

Invited statement to the Joint Oireachtas Committee on the Eighth Amendment

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My name is Patricia Lohr. I am the Medical Director of the British Pregnancy Advisory Service or BPAS. I trained in Obstetrics and Gynaecology at the Harbor-UCLA Medical Center in Torrance, California completed a Fellowship in Family Planning and Contraception Research and a Masters Degree in Public Health at the University of Pittsburgh. I am a Fellow of the American College of Obstetrics and Gynecology and of the US Society of Family Planning. I have an Honorary Fellowship from the UK Faculty of Sexual and Reproductive Healthcare. During my career, I have focused on the delivery of evidence-based abortion care and family planning; developing protocols, training doctors and nurses, providing services, and conducting research. I am a member of the Royal College of Obstetricians and Gynaecologists (RCOG) Abortion Task Force for which I am currently working on post-graduate curriculum development and a pathway for the care of women needing abortions who are medically complex. I am a founding member and the Treasurer of the British Society of Abortion Care Providers which is a RCOG Specialist Society, and currently sit on the National Institute for Health and Care Excellence (NICE) Termination of Pregnancy guideline committee which has been tasked with development a new evidence-based guideline for England. I was a member of the development group who wrote the last RCOG guidance on abortion care and have contributed to other national and international guidelines on contraception.

BPAS is a charity which was established in 1968 to provide not-for-profit abortion care that the National Health Service (NHS), at the time, either could not or would not provide. Today, we provide contraception, pregnancy options counselling, abortion care, and miscarriage management from more than 40 centres across England, Wales and Scotland. As part of our charitable remit we also provide education on the causes and consequences of unwanted pregnancy – and our nurses visit schools and colleges to provide information about contraception and fertility to young people, to empower them with the knowledge to make their own reproductive decisions.

The majority of our services are provided under contract to the NHS, meaning the vast majority of women we see do not pay for their treatment. That now includes women from Northern Ireland, whose care is funded by the UK government and will be managed through a Central Booking Service. The remainder are fee paying patients who overwhelmingly come from the Republic of Ireland. We provide care at or below cost to women from Ireland in recognition of the financial challenges they have already faced in reaching the UK, and we have a policy of never turning any woman away based on her ability to pay.

While I am someone who believes strongly that abortion care is a fundamental part of women's reproductive healthcare, I am here today to provide you with factual information on the experience of Irish women who travel to the UK, how their abortion care is provided, and the limitations of the current framework for providing the highest standard of care. We have no financial interest in Ireland changing its laws, and will continue to provide not-for-profit services to Irish women if they cannot access abortion care at home.

In the UK – with the exception of Northern Ireland – women can access lawful abortion if they meet the terms of the 1967 Abortion Act, and two doctors agree in good faith she does

so. Any abortion outside of that framework falls under the 1861 Offences Against the Person Act and carries the threat of life in prison, both for the woman and those helping her. All abortions must be performed in NHS hospitals or specifically licensed premises such as those run by BPAS.

The majority of abortions are performed under Ground C – which stipulates that the pregnancy has not exceeded its twenty-fourth week and that the continuation 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. A smaller number are performed under Ground E - that if the pregnancy continued the baby would be born with a serious mental or physical disability.

The vast majority of abortions – 92% last year - were carried out at under 13 weeks' gestations, and 81% were carried out at under 10 weeks. This is in no small part due to the increasing availability of medical abortion, which can be offered at some of the earliest gestations. Medical abortion involves taking two medications, mifepristone and misoprostol, ideally 24-48 hours apart for maximum efficacy. Medical abortions account for more than 60% of the total number of abortion performed, although this method becomes less acceptable to women as gestation increases.

Small numbers of abortions are performed after 20 weeks' gestation, and account for around 1% of the total number of abortions performed. Some of these will be for reasons of foetal anomaly which are not detected until the 20 week scan. Others will involve late detection of pregnancy, sometimes as a result of contraceptive use which has disturbed bleeding patterns – so that a missed period is not interpreted as a potential marker of pregnancy. While teenage pregnancies have declined dramatically over the past decade, younger women with an unwanted pregnancy are more likely to need a later abortion. This may be because a pregnancy was not suspected, or because she has felt unable to confide in anyone about her circumstances.

Overall the picture of abortion within the UK is as follows:

- Abortion rate is stable (around 16 per 1,000 women)
- Largely unchanged since the late 1990s
- The age profile at which women have abortions is changing: the teenage pregnancy rate has decreased dramatically and more older women requesting abortion care. We see more women over the age of 35 than women under 20.
- It is estimated that 1 in 3 women will need an abortion in their lifetimes, and that 1 in 5 pregnancies end in abortion.

The abortion rate in England and Wales is similar to that in socially and economically comparable countries such as France and Sweden – that is to say the UK is not an outlier in regard to its abortion rate. There is, in any event, no evidence that laws influence the numbers of abortions: the respected Guttmacher Institute has shown that the rate of abortion in countries with highly restrictive abortion laws is comparable with that in countries with more liberal frameworks.

