White Paper

Right To Life Comment on United Nations Human Rights Committee Draft General Comment on Article 6 (Right to Life) of the International Covenant on Civil and Political Rights

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Contents

Introduction

1. This submission is made in response to the invitation from the Human Rights Committee to comment on the draft General Comment No. 36[1] on Article 6 of the International Covenant on Civil and Political Rights (ICCPR), the right to life.

2. Right To Life (RTL) is an NGO founded in 1998 in the United Kingdom. RTL campaigns for the right to life of all human beings. The issues with which we deal are principally bioethical and engage with the dignity and rights of vulnerable human beings at the beginning of life (abortion, population control and the treatment of embryonic humans in scientific research and medical practice) and at the end of life (assisted suicide and euthanasia). For more information on RTL, see our website: http://www.righttolife.org.uk/

3. This submission focuses on the applications that the draft General Comment makes to Article 6 on vulnerable human beings with specific reference to the sections relevant to violations of the right to life through abortion, embryo-destructive research and practice, and the practices of assisted suicide and euthanasia.

[1] *General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life* (Revised Draft Prepared by the Rapporteur), UNHRC: http://bit.ly/2hPH2yO

Abortion

4. Paragraph 9 of the draft General Comment directly discusses abortion, and so it is to that topic that we will turn first. We must note initially that Article 6 of the ICCPR does not deal expressly with abortion, and the domestic laws of the States Parties to the Covenant accord varying degrees of protection to the unborn child. The classic interpretation of Article 6, in accordance with the rule in Article 31(1) of the Vienna Convention on the Law of Treaties[2], is that it neither prohibits States from providing abortion in certain circumstances nor requires them to permit abortion in any circumstances. The issue was not referred to in the Committee's earlier general comments on Article 6, and there could be said to be a strong argument for the Committee to continue this approach in its new general comment.

5. Since a decision has been made to include abortion in the draft of this General Comment however, any such inclusion must be expected to reflect the implicit protections of all human beings with the International Covenant of Civil and Political Rights (ICCPR), including unborn children. Instead, the current draft of paragraph 9 not only fails to include those protections, but actively contradicts them. In doing so, it not only contradicts the ICCPR, but also the principles enunciated earlier in the text of the draft General Comment itself. We therefore prescribe the radical rewriting of paragraph 9, and shall propose such a re-writing in the rest of this section of our Comment based on the following first principles that are unavoidable in informing any rational reading and application of the ICCPR.

6. The logical interpretation of Article 6 is that it accords the right to life to every human being. As Article 6(1) clearly states, "Every human being has the inherent right to life", and this is an explicit application of the principle enunciated in the ICCPR's

[2] Vienna Convention on the Law of Treaties: http://bit.ly/2xY3hXb

preamble that "the foundation of freedom, justice, and peace in the world" is "recognition of the inherent dignity and the equal and inalienable rights of all members of the human family". Indeed, the draft General Comment clearly recognises this when in paragraph 2 it states that:

> *Article 6 recognises and protects the right to life of all human beings. It is the supreme right from which no derogation is permitted even in situations of armed conflict and other public emergencies. The right to life has crucial importance both for individuals and for society as a whole. It is most precious for its own sake as a right that inheres in every human being, but it also constitutes a fundamental right, whose effective protection is the prerequisite for the enjoyment of all other human rights and whose content can be informed and infused by other human rights*.

7. If Article 6 protects the right to life of "all human beings" then, as a right that "inheres in every human being", understanding what creatures can be signified as 'human beings' is unavoidably necessary in rightly applying the protections of Article 6. A central question therefore, is when the life of a human being begins, for the extent of the life of the human being in its *genesis* as well as its *terminus*, is crucial to understanding the breadth of who enjoys human rights.

8. In answering the question of when the life of a human being begins, science makes the necessary adjudication, and this is provided in numerous biological and specifically embryological textbooks. Keith L. Moore in his *Essentials of Human Embryology* states that the "fertilised ovum, known as a zygote, is a large diploid cell that is the beginning, or *primordium*, of a human being"[3]. Moore, with T.V.N. Persaud, in their description of the 'Developing Human', together state that: "Human

[3] Moore, Keith L. *Essentials of Human Embryology*, Toronto: B.C. Decker Inc, 1988, pg. 2.

development begins at fertilisation when a male gamete or sperm (spermatozoon) unites with a female gamete or oocyte (ovum) to produce a single cell – a zygote. This highly specialised, totipotent cell marked the beginning of each of us as a unique individual"[4]. In another text, they also define the 'zygote' thus: "Zygote. This cell, formed by the union of an ovum and a sperm (Gr. *zyg tos*, yoked together), represents the beginning of a human being. The common expression 'fertilized ovum' refers to the zygote"[5].

9. O'Rahilly and Müller define the zygote similarly: "Zygote: This cell results from the union of an oocyte and a sperm. A zygote is the beginning of a new human being (i.e., an embryo)"[6]. They go on to say that, "[a]lthough life is a continuous process, fertilisation is a critical landmark because, under ordinary circumstances, a new, genetically distinct human organism is thereby formed"[7].

10. The embryologist William J. Larsen conflated the beginning of the unborn child with the beginning of the human being: "... [W]e begin our description of the developing human with the formation and differentiation of the male and female sex cells or gametes, which will unite at fertilisation to initiate the embryonic development of a new individual"[8].

11. Other scientific and specialist embryological textbooks note this same fact. *Van Nostrand's Scientific Encyclopaedia* defines an 'Embryo' as, "The developing

[4] Keith L. Moore and T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology*, 7th Ed. (New York: Saunders, 2003), pg. 16.

[5] Moore, Keith L. and Persaud, T.V.N. *Before We Are Born: Essentials of Embryology and Birth Defects*, 4th edition. Philadelphia: W.B. Saunders Company, 1993, pg. 1.

[6] Ronan O'Rahilly and Fabiola Müller, *Human Embryology and Teratology*, 3rd. ed., (New York: Wiley-Liss, 2001), pg. 8

[7] *Ibid.*, pg. 12.

[8] William J. Larsen, *Human Embryology*, 3rd ed. (Philadelphia: Churchill Livingstone), pg. 1.

individual between the union of the germ cells and the completion of the organs which characterise its body when it becomes a separate organism… At the moment the sperm cell of the human male meets the ovum of the female and the union results in a fertilised ovum (zygote), a new life has begun…"[9]. *Langman's Medical Embryology* points out that, "[t]he development of a human begins with fertilisation, a process by which the spermatozoon from the male and the oocyte from the female unite to give rise to a new organism, the zygote"[10]. Indeed, according to Bruce M. Carlson in *Patten's Foundations of Embryology*, "[a]lmost all higher animals start their lives from a single cell, the fertilized ovum (zygote)... The time of fertilisation represents the starting point in the life history, or ontogeny, of the individual"[11].

12. It is therefore simply an empirical fact that when a human ovum is fertilised by a human spermatozoon, a distinct human being with her own DNA, distinct from that of her mother and father, is created. The beginning of each human being then, biologically and thereby ontologically, is fertilisation (conception). This is the time at which every "member of the human family" begins to exist as a new and unique human individual. Whilst this nascent human being exists in her mother's womb, whether at the embryonic or fetal stages of her development, we call her an 'unborn child'[12].

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[9] Considine, Douglas (ed.), *Van Nostrand's Scientific Encyclopedia*, 5th edition. New York: Van Nostrand Reinhold Company, 1976, p. 943.

[10] Sadler, T.W., *Langman's Medical Embryology*. 7th edition. Baltimore: Williams & Wilkins 1995, pg. 3.

[11] Carlson, Bruce M., *Patten's Foundations of Embryology*. 6th edition. New York: McGraw-Hill, 1996, pg. 3.

[12] Indeed, the term 'Unborn' is defined by the Oxford English Dictionary as "(of a baby) not yet born". It also defines a 'Baby' (the sole possible subject of the term 'unborn'), as a "a very young child", and a 'Child' as "[a] young human being below the age of puberty or below the legal age of majority". Contained within the sheer meaning of words in modern English, as in other languages, is the clear implication and recognition of the humanity of a child at their embryonic and fetal stages:
https://en.oxforddictionaries.com/definition/unborn
https://en.oxforddictionaries.com/definition/baby
https://en.oxforddictionaries.com/definition/child

13. Given these realities, amongst those who must enjoy the protections afforded under the ICCPR are babies in the womb. There is no basis in the Covenant for denying the protection of Article 6 to an unborn child merely on the basis that she is at an early stage of development or has not yet been born. In fact, to do so contradicts the clear duties established by Articles 2 and 26 on each State party to respectively, "ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as… birth or other status", and "prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as… birth or other status". Both these duties proceed from the obligation of All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.

14. Indeed, the particular reference in Article 6(5) to prohibiting capital punishment on "pregnant women" (without qualification) directly implies that the right of another human being to life (her unborn child) is inevitably a reality that must be considered, and which necessitates a special exemption from the death penalty in those jurisdictions where it is practised.

