The Joint Committee met at 1.30 p.m.

MEMBERS PRESENT:

Deputy James Browne,  
Deputy Lisa Chambers,  
Deputy Clare Daly,  
Deputy Bernard J. Durkan,  
Deputy Peter Fitzpatrick,  
Deputy Billy Kelleher,  
Deputy Mattie McGrath,  
Deputy Catherine Murphy,  
Deputy Hildegarde Naughton,  
Deputy Jonathan O’Brien,  
Deputy Kate O’Connell,  
Deputy Louise O’Reilly,  
Deputy Jan O’Sullivan,  
Deputy Anne Rabbitte,  
Deputy Brid Smith,  

Senator Jerry Buttner,  
Senator Paul Gavan,  
Senator Rónán Mullen,  
Senator Ned O’Sullivan,  
Senator Lynn Ruane.

SENATOR CATHERINE NOONE IN THE CHAIR.
Chairman: I would like to welcome Deputy Brid Smith as a new member of the committee. She replaces her party colleague Deputy Ruth Coppinger. I would like to acknowledge Deputy Coppinger’s work on the committee and thank her for her attendance here. She was a very attentive member. Welcome, Deputy Smith, and I look forward to working together.

Deputy Brid Smith: I thank the Chairman.

Chairman: We have received no apologies. The draft minutes for our meeting of 25 October have been circulated. Are they agreed? Agreed. There are no matters arising. We have received 12 items of correspondence, all of which are noted and some require follow-up from the committee. We will return to the correspondence from the Department of Education and Skills in module 3. Sorry, can we just have the one meeting here everybody, please.

On the letter from Renua, the committee has already decided to hear expert opinion rather than advocacy groups. Renua is a registered political party so I do not propose to invite it. Is that agreed?

Deputy Louise O’Reilly: Agreed.

Chairman: Agreed.

Deputy Mattie McGrath: On what grounds has the Chair made that decision?

Chairman: It is a political party as opposed to a group of expert witnesses. We applied that logic to all of the committee decisions. However, if the committee decides otherwise, there is always room for an exception.

Deputy Mattie McGrath: Did the Chairman mention advocacy groups?

Chairman: We decided at the beginning of our meetings that we would invite advocacy groups only in exceptional circumstances. We did hear from a few. Is there still something unclear?

Deputy Mattie McGrath: No. There is but point noted.

Chairman: That is fine. I thank the Deputy.

Deputy Catherine Murphy: I do not know what is being noted. There is a myriad of parties. If we are going to have political parties we are going to have all-comers.

Chairman: That is fine. I would like to say-----

Deputy Mattie McGrath: For my own information, what I am noting is that I do not expect advocacy groups, that is, those having no involvement with political parties, to be here.

Chairman: I am not hearing the Deputy fully.

Deputy Mattie McGrath: What is the issue? I raised a question about advocacy groups. Advocacy was mentioned.

Chairman: What I may have said is that we decided at the outset that we would have experts and, in limited circumstances, advocacy groups. I do not believe that Renua falls into
either of those categories. Unless it is an issue I will move on. I thank the Deputy.

I want to note that the committee on the Future of Mental Health Care is meeting today, which is not satisfactory because this committee is a short-term committee and a clash between those is not ideal. I note that two members, Deputy Browne and Deputy Rabbitte, will have to attend. Hopefully, they can return when it is over but that is completely understood. The clerk will speak to the powers that be about that not happening in future, especially with a committee that tends to change its meeting times. They should avoid this time of the week.

There is a letter from Dr. McCaffrey and from Both Lives Matter. They will be published on our website.

On the issue of witnesses generally, I want to reiterate the position of the committee. I have said this a number of times but I wish to do so again today. We agreed last July to hear from experts. In that regard we decided to look at the availability of witnesses who attended the Citizens’ Assembly and also that members would suggest individual experts or groups that they wish to hear from here. I have asked that we hear all opinion and I have written to members asking for suggestions so as to strike a balance. In the past week I have asked the clerk to make formal approaches to groups but the response has been along the lines of that contained in Dr. McCaffrey’s letter and from the letter from Both Lives Matter. Their response is that it is not worthwhile for those who advocate retention of the eighth amendment to come before the committee given the decision of the committee not to retain Article 40.3.3o of the Constitution in full. Also, sorry I am not-----

Senator Rónán Mullen: I would like to indicate interest and I would like to make a comment when the Chairman is ready.

Chairman: If the Senator will allow me to finish and indicate then.

Senator Rónán Mullen: The Chairman did not see me. Does the Chairman want me to pass up a note?

Chairman: I thank the Senator.

It has also been suggested that we have agreed that the eighth amendment should be repealed. That decision has not been made. We need to be very clear about the fact that the only decision that this committee has made is that Article 40.3.3o of the Constitution will not be retained in full. I do not accept that argument. For the purpose of our deliberations it is a pity that we have not heard legal and medical argument that would be different to what we have heard to date. That said, members have learned a huge amount from our interaction with witnesses and we will continue to do our work with a view to reporting to the Oireachtas by 20 December. The opportunity is still there to suggest particular witnesses to come before us but there is a struggle in getting certain sides of the argument to attend. That is regrettable.

Senator Rónán Mullen: I thank the Chairman. We appear to lack a procedure to allow an intervention at a relevant point because I merely sought and wish to know and request that the Chairman would read the letters into the record, the letters from Dr. McCaffrey and the letter from Both Lives Matter. I think it is as relevant to the work of this committee that people who were invited give their particular reason. The Chairman has given her own personal opinion as to whether a vote to recommend that the eighth amendment not be retained in full constitutes a decision in the matter and only by the most tortured twist of logic could one say that it is not a clear expression of intent from the committee. Given that is the Chairman’s particular point,
I think it is appropriate that she would read into the record, as she did with other letters from invited guests in the past, the explanations from Dr McCaffrey and Both Lives Matter.

**Chairman:** Before I turn to Deputy Durkan and Deputy McGrath, I think the distinction needs to be drawn between a witness who attends here and subsequently sends correspondence and somebody who has not attended. This exact procedure was adopted in the case of Professor Patricia Casey. Deputy McGrath wished for her letter to be read into the record. I did not read it into the record because she did not attend here. We could be reading letters into the record for expects for hours here in the committee but really they were invited to attend and should attend and I think that it proves that they should be here.

**Senator Rónán Mullen:** So may I clarify-----

**Chairman:** We will publish it on the website.

**Senator Rónán Mullen:** May I clarify that first, I think it is a matter for any invited guest to determine whether they should attend. The Chairman is now criticising their decision in their absence. That seems to me-----

**Chairman:** I am not. I was just saying that-----

**Senator Rónán Mullen:** The Chairman clearly is, if she is saying that they should attend. It seems to me that-----

**Chairman:** Can we have some order in the room please.

**Senator Rónán Mullen:** It seems to me all the more reason why one should read their view into the record. May I ask the Chairman about the decision regarding what may be read into the record and what may not? Please assist me. Is this laid out somewhere in procedures? Or is this the Chairman making a decision on the fly?

**Chairman:** No. It is a decision we made in the last number of weeks when certain letters were being sent into the committee. We receive a lot of correspondence. If we were to read all of that correspondence into the record I would spend a lot of my time in the Chair reading letters from-----

**Senator Rónán Mullen:** I think what is different here, Chairman, is that it goes to the credibility of the committee. The committee did, in my view, impugn its own credibility. The Chairman herself was interviewed on RTÉ about this. There is a clear question mark in the public mind as to why the committee did not wait to hear from all witnesses before moving ahead with a very substantial recommendation about what the future of Ireland’s abortion laws should be. Now-----

**Chairman:** That is a decision of the committee.

**Senator Rónán Mullen:** -----there is an issue with certain invited guests. It is interesting that people outside of the jurisdiction have noted this very irregular approach taken by the committee. It forms the basis for their refusal to come before the committee. On that basis I believe it is in the public interest, and in the interests of the credibility of this committee, that the invited guests, and as I understand it they were invited very belatedly, be given the courtesy of putting their explanation on to the record as opposed to just saying, as the Chairman did, that they should come before the committee.
Chairman: I want to come in on that. I understand Senator Mullen did propose this witness originally. There was no backing documentation as to why the travel was required, which necessitated a delay in that witness being invited to the committee. We have been making efforts for a number of weeks to assess if we could find a time that would suit him. Only last night we heard that he did not want to come at all. It is not as straightforward as the Senator has laid out.

