

Dr Peter Boylan, FRCPI, FRCOG, MAO

Position Paper

Joint Committee on the Eighth Amendment

Wednesday, 18 October, 2017

Thank you for your invitation to appear before the Joint Committee on the Eighth Amendment to speak on my concerns and issues arising from the recommendations of the Citizens' Assembly. The content of this statement is rooted in over four decades of practice as an Obstetrician Gynaecologist caring for women in Ireland, the United Kingdom and America since I qualified as a doctor in 1974. I hope to assist you in your deliberations.

I am currently Chairman of the Institute of Obstetricians and Gynaecologists of Ireland. My medical training was at the National Maternity Hospital, Dublin and Queen Charlotte's and the Chelsea Hospital for Women, London. After training, I was appointed to an academic post at the University of Texas Houston Medical Center for four years. I was Master of the National Maternity Hospital (NMH) from 1991-1997 inclusive, and Clinical Director of NMH from 2008-2014.

In 2012-13 I served as a member of the committee of independent experts established by the Minister of Health to advise the Government on the implementation of the European Court of Human Rights judgment in respect of the X Case. The outcome was The Protection of Life During Pregnancy Act (2013).

In 2013 I was the independent expert witness for the coroner in the inquest into the death of Savita Halappanavar.

In 2014 I was an expert witness for the family in the case of PP v HSE in the High Court.

The Institute of Obstetricians and Gynaecologists of Ireland has not been asked to provide a position paper. However, in preparation for this hearing, I canvassed the opinions of members and have incorporated feedback received into this statement.

Background

The Citizens' Assembly 'is an exercise in deliberative democracy, placing the citizen at the heart of important legal and policy issues facing Irish society today. With the benefit of expert, impartial and factual advice the 100 citizen members will consider [certain topics] and any other matters that may be referred to them. Their conclusions will form the basis of a number of reports and recommendations that will be submitted to the Houses of the Oireachtas for further debate by our elected representatives.'¹

Deliberative democracy may be usefully defined as the process in which 'legitimate lawmaking issues from the public deliberation of citizens.'² It can assist legislators in both representative and direct democracies to legislate on difficult political and social issues, by distilling authentic public opinion, independent from political bias.

At the end of their deliberations, during which they heard evidence from twenty-five expert witnesses representing the full spectrum of views on the question of abortion, the Assembly members voted on Article 40.3.3, the Eighth Amendment, as follows:

1. 87% voted that Article 40.3.3 should not be retained in full
2. 56% voted that Article 40.3.3 should be replaced or amended
3. 57% voted that Article 40.3.3 should be replaced with a constitutional provision that explicitly authorises the Oireachtas to address termination of pregnancy, any rights of the unborn, and any rights of the pregnant woman

In relation to the grounds on which termination of pregnancy should be legislated for the Assembly members voted in favour of legislation as follows:

1. Real and substantial risk to the life of the woman (99%), by suicide (95%)
2. Serious risk to the health of the woman (90+%), mental health (90%)
3. Risk to the health of the mother (78%), mental health (78%)
4. Pregnancy as a result of rape (89%)
5. Fetal abnormality likely to result in death before or shortly after birth (89%)
6. Significant Fetal abnormality unlikely to result in death before or shortly after birth (80%)
7. Socio-economic reasons (72%)
8. Without restriction (64%)

In addition, 72% of members felt there should be no distinction between physical and mental health.

¹ Website of the Citizens' Assembly (<https://www.citizensassembly.ie/en/>)

² J Bowman and Rehg, W., *Deliberative Democracy, Essays on Reason and Politics* (Cambridge, Massachusetts and London: MIT Press, 1997).

Members made five ancillary recommendations –

1. Improvements should be made in sexual health and relationship education.
2. Improved access to reproductive healthcare services should be available to all women
3. All women should have access to early scanning and testing as part of their obstetric care.
4. Improvements should be made to counselling and support services, including for those women who have undergone termination of pregnancy.
5. Further consideration should be given as to who will fund and carry out termination of pregnancy in Ireland

I support the ancillary recommendations without reservation.

In relation to the fifth ancillary recommendation, it is my opinion that if termination is legalised it should be funded by the state, rather than delegated to private providers.

