^{28}\)

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\(^{23}\) Albania; Austria; Belgium; Bosnia and Herzegovina; Bulgaria; Croatia; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Greece; Hungary; Iceland; Ireland; Italy; Lithuania; Luxembourg; Macedonia; Moldova; Monaco; Montenegro; Norway; Poland; Portugal; Serbia; Slovakia; Slovenia; Spain; United Kingdom (except Northern Ireland).

\(^{24}\) For example, Germany, Latvia, Netherlands, Sweden, Switzerland.

\(^{25}\) Albania, Croatia; Czech Republic; Hungary; Moldova; Portugal; Slovakia; Spain.

\(^{26}\) Austria; Belgium; Bosnia and Herzegovina; Bulgaria; Croatia; Czech Republic; Cyprus; Denmark; France; Iceland; Italy; Lithuania; Luxembourg; Macedonia; Moldova; Monaco, Serbia; Slovakia.

\(^{27}\) Bulgaria; Estonia 21 weeks; Finland 24 weeks; Greece 24 weeks; Hungary 20 weeks; Portugal 24 weeks; Serbia 20 weeks; Spain 22 weeks; UK 24 weeks.

\(^{28}\) Georgia; Lithuania; Moldova; Sweden.
Sexual crime

39. There are 25 Member States, which specifically legislate for termination in cases of sexual crime. The majority of these specific provisions express temporal limitations, ranging from ten to 28 weeks. Six of these countries provide extensions to the open access provisions for victims of sexual crimes.

40. The procedures for accessing a termination on the basis of sexual crime also differ across Europe. In some states, the decision is made by a single doctor, while others require the authorisation of a Commission or committee of specialists, often comprised of physicians, lawyers and social workers.

41. In other states, there is involvement of the criminal justice process, whereby certification by a police authority is required or where the circumstances of the crime are approved by police inquiry, evidence or a prosecutor.

42. Where there are no specific provisions for sexual crime in a State’s legislative framework, women and girls would be able to access a termination under open access provisions without the requirement to disclose a sexual crime.

The right to information

International human rights standards

43. Access to information about termination of pregnancy, and more broadly on sexual and reproductive healthcare, is raised as an issue connected to decriminalisation and access to termination. The UN treaty bodies have often highlighted this as a general issue and in specific reference to NI.

44. The most recent, NI specific, commentary of a UN Treaty body can be found in the CEDAW Inquiry into termination of pregnancy laws in NI.

45. In its report on the inquiry, CEDAW notes the “limited availability of facilities in NI providing information, counselling and services in

29 Albania; Austria; Bosnia and Herzegovina; Croatia; Cyprus; Denmark; Finland; Germany; Georgia; Greece; Hungary; Iceland; Latvia; Macedonia; Moldova; Monaco; Montenegro; Norway; Poland; Portugal; Russia; Serbia; Slovakia; Turkey; Ukraine.
30 Croatia; Denmark; Macedonia; Montenegro; Norway; Serbia; Slovakia.
31 Germany.
32 Albania; Bosnia and Herzegovina; Croatia; Macedonia; Serbia.
33 Cyprus; Latvia.
34 Finland.
35 Portugal.
36 Poland.
family planning, and particularly about options to access legal abortions in or outside NI.”\(^{37}\) It also highlighted that “medical professionals are neither trained nor encouraged to provide information on abortion options and rely on this information being provided by non-governmental entities.”\(^{38}\)

46. The consequence of the lack of information provision led the Committee to conclude that women and girls in NI “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.”\(^{39}\)

47. CEDAW also looked at the provision of sexuality education and highlighted that the State Party’s "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.”\(^{40}\)

48. The Committee’s recommendations for the UK State Party are to:

"(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”.\(^{41}\)

49. The UN Human Rights Committee, in its 2015 Concluding Observations on the UK, recommended, “the State party should also ensure access to information on abortion, contraception and sexual and reproductive health options.”\(^{42}\)


\(^{38}\) CEDAW, 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 (6 March 2018) CEDAW/C/OP.8/GBR/1, para 45.

\(^{39}\) CEDAW, 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 (6 March 2018) CEDAW/C/OP.8/GBR/1, para 47.

\(^{40}\) CEDAW, 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 (6 March 2018) CEDAW/C/OP.8/GBR/1, para 76.

\(^{41}\) CEDAW, 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 (6 March 2018) CEDAW/C/OP.8/GBR/1, para 86.