15. Given therefore, that the right to life inheres in every human being, and the unborn child is a human being no less than any born child or adult, this entails (especially given the implications of Articles 16, 24, and 26) that the protections of Article 6 must be applied to every baby in the womb, whether at their embryonic or fetal stages of development, from conception onwards.

16. This is in keeping with the U.N. Convention on the Rights of the Child (UNCRC), the preamble of which cites the Declaration of the Rights of the Child in its insistence that "the child, by reason of his physical and mental immaturity, needs

special safeguards and care, including appropriate legal protection, before as well as after birth"[13]. This would include the UNCRC Article 6(1) "inherent right to life" of every child, but the Article 6(2) duty on states parties to "ensure to the maximum extent possible the survival and development of the child".

17. The right to life of unborn children directly entails that they must be protected from deliberate lethal attack, and this is directly implied by principles enunciated in the draft General Comment:

- Paragraph 3 of the draft General Comment rightly says that the right to life "concerns the entitlement of individuals to be free from acts and omissions intended or expected to cause their unnatural or premature death, as well as to enjoy a life with dignity".
- Paragraph 7 states that entitlement obliges State parties to "exercise due diligence to protect the lives of individuals against deprivations caused by persons or entities, whose conduct is not attributable to the State. The obligation of States parties to respect and ensure the right to life extends to all threats that can result in loss of life. States parties may be in violation of article even if such threats have not actually resulted in loss of life".
- Paragraph 6 of the draft General Comment states that "deprivation of life" from which the right to life mandates state protection "involves a deliberate or otherwise foreseeable and preventable life-terminating harm or injury, caused by an act or omission".

18. Abortion can be seen as a violation of Article 6 according to precisely the above definitions, because it is physically destructive intervention intended to kill an

[13] U.N. Convention on the Rights of the Child: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

unborn child. The National Health Service (NHS) of the United Kingdom defines abortion[14] as:

> '*[T]he medical process of ending a pregnancy so it does not result in the birth of a baby. It is also sometimes known as a 'termination' or a 'termination of pregnancy'.*'

This is achieved by three distinct forms of procedure[15]:

- Chemically-induced miscarriage: This is a two-stage procedure that can take place all throughout pregnancy. In the first visit, a pregnant woman is administered an abortifacient (a drug that causes the miscarriage of a baby) called mifepristone. This blocks progesterone, the hormone produced in the ovaries that makes the endometrium (the lining of the womb) suitable for the unborn child to be 'gestated': given necessary nutrients from her mother, whether in the form of 'histiotrophe' – the so-called 'uterine milk' – in the first 11 weeks, or else directly from the maternal blood through the umbilical cord during the rest of pregnancy. The blocking of progesterone causes the lining to break down, which breaks the baby's attachment to her mother, essentially starving (and later in the deprivation of oxygen, suffocating) her to death. In the second visit, prostaglandins are then administered to the woman to cause uterine contractions that expel the remains of the dead child from the womb. More or fewer doses will be needed depending on the precise stage of pregnancy.

[14] 'Abortion', NHS: http://www.nhs.uk/conditions/Abortion/Pages/Introduction.aspx

[15] The following information can be derived from the relevant sections of standard obstetric texts, such as 'Medical abortion in early pregnancy' (Mitchell D. Creinin MD and Kristina Gemzell Danielsson MD, PhD), 'First-trimester aspiration abortion' (Karen Meckstroth MD, MPH, and Maureen Paul MD, MPH), 'Dilation and evacuation' (Cassing Hammond MD, and Stephen Chasen MD), and 'Medical methods to induce abortion in the second trimester' (Nathalie Kapp MD, MPH, and Helena von Hertzen MD, DDS), in Paul *et al*, *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*, Wiley-Blackwell (2009). See also chapter 18 of Cunningham *et al*, *Williams Obstetrics*, 24th ed. (2014).

- Vacuum Aspiration: is a procedure that aims to remove the unborn child from the womb by using suction to break her body into pieces. The procedure usually takes 5-10 minutes and can be carried out under either a local or general anaesthetic. After the pregnant woman's cervix is 'dilated' (widened) to allow the surgical instruments to pass through it (it is naturally closed to protect the baby from miscarriage), the abortion surgeon then inserts a hollow plastic suction tube, which is connected to a pump and has a knife-like edge on the tip, into the uterus. When the suction begins, which is many times more powerful than a household vacuum cleaner, it tears the body of the unborn child into pieces and at the same time sucks these remains into a bottle. The abortion surgeon must then cut the deeply rooted placenta from the inner wall of the uterus, and take care to prevent the uterus from being punctured during this procedure, which may cause haemorrhage and necessitate further surgery. Infection can also easily develop if any fetal or placental tissue is left behind in the uterus. This latter fact means that curettage may also also have to take place. This is when a long-handled curved blade known as a curette is used to scrape the lining of the womb, removing any remaining parts of the baby and her accompanying tissue.
- Dilation and Evacuation ('D&E'): As with vacuum aspiration abortions, D&E first requires dilation of the cervix. Instead of a suction catheter however, forceps with sharp metal jaws are used to grasp parts of the developing unborn child, which are then twisted and torn away. This pliers-like instrument is used because the bones of the fetus are calcified, as is the skull. The surgeon inserts the instrument up into the uterus, seizes a leg or other part of the baby's body, and, with a twisting motion, tears it out. This is repeated again and again. The spine must be snapped, and the skull crushed to remove them. The nurse's job is to reassemble the body parts to be sure that all are removed. If not carefully removed, sharp edges of the bones may cause cervical laceration, and consequent bleeding would be profuse. After 18 weeks, in order to make dismembering the baby easier, D&E will often be preceded by feticide:

- 'Feticide' (Causation of Fetal Asystole): The procedure specifically termed 'feticide' in surgical parlance is when the baby is killed prior to her body being delivered or removed from her mother's womb. This is accomplished by injecting a saline solution (potassium chloride – salt) into the child's heart, causing her to have a fatal heart attack. This happens because potassium is a mineral that possesses an electric charge, and it disrupts the electrical conduction of heart muscle, preventing heart cells from preparing for their next contraction. This means that the baby's heart is forced to stop beating, causing her death. There are two reasons for the use of this procedure prior to D&E:
    - To cause the softening of the baby's bone structure that occurs after fetal demise, in order "to reduce the amount of cervical dilation necessary and to make the procedure easier and faster, thus reducing the risk of complications"[16]. In other words, whilst during the standard D&E procedure the baby may be killed by this process of gradual dismemberment alone, it is difficult to perform after 18 weeks gestational age due to the toughness of the baby's bones. Killing the baby beforehand causes her bodily tissues to soften, making dismembering her easier for the abortionist.
    - To "avoid the possibility of a live birth"[17]. Given the possibility of babies being born alive during late abortions, especially around the point of peri-viability, it is thought necessary to make sure the baby dies, before attempting to dismember her in D&E procedures.

[16] Dr. Patricia Lohr, *Q&A: Late Abortion*, Abortion Review (now Reproductive Review), 12th June 2008: http://www.reproductivereview.org/index.php/rr/article/360/

[17] *Ibid*. Cf. *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7*, Royal College of Obstetricians and Gynaecologists (RCOG), November 2011: pp. 12, 57-58.

19. By any reasonable definition then, abortion (to use the language of the draft General Comment noted above) constitutes an "act... intended... to cause the unnatural and premature death" of the unborn child. It is a threat that results in loss of life, being a "deprivation of life" since it effects a "deliberate... life-threatening harm... caused by an act".

20. Despite the humanity and right to life of unborn children, and the clearly evident inhumane and destructive reality of abortion, paragraph 9 of the draft General Comment not only fails to admonish States parties to establish and further legal protections for unborn children against abortion, but actually prescribes them to allow and guarantee that the right to life of unborn children be violated.

21. In composing paragraph 9 in this manner, the draft General Comment contradicts its own stated principles by utterly unjustifiably ignoring the humanity and the right to life of the unborn child. In doing so, it violates and prescribes the violation of Article 5(1) of the ICCPR, which clearly states that "[n]othing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognised herein".

22. The attempted justifications given in paragraph 9 for prescribing legal access to abortion make no sense, even on their own terms. Two ICCPR Articles are cited in the draft General Comment to prescribe legal access to abortion:

- Article 6 (right to life): The draft General Comment considers access to abortion something entailed by Article 6, because of States parties' "duty to protect the lives of women against the health risks associated with unsafe abortions", and the concern that restrictions on abortion may "jeopardise [women's] lives".
- Article 7 (freedom from torture): The draft General Comment considers access to abortion something entailed by Article 7, because restrictions on abortion might

"subject [pregnant mothers] to physical or mental pain or suffering", "in situations in which carrying a pregnancy to term would cause the woman substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or when the foetus suffers from fatal impairment".

