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To:
Senator Catherine Noone
Chair Joint Oireachtas Committee on the Eighth Amendment of the Constitution

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Room 1.126, First Floor Jenner Wing

Statement to the Joint Oireachtas Committee on the Eighth Amendment of the Constitution – 18'th October 2017.

Senator Noone, respected members of the Joint Oireachtas Committee on the Eighth Amendment of the Constitution:

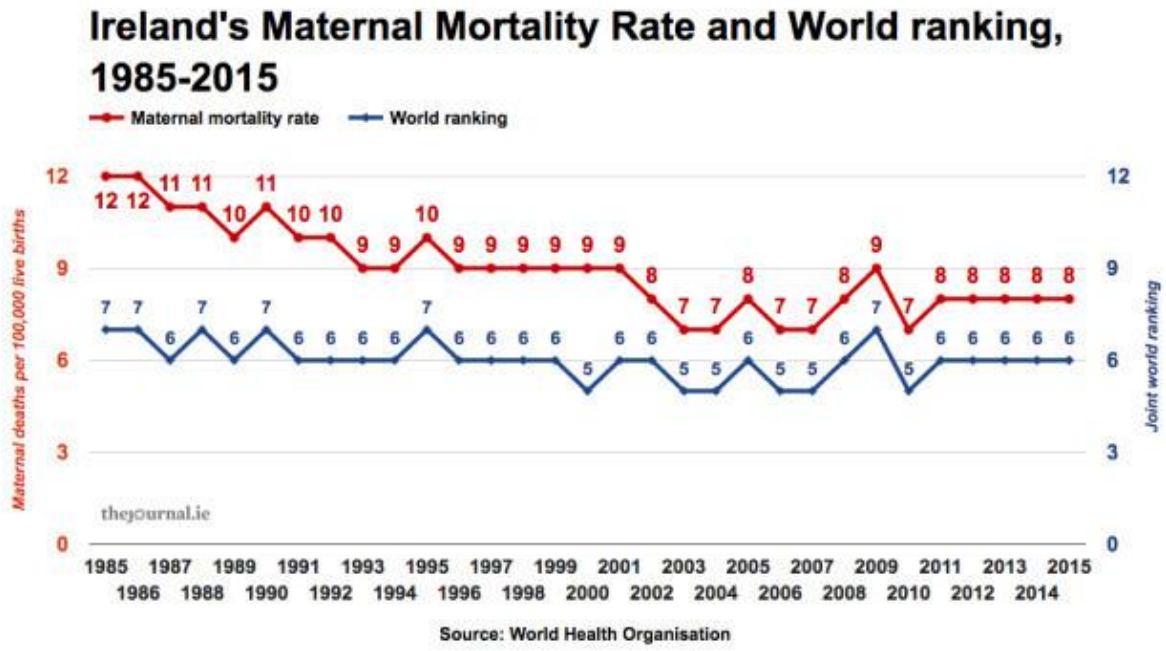
My sincere thank you for providing me the opportunity to give evidence on the important issue of reviewing the Eighth Amendment of the Constitution of the Republic of Ireland.

The issue is linked to the sexual and reproductive health and rights of women, the subject on which I have been working for decades as a women's health physician and in my capacity as President of the Royal College of Obstetricians and Gynaecologists ('07-'10), of the British Medical Association ('13-'14) and of the International Federation of Obstetrics and Gynaecology.

For today, I was specifically asked to focus on "the particular concern to the committee which is the issue of the risk to the health of the mother including her physical health, which the Citizen's Assembly refers to in its recommendations 3, 5, 6 and 8".

Please permit me to start with some general remarks followed by my answers to the specific issues.

First, I would like to congratulate and praise the maternity care in the Republic of Ireland which has very low maternal mortality ratio for years and ranks 6 in the whole world, as shown below. Details of these few deaths are provided in Confidential inquiry into maternal deaths for Ireland which indicates nearly half are due to 'indirect deaths'. This is of some relevance to the issue under discussion. The detail report on the confidential enquiries is attached (Reference 1).



Second, I greatly appreciate the 'First Report and recommendations of the Citizens' Assembly' on the Eighth amendment of the Constitution published on the 29th June 2017 (attached = Ref 2). I commend the citizens for their work: the report is an impressive achievement by people who are not healthcare specialists or experts, but spent five weekends considering the issues.