Senator Rónán Mullen: I will wait for the Chairman to finish.

Chairman: I want to move on from this issue. I do not think it is helpful to the work of the committee to be having a conversation such as this. I note the Senator's comments.

Senator Rónán Mullen: There is more to it than that, with respect. I would submit that the explanation that the Chairman has just given is disingenuous. The Chairman is now saying that when a name was suggested originally, that the Chairman did not take it on. I have always stated at this committee that it is the Chairman's response, and the secretariat behind the Chairman, to propose a list that would test the issues fully. I have always made that very clear. The fact is that the Chairman did not do the necessary investigation and then after the event, after a decision has been made by the committee, an invitation was issued by the Chairman. I would say that it is at the minimum a courtesy and I would argue more than that. It is a matter of fair procedures that the Chairman would put the response on the record. The Chairman’s response just now was disingenuous.

With regard to the second organisation I referred to, the Chairman had already declined to bring it before the committee, as I understand it from correspondence with it. Then the Chairman and the secretariat appear to have changed their minds. It seems to me that different reasons are being offered for different courses of-----

Chairman: We can have a conversation about this another time. We have witnesses waiting. I am going through correspondence at the moment. I call on Deputy McGrath.

Deputy Mattie McGrath: I had indicated.

Chairman: Deputy Durkan indicated before Deputy McGrath. I have not got time to see who has indicated.

Deputy Bernard J. Durkan: I have a clear view, at least in my own humble way, of what this committee is about and what it is supposed to do. Our job is to assess the recommendations of the Citizens’ to double-check and test it as far as we can and to eventually prepare the situation whereby a referendum or referenda will be put to the people on the basis of which the people will be able to vote in the clear knowledge of what they are voting for. I have done my best to raise questions and I have done interviews on this question as well, and I strongly believe that it is our job to test and verify and to try to ascertain where the opinions have come from in so far as we can. I cannot do that unless witnesses present themselves before the committee.

I fully support the points made by Senator Mullen. Please bring the witnesses in before the committee and we can ask questions. Everyone is entitled to have their view heard. It does not matter what votes are taken in this committee. Ultimately, this is the people’s decision. It is not true to suggest, at all, that this is a foregone conclusion. It is far from that. What I strongly urge is this. I want to hear logical submissions from witnesses who have different points of view. I am not in favour of abortion but as I said before, I believe that we need to assess this situation in the light of various submissions that have been made. Let us hear all the submissions. To my mind it is a very serious flaw in what is happening if people do not come before the committee
even though they have a strong view. Let us hear that view and the detail behind it.

**Chairman:** I thank the Senator. I have a lot of people indicating. I am going to let Deputy McGrath in as he was just about to speak. Unless there is something different that people want to say, we have witnesses waiting outside, and I would ask members to be conscious of that.

**Deputy Mattie McGrath:** I thank the Chairman. I too believe that Professor McCaffrey’s letter should be read into the record. I ask this in regard to Professor Casey as well and also Both Lives Matter. I am proposing that they be read into the record. I want to make that proposal to the committee here today. I also take issue with the Chairman saying that it is a pity that we cannot get witnesses. We have to ask ourselves why. I have said the same privately and publically. The secretariat should have secured the attendance of the witnesses. We should not have been involved or asked to get any witnesses, any of us in this room. It is not up to us to get witnesses because we might be tainted one way or the other and everyone knows that.

(Interruptions).

**Deputy Mattie McGrath:** May I continue? I am making my point that I believe that it was the secretariat, with the Chairman, who should have secured the attendance of the witnesses. We are in a situation now that the Chairman has described as a pity. Why should we be surprised? We took a premature vote here and we did change the intent. I agree with Deputy Durkan. It will be the electorate that will make the final decision on this and it will not matter what will happen in committee. I describe it like a jury half way through a trial and the jury foreman approaches the chair and says we are going to give our opinion now, we have found him guilty or not guilty half way through the evidence. That is where we are. That is why we have not got witnesses attending. I believe that a person of that eminence that we have decided to invite should have his letter read into the record. I am proposing that.

**Chairman:** I am resisting the urge to come back in every time. I call on Deputy Smith.

**Deputy Bríd Smith:** I thank the Chairman. I want to make a point of order. The Chairman said at the beginning that we have two letters from people who have declined to appear as witnesses having been invited and that those letters will be published and available on the website. I believe that is sufficient instead of the Chairman being obliged to read a four and a half page reply into the record of this committee. The Chairman has stated, and I fully endorse her announcement, that these letters are available for anybody anywhere in the world to read on the website. We do not have to read every letter into the record of this committee.

**Chairman:** I thank the Deputy. Does anybody have anything different to say?

**Senator Lynn Ruane:** I think it is important to say that there is a very clear strategy in my eyes to undermine this process every step of the way. Pulling out of giving statements at this committee is part of that wider strategy to undermine the work that has been happening and to undermine the Chairman. Everyone was asked to submit recommended witnesses and if it was broken up proportionally, the people that are saying that it is biased submitted a certain number speakers. If that was divvied up around the room everyone got the same amount of speakers. It is a clear strategy every week and we are giving them time to rehearse it, which is eating into the time for the people who are here who are willing to give their time. I will be critical of the people who pulled out because there are people who agree with them who depended and wanted them here to hear their evidence. They are failing to provide that side of the argument. If they do not want to be here they should not be read into the record.
Chairman: I thank Senator Ruane. I call on Deputy Kelleher.

Deputy Billy Kelleher: I think the letter that was sent by Professor McCaffrey was factually incorrect. He said that in observing the proceedings he discovered that the Oireachtas on the 18 October has already taken a crucial vote to repeal the eighth amendment. We did not take a vote to repeal the eighth amendment. We actually took a vote that we would not retain the eighth amendment in full.

Chairman: That point has been made.

Deputy Billy Kelleher: At the end of the day it will not be this committee that will be repealing the eighth amendment, it will be the people.

Chairman: I want to move on, please.

Senator Rónán Mullen: On a point of order.

(Interjections).

Chairman: If it is a point of order.

Senator Rónán Mullen: Yes, it is a point of order. Deputy McGrath has made a proposal which I intend to second, which is that the-----

(Interjections).

Senator Rónán Mullen: Secondly, I feel very sorry for-----

(Interjections).

Chairman: Sorry, let the Senator have the floor please.

Senator Rónán Mullen: I feel sympathy for witnesses who are held up because important issues arise, but I also object to being jollied on on the basis that witnesses are waiting outside. When are these issues going to be ventilated? There has been a pattern at this committee of inviting guests in and then going on to make decisions, including one very big decision, to propose that the eighth amendment not be retained in full, before all the evidence was heard. That decision took place after the briefest discussion, or after practically no discussion. I was here. I have to ask you the question-----

(Interjections).

Senator Rónán Mullen: I have to ask the question-----

Chairman: Sorry-----

Senator Rónán Mullen: Is this committee willing to consider, in public session, the issues arising? For example, it occurs in both the Seanad and the Dáil that issues are brought forward on the Order of Business which may, if they are important enough, have the impact of changing that day’s Order of Business.

Chairman: I think we have-----

Senator Rónán Mullen: What is happening here is that you are jolliing on speakers as though the issues being raised are mere trivialities, which they are not.
Chairman: Sorry, that is your interpretation, Senator. I am not treating anything at this committee as trivial.

Senator Rónán Mullen: You are jollying on speakers. You are trying to close down discussion, Chair.

Chairman: I am not jollying on anything. Sorry, I am not having this conversation. If you would like to have this conversation, we will have it privately.

Senator Rónán Mullen: Chair, I have seconded Deputy McGrath’s proposal. I would be grateful if you would now deal with that matter.

Deputy Mattie McGrath: The proposal was that we read into the record-----

Chairman: Does the committee-----

Deputy Mattie McGrath: -----the letters from Professor McCaffrey and Both Lives Count.

Chairman: That is not a matter for the committee-----

Deputy Mattie McGrath: Why is it not a matter for the committee?