23. Right To Life considers that both these Articles are clearly misapplied in the arguments submitted in paragraph 9. There can be no justification of abortion, for example, on the basis of the right to life of the pregnant mother. None of the procedures signified as 'abortion' are, as a matter of medical fact, ever necessary in order to safeguard maternal life, and prohibiting or restricting them never 'jeopardises' their lives. There are no cases in reality where deliberately feticidal abortion is a necessary means of saving a mother's life. Vacuum aspiration and D&E are both too complicated in emergency cases to perform, and would always be more complicated in serious cases than simple induction. That leaves chemically-induced miscarriage, which could be seen as analogous to induction in those rare or extreme cases when continuation of pregnancy endangers the life of the mother, such as in cases of pre-eclampsia. In such cases, however, whilst pregnancy is being terminated, and this sometimes takes place pre-viability, at the time of peri-viability, this is done without the intention of killing the child as an end in-and-of-itself. That is why pre-viable forms of induction, though it is foreseen that they will lead to the death of the child, are legal treatments in jurisdictions that have strong right-to-life protections for unborn children, such as Ireland.

24. We refer the Committee to the Dublin Declaration on Maternal Healthcare[18], which has been signed by 1,013 medical professionals in Ireland and internationally, including 245 obstetricians and gynaecologists, and states that:

[18] Dublin Declaration on Maternal Healthcare: https://www.dublindeclaration.com/

> "*As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman. We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child. We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women*."

25. Not only is there an absence of any grounds in medicine for abortion to be necessary under Article 6, nor is there any grounds on the basis of States parties' "duty to ensure that women do not have to undertake unsafe abortions". We recognise that the draft General Comment specifies that legal protections for unborn children should be particularly avoided when "taking such measures is expected to significantly increase resort to unsafe abortions". This might then limit the application of that argument to countries where medical and socio-economic infrastructure is sufficiently under-developed such that illegal abortions might be dangerous and cause loss of life. It is important to point out however, that more generally the sheer fact of restricting abortion does not lead to such a situation, and comparing the situation between similar countries, as well as within countries and over time, consistently evidences this.

26. A 2012 study undertaken on behalf of the Chilean Maternal Mortality Research Initiative (CMMRI)[19] analysed 50 years of maternal mortality data (1957-2007) from Chile's National Institute of Statistics, and found that since Chile enacted a law protecting the right to life of unborn children in 1989, the maternal mortality rate had dropped by 70%. This was a continuance of a decline in the overall Maternal

[19] Koch E, Thorp J, Bravo M, Gatica S, Romero CX, Aguilera H, *et al*, *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, PLoS ONE 7(5) (2012): e36613. https://doi.org/10.1371/journal.pone.0036613

Mortality Ratio (MMR) in Chile of 93.8% between 1957 and 2007. The study found that maternal education and quality of health care affected a decline in maternal mortality, not abortion availability.

27. Similarly, according to the most recent collection of World Health Organisation (WHO) statistics on maternal mortality[20], countries with strong right-to-life protections for unborn children, such as Nicaragua, El Salvador, Poland, Chile, and indeed Ireland, have all seen falls in their maternal mortality rates since 1995, and compare favourably to socio-economically similar neighbours in the same region.

28. The same is true within states as well as between them. An American study published in the Journal of Public Health Policy in 2012[21], in which researchers from Stanford University studied data collected from 23 states, showed that more restrictive legislation was associated with lower rates of complications due to abortion. Meanwhile, a study published in the British Medical Journal in 2015[22], comparing the maternal mortality of 18 Mexican states with less permissive abortion legislation and 14 states with a more permissive law, found that between 2002-2011 those with the more restrictive law typically had lower maternal mortalities than those that had fewer protections for unborn children.

[20] Annex 19. Trends in estimates of maternal mortality ratio (MMR, maternal deaths per 100 000 live births), by country, 1990–2015, pp. 92-98), *Trends in Maternal Mortality: 1990 to 2015*, WHO (2015): http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf

[21] A Rolnick, J. & S Vorhies, J., *Legal restrictions and complications of abortion: Insights from data on complication rates in the United States*, Journal of Public Health Policy 33: 348 (2012): https://doi.org/10.1057/jphp.2012.12

[22] Koch E, Chireau M, Pliego F, *et al*, *Abortion legislation, maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal deaths: a natural experiment in 32 Mexican states*, BMJ Open 2015;5:e006013: https://doi.org/10.1136/bmjopen-2014-006013

29. The converse of all this is that making abortion legal does not necessarily reduce maternal mortality, as a 2014 WHO editorial[23] made clear when it admitted that "illegal abortion is not synonymous with unsafe abortion", conceding that its historical measure of 'safe' abortion – legality – simply was not sound. 'Safety' is not a dichotomy but a continuum. Illegal abortion that takes place in a modern developed country will not carry the lack of safety associated with abortion in far less developed nations. What actually makes a consistent and general difference, as the studies above also demonstrate, is the quality of general maternal healthcare and emergency obstetric care, as well as basic qualities such as female education and literacy, clean water and sanitation, and lower levels of domestic violence.

30. Even if this empirical reality were not the case, as a matter of prior principle, given that abortion is an intrinsic human rights abuse in-and-of-itself, the threat of women committing unsafe illegal activity that may harm themselves cannot justify legalising or restricting it less.

31. As an illustration of this point, we know that girls from certain minority ethnic communities in the United Kingdom are subjected to the barbarity of 'Female Genital Mutilation' (FGM), whether in Great Britain or abroad. 2,421 mutilation cases were reported to health authorities between April 2015 and September 2015, and one campaign group has estimated about 137,000 women and girls in England and Wales have been cut[24]. FGM involves an abusive surgical procedure, carried out in a medically primitive and amateur manner[25]. In the worst cases, this can even be life-threatening[26].

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[23] Ganatra *et al, From concept to measurement: operationalising WHO's definition of unsafe abortion*, Bulletin of the World Health Organisation, 2014;92:155 | doi: http://dx.doi.org/10.2471/BLT.14.136333

[24] *FGM: number of victims found to be 70 million higher than thought*, Jessica Elgot, The Guardian, 05th February 2016: https://www.theguardian.com/society/2016/feb/05/research-finds-200m-victims-female-genital-mutilation-alive-today

[25] *The forms of female genital mutilation*, Emma Howard, The Guardian, 06th February 2014: https://www.theguardian.com/society/2014/feb/06/the-forms-of-female-genital-mutilation

Yet the existence of such abuse does not, under the right to life, necessitate or justify the legalisation of FGM by countries in which it is currently illegal, such that the dangerous and unhygienic nature of such a procedure be removed by the way it is performed in these areas. Rather, even if a legalised form of that practice, carried out with all the hygiene and clinical precision of modern surgical practice, would guarantee that fewer girls would die or be less gravely mutilated, this cannot form grounds for the legalisation of FGM. This is, quite simply, because FGM is an inherent human rights abuse, violating the Article 7 right to freedom from torture or cruel, inhuman, or degrading treatment or punishment, as well as the Article 6 right to life when the procedure results in death, amongst other rights[27]. No possibility of otherwise illegal FGM that would harm the health of girls even more than legal FGM would, could justify the legalisation of it.

32. By the same token, as abortion is an inherent human rights abuse (since it always violates the right to life of the unborn child), the possibility of dangerous illegal abortions forms no basis for the legalisation of abortion so as to make it less 'unsafe'.

33. Rather, the means by which any positive obligation to prevent unsafe abortions might take place is by three means:

- Provision of quality effective maternal healthcare and emergency obstetric care.
- The establishment of basic social conditions necessary for human flourishing and such as female education and literacy, clean water and sanitation, and lower levels of domestic violence.

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[26] *Will the deaths of these 5 girls from FGM spark a global wake-up call?*, Mary Wandia, New York Times, 24th August 2016: http://nytlive.nytimes.com/womenintheworld/2016/08/24/will-the-death-of-these-5-girls-from-fgm-spark-a-global-wake-up-call/

[27] *Eliminating Female genital mutilation: An interagency statement*, World Health Organisation, 2008, pp. 8-10: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

- The maintenance of a legal framework that protects women and unborn children from illegal abortion providers.

34. This latter element will include strong laws that criminalise illegal abortion, with a judicial culture and law enforcement mechanisms that provide a deterrent for those performing such abortions, as well as the flexibility to treat cases differently. The UK provides a model for this to the extent that abortion is still treated as a criminal offence (subject to a number of specific prosecutory exemptions). Two recent cases suffice as illustration:

35. In 2015, a woman in County Durham called Natalie Towers self-performed an abortion at 32-34 weeks (beyond the 24 week 'upper limit' for the majority of abortions in England and Wales, as well as Scotland), by taking prostaglandins in order to miscarry her unborn son, who consequently died of oxygen starvation. She gave birth to her dead child in a toilet, and then called 999 to report her miscarriage. The medical staff who arrived on the tried desperately to save him, and posthumously named him 'Luke'. It being determined that the death of her child was caused artificially by her own actions, Towers was prosecuted for self-administering drugs with the intent to procure a miscarriage, a crime under section 58 of the Offences Against The Person Act 1861. She was found guilty of the crime, and sentenced to two-and-a-half years in prison.

The Daily Telegraph[28] reported the words of the Judge at her trial, Judge Jay, in passing sentence:

[28] *Woman who took poison to terminate pregnancy jailed*, Daily Telegraph, 17th December 2015: http://www.telegraph.co.uk/news/uknews/crime/12057229/Woman-who-took-poison-to-terminate-pregnancy-jailed.html

'"The case has nothing to do with the general immorality or otherwise of the termination of unborn foetuses. The law in this country is quite clear, you must have been fully aware no doubt in line with your internet searches, it was open to you to seek termination at any stage before 24 weeks gestation". The judge said her baby at 32-34 weeks would have had a "very good chance of survival, but had no chance once you administered this drug". He said the offence was so serious that immediate custody was required.'