In the first ten weeks of pregnancy terminations are by tablets taken under medical supervision initially in a clinic and then at home. All terminations should be medically supervised. Medical personnel with a conscientious objection should be excused from involvement. Later terminations should be performed in approved hospitals.

Article 40.3.3 and current obstetric practice in Ireland

The presence of the Article 40.3.3 in our constitution gives rise to significant difficulties for doctors practicing in Ireland and has caused grave harm to women, including death. The two outstanding examples of which I have direct experience are the death of Savita Halappanavar in 2012 and the case of Miss P in PP v HSE in December 2014.

Savita Halappanavar died of sepsis following spontaneous rupture of membranes at 17 weeks. She would not have developed sepsis had her uterus been empty following the termination which she requested when she understood the dismal prognosis for her baby. However, termination was not permissible under the law as long as her baby was alive and she was not at risk of death. When she became septic, the course of the sepsis was rapid. While there were deficiencies in her care as she became critically ill, these deficiencies would not have arisen had the pregnancy been terminated when she requested it. You heard last week in detail from the Masters of the Rotunda and the National Maternity Hospital about the uncertain nature of the clinical course of illness in pregnant women. I concur with their evidence.

Miss P suffered irreversible brain damage, so severe that she required life support, at 15 weeks of pregnancy. Doctors caring for her were uncertain as to whether or not the Eighth Amendment prevented them from turning off life support as long as there was a fetal

heartbeat present. It was left to the High Court to rule following a hearing in the days before Christmas 2014 where multiple legal teams representing the family, the fetus, Miss P, the HSE, and the State presented their case, a scenario rightly described as ‘grotesque’. I understand that this was the first medical case in which a court has considered the Eighth Amendment outside a direct abortion context.³

These are only two examples of cases where doctors in Ireland continue to be put in the inappropriate position arising from the presence of the Eighth Amendment of having to interpret the Constitution of Ireland in the course of caring for sick women. Medical personnel have no difficulties in obeying clear legislation and medical regulations, but we are not trained for the complexities of constitutional interpretation, nor should we reasonably be expected to be.

The Eighth Amendment has also given rise to legal cases including the X case (1992), the C case (A & B v EHB and C., 1997), D v Ireland (2002), the Miss D case (2007), A, B, and C v Ireland (2009), Miss Y (2014), Mellet v Ireland (2016), and Whelan v Ireland (2017). Behind these anonymous initials are the difficult and painful cases of Irish women and girls who have had to resort to stressful legal processes in the absence of comprehensive legislation on abortion. If the Eighth Amendment is not repealed, it is inevitable that this list will continue to grow and Ireland will continue to be subject to censure by international bodies such as the European Court of Human Rights and the United Nations.

The current legal situation whereby termination of pregnancy on grounds other than risk to the life of the woman is subject to a criminal prosecution with the penalty of imprisonment for up to 14 years for women and their doctors, while simultaneously the 13th Amendment provides constitutional protection for women to travel to obtain a termination outside the state, and the 14th Amendment protects the right to access information necessary to achieve this, is regarded by many, including myself, as profoundly hypocritical. Our constitution effectively enshrines a woman’s right to commit an act which is a criminal offence in her own country, as long as it is committed outside the state. By any yardstick this is a bizarre situation and a source of embarrassment to many. Moreover, testimony from numerous Irish women demonstrates the pain and stress they have undergone and continue to experience as a result of Ireland’s ongoing failure to legislate comprehensively.

There are 260 million women and girls living in the EU.⁴ Approximately 2.6 million of these – or 1% - live in Ireland and Malta.⁵ This means that 99% of women and girls in the EU live in countries where their legislatures have grasped the nettle of legislating for termination of pregnancy. No doubt many other EU countries have had difficulties with the subject too,

³ Mairead Enright, ‘Human Rights in Ireland: PP v HSE: Practicability, Dignity and the Best Interests of the Unborn Child’ (<http://humanrights.ie/gender-sexuality-and-the-law/pp-v-hse-futility-dignity-and-the-best-interests-of-the-unborn-child/>)

⁴ Most recent Eurostat figures for 2014 (http://ec.europa.eu/eurostat/statistics-explained/index.php/Gender_statistics)

⁵ Estimate based on 51% of 2016 population of both countries drawn from 2016 censuses.

given their own differing religious, political and social histories, but it is a fact that their legislators have had the will to deal with the issue. The Irish position remains deeply anomalous and obviously politically contentious. We Irish are enthusiastic Europeans. In the context of Brexit, 88% of Irish people (99% of students) remain committed to membership of the EU, but in the matter of women's reproductive health, we remain outliers in a tiny minority in Europe.⁶

I include here a summary of current legislation in the 28 countries of the EU:

Termination of Pregnancy Law in the 28 European Union countries

Malta – total ban: 18 months to 3 years in prison for woman; 18 months to 4 years in prison for doctors and lifelong ban on practicing. Population: 450,000

All other 27 countries all have some legislation on abortion. Ireland, Poland, and Cyprus are the most restrictive.