Chairman: I have ruled-----

Deputy Mattie McGrath: Sorry-----

Chairman: -----that this is the situation. I want to be very clear about this. We invited witnesses who we wanted to attend but who chose not to do so. I am not going to read letters from people who choose, regardless-----

Deputy Mattie McGrath: I have made a proposal.

Chairman: They could have told us the reason when they came. The letter has been published. It would be a poor precedent for a Chair of a committee of this House to read out letters from people who decide for whatever reason not to attend.

Deputy Mattie McGrath: I have made a proposal and I want to vote on it. I am calling a vote.

Chairman: As far as I am concerned, that is the end of the matter.

Deputy Mattie McGrath: Where has democracy gone?

Senator Rónán Mullen: It is fine for you to give your opinion on a point of order, Chair-----

Deputy Mattie McGrath: Where is the democracy?

Chairman: Sorry-----

Senator Rónán Mullen: -----but as I understand it, it is not a dictatorship here.

Deputy Mattie McGrath: How can you say, Chair, that we cannot have a vote? I am calling a vote. We invited this person-----

Chairman: This is the farthest thing from a-----
Chairman: I am sorry, Deputy McGrath, it is not possible to have a vote on this.

Deputy Mattie McGrath: Why not?

Chairman: It is a matter that I have decided as Chair.

Deputy Mattie McGrath: Where is the democracy?

Chairman: There is democracy here.

Deputy Mattie McGrath: I am proposing that we have a vote on it. I called the vote and it was seconded by Senator Mullen.

Chairman: Sorry-----

Senator Rónán Mullen: On a point of order, Chair, if your concern has to do with delaying witnesses, I would have no problem with a vote being taken after we have heard from the witnesses. It is not our desire to be discourteous to anybody.

(Interruptions).

Senator Rónán Mullen: It is certainly my desire to highlight major flaws-----

Chairman: Sorry-----

Senator Rónán Mullen: -----in the way this committee is doing its work.

Deputy Mattie McGrath: Can we have some respect shown by people in here who are clearly ignorant? Can we have some respect shown when we are speaking? To be scoffed at and hissed at is disgraceful. If we did it, we would be accused of bullying. It has been already said that we were bullying.

Chairman: I reiterate what I have said many times, that each speaker should be given time to speak. However, at the end of the day, we are trying to hear from witnesses and to discuss matters that are pertinent and important to the committee. We will come back to this issue after we hear from the witnesses and-----

Deputy Mattie McGrath: Can we decide now? I am calling a vote. I am happy to wait until afterwards. I do not want to delay them.

Chairman: You cannot call a vote.

(Interruptions).

Deputy Mattie McGrath: I have called for a vote.

Chairman: There is no question.

Deputy Mattie McGrath: Sorry?

(Interruptions).

Deputy Mattie McGrath: I am not in the habit of walking out.

Chairman: Can I have some order? Please, can I have some order in the room?
Deputy Mattie McGrath: You do not have it. We need respect, not order. Please, chair. I am calling a vote.

Chairman: You cannot.

Deputy Mattie McGrath: I do not mind if it is left until later. I am asking for a vote. You can call the vote. I am asking you, Chair. It was seconded. Can we have a vote on the issue?

Chairman: You are not entitled to call a vote on this at this point. That is just not the way things work in committee.

Deputy Mattie McGrath: Why not? It does in other committees.

Chairman: Deputy, I am saying that we will revisit this issue later in the day.

Deputy Mattie McGrath: I do not mind that at all. I have no problem with that. I am just asking that we have a vote later.

Chairman: We will decide on this issue later on.

Deputy Mattie McGrath: No, I want to decide it now.

Chairman: Members may be intent on discussing this issue for another half an hour or an hour but it is simply not possible to do so at this juncture. We have to show witnesses more courtesy. We will return to this issue later on, and that is where it is being left. I am going to suspend the meeting for a couple of minutes to allow witnesses to take their seats. We will then interact with witnesses as we do every week.

Sitting suspended at 2.04 p.m. and resumed at 2.07 p.m.

International Legal and Services Context: Dr. Gilda Sedgh, Guttmacher Institute and Ms Leah Hoctor, Center for Reproductive Rights

Chairman: I welcome members and viewers, who may be tuning into our proceedings on Oireachtas television, to the Joint Committee on the Eighth Amendment of the Constitution. We will be holding three separate sessions this afternoon. The first session will address international legal rights and services. Our second session will consider a view of medical law and our third session will look at risks to mental health. Before I introduce our first witnesses, at the request of the broadcasting and recording services, members and visitors in the Public Gallery are requested to turn off their telephones completely or put them in airplane mode. That really is an issue. The week before last there was an awful lot of interference, even on the RTÉ coverage. It is really important that mobile telephones are off, because it causes a lot of interference both for the staff working here and for the television studios.

On behalf of the committee, I would like to extend a warm welcome to the witnesses, Dr. Gilda Sedgh, principal research scientist with the Guttmacher Institute, Ms Leah Hocter, regional director for Europe, Center for Reproductive Rights, and Ms Katrine Thomasen, senior legal advisor for Europe, Center for Reproductive Rights. You are all very welcome to this afternoon’s meeting.

Unfortunately, before we commence formal proceedings, I must advise witnesses on the
Dr. Gilda Sedgh: Thank you for inviting me to give evidence to the joint committee. It is a privilege to be here. By way of introduction, and to add to the introduction the Chairman provided, I am a principal research scientist at the Guttmacher Institute in New York. We are a research and policy organisation and we conduct population-level research on reproductive health in the United States and globally. The Guttmacher Institute advocates for evidence-based policies that promote reproductive and sexual health. Our evidence is used by stakeholders on various sides of the discourse. I have been asked to present evidence on abortion trends worldwide and on the characteristics of women who have abortions. I will start by giving a global overview of abortion trends, which can provide some context for abortion incidents and trends in Europe. This evidence was published in *The Lancet* last year, and it is based on work that we did in collaboration with our colleagues at the World Health Organization.

We estimate that worldwide approximately 56 million abortions took place each year between 2010 to 2014. The annual number of abortions has increased slightly since the early 1990s. It can be more useful to talk about how many abortions take place for every 1,000 women of child-bearing age. This is because the absolute number of abortions can increase as the number of women in a population increases, but the number of abortions for every 1,000 women, also known as the abortion rate, is not influenced by the size of the population. The 56 million abortions that take place each year translate to about 35 abortions for every 1,000 women of reproductive age. Another way of saying this is that, roughly speaking, about 3.5% of women of child-bearing age have an abortion each year globally. The global abortion rate has declined slightly over the past 25 years.

We have also estimated abortion incidence across the 17 major subregions of the world. We were not able to estimate incidence for every individual country because we did not have enough data on which to base country estimates. I refer the trends in the abortion rate in major parts of the developed world, that is, Europe and North America. We can look at northern, western and southern Europe together because the abortion levels and trends in these three sub-regions are similar. The abortion rate is much lower in North America and in Europe, outside of eastern Europe, than the global average of 35 per 1,000 women. It is about 17 in North America and 21 in non-eastern Europe, and the rate has declined modestly in both of these regions in the past 25 years or so.

Eastern Europe is a different story. As members are probably aware, the abortion rate was very high in eastern Europe during the Soviet era. It declined dramatically in the past 25 years to less than half of what is was in the early 1990s. The abortion rates in northern, western and southern Europe are the lowest sub-regional abortion rates in the world, and the decline in east-
ern Europe is by far the sharpest decline that we have seen in the world.

While we were not able to estimate abortion incidence for all countries, we compiled statistics from countries with good reporting systems for the most recent year for which such evidence was available at the time of our compilation. I refer to the countries where it is recognised that at least 90% of all abortions are included in the official reports. Across these 18 countries, almost all of which are all in Europe, the abortion rate varies from five per 1,000 in Switzerland to 18 per 1,000 in Sweden. In eight of these 18 countries, the abortion rate is fewer than ten per 1,000. Globally, when we grouped countries according to their abortion laws, we found that, on average, the abortion rate in countries where the procedure is prohibited altogether or allowed only to save a woman’s life is not significantly different from the rate in countries where abortion is allowed without restriction as to reason. The vertical lines around the points indicate the margins of error around these estimates and members can see they all overlap. This is a bird’s eye view of abortion rates in these groups of countries and it does not examine the various factors that could influence abortion rates in these countries.