36. Another occasion of a woman being prosecuted for causation of miscarriage was in 2016, when a conviction was brought in the Northern Irish courts against a woman (whose identity has remained redacted from public reports) who, when she was 10-12 weeks pregnant, bought the abortifacients mifepristone and mifoprostol over the internet and induced a miscarriage, also killing her unborn son.

37. After the woman pleaded guilty, Justice McFarland at Belfast Crown Court gave her a three-month prison sentence, but even this was suspended over two years. Which is to say, as long as she does not try to commit the same crime within that time of probation, she will not have to serve the time in prison. This was an unsurprisingly merciful ruling, given that the woman is reportedly now the mother of a young child, and "trying to put her life back together".

38. Yet it might also not have been, when we consider the testimony of the witnesses in the case, her then housemates. According to the account they gave to the BBC[29], they reported the crime to the police after finding the body of the woman's baby son inside a black bag in a household bin, discarded as if he were garbage. As one of them related:

[29] *Abortion pills: Housemate speaks of guilt over 'baby in bin',* BBC News, 06th April 2016: http://www.bbc.co.uk/news/uk-northern-ireland-35976228

'"*I was putting rubbish out in the bin and realised that must be it", she said. "We saw the wee baby and I was like 'oh my word'. You would never want to see it in your life. It was a full wee proper baby… About a week went by, the guilt of a baby in the bin was eating us up".*'

The same woman gave a fuller description in an interview with the Belfast Telegraph[30]:

'"*A bit later I was going to put rubbish out in the bin and there was the bag. When my other housemate came home on the Sunday we went and looked in the bag in the bin. There was the baby on a towel. I didn't expect the baby to be so fully formed. The court was told she was 10 to 12 weeks pregnant when she obtained the tablets, but he seemed older. He had fingers, little toes. Even now I just have a picture in my mind of it. Its wee foot was perfect. Even now I feel sick. It has done so much damage to me mentally. It is something I can't get out of my head. On bin collection day I couldn't bring myself to put the bin out for collection. I didn't want to throw a baby away. I didn't know what to do*".'

This same testimony goes on to explain why the court was told that the two housemates were "taken aback by the seemingly blasé attitude" that the woman displayed in her actions:

'"*She called the baby 'the pest' and kept saying she just wanted rid of it. She said: 'I don't want this inside me'… This is about her attitude. It was*

[30] *Why we reported abortion pills girl to Northern Ireland police*, Deborah McAleese, Belfast Telegraph, 06th April 2016: http://www.belfasttelegraph.co.uk/news/northern-ireland/why-we-reported-abortion-pills-girl-to-northern-ireland-police-34602857.html

as if she was getting rid of a piece of clothing", she stated. "There was absolutely no remorse. Even the way she was up and away out and doing her own thing a day after the abortion, while me and our other house-mate just walked around in shock. She wasn't forced into anything".'

39. Such careless callousness must have been especially horrifying for one housemate in particular, a 38-year old woman who had actually suffered a miscarriage before the incident, and "offered to be legal guardian to the teenager's child if she still did not want the baby after giving birth". Again, as she relates in the Belfast Telegraph interview:

'"*I really tried to help her. I talked through a number of options but she just didn't want to know" said the Belfast woman… We tried to help her. She was given lots of different options. We even tried to talk to her family to get them to help her, but we didn't know them and she wouldn't give us their contact details. People are saying we contacted police out of malice. That's not true", she added*.'

40. What we see in these accounts then, is a callous and cruel action on behalf of the pregnant woman towards her unborn child, even whilst offered as much help as those around her could give her. In general circumstances, her being sentenced as Natalie Towers was, would have been just. Yet we also see the pragmatic mercy shown by the British courts due to the fact that she had since had a child, who needed her. This exemplifies the ideal balance of justice and mercy that ought to, and can, be shown when it comes to protecting Article 6 and 7 rights.

41. Contrary to the current phrasing of paragraph 9 then, insofar as there is a "duty to ensure that women do not have to undertake unsafe abortions", it is a duty on the part of States parties to ensure that there are medical and social conditions that

decrease the lack of safety associated with illegal abortion, as well as clear restrictions in law, and well-enforced sanctions against illegal abortion activity. This should indeed include, as it does in the United Kingdom, "criminal sanctions against women undergoing abortion or against physicians assisting them in doing so".

42. Given this, it is patently incorrect to prescribe that, "States parties must provide safe access to abortion to protect the life and health of pregnant women". Not only would such a prescription compromise the right to life of the unborn child, thereby prompting States parties to actively violate their obligations under Article 6, it has no basis whatsoever in sound medical practice, or in the prevention of illegal abortions. Abortion is never a medical necessity, nor is it necessary or right as a means of reducing deaths due to unsafe abortion procedures.

43. It is also erroneous to suggest that States parties must ensure provision of abortion "in situations in which carrying a pregnancy to term would cause the woman substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or when the foetus suffers from fatal impairment". This is because the violation of the right to life of the unborn child cannot be justified on the basis that her existence is somehow part of a causal nexus that entails pain or suffering to her mother.

44. If the existence of a born child in a situation of localised starvation meant that the parents suffered from less nutrition due to the extra mouth to feed, this would not form justification for ending the life of that child due to the pain or suffering her very existence, and the consequent responsibility for her care, caused. Similarly, the pain caused by the existence of an unborn child demands the best medical and social help for her mother, not the violation of the right to life of a baby in the womb, whether at embryonic or fetal stages. Nor do the specific cases of pregnancy after

sexual crime or life-limiting impairment give any contextual justification for denying Article 6 protections to the unborn child.

45. Any form of sexual crime is a horrifying form of brutality, and a violation of the dignity and rights of any person who is subject to such wicked abuse. In cases where pregnancy results from sexual crime however, it must be remembered that there are two survivors of that barbarity: the pregnant mother, and her unborn child. Every help and assistance must be given to a pregnant woman in that situation, but to organise the killing of her child in the womb, who is an innocent party, would be an act of grave injustice and constitute a violation of her human right to life.

46. In cases where a prognosis or diagnosis is made of life-limiting impairment, again abortion cannot be seen as a reasonable ethical response to such tragic situations. Even assuming that a child will certainly not survive pregnancy, birth, or for very long afterwards, that child still has a right to life that may not be violated (again, bearing specifically in mind the important implications of Article 5). To affirm the legality of abortion in such cases is to prescribe a form of child euthanasia *in utero*, which is morally abhorrent. Authentically humane and compassionate alternatives are again clear: every care must be given to parents who find their child afflicted with the severest of impairments, and perinatal hospice care for the child, as well as counselling analogous to the kind one would offer to those who have suffered miscarriage, is foremost amongst such care.

47. As well as prescribing that States parties work to ensure that such alternatives be provided to parents and unborn children, we further suggest that the UNHRC might invite states to consider ways in which they can collect reliable data on the experiences of women who face unplanned or difficult pregnancies to amend health policy guidelines, medical practice and public information in a manner conducive to better outcomes in maternal and child health.

48. Also worth noting in the area of health, is that paragraph 9 fails to acknowledge the role coercion plays in the decision of some women to seek an abortion[31], and so offers no protection to women who are coerced into aborting their child. In 2012, the European Parliament in response to the scandal of forced abortions in China, recognised that it could not fund international aid programmes which facilitated the practice of forced abortions in a third state[32], and so forbade members of the Community from assisting coercive reproductive health practices in African, Caribbean and Pacific states[33]. Without prejudice to the above, the Committee should prescribe the development of proper systems of data collection, to record the specific diagnoses pregnant women present with that cause them considerable pain and suffering in order to direct them to appropriate treatment maternal and child health treatment and to protect them from instances of coercion in a reproductive health context in violation of Article 7 and 23 of the ICCPR, and articles 11,12 and 16 in CEDAW.

[31] For a further discussion of coercion in a reproductive health context, see *EU Development Aid and Coercive Abortion and Sterilisation 2012*, Juan Ignacio Fernandez and Meghan Grizzle: https://www.wya.net/wp-content/uploads/2014/04/EU-development-aid-coercive-abortion-sterilisation-White-Paper.pdf

[32] See Resolution of 5 July 2012 on the forced abortion scandal in China, EUR. PARL. DOC. P7_TA(2012)0301: http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P7-TA-2012301

[33] Title 21 of Section III (the Commission section) of the 2012 European Union Budget forbids Community assistance for coercive reproductive health practices in African, Caribbean and Pacific states. It states, "Union assistance should not be given to any authority, organisation or programme which supports or participates in the management of an action which involves such human rights abuses as coercive abortion, involuntary sterilisation or infanticide, especially where such actions apply their priorities though psychological, social, economic or legal pressure, thus finally implementing the specific Cairo International Conference on Population and Development (ICPD) prohibition on coercion or compulsion in sexual and reproductive health matters". It also calls on the Commission to "present a report on the implementation of the Union's external assistance covering this programme". Section III, Title 21, General Budget of the European Union for the financial year 2012, available at: http://eur-lex.europa.eu/budget/data/D2012/EN/SEC03.pdf.