\(^{42}\) UNHRC, Concluding Observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland (17 August 2015) CCPR/C/GBR/CO/7, para 17.
50. The Committee on Economic, Social and Cultural Rights (CESCR Committee) highlights that comprehensive sexual and reproductive healthcare contains the four interrelated and essential elements of availability, accessibility, acceptability and quality.\(^{43}\) Under accessibility, ‘information accessibility’ includes: “the right to seek, receive and disseminate information and ideas concerning sexual and reproductive health issues generally, and also for individuals to receive specific information on their particular health status. All individuals and groups, including adolescents and youth, have the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer.”\(^{44}\)

51. Such information must be provided in a manner consistent with the needs of the individual and “information accessibility should not impair the right to have personal health data and information treated with privacy and confidentiality.”\(^{45}\) The CESCR Committee further explains, “States must refrain from censoring, withholding, misrepresenting or criminalizing the provision of information on sexual and reproductive health, both to the public and to individuals. Such restrictions impede access to information and services, and can fuel stigma and discrimination.”\(^{46}\)

52. In respect of the core obligations of the right to sexual and reproductive health, the minimum essential level of satisfaction of Article 12 CESCR means the State Party must “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information”.\(^{47}\)

53. The CESCR Committee confirms that, “violations of the obligation to fulfil also occur when States fail to take measures to ensure that up-to-date, accurate information on sexual and reproductive health is publicly available and accessible to all individuals, in appropriate languages and formats, and to ensure that all educational institutions incorporate unbiased, scientifically accurate, evidence-based, age-


appropriate and comprehensive sexuality education into their required curricula.”

54. The Committee on the Rights of the Child also considers access to information in the context of education. It recommends that the UK State Party “develop and adopt a comprehensive sexual and reproductive health policy for adolescents, with particular attention to reducing inequalities and with participation of adolescents”. The Committee’s general comment on the rights of the child during adolescence also requires that all adolescents should have “access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person”.

55. The UNCRC requires that “meaningful and sexual and reproductive health education is part of the mandatory school curriculum for all schools” and this should be “age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards”.

56. Finally, the UNCRC highlights that, “there should be no barriers to commodities, information and counselling on sexual and reproductive health and rights”.

NI guidance on access to information

57. The Department of Health (NI) guidance states, “if requested, health professionals may inform women of the availability of information on [termination of pregnancy] services to ensure that the woman is able to come to a fully informed decision”. At present, the Department does not provide any information of its own. The Department has produced an information leaflet about the pathway for services and support in NI and has sought legal advice on whether the leaflet can be disseminated, given the absence of a Minister. This issue has been outstanding for a considerable length of time.

58. The Commission understands that the British Pregnancy Advisory Service has provided information to GP practices on the current

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49 UNCRC, Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (12 July 2016) CRC/C/GBR/CO/5, para 65a.
50 UNCRC, General comment No. 20 (2016) on the implementation of the rights of the child during adolescence (6 December 2016) CRC/C/GC/20, para 59.
51 UNCRC, Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (12 July 2016) CRC/C/GBR/CO/5, para 65b.
52 UNCRC, General comment No. 20 (2016) on the implementation of the rights of the child during adolescence (6 December 2016) CRC/C/GC/20, para 61.
53 UNCRC, General comment No. 20 (2016) on the implementation of the rights of the child during adolescence (6 December 2016) CRC/C/GC/20, para 60.
54 DH, Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland (March 2016) para 5.11.
pathway to access services in GB. However, this does not discharge the duty on the State Party to provide access to information for women and girls seeking a termination of pregnancy. In practice, information provided by the Department will carry more weight and influence than that provided an NGO.

59. The Department of Health (NI) guidance further identifies that the courts have not yet considered whether it would be lawful to advocate or promote termination of pregnancy in another jurisdiction.\textsuperscript{55} However, no further information is provided in order to support healthcare professionals in understanding where the line is drawn between information provision and advice.

60. \textbf{The Commission recommends that appropriate information is provided to women and girls in respect of their options relating to sexual and reproductive health. This includes the current pathway available in Great Britain to access a lawful termination of pregnancy.}\textsuperscript{56}

January 2019

\textsuperscript{55} DH, Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland (March 2016) para 5.13.

\textsuperscript{56} NIHRC, Response to the Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland (December 2018) para 94.