The Citizens' Assembly members voted on their recommendations for access to abortion for certain medical and other conditions. You are, of course, familiar with the results of the ballots, and these can be viewed in the report.

I would like you to consider the opposite side to the coin – if the same questions were asked as 'Would you send the women who procured abortion for these reasons to prison?" A research project in Brazil, led by the eminent OBGYN, Professor Anibal Faundes, surveyed 1660 civil servants and 874 medical

students. They were asked two different questions: under what circumstances should abortion be allowed under law, and whether they agreed that women who had abortions outside the law would be imprisoned. The research concluded that Brazilians have different views on when abortion should be legal, but most do not agree with imprisoning women for abortion. (A report was published in 2013: Ref 3 – attached).

Hence, I would urge the Oireachtas, the newspapers and the public to take that into consideration and ask the question whether they would wish to imprison women who procure abortion. Because a law that allows abortion for only certain, minimum grounds mandates the imprisonment of women have abortion under all other grounds. I think you would find that this is not what the public wants, neither in law nor in practice.

I shall now give my views on the specific health issues that were raised in the 'Citizen's Assembly Report' and other health issues that were not raised but that are of relevance to the Eighth Amendment of the Constitution;

1. Abortion is life-saving in certain health conditions, for example, a mother with chorio-amnionitis and severe sepsis, pre-existing severe heart disease (for example Eisen Menger's syndrome), poor mental health with the threat to commit suicide. There are examples of such incidents from the Republic of Ireland. Deaths with these conditions occur due to the difficulty in assessing that the seriousness of the condition meets the legal criteria of "real and substantial risk" that can only be averted by ending the pregnancy, and the fear of legal punishment that prevents the doctor from taking a firm and early decision.

2. Abortion in certain health conditions will avoid deterioration of health e.g. cardiac, renal, neurological etc. We could formulate a list of conditions, but will not be able to cover all the different conditions and combinations of conditions that we encounter as clinicians. Each mother need to be individually assessed as to whether the condition is serious enough to terminate a pregnancy. Such lists are used in certain countries where restrictive abortion laws operate. However, mothers slip through the 'net' and end up with worse organ disease. An example list of medical conditions from Peru is given here:

- Hyperemesis gravidarum refractory to treatment with severe hepatic and/or renal impairment;

- Malignant neoplasm requiring surgical treatment, radiotherapy and/or chemotherapy;

- Functional class III-IV congestive heart failure due to congenital or acquired cardiac disease (valvular and non-valvular) with arterial hypertension and refractory ischemic heart disease;

- Severe chronic arterial hypertension and evidence of organ damage; Severe neurological injury that worsens with pregnancy;

- Systemic lupus erythematosus with severe renal damage refractory to treatment;

- Advanced diabetes mellitus with vital organ damage;

- Severe respiratory failure demonstrated by the existence of a partial oxygen pressure < 50 mm Hg and O2 saturation < 85% due to chronic pathology; other maternal conditions that jeopardizes the life of the pregnant woman or leads to serious ill health and permanent illness.

- The Peruvian document is attached and is given as Reference 4 (in Spanish).

- The errors due to conservative management of continuation of pregnancy compromises mother's health with further deterioration of organ function that leads to shorter life span and at times death. Such incidents are greater in the countries with restrictive abortion laws and is due to fear by the doctor of facing legal action. An example article of such deterioration with cardiac condition is given as Ref 5 (attached).

3. Abortion under optimal conditions has less maternal mortality in developed countries compared with continuation of pregnancy. It is 0.7 per 100,0000 with safe abortion care compared with 10 per 100,000 with continuation of pregnancy. These are due to life threatening complications such as thrombo-embolism, hypertensive disease, postpartum haemorrhage, amniotic fluid embolism or worsening of existing medical conditions. (Ref 6 – WHO document – Second Edition 2012. Chapter 1. Fig 1.2 on page 21).

In the UK about 190,000 abortions are carried out each year and there were only two recorded maternal deaths over the last five years (2012 to 2016). Reference 7 – attached. The clear majority of abortions were done under clause C – "the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated,

of injury to the physical or mental health of the pregnant woman – mainly mental health.

4. Abortion is not associated with physical or mental health hazards to the mother and it has no impact on future pregnancies. This has been made clear by the Royal College of Obstetricians and Gynaecologists. (Appendix 1.)

5. Abortions should be permitted for lethal fetal malformation and severe congenital malformation that may have a major impact on life. This is also the position of the Royal College of Obstetricians and Gynaecologists. (Appendix 2.)