49. Due to all the above, the content of the current draft General Comment requires significant and radical re-writing. Paragraph 9 of the draft General Comment is not only based on profound misapplications of Articles 6 and 7, but it actually contradicts no less than six Articles in ignoring and prescribing the denial of the human dignity and equality of unborn children: 2, 5, 6, 16, 24, and 26. This must be reversed so as to better respect the dignity and rights of human beings in the womb.

50. It is simply a fact that abortion is not a human right, but a human rights violation. It cannot be justified on the grounds of the life or health of a pregnant mother. Even if there were an absolute international 'right to health' (which is implausible as no State, no matter how developed, can guarantee a citizen's state of good health), the fact that abortion is the destruction of a human being cannot be avoided. States are therefore under no obligation to pass laws which legalise or extend the legality of abortion, whereas they do have an obligation to develop their nation's infrastructure to improve health provision through the construction of safe roads to access hospitals, education to train health professionals, public health education campaigns by authorities and relevant institutions for the promotion of health. These are the true answers to deficiencies in maternal health.

51. We submit therefore, that the Committee should take one of two actions with regards to paragraph 9:

1) Replace paragraph 9 with language that reflects biological, moral, and legal reality. That is, remove the language that contradicts the dignity and humanity of unborn children, and their right to life, as well as the failed justifications for legal abortion currently present, with language that prescribes thoroughgoing respect for the right to life of unborn children and reflect the state parties legal requirements to ensure the provision of healthcare to realise to highest possible level of maternal and child health

through evidence based policies. An alternative version of paragraph 9 is given in Appendix A of this document.

2) Delete paragraph 9 entirely, and leave it to States parties to decide for themselves how they wish to interpret Article 6 in applying it to domestic abortion laws, without any further prescription from the Committee.

Embryo-Destructive Research & Medical Practice

52. Whilst the draft General Comment does not deal with research and medical practices that destroy embryonic human beings, since a decision has been made to mention abortion in paragraph 9 of the text, it follows from our comments directly above – particularly in noting the humanity and rights of the unborn child, including in her embryonic stage of development, in paragraphs 6 through 16 – that similar changes might be made that also prescribe protections for embryonic human beings.

53. Very commonly in jurisdictions like the United Kingdom, the law allows for scientific research that involves the commodification and destruction of human embryos. Such exploitation also exists commonly in in-vitro fertilisation practices, and especially newer forms such as pro-nuclear transfer (PNT). Given that human beings, as all mammals, begin to exist at fertilisation, such actions constitute a direct violation of Article 7 in their subjection of the embryonic human to inhuman and degrading treatment, and Article 6 when this leads to the embryonic child's destruction.

54. Following from our comments on abortion therefore, we submit that the Committee should take one of two actions with regards to paragraph 9:

1) Add language into paragraph 9 that prescribes thoroughgoing respect for the right to life of embryonic human beings, and proscribes embryo-destructive research and medical practice. Such language is included in the alternative version of paragraph 9 given in Appendix A of this document.
2) Delete paragraph 9 entirely, and leave it to States parties to decide how they wish to interpret Article 6 in applying it to domestic laws concerning embryo-destruction, without any further prescription from the Committee.

Assisted Suicide & Euthanasia

55. We are glad to see that paragraph 10 of the draft General Comment affirmed the importance of States parties taking "adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations". Suicide prevention policies are an important part of States parties' obligation to safeguard the right to life.

56. Just as important however, are laws that forbid assisting and encouraging suicide, or even causing the death of another at their behest. These serve several functions:

- They serve a cultural purpose in indicating the fundamental social principle that society values human life, and that the taking of human life is normally and prima facie to be regarded as wrong.
- They possess an important public safety role in providing appropriate special protection to those who are psychologically vulnerable, from pressures to kill themselves both within and without.
- Through both these means, they are expressions of every Government's obligation to safeguard the human right to life.

57. The law reflects and reinforces an important cultural value in society to the effect that, whilst individuals who attempt to take their own lives should not be prosecuted for doing so but given help and compassion, suicide as a rule is nonetheless an objectively negative phenomenon, and not something another person should encourage or assist. This is why developed societies maintain emergency responses to attempted suicides, 'suicide watches' of those who may seek to harm themselves, and Government suicide prevention strategies that paragraph 10 rightly implicitly affirms.

58. Indeed, the United Kingdom provides a model for other countries in how right-to-life protections from encouraging and enabling suicide of others, or causing their 'euthanasia', can work with both the strength to effectively protect, and yet also the flexibility to achieve compassion. British legal practice shows that the law can be both strong in the sense of successfully discouraging would-be assisters in suicide who are taking advantage of those in a compromised and vulnerable state (e.g. due to illness, infirmity, or disability), whilst affecting leniency in those cases where it is discerned that someone acted for genuinely 'merciful' reasons. In the former case, there is a clear public interest in prosecution, especially for the general purpose of discouraging similar actions. In the latter, prosecutorial discretion, even if later at the judicial level, may be shown.

59. Take, for example, section 2 of the UK Suicide Act 1961[34]. Two elements may be noted about this law: firstly it is very widely drawn, and secondly in section 2(4) it requires that no prosecution for an offence of encouraging or assisting suicide be undertaken without the consent of the Director of Public Prosecutions (DPP). Both elements exist for a similar reason: a wide spectrum of circumstances may be involved when individual acts of assisting suicide occur.

60. The law recognises that some may involve malice on the part of the perpetrator with the assistance of the suicide of another person being designed to secure personal gain. Others may involve a reluctant assistance given after much soul-searching and with genuinely compassionate intent. Prosecutorial discretion is necessary therefore, as with other applications of criminal law, in order to discern what these circumstances are, and whether they constitute 'aggravating' or 'mitigating' factors that affect the decision to prosecute.

[34] Suicide Act 1961: http://bit.ly/2gYXVm3

61. A widely drawn offence is therefore desirable in order that the law might properly protect as many people in as many cases as possible. Precisely due to this latitude however, a possibility exists that the law might be abused by prosecutors who are either insensitive or partisan. It is for that reason that the DPP must specifically consent to every prosecution.

62. Prospective prosecutions must go through a 'Full Code Test', which involves two stages:

- The Evidential Stage, where it is determined whether or not here is sufficient evidence to justify prosecution.
- The Public Interest Stage, where it is determined whether or not prosecution would be in the public interest. Prosecution does not follow automatically whenever an offence is believed to have been committed. As a convention and rule however, a prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour.

63. In 2010, the serving DPP Keir Starmer QC released guidelines[35] that clarified what the bases would be for prosecution according to the Code Test, in cases of assisted suicide (having been required to do so by the Law Lords[36] after they ruled that a lack of prosecutory clarity was a violation of the right to a private and family life).

64. In the UK, our experience is that both the law's purposes can be seen to be fulfilled, and its flexibility demonstrated, by the record of prosecutions for the offence of assisted suicide. In 2014, Lord Faulks reported[37] to the House of Lords that:

[35] Policy for Prosecutors in respect of cases of encouraging or assisting suicide, Crown Prosecution Service, February 2010: http://bit.ly/1UcrYVd

[36] R (Purdy) v DPP (2009) UKHL 45: http://bit.ly/1HvB0sV

[37] Lord Faulks, Hansard, 5 Mar 2014: Column 1429: http://bit.ly/1HsvHZk

"Records show that from 1 April 2009 to 13 February 2014, 91 cases have been referred to the CPS [Crown Prosecution Service] by the police recorded as assisted suicide or euthanasia. Of those 91 cases, 65 were not proceeded with by the CPS, 13 were withdrawn by the police and there are currently eight ongoing cases. One case of attempted assisted suicide was successfully prosecuted in October 2013. The facts of the matter would not trouble anyone, whichever side of the argument they were on. It involved someone with lower mental capacity. Four cases were referred onwards for prosecution for murder or serious assault".

65. What we see then is that no plainly inappropriate prosecutions have been brought. In the light of the DPP's guidelines it is evident that no one will face prosecution who, in the light of genuine compassion, should not face prosecution. The law, meanwhile, continues to make an important declaration about basic principles, and continues to protect the vulnerable, in particular by forcing would-be assisters or encouragers to consider their position very carefully.

66. The small numbers of such prosecutions are also evidence of the law's efficacy. That so few cases (roughly 15 a year) are presented to the DPP suggests that the law effectively deters assistance in suicide. When prosecutions do occur, they are rare, because the law has both the clarity and 'teeth' to make anyone minded to encourage or assist another person's suicide think very carefully before doing so. As a result the handful of cases that pass the evidential test and reach the DPP's desk tend to be those where the assistance given has been of a minor nature or there is evidence of genuinely compassionate motivation and of serious soul-searching.