To address specifically the women from Ireland needing abortion care.

Last year 3,625 women were recorded in the annual abortion statistics produced by the Department of Health in England as having given an Irish address when they presented for treatment. Over the past 10 years, the number of women giving Irish addresses has fallen, from 4,600 in 2008. This decline may be underpinned by a number of factors, including: better access to contraceptive services, and emergency contraception, increased access to abortion medication, as well as raised awareness that free treatment can be obtained with a UK address. A paper in the British Journal of Obstetrics and Gynaecology published in July reported that between January 2010 and December 2015, 5,650 women from Ireland and Northern Ireland contacted one online provider alone to request medical termination of pregnancy.<sup>1</sup>

BPAS has been providing abortion care to women from Ireland since 1968. There is little difference between the reasons why women from Ireland present compared to those from the UK – they will be diverse and multi-faceted, involving financial hardship, knowledge that her family is complete, inadequate partner or family support, domestic violence, or simply feeling they are not in the position to care for a baby at that point in their lives. While some abortions take place of pregnancies that were planned and indeed wanted, such as those for foetal anomaly, the majority of the women we see were trying to avoid pregnancy when they conceived.

The majority of women who we treated from Ireland were using a form of contraception when they conceived. An analysis of 2,703 women from Ireland who were treated at BPAS over a 4-year period found the following:

- 3.1% IUC/implant/sterilization (n=84)
- 28.8% Injection/oral contraceptives/patch/ring (n=779)
- 47.6% Condom/diaphragm/Fertility-awareness based methods (n=1,286)
- 20.4% No method (n=554)

Of Irish women who receive abortion care in the UK, 70% are married or with a partner. Nearly half have already had at least one previous birth, i.e., are already mothers. All this is in keeping with information we have for women from the UK.

### **What is different for Irish women?**

As previously noted, medical abortion now accounts for the majority of early terminations in the UK. Many women prefer it as it is akin to a natural miscarriage, they can avoid an anaesthetic, and they can be at home when the pregnancy passes.

In contrast, the majority of early abortions provided for Irish women are performed surgically – 71%, compared to 28% for women resident in England and Wales. This is because for financial and practical reasons, many women travelling from Ireland often aim to fly in and out of the UK within a day, and as medical abortion involves leaving the clinic after taking the second set of medication and going home to pass the pregnancy, it is not clinically optimal for that to happen on the way to the airport or the flight home. Effectively this means that women from Ireland are in all practical senses denied a choice of method in abortion.

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<sup>1</sup> Aiken A, Gomperts R, Trussell J. Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis. BJOG. 2017 Jul;124(8):1208-1215.

Irish women also have abortions at slightly later gestations than women resident in England and Wales.

Residents of England and Wales:

Gestation (weeks) at abortion	Proportion
3-9	81
10-12	11
13-19	7
20 and over	2

Residents of Republic of Ireland:

Gestation (weeks) at abortion	Proportion
3-9	69
10-12	16
13-19	12
20 and over	3.2

Nearly a third of abortions (31%) for women from the Republic of Ireland are performed at 10 weeks and over, compared to 20% for women resident in England and Wales.

Abortion is an extremely safe procedure, but the earlier in pregnancy it can be performed the better for women's physical and mental wellbeing. Reasons for later presentation will include the time it takes to organise travel and make logistical arrangements, particularly for those with work and childcare commitments.

### Contraception care

All women who receive NHS-funded treatment at BPAS are also entitled to contraceptive counselling, can choose from the full range of methods available, and if they wish to, can leave with the method of their choice. Provision of contraception at the time of abortion has several advantages: the woman is known not to be pregnant, it confers immediate protection against pregnancy, and, with regard to implants and intrauterine contraception, increases the likelihood of receipt of the method compared to women who must return to undergo insertion at a later date.

Irish women who attend BPAS are also offered contraceptive counselling, and the overwhelming majority take that up. However, because of the costs associated with receiving their chosen method, as well as the logistics of integrating contraception care with travel, in our analysis only 31% chose to receive their preferred method from BPAS. This is compared to 85% of those who are funded.<sup>2</sup> This means that an important opportunity to enable women to make a choice about contraception and receive that method is lost. It is possible women do visit their GP or family planning clinic on return to Ireland and receive the method they have chosen, but we have no way of establishing this or following this up.

<sup>2</sup> Aiken A, Lohr PA, Aiken CE, Forsyth T, Trussell J. Contraceptive method preferences and provision after termination of pregnancy: a population-based analysis of women obtaining care with the British Pregnancy Advisory Service. BJOG. 2017 Apr;124(5):815-824.