We were also able to estimate the percent of all abortions that were obtained by married women and the percent obtained by unmarried women. We used data from the United Nations, which defines married women to include women in cohabiting unions. We estimate that about 73% of all abortions worldwide are obtained by married women, and 27% are obtained by unmarried women. In the developed world, about 69% of all abortions are obtained by married women. These are estimates across broad geographic areas, and there are variations across countries within each of these groups of countries.

I showed abortion rates in countries grouped by the legal status of abortion. Last month we published estimates of the safety of abortions performed worldwide, and in groups of countries classified according to their abortion laws. These estimates were also made with colleagues from the World Health Organization, and are also published in The Lancet.

As defined by the World Health Organization, safe abortions are those done by a trained provider or a trained person and using methods appropriate to the gestational age of the pregnancy. Less safe abortions are those for which only one of these criteria is met, and least safe abortions are those for which neither of these two criteria are met. About 31% of abortions are in the least safe category in countries where abortion is illegal on all grounds or only allowed to save a woman’s life or preserve her physical health. Less than 1% of abortions are in the least safe category in countries where abortion is permitted without restriction as to reason. We also found that abortions are also more likely to be unsafe in low income countries than in high income countries, based on the World Bank classification of countries. Countries with restrictive abortion laws tend to be low-income countries, and Ireland is anomalous as a high-income country with a restrictive abortion law, so it is not easy to assess the relationships of economic development and legal status with the safety of abortion.

We did not have enough information with which to estimate the ages of women obtaining abortions across the world’s sub-regions. Instead we compiled statistics from the countries with good quality reporting. These are countries with liberal abortion laws where at least 90% of abortions are included in the reporting systems. Across the countries with this information, about half of abortions are obtained by women in their 20s, and another third are obtained by women in their 30s. Across all these countries, adolescents of 19 years old or younger, predominantly adolescents of 15 to 19 years old, account for a smaller share of abortions than their share of the population - that is, the abortion rate is lower among adolescents than among women in their 20s and 30s. In almost all these countries, adolescents’ share of all abortions
has decreased since the early 1990s. In the countries that further break down the ages of women having abortions into smaller windows, the majority of adolescents’ abortions are obtained by 18 and 19 year olds.

According to the statistics we compiled from 15 countries, 48% to 74% of women who obtained an abortion already had at least one child. In all but two of these countries, more than half of women obtaining an abortion already had at least one child.

We are currently preparing a report on the gestational ages of pregnancies when they are terminated across countries that have reliable statistics. I refer to abortions done in the first trimester of pregnancy. According to these preliminary findings, in all but three of these countries, 90% or more of abortions are obtained in the first trimester.

For four countries we have information from nationally representative surveys of women on the reasons for wanting an abortion, among those who have had an abortion. Women obtain abortions for a wide variety of reasons. In these surveys women were asked to give just their primary reason for having an abortion. For example, in Belgium, about one fourth of women said they sought an abortion for socioeconomic reasons, and another one fourth had an abortion for partner-related reasons - for example, their partner did not want to have a child or their relationship was dissolving. Approximately 18% wanted to space their children or postpone having a child, and another 13% already had as many children as they wanted or could manage. Approximately 1% of women in Belgium said that they were having an abortion because of issues related to the health of the foetus. In the other three countries, less than 1% of all abortions were for reasons related to foetal health.

In a survey in the United States, women who had an abortion were asked to indicate all their reasons for having the abortion. An interesting take-away message from this survey is that many women gave more than one reason. Financial issues, wanting to space or delay childbearing and partner-related issues remained common. Approximately 30% of women said they sought an abortion because they needed to focus on the children that they already had at home.

I will shift gears and wrap up by giving a broad overview of abortion laws of countries across the world. Ms Leah Hoctor will go into more detail on this topic. Of the 199 countries and major territories in the world, 75 allow abortion without restriction as to reason or for socioeconomic reasons; 58 countries and territories allow abortion to preserve a woman’s physical or mental health; and 40 allow abortion to save a woman’s life. Ireland is one of these 40 countries. In 26 countries, abortion is not allowed for any reason, although some of these make exceptions in cases of rape, incest or foetal anomaly.

Using the UN’s classification of countries according to whether they are developed or developing, 41 of the 50 developed countries allow abortion without restriction as to reason or for socioeconomic reasons, five allow abortion to preserve a woman’s physical or mental health, one – Ireland – allows abortion to save a woman’s life, and three do not allow abortion on any ground.

I will end by summarising some of the key points from the review. The sub-regions with the lowest abortion rates are those in which most countries are developed, where abortion is legal on broad grounds and there are strong reproductive health programmes. Women obtaining abortions represent a broad spectrum of all women - young and old, single and married, childless and with children - and many who seek an abortion have multiple reasons for doing so.
Chairman: I thank Dr. Sedgh. I call Ms Hoctor.

Ms Leah Hoctor: I thank the Chairman for her introduction and the committee for its invitation to present today. Receiving this request was an honour. My purpose will be to provide members with an overview of comparative European law on the termination of pregnancy. To that end, I will describe the grounds and timeframes on which abortion is legal in 46 other European countries. I hope that this information will assist the important and valuable deliberations that the committee is conducting on behalf of the citizens of Ireland, among whom I am proud to belong, in case my accent has not given it away.

Before I turn to the substance of European laws on abortion, it might be helpful to clarify certain matters regarding the Center for Reproductive Rights as it relates to Ireland. As time is short, I will also refer members to the centre’s website. The mandate of the Center for Reproductive Rights is well known. We work across the world, specifically in Africa, Asia, Europe, Latin America and the US, to advance the legal protection of women’s reproductive health and rights. This means that the centre uses law to advance women’s access to reproductive health care, including affordable contraception and family planning, safe and legal abortions and quality maternal health care. We also work to prevent child marriage and forced sterilisation.

As many committee members will know, the centre’s work in Ireland has focused on representing Ms Amanda Mellet and Ms Siobhán Whelan in their complaints to the United Nations Human Rights Committee, OHCHR, and in all advocacy, governmental, media and political engagement related to those cases and the OHCHR’s decisions on same. Both decisions held that Ireland was obliged under international treaties to provide effective remedies to Ms Mellet and Ms Whelan. The decisions specify that these remedies must entail compensation, psychological support services and reform of Irish abortion law in order to prevent similar violations in the future.

As the representative of Ms Mellet and Ms Whelan, the centre must call and advocate for Ireland’s compliance with the OHCHR’s decisions and the Government’s provision of the specified remedies. All advocacy, political or governmental engagement by the centre in Ireland has been undertaken in the context of these two cases. The centre’s general fundraising for its work in Europe includes Ireland in terms of support for its work on the OHCHR cases and its advocacy to ensure the required law reforms. The centre is not providing any funding to Irish organisations for campaigning or political activities. In addition to our work representing Ms Mellet and Ms Whelan, the centre has contributed modest amounts to the National Women’s Council of Ireland, NWCI, and the Irish Family Planning Association, IFPA, to support expert events for lawyers and medical practitioners regarding international human rights law and World Health Organization, WHO, guidelines on safe and legal abortion, as well as events to provide women and men a diversity of views and an opportunity to engage in non-directive discussions about abortion.

Turning to the substance of my presentation, my goal will be to provide members with a quick overview of the laws on abortion in 46 other European countries. In particular, I will aim to outline the standard approach among most European countries to the legality of abortion. To assist with this, I will take us through eight slides. To supplement that information, we have provided a large chart to all members - there are hard copies in the room - illustrating the grounds and some of the timeframes on which abortion is legal in each of the 46. All this information is taken from primary legal sources, which can be independently verified. We have also submitted a booklet to members, containing copies of many or most of the relevant legal provisions. We have brought some hard copies as well.
As members will see from the slides and supplementary materials, the Citizens’ Assembly recommendations on the full set of reasons and timeframes within which abortion should be made lawful in Ireland align almost in their entirety with the laws on abortion in almost all other European countries. As a result, if the recommendations on future legislation were adopted, it is safe to say that they would bring Irish law on abortion into line with the laws of almost all other European countries.