67, Laws against euthanasia and assisted suicide certainly therefore serve an important purpose as part of legal and cultural framework of a society that cares to

provide strong protections for the vulnerable, whilst having the capacity to show mercy on those who involve themselves in the deaths of others for genuinely 'merciful' reasons. It is, as has been said, 'a hard law with soft face', and when practised correctly can achieve the right balance.

68. It is because of this exemplary situation, that achieves the best possible balance between justice and mercy, that we are profoundly disappointed that paragraph 10 of the draft General Comment addresses by implication the phenomena of assisted suicide and euthanasia, not by proscribing or even just discouraging either, but by actively prescribes and encouraging both with a lesser or greater degree of confidence, when it states:

> "*States parties [may allow] [should not prevent] medical professionals to provide medical treatment or the medical means in order to facilitate the termination of life of [catastrophically] afflicted adults, such as the mortally wounded or terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity*".

69. Further, it implies a prior commitment to the legality of such practices, when it pre-qualifies its comments about suicide prevention with an 'acknowledgement' of "the central importance to human dignity of personal autonomy".

70. There are several things wrong with this approach, in that it misapplies the concepts of human 'dignity' and 'autonomy', and the right to life, in affirming assisted suicide and euthanasia. All of these principles as defined by their use in the ICCPR should lead the Committee to firmly reject both those practices.

71. The words 'dignity' and 'autonomy' are typically employed in debates surrounding assisted suicide and euthanasia to affirm both those practices, and given

their implicit affirmation in paragraph 10, we can reasonably assume that the draft General Comment is using those terms in that context. This is a problem, as it means that the draft General Comment is applying them away from the meaning of those words framed by their use in the ICCPR.

72. When related to debates concerning assisted suicide and euthanasia, 'dignity' is misconceived as an experiential value that may be possessed to a lesser or greater extent depending on each human subject, rather than what it is meant as in the ICCPR: the 'inherent' value inalienably possessed by each human being. (See the "recognition of the inherent dignity… of all members of the human family" referred to in the ICCPR Preamble, and the reference to "the inherent dignity of the human person" in both the Preamble and Article 10(1).)

73. Paragraph 10 also seems to misframe the idea of 'autonomy'. As it relates to 'dignity' as used in the ICCPR, 'autonomy' should be seen in the sense of the capacity of an agent to freely act in conformity with objective moral and ethical norms. This means seeking the good for themselves, and for others, and thus respecting the dignity (inherent value) in both. Autonomy in the sense used in campaigns in favour of assisted suicide and euthanasia however, tends to mean the personal freedom and self-determination of the individual to act in a relativistic sense: to do whatever they want according to their own desires, even if this is not in accordance with the good for them.

74. If then, 'dignity' is misconceived away from its meaning in the ICCPR as the subjective feeling of self-esteem and an absence or cessation of personal suffering, and 'autonomy' as a relativistic right achieve one's desired aims, then what is being adopted here is the rhetoric of 'right to die' advocates across the world, who argue for legalised assisted suicide and euthanasia.

75. Insofar as the draft General Comment adopts these alternative meanings, which go unmentioned and unsupported by the ICCPR, it adopts a false understanding. We can see this in paragraph 10's use of the phrase, "to die with dignity". If dignity is 'inherent' value, as it is clearly meant within the ICCPR, then it is not possible not to die *without* dignity, as dignity is inalienably possessed by each human being. Similarly then, 'autonomy' is defined in a way that does not cohere with the ICCPR, as personal autonomy can only be of "central importance to human dignity" if it means acting in accordance with the good (the flourishing) of the human individual, which excludes their suicide or the causation of their death, given the alternatives of palliative care or alternative treatment.

76. When we understand these concepts properly, and when we properly understand the nature and observable problems and negative effects of assisted suicide and euthanasia, we see that both practices are incompatible with human dignity, human autonomy meaningfully appreciated, and the Article 6 right to life.

77. Assisted suicide is the provision of assistance by one person (usually a physician) to another that enables the person being given assistance to end their own life. Euthanasia is the active 'killing' of a patient by their physician, usually at the patient's request. Both these things are profoundly damaging to human lives, especially those of the most vulnerable members of human societies. Amongst the problems that assisted suicide / euthanasia regimes in places like Belgium, the Netherlands, and Oregon have shown, we see the following:

- Incremental Extension of Eligibility Criteria: in Belgium and the Netherlands, even though the original euthanasia laws there were restricted to those who (similar to the language given in paragraph 10) are in a "medically futile condition of constant and unbearable... mental suffering that cannot be alleviated", or who

are experiencing suffering that is "lasting and unbearable"[38], euthanasia has been applied to those who are depressed[39], suffering from dementia[40], afraid of becoming deaf[41], survivors of sexual abuse[42], transgender[43], alcoholic[44], autistic and broken-hearted[45], and suffering from PTSD[46], as well as borderline personality disorder and chronic-fatigue syndrome[47]. Calls have been made to extend euthanasia to prisoners[48], those who cannot accept their sexuality[49], and even those who experience existential *ennui*[50]. In the Netherlands, euthanasia has even been extended to occurring without request to newborn infants with

[38] Belgian Euthanasia Act 2002: http://bit.ly/2efDCmj

[39] *Son challenges Belgian law after mother's 'mercy killing'*, Bruno Waterfield, Daily Telegraph, 02/02/15: http://bit.ly/2fvAOkI See also *The Death Treatment*, Rachel Aviv, The New Yorker, 22/06/15: http://bit.ly/2fw8n42

[40] *Go-ahead for world's first mobile euthanasia unit that will allow patients to die at home*, Simon Caldwell, Daily Mail, 10/02/12: http://dailym.ai/1nW9ZGU

[41] *Marc And Eddy Verbessem, Deaf Belgian Twins, Euthanised After Starting To Turn Blind*, Eline Gordts Huffington Post, 14/01/13: http://huff.to/2fa4tiG

[42] *Sex abuse victim in her 20s allowed to choose euthanasia in Holland after doctors decided her post-traumatic stress and other conditions were incurable*, Steve Doughty, Daily Mail, 10/04/16: http://dailym.ai/2fhjnRU

[43] *Nathan Verhelst Chooses Euthanasia After Failed Gender Reassignment Surgeries*, Eline Gordst, Huffington Post, 10/05/13: http://huff.to/2efFbka

[44] *Dutch euthanasia law is used to kill alcoholic, 41, who decided death was the only way to escape his problems*, Steve Doughty, Daily Mail, 29/11/16: http://dailym.ai/2grDugV

[45] *Controversial case re-opens euthanasia debate*, Andy Furniere, Flanders Today, 04/0216: http://bit.ly/2g2fUpD See also *Terzake*, 02/02/16: http://bit.ly/2ha0RPH

[46] *Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to 'incurable' PTSD*, Matt Payton, Independent, 11/05/16: http://ind.pn/2gDx4L8

[47] *Op. cit.*, *The Death Treatment*, 22/06/15: http://bit.ly/2fw8n42 See cases discussed therein.

[48] *Belgian rapist Frank Van Den Bleeken 'to be euthanised' in prison this week*, Roisin O'Connor, Independent, 05/01/15: http://ind.pn/2gzs3Dx

[49] Man seeks euthanasia to end his sexuality struggle, Jonathan Blake, BBC News, 09/06/16: http://bbc.in/2efDJ17 An interview with 'Sébastien' can be found here: http://bbc.in/2gHnoQp

[50] *24 and Ready to Die*, The Economist (YouTube), 10/11/15: http://bit.ly/2fhmFEM See also, *Right to die: Belgian doctors rule depressed 24-year-old woman has right to end her life*, Rose Troup Buchanan, The Independent, 02/07/15: http://ind.pn/2ewqrso

disabilities[51]. The 2011 annual report of the five Dutch Regional Euthanasia Review Committees[52] found that 13 psychiatric patients were killed by euthanasia in 2011, up from 2 in 2012. This, despite a notional legal requirement that the patient should be mentally competent.

- Involuntary Euthanasia: In the 1990s, the initial evidence of a number of deaths without explicit patient request (in other words non-voluntary euthanasia). The rates were 0.8% and 0.7% being equivalent to 1,000 and 900 deaths per year[53]. More recently, a 2007 study found that in Holland in 2005, 500 patients were given a lethal injection without request[54]. For such reasons, we would remind the UNHRC that the law and practice of euthanasia and assisted suicide in the Netherlands has been criticised twice by their Committee, in 2001[55], and in 2009[56]. More recently, the 2012 report of the Dutch Central Bureau for Statistics has said that of the almost 4,000 euthanasias and assisted suicides it recorded, 310 were ended without the patient's explicit request[57]. As the Mackay Report

[51] You can see a description of the 'Groningen Protocol', through which this extension took place, given by two authors who helped develop this practice, in *End-of-Life Decisions in Newborns: An Approach From the Netherlands*, A. A. E. Verhagen and P. J. J. Sauer, Pediatrics (September 2005), 116(3):736-739: http://bit.ly/2ewwFsb

[52] Regional Euthanasia Review Committees Report (2011): http://bit.ly/23BHRJF

[53] *Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995*, P J Van der Maas *et al*, New England Journal of Medicine 335.22 (1996): 1699-1705 (http://bit.ly/2fUehPf); *Euthanasia in the Netherlands: Sliding down the Slippery Slope*, J Keown, Notre Dame Journal of Ethics & Public Policy 407 (1995) (http://ntrda.me/2fa7j7k); *Reports from the Netherlands. Dances with data*, J M van Delden, L Pijnenborg, and P J van der Maas, Bioethics 7 (1993), 4:323-329 (http://bit.ly/2fUfOF4); *Non-voluntary and involuntary euthanasia in The Netherlands: Dutch perspectives*, R Cohen-Almagor, Issues in Law and Medicine 18.3 (2003) (http://bit.ly/2efFzza).