Ireland – Permitted in the case of risk to the life of the mother. Otherwise 14 years in prison for woman and doctors.

Poland and **Cyprus** permit in cases of risk to life or health (mental or physical) of mother, fetal abnormality and rape/incest. Gestational limit is 28 weeks in Cyprus. Unlike in other countries with a ban on abortion, women in Poland are not subject to penalty for illegal termination.

Netherlands and UK most liberal. 5-day wait in Netherlands after first consultation and all terminations must be carried out in a licensed hospital or clinic. In the UK certification of two doctors is required. 24 weeks gestational limit.

Without restriction up to:

10 weeks: Croatia, Portugal, Slovenia

11 weeks: Estonia

12 weeks / 90 days: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Slovakia, Spain

14 weeks: Romania

16 weeks: Sweden

24 weeks: Netherlands, {UK}

⁶ Red C Poll, 9 May 2017.

Legal Provision of termination of pregnancy in the case of:

- **Risk to the life of the mother:** all countries except Malta
- **Risk to the health of the mother:** all except Malta and Ireland
- **Rape:** all except Malta and Ireland
- **Fetal abnormality:** all except Malta and Ireland
- **Medical reasons beyond 12 weeks** (varying by country): all except Malta, Ireland, Poland

Current Situation in Ireland

I suggest that in 2017 the Eighth Amendment is unworkable. When it was enacted thirty-four years ago in 1983, neither the World Wide Web nor the abortion pill had been invented. You heard evidence last week that the rate of women accessing the abortion pill from online service providers is increasing. Importation of the pills into Ireland is illegal, in reality though, there are many services that facilitate people living here with a means of securing delivery to a designated address, which means they can legitimately use a virtual address to access these type of items.

The genie is therefore out of the bottle in respect of online access to the abortion pill. The grave concern that doctors have as a consequence of this reality is the potential for harm caused by the use of unregulated medication by Irish women and girls. I believe it is a matter of priority for the Oireachtas to address the reality of this situation.

The Citizens' Assembly vote result clearly recommends that the Oireachtas deal with the question of termination by legislation rather than through the constitution. I entirely concur with this conclusion, but I would add that legislation needs to be supported by regulation with regard to clinics and hospitals, and by the Medical Council and An Bord Altranais.

Practical Implementation of the Recommendations of the Citizens' Assembly:

Viability and Gestational Limits

Prior to discussing the grounds on which legislation may be enacted, the question of gestational limits should be considered. Viability – the ability to survive outside the womb - exists as a function of biomedical and technological capacities, which are different in different parts of the world. As a consequence, there is no uniform, worldwide gestational age that defines viability. Viability is not an intrinsic property of the fetus because it depends on both biological and technological factors.

In Ireland, viability is currently considered to occur at approximately 24 weeks gestation. However, some babies born at 23 weeks may survive while others born after 24 weeks may not. Among survivors the rate of disability is high, with complications such as cerebral palsy. When obstetricians deliver a baby at the margins of viability, it is standard practice in this country to have a full neonatal team present at the birth to make an immediate assessment about viability and institute intensive care in every case where appropriate. I cannot envisage a scenario whereby any doctor in Ireland would support any proposal that termination of pregnancy would be contemplated beyond 23 weeks. I hope this is reassuring to the committee in respect of the uninformed discussion that regrettably occurs in respect of so-called ‘late term abortion’.

Methods of termination:

Medical termination is performed by the administration of two medications. Mifepristone blocks the action of progesterone, a hormone necessary to support pregnancy before the placenta develops, and misoprostol makes the uterus contract. Taken in combination, two or three days apart, these tablets have a success rate greater than ninety per cent if taken in the first trimester, preferably before ten weeks. The first tablet is taken in a clinic or doctors surgery and the second is taken at home. The woman then experiences symptoms the same as a miscarriage. The rate of side effects is very low.