Regarding the standard legal approach to abortion across Europe, the first slide shows a map of Europe. Almost every European country - 40 in total - is coloured either green or light yellow. This means that they have made abortion legal either on a woman’s request without restriction as to reason or for reasons of distress - those are the ones in green - or on broad socioeconomic or psychological grounds. The countries in red or dark orange do not allow abortion on request or on broad socioeconomic grounds and only in exceptional circumstances.

This map shows that 25 of 28 EU member states have made it lawful for women to access abortion on their request or on broad socioeconomic grounds, at least in early pregnancy. It also shows that 40 of 47 Council of Europe member states have taken this approach. As the committee members will know, all 28 EU member states are also members of the Council of Europe. Only three EU member states do not allow abortion on a woman’s request or on broad socioeconomic or psychological grounds. These are Ireland, Malta and Poland. Within the 47 Council of Europe member states, these three EU countries are joined by only four micro-state jurisdictions - Andorra, Liechtenstein, Monaco and San Marino.

The next few slides will focus on the approach of the countries in green and light yellow. As we can see from the map, 36 countries have legalised access to abortion on a woman’s request. The following slide shows a quick recap of these countries. In the majority, a woman does not need to give any reason when asking for an abortion. In a small number, as shown in the next slide, a woman must explain that she is seeking an abortion because of social or family circumstances or because continuing the pregnancy would cause her distress. The committee can see the breakdown across countries.

What about gestational limits? All these European countries impose a time limit on the legality of an abortion on a woman’s request. We can see their time limits on this slide. A time limit in or around early pregnancy is the norm, with a 12 week limit the most common. In addition to the 36 countries that are green on the map and that have legalised access to abortion on a woman’s request, four European countries are light yellow on the map and these four have taken a different approach. They have not legalised abortion on a woman’s request but on broad socioeconomic or psychological grounds. In these four countries, for abortion to be lawful doctors or sometimes social workers must certify the existence of the relevant socioeconomic or psychological reason. The slide on display right now shows the four countries, the different reasons and the time limits involved.

What happens in these 40 countries once the time period for abortion on a woman’s request or on broad socioeconomic or psychological grounds ends? In almost all of them, after the time period ends, doctors can still legally perform abortions for one or more exceptional reasons. The next slide shows the usual reasons that are allowed under the laws of almost all European countries. Sexual assault and socioeconomic reasons are present in the laws of many countries as exceptional reasons but not always explicitly. The terminology and the approach differs across countries. In some of these countries, these exceptional reasons are each articulated as an explicit ground in the relevant law while in others, the grounds are implicitly included in other grounds. We do not have time to go through all of these grounds now but will focus
briefly on women’s health and on sexual assault. All of the grounds are listed in the chart that we submitted to all committee members, with a breakdown across the various countries.

In terms of women’s health, I wanted to capture for the committee the fact that although legal terminology differs across countries, in almost all of the 40 countries we have looked at the laws explicitly or implicitly allow abortion when a woman’s health is at risk. As members will see from the slide on display, the majority of these laws do not specify a time limit for this ground.

Finally, what is the approach across the 40 countries to the legality of abortion following situations of sexual assault? First, it is important to note that in all of the 36 countries where abortion is legal on a woman’s request, women who are pregnant as a result of rape or incest can always access abortion within the relevant time limit under the on-request ground. In these countries, women who have survived sexual assault can follow a generally applicable process to obtain a lawful abortion and do not have to fulfil special procedures or report the rape. For this reason, many of these countries do not include an explicit ground for abortion in their laws. At the same time, about half of these countries do have an explicit ground for sexual assault in their abortion laws and this means that women who are pregnant as a result of rape can either access abortion in early pregnancy under the on-request ground or, often later in pregnancy, under an explicit, separate ground related to sexual assault.

I thank members for their attention. I hope this overview has been helpful and informative and I look forward to members’ questions.

Chairman: Thank you, Ms Hoctor. Is Ms Thomasen going to make a presentation?

Ms Katrine Thomasen: No.

Chairman: Fine. We will now move to the lead questioners for today, the first of whom is Senator Ruane, who has ten minutes in total.

Senator Lynn Ruane: I will use five minutes now and reserve five for later. I thank the witnesses for their presentations, which were very informative. I have two questions for Ms Hoctor and one for Dr. Sedgh.

An issue of which we are aware is the difference between making abortion procedures nominally legal in State laws and ensuring practical and real access to abortion services for women. What are the common challenges that emerge in this respect and what should Ireland do to ensure practical access to abortion if we decide to change our laws, based on the experience of other countries? In our last meeting we heard detailed evidence on the issue of abortion in cases of rape and sexual assault, an issue that Ms Hoctor also touched on in her presentation. In the 21 countries she mentioned that have an explicit sexual assault ground for abortion, what types of verification processes exist to determine if the ground is met? What is her opinion of how they operate in practice and their impact on the women involved?

My next question is for Dr. Sedgh and I hope I am pronouncing her name correctly.

Dr. Gilda Sedgh: Yes, Sedgh is right.

Senator Lynn Ruane: Has any research been done on the impact of broad socio-cultural views on the acceptability or stigma surrounding abortion within a state on abortion rates or abortion access? I am a little concerned that after a potentially divisive referendum campaign
the stigma surrounding abortion could become a practical barrier to access. Has this issue arisen in any other countries and what is its impact?

Chairman: I will ask Ms Hoctor to respond first. While I do not want to put witnesses under pressure to answer, I must point out that we are under quite tight time constraints.

Ms Leah Hoctor: In the brief time available we can identify three factors which explain why - in some cases - laws that have allowed abortion, either on broad grounds or on very limited grounds, may not enable access in practice. Affordability and how abortion services are being covered by public health insurance or integrated into the subsidisation schemes of health systems is one factor that can impact access, even where abortion may be legal. Often in countries that have not legalised abortion on request or on socioeconomic grounds, the certification processes that must be followed to obtain access on a health ground or in situations of foetal impairment or rape, for example, can be onerous. These processes can often involve multiple levels that a woman must go through or multiple doctors and social workers being involved in certifying the existence of the reason. We see other barriers in some countries which can relate to waiting periods, for example, or mandatory and sometimes biased counselling requirements.

In the European countries that were green and light yellow on the map, while it is not true to say that there are not sometimes problems for women in accessing a legal abortion, in general these countries have taken an approach in their laws which enables women to access services early in pregnancy at least. That often means that some of these barriers create fewer problems. In terms of sexual assault, which I tried to address in my presentation, all of the 36 countries in Europe that have legalised abortion on a woman’s request, mainly in early pregnancy, thereby allow women who have survived an experience of sexual assault to access abortion in early pregnancy through that ground. In that context, many women across Europe who have faced sexual assault and who then choose to have an abortion do so under the on-request ground. Many of those countries in Europe that have explicit sexual assault grounds in their laws include a particular certification process. The most common process is that a committee or a number of doctors and social workers must look at the case and agree that the reason exists and that there is evidence of a sexual assault. Some countries require a prosecutor or police certificate and speak to the need for clear evidence or sometimes for a criminal legal procedure to be initiated. Only one country refers to a process before a court in the case of sexual assault. It is very important to understand that 40 countries out of 47 in Europe allow access, in a general sense, on request for socioeconomic grounds in early pregnancy. It is probably in that way that women access abortion in situations of rape.

Chairman: We will move on to Dr. Sedgh now.

Dr. Gilda Sedgh: The Senator’s question was whether stigma around abortion can prevent women from having access to abortion services even when the law is changed to expand the grounds for legal abortion. Do I understand the question correctly?

Senator Lynn Ruane: Yes.

Dr. Gilda Sedgh: The presence or prevalence of stigma tends to be aligned with the presence of restrictive abortion laws so we cannot fully disentangle the roles of the two. There are some countries where abortion is legal on broad grounds but still stigmatised, including Italy, for example. In other countries, like South Africa for example, the grounds for legal abortion have been expanded but it is still stigmatised. Stigma has prevented women from having access to abortion services where providers are allowed to invoke conscientious objection and mecha-
isms are not put in place to ensure women nevertheless have access to alternative sources of care. A literature review has brought together 14 studies of the effects of stigma on women who have had an abortion, which is not to say it has prevented them from seeking an abortion. Some of the summary findings of the review are that women who have abortions in these settings feel socially isolated, are afraid their loved ones will find out they had an abortion and suffer stress for these reasons.