[54] *End-of-Life Practices in the Netherlands under the Euthanasia Act*, Van der Heide *et al*, New England Journal of Medicine, 10/05/07: http://bit.ly/2eOK9Ri

[55] UNHRC Concluding Observations: Netherlands, 27 August 2001, CCPR/CO/72/NET: http://bit.ly/2fsvSuy

[56] UNHRC Concluding Observations: Netherlands, 25 August 2009, CCPR/C/NLD/CO/4: http://bit.ly/2fvDA9y

[57] Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey, Chambere *et al*, Canadian Medical Association Journal 182(9):895-901 (2010): http://bit.ly/2fvJNSZ

found, involuntary euthanasia deaths often involved comatose patients and severely disabled newborn babies[58].

- Euthanasia for Organ Harvesting: In Belgium, a June 2010 study[59] of assisted suicide/euthanasia examined 208 euthanasia deaths in the region of Flanders. The study found that 66 (32%) of the euthanasia deaths were done without explicit request or consent, and the life-ending drugs were sometimes administered by nurses (as opposed to physicians) in some of the cases of euthanasia, operating "beyond the legal margins of their profession". More recent research has even shown that organ donors (including 23.5% of all lung donors) had been euthanised, raising concerns that patients may be given an emotional inducement to be killed, believing that they can be better use being euthanised and harvested[60].
- A 'Duty to Die': Whilst very little can be said about the system of assisted suicide in the U.S. State of Oregon, due to the paucity of studies and data about the reality of assisted suicide practice in that jurisdiction, what little we can say is disturbing. As but one example, the Oregon State Public Health Division brings out an Annual Report each year, and in 1998, the year in which the 'Death with Dignity' act, legalising assisted suicide in Oregon took effect, it reported that 13% of patients applying for medication to commit suicide did so because they were frightened of being a burden on their families[61]. This percentage has substantially increased since, even whilst fluctuating, to the extent that in 2014 almost four times more patients (40%) were opting for assisted suicide for this

[58] CBS Statistics Netherlands, Deaths by medical end-of-life decision; age, cause of death (2012), section 178: http://bit.ly/1nwHdMC

[59] *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*, Chambere *et al*, Canadian Medical Association Journal 182(9):895-901 (2010): http://bit.ly/2fvJNSZ

[60] *Initial experience with transplantation of lungs recovered from donors after euthanasia*, Van Raemdonck *et al*, Applied Cardiopulmonary Pathophysiology 15:38-48 (2011): http://bit.ly/2fwhX7h

[61] Oregon Public Health Division Death with Dignity Act Report (1998), Table 3: 'Characteristics of case patients and matched controls', sub-heading 'End of Life Concerns', page 16: http://1.usa.gov/1IJI6XT

reason[62]. In 2015, it was 48.1%[63]. In 2012, only five years ago, this figure had exceeded it, at 57.1%[64]. Meanwhile, in Washington State, which also uses a similar system, the most recent figure for this reason cited by those opting for assisted suicide is 61%[65].

78. A more comprehensive account of all these demonstrable demerits of assisted suicide and euthanasia systems can be found in Right To Life's White Paper to the Health Select Committee of the New Zealand House of Representatives, in their recent Investigation on Euthanasia and Suicide[66].

79. We see from this evidence that those people offered assistance in suicide, or euthanasia, are generally those with the least personal autonomy, as their wills are so often compromised by physical illness, mental depression, or simply the impatience of those around them with the protracted and 'burdensome' nature of their continued existence. This can lead to their being pressured into an untimely death.

[62] Oregon Public Health Division Death with Dignity Act Report (2014), Table 1: ' Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014', sub-heading 'End of Life Concerns', page 5: http://1.usa.gov/1G0jDub

[63] Op. cit., Oregon Public Health Division Death with Dignity Act Report (2015), Table 1: ' Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2016, by year, Oregon, 1998-2015', sub-heading 'End of Life Concerns', page 5: http://bit.ly/2h3md0I

[64] Oregon Public Health Division Death with Dignity Act Report (2012), Table 1: 'Characteristics and end-of-life care of 673 DWDA patients who have died from ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012', sub-heading 'End of Life Concerns', page 5: http://1.usa.gov/1LdpEum

[65] Washington State Department of Health 2013 Death with Dignity Act Report, Table 2: 'End of life concerns of participants of the Death with Dignity Act who have died', page 7: http://1.usa.gov/1Tqy18k

[66] *Submission to the New Zealand Parliament Health Select Committee Investigation on Euthanasia and Suicide*, Right To Life (February 2017): https://righttolife.org.uk/wp-content/uploads/2017/02/RTL-Submission-to-NZ-Health-Select-Committee-Euthanasia-Suicide-Investigation.pdf

80. It is clear from these consequences of assisted suicide and euthanasia implementation, amongst many others, that both practices constitute an explicit threat to the right to life of the most vulnerable members of society. So far from enabling 'autonomy' and safeguarding 'dignity', even in the false conceptualisation of those concepts used by so-called 'right-to-die' lobbyists, they actually act to undermine both for those who are compromised by their physical and mental impairments or illnesses, and medical systems or professionals the scruples of which and whom have been undermined by a culture in which the killing of patients has become normalised and accepted.

81. It is for this very reason that in the United Kingdom, those opposing the removal of protections against such practices include Royal Colleges of Physicians[67], Surgeons[68], and General Practitioners[69], the Association of Palliative Medicine, the British Medical Association[70], and the World Medical Association[71], as well as by organisations that represent and campaign for the welfare of the disabled and elderly, such as the British Geriatric Society[72], Scope[73], the UK Disabled People's Council[74], and Not Dead Yet UK[75].

[67] *RCP Briefing: Assisted Dying Bill 2015-16* (http://bit.ly/2ewhCPe).

[68] *House of Lords Briefing: Assisted Dying Bill* , Royal College of Surgeons: http://bit.ly/2eFJOTc

[69] *RCGP announces continued opposition to change in law on assisted dying*, 21/02/14: http://bit.ly/2fxWsBq

[70] BMA Policy: Assisted Dying, 06/09/12: http://bit.ly/2fxVjth

[71] *WMA Statement on Physician-Assisted Suicide*, adopted September 1992; and reaffirmed 2015: http://bit.ly/2efFrzw

[72] Physician-Assisted Suicide – BGS Position Statement, 19/04/11: http://bit.ly/2fLGTe2

[73] *Why Scope is against legalising assisted suicide*: http://bit.ly/2fy0ARR

[74] *UKDPC Position Statement: Assisted Suicide*: http://bit.ly/2fxXRYL

[75] *About Not Dead Yet UK*: http://notdeadyetuk.org/about/

82. Not only is paragraph 10 of the draft General Comment mistaken to prescribe the introduction of clinical killing of patients, or the enabling of patient suicide, by physicians, it is also mistaken to think that this can happen with sufficient 'safeguards':

> *States parties must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and, unambiguous decision of their patients, with a view to protecting patients from pressure and abuse*.

83. No safeguards have been proposed in any nation yet, that would truly act as effective means of protecting patients from pressure and abuse. We see this excellently illustrated by the standard process that has recently been proposed throughout English-speaking countries. This was proposed to the UK Parliament in 2015 in the Assisted Dying (No. 2) Bill of Rob Marris MP[76], itself a copy of an earlier Bill by Lord Falconer of Thoroton, by which two doctors, an 'attending' doctor and an 'independent' doctor, would have to be satisfied that a patient applying for assisted suicide met the eligibility criteria in the Bill, and thus possessed "a clear and settled intention to end their own life that has been reached voluntarily, on an informed basis and without coercion or duress".

84. We saw essentially the same system repeated in Bills proposed by the New Zealand (NZ) Voluntary Euthanasia Society[77] and David Seymour MP[78] in 2015, as well as the Voluntary Euthanasia Bill of Steph Key MP and the 'Death with Dignity Bill' 2016 proposed by Duncan McFetridge MP[79] in the State of South Australia[80] during a debate

[76] Assisted Dying (No. 2) Bill 2015, section 3: http://bit.ly/2hcR5sf

[77] End of Life Options Bill 2015, sections 7-10: http://bit.ly/2gILugb

[78] End of Life Choice Bill 2015, sections 12-14: http://bit.ly/2gLu2Yh

[79] Death with Dignity Bill 2016, sections 9-11: http://bit.ly/2fWuhjJ

[80] Voluntary Euthanasia Bill 2016, sections 11-13: http://bit.ly/2fw34l4

over euthanasia in that jurisdiction in late 2016. (In the later Seymour and McFetridge Bills, a third safeguard of a psychiatric specialist was added.)