For pregnancies of later gestation the procedure needs to take place in the hospital setting and will require more medication over a longer period of time. If the Oireachtas legislates to allow termination it is likely that later terminations will only be legalised for reasons other than socio-economic or without restriction.

Surgical termination is where the contents of the uterus are removed either by suction or curettage following dilatation of the cervix.

Grounds on which the Citizens’ Assembly recommended legislation:

- 1. 99% of members of the Citizens’ Assembly voted in favour of termination being legal where there is a risk of life to the mother.**

The Protection of Life in Pregnancy Act 2013 deals with the question of termination of pregnancy in circumstances where there is a threat to the life of the mother, including by suicide. In the years in which it has been in force there have been approximately 25 terminations each year. Although it is difficult to calculate exact numbers of Irish women accessing terminations, this group accounts for less than 1% of “Irish” terminations per annum.

A major difficulty with this Act is that it is entirely the responsibility of doctors to determine how close to death, or how sick, a woman must be before legal termination can be performed. The woman herself has no input into the decision, other than the option of refusing termination and placing her life at risk. Doctors are subject to criminal prosecution if it can be established that they acted in bad faith in recommending a termination, even if the woman herself is happy with the decision.

2. 90% of members of the Citizens' Assembly voted in favour of termination being legal where there is a serious risk to the health of the mother.

Serious risk to the physical or mental health of the woman overlaps with threat to the life of the mother insofar as a risk to health may develop into a risk to life. Under current legislation doctors have to make judgment calls as to when a risk to health becomes a risk to life. If the judgment is wrong either the mother will die or the doctor will be guilty of committing a criminal offence. Lack of legislation in this area places considerable strain on doctors who have to make these judgments. Under current legislation a mother's view is not taken into consideration, a unique situation in the practice of obstetrics.

3. 78% of members of the Citizens' Assembly voted in favour of legal termination where there is a risk to the health of the mother.

Risk to the health of the mother, either physical or mental, raises the important question of how different people deal with risk. With an ageing, more obese pregnant population and complex associated co-morbidities (i.e. the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder), more women are presenting with pre-existing conditions which may deteriorate during the course of a pregnancy. Examples include high blood pressure or diabetes which may deteriorate rapidly and become very difficult to control. Some women (perhaps those expecting a much longed-for first baby) are willing to accept any risk in order to have a baby, while for others (perhaps those with small children at home) the deterioration in their health represents an unacceptable risk. In these complex circumstances, a decision to terminate is best left to the woman and her doctor.

4. 89% of members of the Citizens' Assembly voted in favour of termination being legal in the case of pregnancy as a result of rape.

Pregnancy as a result of rape could be dealt with in a straightforward way by legislating for the legal prescription of the 'abortion pill' which I have previously described. Pregnancy tests are now so sensitive that they are positive just before a missed period and so the pills would be 99% successful if taken within the first 8 weeks. There is no diagnostic test to confirm rape and so I would strongly recommend that a woman who has undergone the trauma of rape should not be forced to 'prove' rape if she chooses to terminate a resulting pregnancy. Women should be taken at their word, hardly a revolutionary concept.

5. 89% of members of the Citizens' Assembly voted in favour of legal termination where there is a fetal abnormality likely to result in death either before or soon after birth.

Fetal abnormality likely to result in death either before or soon after birth was covered in detail in evidence last week from the Masters of the Rotunda and National Maternity Hospital. They both outlined the clinical risks associated with current legislation and recommended that for women who choose the pathway of termination this option should be legislated for. Professor Malone in particular emphasised his unhappiness with a system that allows obstetricians to care only for one group of patients – those who choose to continue with their pregnancies – but not for the other group – those who find it too difficult to continue and to choose to terminate the pregnancy early.

Both Masters also emphasised that women who choose to continue their pregnancies receive the full support of a multidisciplinary team, including palliative hospice care for the newborn. The concept of hospice care for the newborn with little or no chance of survival outside the womb has, in my experience, been a long-standing practice in this country in our neonatal units. It is simply incorrect to state that this care is not available.