## Post-abortion care

All women undergoing an abortion at BPAS have access to 24hour telephone support, and while follow-up appointments are only provided to those women who want them, all women know they can contact the clinic which treated them and return for a check-up or discuss any concerns at any time.

Women from the Republic of Ireland can access the telephone support line, but if they have any concerns that need in-person care will need to access local services, which can present its own problems in view of the stigma and secrecy that continues to surround travel for abortion.

Complications from abortion are uncommon and serious complications are rare. In its Best Practice Paper on Comprehensive Abortion Care<sup>3</sup>, the RCOG recommend that women are advised of the following:

- Risk of failure: 1-2/100 for medical and surgical abortion
- <2/100 surgical and 5/100 medical abortions are incomplete/need further intervention
- The following complications may occur
  - Bleeding needing transfusion: <1/1000 first trimester; ≈4/1000 >20 weeks
  - Uterine rupture with second-trimester medical abortion: <1/1000
  - For surgical abortions
    - Cervical trauma: ≤1/100; lower for first trimester abortions
    - Uterine perforation: 1-4/1000; lower for first trimester abortions
- Further treatment (e.g. blood transfusion, laparoscopy, laparotomy or hysterectomy) may be required, should one of these complications occur
- Upper genital tract infection of varying degrees of severity is unlikely, but may occur after medical or surgical abortion and is usually associated with pre-existing infection

In terms of the mental health impact of abortion, the risk of developing mental health problems is the same for a woman facing an unwanted pregnancy whether she has an abortion or goes to have the baby.<sup>4</sup>

While most women will not require further counselling, post-abortion counselling is available to all women who have had an abortion at BPAS, on the phone or in person. Needless to say for women from Ireland the option of in person counselling would be difficult, although this is available through some of the agencies in Ireland.

For women undergoing abortion for foetal anomaly – we can arrange the transport of foetal remains for autopsy. Women from Ireland must take the foetal remains home themselves, and find a carrier which will accept the remains on board. If they wish to have an autopsy or other testing, this would be self-funded.

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<sup>3</sup> Royal College of Obstetricians and Gynaecologists. Best practice in comprehensive abortion care Best Practice Paper No. 2 June 2015. Available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf>

<sup>4</sup> National Collaborating Centre for Mental Health. Induced abortion and mental health. A systematic review of the mental health impact of induced abortion. London: Academy of Medical Royal Colleges; 2011.

## **What can Ireland learn from the UK?**

If Ireland does overhaul its abortion laws, and it is certainly not for me to prejudge, it would do well to avoid some of the pitfalls and problems that the UK framework presents.

The 1967 Abortion Act was passed at a time when abortion was almost entirely surgical, and when all surgery was much riskier than it is today. Against that backdrop it is unsurprising that politicians stipulated that all procedures should be carried out in NHS hospitals or in specific premises licensed by the Secretary of State for Health, and that all such procedures should be performed by a doctor.

Few could have imagined in 1967 that early abortion could be safely provided using medication. Our laws have prevented the provision of early medical abortion in line with guidance from the World Health Organization, which recommends that women should be able to use misoprostol at home once lawfully prescribed. This means that women can time the passing of their pregnancy and do not have to risk bleeding or miscarriage on the way home, nor have to attend multiple appointments. I mentioned the numbers of women from Ireland using online abortion services – it may surprise you to know that women living in areas of the UK where funded, legal abortion is available are also turning online. Over a 4 month period alone, more than 500 women in England, Wales and Scotland requested help from Women on Web.<sup>5</sup> For some women, the multiple appointments – sometimes considerable distances from where they lived – were an absolute impediment to accessing lawful care.

Our laws have also prevented the full development of nurse and midwife led services that are now the standard in other areas of care like colposcopy. Nurses are lawfully able to provide surgical and medical miscarriage management – using the same techniques as an early termination – but are prohibited from providing that service to women needing an abortion.

In terms of premises, there is no reason why early abortion – whether by vacuum aspiration or pills – could not be safely provided from a GP surgery, but again our laws make that all but impossible.

Keeping abortion within the criminal law, as opposed to regulated by healthcare law like all other procedures can be hugely stigmatising. Canada and parts of Australia have opted for the decriminalisation of abortion, regulating it through healthcare law and professional standards. There is no evidence that abortion is more widely used or indeed more available as a result. You do not need a criminal law to impose a time limit for example, but keeping the procedure outwith the criminal law and the subject of professional guidance and healthcare regulation means that lawful abortion care can be provided in accordance with the highest clinical standards and best practice, not a rigid law that will only ever be a product of its time.

Ireland has the opportunity to create a humane abortion framework that is fit for the 21st century. I hope the information that I have provided is helpful for this discussion, and I would be glad to take questions.

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<sup>5</sup> Aiken ARA, Guthrie KA, Schellekens M, Trussell J, Gomperts R. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception*. 2017 Sep 20. pii: S0010-7824(17)30435-3.