**Chairman:** I call Deputy Kelleher who has ten minutes. Members may contribute twice for five minutes each time.

**Deputy Billy Kelleher:** I may not need five minutes as some of the questions I intended asking have already been answered.

On fatal foetal impairment and time or gestational limits, the committee heard evidence from obstetricians and gynaecologists that an anomaly scan will normally be carried out at between ten and 12 weeks into a pregnancy and one must wait until between 22 and 24 weeks of a pregnancy to obtain definitive diagnostic results. Ms Hoctor referred to a number of countries in Europe. Do these countries apply time limits in cases of fatal foetal impairment and, if so, how do these work in the context of diagnostic difficulties? I ask Ms Hoctor to elaborate on that issue.

When one goes beyond Europe, I assume in countries such as Gabon terminations are not carried out in cases of fatal foetal impairment because anomaly scanning services and knowledge of the impairment of the foetus are poor. I assume the absence of information on these matters, as opposed to cultural or other reasons, is the reason for not carrying out abortions. I ask Ms Hoctor to clarify that matter.

On the issue of culture, is there any evidence of partners or fathers forcing women to have a termination against their wishes? Has any research been done on that issue in the context of cultural differences across the globe to identify whether women are vulnerable to this potential threat of having a termination against their wishes?

I am interested in an issue on which the witnesses may have some observations to make. While terminations are carried out in Finland for various reasons, in one particular area the father may be given an opportunity to present his views prior to the decision to terminate the pregnancy being made, albeit only if there are special reasons that warrant doing so. I am not sure if the witnesses are aware of the specific circumstances but perhaps they could clarify or expand on what is meant by this aspect of Finnish law.

**Ms Leah Hoctor:** On the Deputy’s first question regarding timeframes and foetal impairments, specifically fatal foetal impairments, the basic point to make is that while some European countries impose time limits, the majority do not. Some European countries do not distinguish in law between fatal and severe foetal impairments and will have a general ground for severe foetal impairment within which fatal foetal impairment would come. Some countries distinguish between the two, however, and will have a specific reference to severe impairment and another reference to fatal impairment. Some of these countries will impose a limit for severe foetal impairments but no limit for fatal impairments. However, the majority of European countries do not impose limits in the case of a severe or fatal foetal impairment. I believe the vast majority of them do not do so when the impairment is fatal. In all of these countries, a detailed certification process is involved whereby doctors confirm the existence and nature of the impairment. Where countries set out timeframes, these often fall at around 24 weeks, with
some a little earlier, perhaps 20 or 22 weeks. The most common practice, as I stated, is not to
distinguish between severe and fatal, and where a distinction is made, there is often no limit for
the fatal impairment.

Dr. Gilda Sedgh: I might add that in the evidence that I presented and also in evidence in
the paper, which goes beyond what I presented, on reasons women have abortions, including in
countries where testing and diagnostic services are available, for example, Belgium, the United
States, Sweden and a couple of other European countries which I will not attempt to list as I do
not wish to identify them incorrectly, fewer than 5% of women who have an abortion indicate
that fatal foetal impairment is the reason they are having an abortion. It is still not one of the
more common reasons, even where the necessary services are available.

With respect to men forcing their partners to have abortions, I am not aware of any kind of
systematic or large-scale evidence to that effect. I imagine that anecdotal evidence along those
lines exists but I cannot speak to it.

Ms Leah Docter: On the issue of men - the father or partner - being involved in decision-
making, I believe, although I could be wrong, that Turkey is the only country of the 47 Council
of Europe member states which has a spousal consent requirement for a married woman. No
other European country has any kind of provision along those lines. Finland has the provision
to which the Deputy referred and a few other European countries also indicate in their laws
that, if possible, the father - the woman’s partner - should be involved in the decision-making
process. However, my understanding is that a degree of discretion applies and it is always con-
sidered appropriate that the woman’s decision-making and her perspective be front and centre,
while her partner or husband, if he is accompanying her, may be involved. I believe Finland
may be unique in specifying that a man may have a possibility of having his voice heard. That
provision is more unusual. It is rare for the law of a country to include a reference to the views
of the partner or husband being taken into account, where possible. In some cases, the partner
or husband may be asked to attend the consultation with the relevant physician or clinician, if
possible.

Deputy Billy Kelleher: Does that happen in practice? From this side of the table, I expect
this would be very complex for many different reasons. For example, the male parent may not
necessarily be the partner, which would give rise to complexities. The whole issue of domestic
violence also arises. Does this happen in practice in certain countries?

Ms Leah Docter: Is the Deputy referring to European countries?

Deputy Billy Kelleher: Yes

Ms Leah Docter: No, I do not believe so. I believe these laws are meant to deal with
circumstances in which a woman wants her husband or partner to be involved with her in the
decision-making process. I do not believe these provisions are intended as a means of dealing
with a conflict in views or surrounding decisions. In almost all of the 40 European countries
we examined, with the exception of Turkey, the laws which allow access on request or on socio-
economic grounds prioritise the woman’s wishes and decision-making and those of the doctor
working with her. There is also the right or ability of the woman to have her partner or husband
involved in that process with her.

Chairman: Senator Mullen has ten minutes to make his contribution.

Senator Rónán Mullen: With the Chairman’s permission, I will ask one short question, to
which I hope to receive a short answer, and use the rest of my time later.

Chairman: That is not a problem.

Senator Rónán Mullen: Ms Hoctor is probably aware that advocacy groups were not supposed to appear before the committee. While I do not know if she was aware of that, I will draw attention to an email from the Center for Reproductive Rights dated 28 September which reached my inbox-----

Chairman: I do not wish to interrupt but a telephone is ringing and causing interference with the sound system.

Senator Rónán Mullen: I am reading from my phone, perhaps I should have it on airplane mode. Apologies Chairman.

Chairman: I am alerting the Senator to the interference for his own sake.

Senator Rónán Mullen: I appreciate that. The joys of modern technology; let me see if we can have a quick recovery.

The advertisement reads:

Harsh abortion laws put women at risk and deny them their fundamental rights. We are fighting back [and then there are maps of five countries, Ireland, Kenya, India, El Salvador and Nepal and around the world]. We will not stop until every woman has access to safe and legal abortion. Your support is essential to our fight for reproductive rights. Chip in now.

When you click you get the opportunity to contribute dollars. I also notice in the script that Ms Hoctor is upfront about her involvement in advocacy and political engagement in cases and decisions. The cases are mentioned and she also mentions donating to the Irish Family Planning Association.

I take it that Ms Hoctor would accept that she is a member of an advocacy group, par excellence, that advocates for abortion on fairly unrestricted grounds. In the light of that was Ms Hoctor surprised to receive an invitation from this committee?

Ms Leah Hoctor: As I made very clear in my opening remarks and as is very clear from the centre’s website, the centre works to advocate for women’s access to reproductive health care and reproductive rights and this includes access to safe and legal abortion care. The centre’s work on the human rights committee cases means that the centre is obliged as the representative of Amanda Mellett and Siobhan Whelan, to advocate for the remedies which include law reform to be fulfilled by the Irish State. Any fundraising that the centre does for Europe for its work on Ireland has been for the cases. There is a line in the email that refers to the fact that the centre uses legal action in its work to advance women’s reproductive health and rights. I was very honoured to be invited by the committee to present to it.

Senator Rónán Mullen: I asked Ms Hoctor if she was surprised to receive an invitation from the Oireachtas?

Ms Leah Hoctor: I think the centre’s work in Ireland, representing Amanda Mellett and Siobhan Whelan, meant that I was not surprised. I think we also have very deep expertise in the area of European comparative law, as I have just presented; the evidence that I have provided is evidence based.
Senator Rónán Mullen: Notwithstanding the prohibition on advocacy groups.

Chairman: That is a matter for the committee, Senator. In fairness to the witnesses-----

Senator Rónán Mullen: Thank you Chairman. I thought we had done with the Chairman cutting in on people’s questioning. That concludes my question and I thank the witness for her reply.