6. Safe abortion care should be considered as a public health and human rights issue. Despite good contraceptive coverage, about 10% of women get pregnant and seek abortion care. In countries where abortion is legalized the total abortion rates and maternal mortality have declined due to safe post abortion care and post abortion contraception. (Ref 6 – Chapter 1)

7. Making abortion illegal has not stopped illegal abortion - for centuries and in different countries - it increases maternal mortality. (Ref 8). About 4800 women in Ireland have their abortions done in the UK (Ref 7). These numbers are reduced by 20% due to availability of medication by post for self-procuring abortion. These have their own complications.

8. Abortion is a sexual and reproductive rights issue and the decision should be made by individual women after adequate information is given. (UN papers)

If abortion is not made legal it will promote illegal abortion. Those women with influence and financial resources will get it performed in a safe environment. Those who are poor with less influence will resort to unsafe methods.

I shall conclude with a few extracts from some world bodies;
A) "....abortions and the high maternal and child mortality rates constitute a serious public health problem in many countries."
World Health Assembly Resolution 20.41, 23 May 1967

B) “Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health.

“Certain criminal laws effectively shift the burden of realizing the right to health away from States onto pregnant women, punishing women for the lack of effective provision of health-care goods, services and education by the Government.”
Report of the UN Special Rapporteur on the right to health to UN General Assembly 2011

Ireland can and should provide first class sexual and reproductive health based on rights and public health perspectives. There are minimal ill effects to health with a well-informed safe abortion – RCOG (Appendix 4). Health advantages of avoiding or not having unwanted pregnancy need to be considered in addition to specific socio-cultural issues faced by the women.

Thank you for considering my submission statement.

Yours sincerely,

S Arulkumaran
17’th October 2017

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Appendix 1.

Royal College of Obstetricians & Gynaecologists

Q&A: **Abortion and mental health**

(https://www.rcog.org.uk/en/news/campaigns-and-opinions/human-fertilisation-and-embryology-bill/qa-abortion-and-mental-health/)

This Q&A page provides the O&G perspective on abortion and mental health. It was published by the RCOG in August 2008 to accompany the passage of the Human Fertilisation and Embryology Bill through Parliament.

Abortion has been linked to depression. What does the latest scientific evidence show?

The present RCOG clinical guidelines The Care of Women Requesting Induced Abortion (at time of writing; 2004 edition) state that there is no causal association between an induced abortion for an unwanted pregnancy and future psychiatric illness or self-harm. In the cases where psychiatric illness is detected, this is a result of a pre-existing psychological condition (see recommendation 16.9, p. 35).

The report of the Science and Technology Committee Inquiry[1] in October 2007 recommended that there is no evidence to show that mental health risks, such as depression, anxiety and suicidal behaviours, are linked to abortion.

The latest report by the American Psychological Association[2] in August 2008, which analysed empirical studies in English published in peer-reviewed journals since 1989, confirm that there is no credible evidence to show that elective abortions carried out on unwanted pregnancies pose a threat to women's mental health. The authors conclude that the relative risk of mental health problems for adult woman with unplanned pregnancies 'is no greater than if they have a single elective first-trimester abortion or deliver that pregnancy'.

However, the report authors agree that more research needs to be conducted on the effect of repeat abortions on mental health.

What about the studies which show that there is a link between abortions and mental health problems?

Some studies purporting to demonstrate a link between abortion and mental health problems have been not been considered good quality evidence because of methodological weaknesses. These range from having an unrepresentative sample, selection bias in the presentation of findings and poor control of variables.

Some media reports on the issue have skewed the facts and this has resulted in further confusion over the validity of evidence.

Does this change medical practice and make the case for the counselling of women before and after the abortion?

This does not change medical practice for healthcare professionals offering abortion care.

The RCOG Patient Information[3] provides details on the checks and support which women should have prior to an abortion. This includes written information about the risks of abortion and the likely experiences they may have after an abortion. A follow-up appointment within two weeks of an early medical abortion should take place to check on the woman's mental, physical, contraceptive and sexual health, alongside further counselling if the woman suffers distress after the abortion.

As part of pre-abortion management, the RCOG guidelines recommend that the doctors caring for the women identify those who may require extra support. Risk

factors are: women with a psychiatric history, poor social support or lack of a supportive partner, evidence of coercion to have the abortion, ambivalence before the abortion or being a member of a cultural group that considers abortion to be wrong. Care pathways for additional support, including access to counselling and social services, should be available to these women.