85. The problem with the system as laid out in these Bills is that nowhere do they set out how a doctor might go about evaluating a patient to discern that they are not acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to his or her wish to request voluntary euthanasia, nor is there any requirement that they have psychological training, but even with the stipulation of a qualified psychiatric specialist, such a question of motivation is not a medical one, but a personal, social, and domestic one, outside of the expertise of doctors and even psychologists.

86. Even if all this were not the case, this also relies on both Doctors knowing the patient well enough, and their families, to be able to evaluate their intentions, mental capacity, and freedom from duress such as subtle pressure from relations. Given the relationship between most patients and even their General Practitioners, which is much less familiar than would be required, this is incredibly unrealistic. Not only would their time with the patient be limited, it would be very unusual for any doctor in Western countries like the UK to have the kind of deep relationship with their patient that would allow them to detect undue influence, or even feeling a burden and other incentives, all of which undermine the 'voluntary' desire to end their own lives.

87. With the work of the psychiatrist, the amount of time s/he would have to check the patient would also be limited, and given this there is no way they would be able to develop the kind of similarly long term and in-depth rapport with the patient that *might*, and only *potentially*, allow them to detect (for example) the problems mentioned above. Since the process is inherently flawed, the so-called 'safeguards' in the Bill are effectively toothless, and lack the detail and power to protect vulnerable people.

88. The same problems were relevant to another proposed New Zealand euthanasia Bill by a Private Member's Bill by Louisa Wall MP, which proposed a system operating not on the basis of a two doctor system, but an 'Ethics Committee on Assisted Dying' (ECAD)[81]. How a Committee would have any greater relationship with a patient, or have the requisite expertise, or have any way of detecting undue pressure, was left entirely unclear, but there seems little reason to think that this would function as any greater safeguard than two or three medical professionals, especially as such a Committee need not even necessarily meet the applicants for euthanasia in person, but may use a video or skype link[82].

89. Suffice it to say then, the theoretical underpinnings of how assisted suicide and euthanasia are meant to work in practice are greatly lacking, and sadly, the human cost of this ill-thought practice in reality are demonstrable, as we have already illustrated above.

90. In conclusion then, it is clear that the ICCPR offers no support at all for the introduction of either assisted suicide or euthanasia, or a so-called "right to die". The conceptualisation of 'dignity' and 'autonomy' in paragraph 10 is utterly contrary to the usage and meaning of those terms found in the original text of the ICCPR. The clinical killing of patients or involvement in their suicide are proposals that cannot be derived from the right to life, nor are they compatible with "the inherent dignity of the human person". The legal liberty to attempt to commit suicide already exists in many jurisdictions, but there nowhere exists a positive right to assistance in that venture.

[81] Authorised Dying Bill 2016 (recoverable after 13th paragraph in link), Part 3, Ethics Committee: http://bit.ly/2h7mcFc

[82] Ibid., 15(1)(d).

91. Instead, the Committee could, however, call for States to encourage the highest possible level of palliative care as a means of protecting the right to life, and the provision of effective analgesic medicine. These remain, even in the most developed countries, starkly underdeveloped and inconsistent in the health systems of the world, and would not only be the real answers to patient suffering, but also discourage suicidal ideation. They therefore fall underneath the remit of Article 6 right-to-life obligations.

92. Given all of the above, we recommend that paragraph 10 of the draft General Comment be rewritten radically to emphasise the need for provision of proper palliative care, of care provision at home, or proper legal provision for the regulation of homecare workers so that they are paid a proper salary. All this in order that, where possible, proper regulation is in place in corporate regulation to ensure the protection of the right of workers to take leave to care for an elderly or ill relative or partner. References should be made to increase funds available for analgesic drugs and pain reduction strategies.

93. We submit therefore, that the Committee should take one of two actions with regards to paragraph 9:

1) Replace paragraph 10 with language that calls on States parties to reject assisted suicide and euthanasia, and instead affirm and support the development of palliative care and analgesic medicine as the right response to terminal illness and patient suffering. An alternative version of paragraph 10 is given in Appendix A of this document.
2) Delete paragraph 10 entirely, and leave it to States parties to decide for themselves how they wish to interpret Article 6 in applying it to domestic abortion laws, without any further prescription from the Committee.

Conclusion

94. The consistent concern of the UNHRC ought to be to make sure that right-to-life protections of the most vulnerable human beings are protected. That means that the abuses of abortion, assisted suicide, and euthanasia, if they are addressed at all, should be actively discouraged if not condemned.

95. As has been noted in this comment, other language within the text of the draft General Comment can also be problematic, as it undermines the philosophy that is implicit in and undergirds the International Covenant. We recommend therefore, the removal of all references to "autonomy", because this introduces an element of ambiguity in the treaty that either contradicts or potentially contradicts the otherwise laudable language in paragraphs 17-19, 22, 23, 28, and 29.

96. For a similar reason, we recommend that all the references within the draft General Comment to a "life of dignity" be deleted. This introduces a contradictory concept to that existing in the original text of the ICCPR, and introducing such subjective appreciations into interpretations of international law will weaken the authority of such law. Judges would have less reliable parameters by which they might adjudicate when the right to life is being violated or not.

97. Furthermore, it has always been the understanding that a life worth living (a more straightforward term than "a life of dignity") results from the full manifestation of the person's inherent dignity, in other words, from the fulfilment of their potential. The introduction of the notion of a "life of dignity", poorly expressed as it is in this comment, implies not only that persons with disabilities have no potential to fulfil, but that a pregnancy with a child who has a disability is *de facto* a threat to the parents' (and particularly the pregnant mother's) ability to fulfil her and their potential, in other words, to live a life that is commensurate with their 'dignity'. This would be very

difficult to reconcile with the principle of the equality of every person regardless of their abilities.

98. The addition of the suggested qualifier of the right to life and a "life of dignity" whilst seemingly harmless, voids the treaty of the value that provides its interpretative framework, namely, that every person has an "inherent" and intrinsic human dignity (value), that no person, community or state or law can grant or rescind. In so doing, the treaty would pit women against the rights of persons with physical and mental impairments, the unborn. Just as indeed it also potentially compromises the right to life of the elderly, the terminally or severely ill, and other people whose current physical or mental state leaves them in a more vulnerable position.

99. It is the hope of Right To Life that the UNHRC reconsider the fundamental grounding of human dignity and human rights, realise the importance of recognising the value of humanity, and the fact of humanity in every human being, including the unborn child, and consider that the true nature of autonomy cannot contradict the duties we have towards those members of the human family who most need our protection, our support, and our compassion.

Appendix A: Amended Version of Paragraph 9 (Abortion) of the draft UNHRC General Comment on Article 6

States parties must *adopt legal sanctions against terminations of pregnancy that are designed to cause the destruction of the unborn child. Such procedures are direct violations of article 6 (right to life), as they constitute the deprivation of an unborn child of her life. When laws fail to recognise the full humanity of children in the womb and give them equal protection of the law, they violate article 2 (right to non-discrimination), as well as article 16 (right to recognition of a person before the law), and article 26 (right to equality before the law). Further, they fail to respect the right of unborn children to those special protections particular to them as minors guaranteed by article 24 (rights of children)*[12]*. As part of States parties' obligations to women who experience unplanned pregnancy, especially in the most difficult circumstances, they should ensure as far as possible the provision of viable alternatives to abortion that safeguard and help both pregnant women and their unborn children, including financial and social support, medical provision, and adoption services. Additionally, States parties should develop proper systems of data collection, to record the specific diagnoses pregnant women present with that cause them considerable pain and suffering, in order to direct them to appropriate maternal and child health treatment, and to protect them from instances of coercion in a reproductive health context in violation of Articles 7 and 23.*

[12] Cf. United Nations Convention on the Rights of the Child (UNCRC), Preamble.
[13] Cf. Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Articles 11, 12, and 16.

Appendix B: Amended Version of Paragraph 10 (Assisted Suicide / Euthanasia) of the draft UNHRC General Comment on Article 6

[The Committee considers that States parties should recognise that individuals planning or attempting to commit suicide may be doing so because they are undergoing a momentary crisis which may affect their ability to make irreversible decisions, such as to terminate their life. Therefore,] States should take adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations[13]*. In keeping with this principle, States parties should prevent medical professionals from providing poisons to their patients with the intent of assistance in suicide, or from actively causing the death of their patients. Clear legal sanctions against physician assistance in the suicide, or involvement in the causation of the death, of seriously afflicted adults, such as the mortally wounded or terminally ill, who experience severe physical or mental pain and suffering, are necessary for the protection of patients from pressure and abuse that would lead to their untimely death, especially the elderly, the terminally ill, and those with physical and mental impairments. For the sake of truly serving and alleviating the suffering of those wh suffer due to physical and/or mental impairment or illness, States parties should encourage and ensure as far as possible the provision of analgesia and palliative care for all those who need it in their jurisdictions, as well as care provision at home, and proper legal provision for the regulation of homecare workers so that these are paid a proper salary and a system of high-quality care for vulnerable people is assured.*

[13] Concluding Observations: Ecuador (1998), para. 11.