Chairman: I do not interrupt, I am just making a ruling. Deputy Hildegarde Naughton has ten minutes

Deputy Hildegarde Naughton: I thank the witnesses for coming before the committee this afternoon. I wish to address a few questions to Dr. Sedgh in respect of slide 6. Will she clarify whether she is saying that in countries where abortion is freely available, the abortion rate is similar to countries where it is very restricted or not available at all and will she expand on that? I wish to ask Dr. Sedgh about her figures on the gestation duration of pregnancies where they are terminated. She states that 90% of abortions are obtained in the first trimester; does she have any detail on the reasons for the other 10% of abortions? Is there any reason to think that the reasons for women having abortions as outlined in slide 12, would be replicated here? The figures show that roughly 25% of abortions were for socio-economic reasons; 25% for partner-related reasons; about 18% in order to space their children; 13% for reasons for having as many children as they wanted; and 1% related to health of the foetus. Dr. Sedgh may not be able to give exact feedback but perhaps she has a viewpoint on it.

Would Ms Hoctor speak about her opinion on the so-called floodgates argument? Should access to abortion be broadened after the referendum in this country? Is there experience in other countries of a floodgate opening once abortion is allowed on demand? Ms Hoctor responded to a colleague’s question on this but where there are restrictions on abortion inserted in the Constitution in other countries, how did that affect the policy and practice in those countries and how it impacts on women and on the medical profession?

Chairman: We will start with Dr. Sedgh.

Dr. Gilda Sedgh: I was asked to expand on the slide, on the finding that abortion rates on average are similar in countries whether there are strict or liberal abortion laws. Let me make a couple of points. Within each of these groups of countries there is a wide variation in the abortion rates and these figures are averages. We do not see a strong relationship in an univariate correlation between laws and incidence. We do see a strong relationship between contraceptive prevalence and the abortion rate. We see it more clearly when we look at the proportion of women with an unmet need for contraception and the abortion rate. One would then see a much stronger relationship, if that is what we were looking at in this slide, rather than the abortion laws.

Deputy Naughton asked about late term abortions. Among the small proportion of women who do have late term abortions the reasons for late term abortions are where we will tend to see abortions for reasons that have to do with risks, to foetal health and to foetal life. Adolescents comprise a larger share of late term abortion than early term abortions and it suggests that it is restrictions or barriers to accessing abortion that causes some women to obtain their abortions later. Young women might not know they are pregnant, might be afraid to tell somebody they are pregnant and thereby also admit they have had sex, or they do not know where to go and who to ask. In countries with restrictive abortion laws, some slightly larger proportion of abor-
tions are done later in pregnancy compared to countries where abortion is allowed on broad grounds, so that is another indication that access to legal abortion that can drive the proportions of abortions that are done late.

If it okay-----

Deputy Jonathan O’Brien: Chairman, may I ask Dr. Sedgh to repeat the point on late abortions?

Dr. Gilda Sedgh: Where access to legal abortion is more restricted, one will see more abortions being done later in pregnancy because of the delays in the person figuring out where to go, admitting that one needs to go somewhere and so on.

Deputy Hildegarde Naughton: May I ask about the relationship between abortion and the availability of contraception?

Dr. Gilda Sedgh: A big determinant of the level of abortion in a country is the proportion of women who need but are not using a method of contraception, whether that be because they do not have access to or actually more often because they face other barriers to choosing a method of contraception. They need options and choices so that they can choose and not just have one method made available to them. They need counselling to help them navigate the side effects that accompany these methods. They think they can avoid getting pregnant because they think they are not having sex as often as other couples so they are operating under this misconception that they are not at risk of getting pregnant. These are some of the reasons that come up very often, both in developed and developing countries.

Deputy Billy Kelleher took the Chair.

Deputy Hildegarde Naughton: Could Dr. Sedgh round that off by saying that sex education and knowledge about contraception is a part of that whole issue?

Dr. Gilda Sedgh: One of the pathways to reducing the level of unmet need for contraception is providing comprehensive sexuality education and improving not just the existence but the quality of services that are available. I may help Ms Hoctor answer a question that I think might be more in the Guttmacher Institute’s area.

Deputy Naughton asked about the floodgates. We have tried to look at trends in abortion incidence before and after a large change. That is one aspect of the question. We are not able to do that very well because where abortion is illegal we often do not have a good fix on the number of abortions that are happening and then when abortion becomes legal, the number of abortions that are on the official record begin to increase, but we do not know to what extent that represents a shift from abortions that had been clandestine to abortions that are now not more common but more on the record. That will be the case in Ireland where we have accounts of women having abortions in England, Wales and in the Netherlands and some obtaining from Women on Web, but we do not fully know how many abortions are happening now.

Ms Leah Hoctor: Let me follow on from that point. We saw from Dr. Sedgh’s slides as well that some of the lowest rates of abortion in the world are in the western European countries that we looked at in our map that would have access to abortion on request. I am living in Switzerland at present and that was the country with the lowest incidence of abortion on the slide. What we can see from those data is that there is no correlation between the availability of abortion on request, in early pregnancy, for example, in the law, and a higher rate of abortion.
In fact, WHO evidence indicates that once the law is changed, unsafe abortions then become safe. In the Irish context, this would mean women who are travelling outside the State for abortion care would, in most cases, no longer do so, and women who take an abortion pill in a clandestine manner would be within the law. Abortions had by Irish women outside the State would happen here.

I was asked about constitutions. The Irish approach, involving the regulation of abortion starting with a constitutional provision, is very rare across the world. In Europe, there is, I believe, only one other country in this category, Andorra. I do not have exact numbers but I believe Andorra has a complete ban on abortion. That protects the right to life before birth. It applies prenatally. Beyond Ireland and Andorra, it is virtually unheard of in Europe to include abortion within a constitutional provision. Some countries in Latin America, such as Chile and Honduras, and in Africa have constitutional provisions that address the right to life and whether it applies before birth. It applies prenatally in those countries. All these countries have highly restrictive abortion laws. Since Ireland, being in western Europe, is a country whose socioeconomic status is higher than that of Chile, Irish women can leave to gain access to safe abortion services in another country. In Latin America and Africa, however, we see, as a result of the very restrictive laws and constitutional provisions, there are very high rates of unsafe abortion.

**Acting Chairman (Deputy Billy Kelleher):** Are there any more brief comments?

**Deputy Clare Daly:** I have two agriculture questions to ask, so I must leg it.

**Acting Chairman (Deputy Billy Kelleher):** Are they to be asked here or in the Dáil?

**Deputy Clare Daly:** In the Dáil.

**Acting Chairman (Deputy Billy Kelleher):** The Deputy should save the agriculture questions for the Dáil.

**Deputy Clare Daly:** I could introduce them here. They are on horse racing, testing, etc. I apologise if I have to leg it before hearing an answer to my questions to the witnesses.

I was going to raise the floodgates issue. I note my question has largely been answered. On page 5 of Dr. Sedgh’s report, she refers to varying rates across countries where abortion is broadly available. The report touches on the point that it is not necessarily a question of legality or illegality in terms of abortion rates but a question of a range of other factors. Could Dr. Sedgh expand on some of the points on the variance within the countries where abortion is broadly legal?

With regard to the Siobhán Whelan case, it was stated in the media yesterday that she was awarded €30,000. While financial considerations are of far less consequence than the emotional damage being done to women, could Ms Hoctor outline the minimum criteria Ireland needs in its legislation to avoid this? I presume there will now be many other cases coming on stream that will highlight not only the emotional impact but also the financial cost to the State. What do we need to do in our law to prevent what occurred from happening again, making reference to the cases in which Ms Hoctor’s organisation has represented people?

My other point is on the preamble to the UN Convention on the Rights of the Child. It has been bandied around this committee a bit. It refers to the protection of the child before birth. Could the witnesses deal with that in the context of clarifying what has been alleged, namely, that this gives the foetus the right to life, as such, and, therefore, prohibits abortion? Clearly,
it does not considering that all the countries among which we stand out like a sore thumb are signatories to the convention. A little more information on this would be very useful.