There have been calls for more counselling to be given and an introduction of a 'cooling off' period prior to approval for the abortion. What is the RCOG's view?

The RCOG guidelines state that non-directional counselling should be available to women, prior to informed consent being given. However, not all women want this and it should not be forced upon them.

Information provided includes the risks from an induced abortion, the possible complications that may arise due to abortion and future contraception options. Special arrangements should be made for some women and this includes access to a female doctor if requested, interpreter services for non English-speaking women and decision-making counselling if requested.

Calls for mandatory counselling and a period for reflection have the potential to delay the abortion, thereby increasing the risk. Evidence shows that the earlier an abortion is performed, the lower the risk of complications. Complications include haemorrhage, cervical laceration, uterine perforation and infection. It is also questionable that such counselling should be imposed on a woman, even after she has decided to undergo the procedure, unless the intention is to dissuade her from having the abortion.

It is for these reasons that the RCOG does not support the suggestion of a mandatory 'cooling off' period.

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Appendix 2.

Royal College of Obstetricians & Gynaecologists

Q&A: **Abortions for fetal abnormality**

(https://www.rcog.org.uk/en/news/campaigns-and-opinions/human-fertilisation-and-embryology-bill/qa-abortions-for-fetal-abnormality/)

This Q&A page provides the O&G perspective on abortions for fetal abnormality and syndromatic conditions indicated by cleft lip and/or palate. It was published by the RCOG in July 2008 to accompany the passage of the Human Fertilisation and Embryology Bill through Parliament.

What is the law regarding abortions for fetal abnormality?

Currently, the Abortion Act 1967 states that abortions on grounds of fetal abnormality are permitted provided "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

How are these abnormalities detected?

Antenatal recognition of fetal malformations relies on accurate detection from screening programmes using either maternal serum screening, routine ultrasound scanning or a combination of both.

The early pregnancy scan (between 10 and 14 weeks) is undertaken to determine the gestational age of the fetus, if the mother is expecting a multiple birth and the risk of Down syndrome. Structural abnormalities are picked up during the second ultrasound scan which occurs between 18 and 20 weeks. Detection rates of significant anomalies at this gestation are around 50%.[1,2] If an abnormality is suspected, the woman will be invited to have a third scan at 22 weeks to confirm if the fetus has a malformation. Some fetal malformations become clearer after 24 weeks. Examples of these are the Hypoplastic Left Heart Syndrome and cerebral ventriculomegaly. As noted in a Europe-wide study, the antenatal detection rate was highest for anencephalus.[3]

In reference to abortion for fetal abnormality, is it desirable to define specifically what constitutes a serious abnormality?

The RCOG has stated that a strict definition is impractical because we do not have sufficiently advanced diagnostic techniques to detect malformations accurately all of the time and it is not always possible to predict the 'seriousness' of the outcome (in terms of the long-term physical, intellectual or social disability on the child and the effects on the family). The RCOG believes that the interpretation of 'serious abnormality' should be based upon individual discussion agreed between the parents and the mother's doctor.

Based on the recommendation by the Science and Technology Committee Inquiry 'Scientific Developments Relating to the Abortion Act 1967', the RCOG was recently commissioned by the Department of Health to review and update its guideline Termination of Pregnancy for Fetal Abnormality in England, Wales and Scotland (1996). Work on this will commence shortly.

There have been calls for cleft lip and/or cleft palate to be excluded from being classified as a 'serious handicap'. What is the RCOG's view?

The medical view on observed instances of cleft lip and/or cleft palate is that in some cases, these are symptoms of more serious conditions. For this reason, it is important that doctors provide a good assessment and a decision is made based on the consultation with the doctor.

The general prevalence of cleft lip and/or palate is around 1.5 per 1000 live births.[4] According to the latest statistics, 6.6 out of 10, 000 live births and stillbirths in register areas in England and Wales provided notifications of cleft lip and/or palate.[5]

Research shows that children with cleft lip and palate often have associated malformations. Around 30% of all children born with cleft palate have been found to have an associated malformation, and similar numbers have also been observed for those with cleft lip and/or cleft palate.