I have considerable experience of couples who have had the misfortune of receiving diagnoses of fetal abnormalities. In some cases, the parents have chosen to continue with the pregnancy and have been much comforted by having some time, however brief, with their baby. In other cases, couples have been unable to continue with the pregnancy, often fearing that their baby will suffer, and have travelled abroad for termination. However, what is not so well understood is that some couples experience a diagnosis of fetal abnormality on subsequent pregnancies. My experience has been that in the vast majority of these sad cases, on the second or subsequent occasions the couples choose to terminate the pregnancy.

I also have experience of couples who, prior to screening for an abnormality declare confidently that they would not seek termination in the event of a serious abnormality being diagnosed, only to change their minds when confronted with the reality of serious fetal abnormality. I think most people in Ireland would sympathise with this.

Termination in cases such as these can be compared with the withdrawal of life support from someone in an intensive care unit, for example a patient on a ventilator. The uterus in pregnancy performs the function of an intensive care unit. The lungs are bypassed via the placenta; the placenta functions as an artificial kidney so that the fetus is effectively undergoing continuous renal dialysis; the fetus is fed intravenously via the umbilical cord. Delivering a baby unable to survive without such support is analogous to removing its life support, as happens in intensive care units in Irish hospitals every day.

6. 80% of members of the Citizens' Assembly voted in favour of legal termination where there is significant fetal abnormality unlikely to result in death either before or after birth.

Significant fetal abnormality unlikely to result in death before or shortly after birth raises more difficult questions. In particular, how can we define 'significant' abnormality. Antenatal diagnosis, including ultrasound, genetic testing, and MRI, is now much more sophisticated than in the past. It bears repeating that when the Eighth Amendment was enacted in 1983, this level of diagnostic capability was not available.

The 'significance' of the abnormality may depend on the extent of the disability and/or the parents' ability to cope with the consequences. In some conditions, particularly genetic, there is a wide spectrum of severity. Trisomy 21, or Down syndrome, for example, is sometimes accompanied by severe heart, bowel, and/or brain abnormalities. Each person with Down syndrome is an individual. Intellectual and developmental problems may be mild, moderate or severe with some people able to achieve independent living and academic success while others have significant life-limiting health problems. Parents, in consultation with their doctor, are the people best able to make decisions in their individual circumstances.

In other cases such as anencephaly (a severe congenital condition in which a large part of the skull is absent along with the cerebral hemispheres of the brain) or renal agenesis (when the fetal kidneys fail to develop), there is no realistic chance of survival beyond hours or days and parents are very concerned that their child may suffer pain and distress. Very occasionally, cases are cited of apparent survivors. Most of these cases are decades old, and may in fact be due either to a mosaic condition (where symptoms vary and both normal and abnormal cells may be present) or a straightforward misdiagnosis.

Diagnosis of genetic abnormalities can now be made before 12 weeks gestation by means of a blood test on the mother, confirmed by either amniocentesis (taking a sample of fluid from the uterus), or chorion villus sampling (taking a sample of tissue from the developing afterbirth).

7. 72% of members of the Citizens' Assembly voted in favour of legal termination for socio-economic reasons and 64% voted for access with no restriction.

Termination for socio-economic reasons and without restriction can be considered together. Throughout Europe 99% of women and girls have access to termination of pregnancy without restriction up to 10 weeks of pregnancy. As stated earlier, the remaining 1% are those who live in either Ireland or Malta, and more than 90% of these in Ireland. The method used in these cases is by using medication, the 'abortion pill', which as we know is increasingly accessed via the internet by women living in Ireland.

Of the Citizens who voted for termination without restriction, 92% voted to limit gestation to 12 weeks, 44% to 22 weeks, and 8% voted for no gestational limit. I have referred previously to generally accepted viability outside the womb as 24 weeks.

International Context

The UK Abortion Act 1967 sought to clarify existing law, in the context of rising concerns about the numbers of deaths of women undergoing illegal abortion.⁷ In Ireland before the UK Act illegal abortion and infanticide (which were not differentiated in official statistics) were common with some high profile prosecutions being reported in the media.⁸ Before 1964 the death penalty applied, but there were many cases of sentences being commuted and judges appealing for mercy on behalf of women. As historian Louise Ryan observes in the context of the early years of the Free State: ‘The Courtroom provided an environment where the private worlds of desperate decision, made in heartbreaking circumstances, encountered the public world of uncompromising law and order.’⁹ Nothing has changed. Ease of access to the UK has resulted in women living in Ireland having similar rates of termination of pregnancy as women domiciled in the UK, although at later stages in pregnancy, because of the difficulties inherent in having to travel to a foreign jurisdiction.