A study conducted in Pakistan revealed that the most common malformation for such children was congenital heart disease.[6] A study in Switzerland noted that two thirds of cleft lip and/or palate patients with minor anomalies also had major malformations, drawing the link between the close interplay between craniofacial and brain development.[7] Other common malformations recorded in prospective studies include those in the central nervous system, the skeletal system, the urogenitial and cardiovascular systems.[8] In some cases, malformations are multiple[9,10] and frequently associated with mental retardation or chromosomal anomalies.[11]

The issue of fetal abnormality is a sensitive one since there are differing interpretations of what constitutes a serious handicap. The evidence outlined above show that cleft lip and/or palate are, in some cases, indicators of serious congenital malformations.

It is important for parents to be provided with good information on the future quality of life for their babies and family. Further support should be provided to parents and there are several charities providing good networks and resources such as Antenatal Results and Choices (ARC), the Association for Spina Bifida and Hydrocephalus (ASBAH), the Cleft Lip and Palate Association (CLAPA) and STEPS.

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Appendix 3.

Royal College of Obstetricians & Gynaecologists

RCOG opinion: The Abortion Act, 40 years on

(https://www.rcog.org.uk/en/news/campaigns-and-opinions/human-fertilisation-and-embryology-bill/rcog-opinion-the-abortion-act-40-years-on/)

This opinion piece was published in 2008 to mark the 40th anniversary of the 1967 Abortion Act, which became law on 28th April 1968. It was published to accompany the passage of the Human Fertilisation and Embryology Bill through Parliament, as it was timely to reflect on what abortion legislation has meant for our specialty and our patients.

Hard facts about abortion in Britain before 1967 are few. Estimates of annual numbers varied from 14,600 (the figure given by the RCOG) to 100,000 (the Home Office estimate). In 1969, the first full year of the new law, 49,829 abortions were performed on residents of England and Wales, the total rising to 108,565 in 1972.

For the twelve years before the Act, abortion was the leading cause of maternal mortality in England and Wales. The first Confidential Enquiry into Maternal Deaths in 1952–54 reported 153 deaths from abortion, which was “procured ... by the woman herself in 58 instances.” The terminal event in 50% of illegal cases was sepsis but in 25% it was air embolus from “the injection under pressure of some fluid, nearly always soapy water, into the cervix or into the vagina.” The Report commented that most of the women were “mothers of families”. After 1968 maternal deaths from illegal abortion fell slowly but did not disappear until 1982.

Abortion numbers, however, rose steadily, helped by media “pill scares”, and reached 193,700 in 2006. The current British rates – 18.3/1000 in England and Wales and 12.4/1000 in Scotland – are similar to those in many Western European countries, but higher than those in Germany (7.6) and the Netherlands (6.5) and slightly lower than those in the USA (20.9) and Australia (19.7).

In 1973 34% of abortions in Britain were on women from abroad but this figure fell as laws changed across Europe. In 2006 there were 7,436 abortions to residents of other countries, mainly Northern Ireland (17%) and the Irish Republic (68%).

Among British women, the rate peaks at age 19 and falls sharply after age 24. Around 60% of women aged 20–24 use the pill and 13% now use long-acting

progestogens but contraceptive use is highest among educated women and abortion rates are highest in deprived areas. The College is deeply concerned about the widespread closure of local family planning services and believes a rethink is needed in the way Sex and Relationship Education is provided in this country.

The rise in numbers over the last decade has been due to more abortions at <10 weeks. The total at 10–12 weeks has fallen and at >13 weeks remains steady, with 1.5% at 20 weeks and over. The upper limit has been 24 weeks since the HFEA Act of 1990. Responding to concerns about fetal awareness, the College assessed the scientific evidence and concluded that development of neural pathways necessary for awareness does not begin before 26 weeks' gestation. Nevertheless at 22 weeks and beyond, abortion should now include feticide.

In June 2007 the Parliamentary Select Committee on Science and Technology set up an enquiry into scientific developments relating to the 1967 Act, including the 24 week limit, access to first trimester abortion and evidence on long-term health outcomes. The College will submit evidence to this enquiry.

In Britain, abortion is now safe for women, though still a distressing experience. Safe abortion is easily taken for granted and increasing numbers of trainees want nothing to do with this service. Conscientious objection is the right of every doctor but is a decision that needs careful consideration.

Nobody enjoys performing abortions. The doctors who do so are the ones who feel most strongly about reducing the need for abortion, and many work in difficult circumstances giving contraceptive advice to young women. They have the support of the College.

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