It is well-documented that in countries where abortion is banned, the rate of women dying remains high. 21.6 million women worldwide experience an unsafe abortion each year, 18.5 million of those in developing countries. Approximately 70,000 women die each year from complications relating to unsafe abortion, and deaths due to unsafe abortion are the leading cause of maternal death, remaining close to 13%.¹⁰ You heard testimony last week that Irish women today are attempting self-abortion with potentially fatal consequences.

It is equally well-documented that countries with liberal laws, and easy access to contraception, have lower rates of abortion than those with restrictive laws. In Africa and Latin America for example the abortion rate is up to 39 per 1000 women aged 15 to 44 years, while in Belgium, Germany and the Netherlands the rate is less than 10 per 1000.¹¹ Women in Ireland with financial resources have access to termination of pregnancy, primarily in the UK. However, women who are poor, in the care of the state, or refugees for example do not

⁷ The long title of the Act is ‘An Act to amend and clarify the law relating to termination of pregnancy by registered medical practitioners.’

⁸ Infanticide and abortion figures were not differentiated in official reports. See ‘Sexual Crime and Juvenile Offenders’ Memorandum by Intelligence Division in connection with Mr Justice Hanna’s speech in March 1936 on infanticide and concealment of births. National Archives of Ireland, Department of Justice 8/451 quoted in Diarmaid Ferriter, *Occasions of Sin* (London: Profile Books, 2012), 126.

⁹ Louise Ryan, ‘The Massacre of Innocence: Infanticide in the Irish Free State’, *Irish Studies Review*, No. 14, Spring 1996, 17-21.

¹⁰ Lisa B. Haddad and Nawal M. Nour, ‘Unsafe Abortion: Unnecessary Maternal Mortality’ in *Reviews in Obstetrics and Gynaecology*, 2 (2) Spring 2009, 122-6,

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2709326/>

¹¹ *Ibid.*

have such access. The Thirteenth and Fourteenth Amendments to the Constitution are of no assistance to these women.

The case of Romania under the rule of the dictator Nicolae Ceauscescu (1965-1989) provides a good example of the consequences of restrictive legislation. Before 1965, when Ceauscescu came to power, Romania had liberal access to abortion and the abortion mortality ratio was 20 per 100,000 live births. By 1989 the mortality ratio had risen to 148. In 1989, after the fall of Ceauscescu, restrictions were lifted and within one year the ratio had fallen to 68, and by 2002 it was 9 per 100,000 live births.

Without access to abortion in the UK it is inevitable that Ireland would have an epidemic of illegal abortions and a massive increase in maternal mortality. If or when the Eighth Amendment is removed from the constitution, the Protection of Life in Pregnancy law would still be in place. It would then be the responsibility of the Oireachtas to legislate for the grounds on which termination of pregnancy would be permitted.

The Citizens' Assembly clearly recommended that termination should be legalised in cases of risk to the life of the mother, in cases of threat to the health of the mother, in cases of fetal abnormality, in cases of pregnancy resulting from rape, for socio-economic reasons, and without restriction. I would add that in my opinion, legislation should be accompanied by regulation through the Irish Medical Council.

I believe that the forthcoming referendum on the Eighth Amendment should put a simple binary question to the electorate for or against repeal. The details of legislation are the responsibility of the Oireachtas, not the people. On repeal of the Eighth Amendment, Irish law on termination of pregnancy would continue to be governed by the Protection of Life in Pregnancy Act (2013) and there would be no legislative vacuum pending further legislation by the Oireachtas. In the meantime, women in Ireland will continue to access services in the UK or elsewhere in Europe, or access the abortion pills illegally.

Across the European Union, with the exceptions of Ireland and Malta, women have access to termination of pregnancy in cases of risk to the life or health of a woman, rape, fetal abnormality, and medical termination without restriction up to ten weeks. Beyond this minimum, countries have varying laws. If Ireland were to enact legislation in line with EU consensus, our law would be among the most conservative in Europe but would deal with the vast majority of circumstances in which women currently access services outside the State.

Ends.