*Senator Catherine Noone resumed the Chair:*

**Dr. Gilda Sedgh:** I thank the Deputy for asking me to elaborate on whether the floodgates will open if the abortion laws changed. The slide with country-specific abortion rates shows that almost half of the countries have abortion rates lower than ten. The countries with the lowest abortion rates on record are countries where abortion is allowed on broad grounds. The countries where we see the sharpest declines in the abortion rate on record are countries that have allowed abortion on broad grounds throughout the period of the decline. These findings indicate that a liberal abortion law does not necessarily represent the groundwork or setting for a high abortion rate. I could elaborate but I will stop there because there is limited time and there are many questions in the Deputy’s set of questions.

**Ms Leah Hoctor:** What the Human Rights Committee specified in the Siobhán Whelan and Amanda Mellet decisions is that, in regard to law reform, Ireland must amend its law on abortion, including, if necessary, its Constitution, to ensure similar violations do not occur in the future. It stated it must make abortion services practically accessible in a timely and effective manner in Ireland. What is really key here is the phrase “similar violations”. The violations that the committee found in the decision were violations involving inhuman and degrading treatment, the right to privacy, and inequality before the law. The facts of the cases of Amanda Mellet and Siobhán Whelan concerned the circumstances of fatal foetal impairment and the really tragic circumstances the women were in. The analysis of the committee, however, and the decision on why the suffering the women endured was inhuman and degrading focused a lot on the experience of travel and what it meant to have to leave the country to gain access to care in another country, in addition to the breach in the continuum of care that they endured and the fact that they could not obtain health care here from doctors and nurses they knew and trusted. What is really key for Ireland, the committee and lawmakers as they move ahead is to understand that until Ireland changes its laws on abortion so women, whatever their circumstances, will not face inhuman and degrading treatment or violations of the right to privacy and equality before the law, it may happen that Ireland will continue to appear before the committee. I am not aware of cases that are pending.

Under international human rights law, making abortion legal is one requirement in a broad range of circumstances. Another requirement, however, is to make abortion that is legal under domestic law accessible and available in practice. This is really critical. Poland serves as an interesting example in Europe. In that country, abortion has been legalised on many more grounds than it is currently legal in Ireland. These grounds cover circumstances of severe foetal impairment, rape and the risk to a woman’s health, but do not cover abortion on request or socioeconomic grounds. Owing to the strictures and restrictive nature of the Polish law, however, it is very difficult for women to gain access to services in practice. Therefore, Poland has been held accountable by the European Court of Human Rights three times. We can see, therefore, that it is not simply a matter of the grounds on which abortion is legal in a country’s law; it is also a matter of ensuring that it is available in practice when it is legal.

With regard to the UN Convention on the Rights of the Child, the provision is preambular. It does not in any way refer to the right to life prior to birth, or prenatally. In fact, in the *travaux preparatoires*, which are the legal documents used to interpret the treaty, namely, the negotiations of the states that drafted it, it is very clear and specific that the inclusion of this preambular provision was not in any way meant to lead to the application of Article 1 of the convention, on
the right to life, prior to birth or in a manner as to prevent the legalisation of abortion in countries that have ratified the treaty. In fact, we have seen from the jurisprudence and recommendations of the Committee on the Rights of the Child, which is the monitoring and adjudicative body that oversees the convention, that the body has called on Ireland and many other countries with restrictive abortion laws to ensure abortion is decriminalised and that adolescents and girls can gain access to safe and legal abortion services.

**Deputy Catherine Murphy:** I thank the delegates for their presentations. It is useful to see how we compare with other countries, particularly countries in Europe, and the cause and effect when changes are made. I have a question about the position in Malta and Poland. As Ireland does not allow legal abortion, women travel. Do the delegates have any information on what happens in Malta and Poland? The system in Poland is less restrictive than in Ireland, but nonetheless it is very restrictive.

In countries where there is a legal framework in place, what role does the medical profession play within it? Is there a general trend in regard in the regulatory process?

**Ms Leah Hoctor:** I do not have data for what happens for women in Malta and Poland. My understanding is that many women in both countries also travel outside the country, in Poland’s case potentially to neighbouring eastern European countries and in Malta’s case often to the United Kingdom. Although I do not have data, I also believe that, similar to the position in Ireland, women are accessing abortion pills and ordering them online. In Poland there are reports from non-governmental organisations that there are quite high rates of clandestine abortions. As the socioeconomic status of women in Ireland is obviously higher relative to that of women in Poland, travel might be easier for women in Ireland than for women in Poland. Does that answer the question?

**Deputy Catherine Murphy:** Yes, that is fine.

**Ms Leah Hoctor:** The second question was about the role of the medical profession. In most of the European countries where we examined their laws the reform processes moved from a highly restrictive law on abortion in the 1970s and 1980s to the laws in place today. Medical professionals in these societies were very involved with legislators and law makers in crafting these laws and advising on what would be workable and bring about a solution in these countries. Many of them were dealing with very high rates of unsafe abortion and often the law reform processes occurred because of calls from within the medical profession for change because its members were seeing such high rates of maternal deaths as a result of unsafe abortions. Usually across Europe laws on abortion in legislation or primary legal sources are also accompanied by regulations, by-laws and often medical guidelines adopted by medical professional bodies.

**Deputy Catherine Murphy:** With regard to gestation limits for requests, obviously they vary, but the limit is mainly the first trimester. Is there a big difference between, for example, ten and 14 weeks in terms of practicality? Is there any noticeable change or movement in any of the countries that have these limits in terms of changing because something is not workable?

**Ms Leah Hoctor:** It might not be true in every case, but it is my understanding the limit was decided in the law reform process and I do not believe we have seen change in a European country. A country that has set a ten or 12-week limit on request or a later limit has not shifted. Other requirements and facets of the law have changed and developed over time. The most common limit is 12 weeks. Although these countries’ laws were adopted at a time when medi-
cal abortion, the abortion pill, was not available, it is interesting that the ten to 12-week period in place in their laws is the time period within which medical abortion is safe and now available. Even though that was not the case at the time, it is interesting to see that the time period they set also lines up with the time period for medical abortion being safe, as stated by the WHO.

**Deputy Jan O’Sullivan:** I have a question for Ms Hoctor. With regard to the Amanda Mellet and Siobhan Whelan cases, she said in her presentation that the Human Rights Committee’s judgment detailed remedies which included reform of Irish abortion law and, if necessary, the Constitution. In her analysis of the judgment does she consider that it would entail changing the Constitution? In other words, within the current constitutional restrictions is it possible to implement the decision?

**Ms Leah Hoctor:** I cannot speak for the Human Rights Committee, but my sense is that its use of that language was because it was not for a adjudicative body of that nature to dictate the specific legal process that a state should undertake. It has set out an obligation of result - law reform - and will not dictate the legal model of law reform that the state must adopt. However, the Government in its response to the decision in both the Amanda Mellet and Siobhan Whelan case has specified clearly that in order for Irish law on abortion to be changed, the constitutional provision must change. The State made this argument in its pleadings and written submissions as the case was being considered by the committee. It is also the position it specified clearly in its responses to the committee. In order for law and legislative reform to occur, the constitutional reform must first take place. On that basis, it is our view that this is critical. Without constitutional reform, it is clear that legislative reform cannot occur.

**Deputy Jan O’Sullivan:** That is useful for the committee to know. Clearly, it is a basic issue we must examine. Both delegates have answered about the floodgates being opened and so forth. I understand Dr. Sedgh’s research is mainly on groups of countries and that it is hard to be specific about Ireland’s case, but is there any other comparison in respect of women in one country who have easy access to abortion in another, as we do in Ireland, and to show how statistics might have changed when the law became more liberal such that women did not need to travel?

I do not know if the delegates have statistics for the use of the abortion pill bought online, but are there statistics in other countries? Judge Laffoy said the Citizens’ Assembly was unable to deal with the issue in great detail, but it is one of the issues that have arisen for the committee.

**Dr. Gilda Sedgh:** On whether there are other precedents that can help us to understand what might happen in Ireland, the precedents being countries where women were previously able to travel somewhere else to have an abortion and then did not have to do so, none comes to mind. When the Deputy was asking her question, I thought about Zambia where women travel to South Africa for abortions, but we do not have the rest of the scenario described by the Deputy, where the abortion law or access to legal abortion changes, in Zambia.

I am hard-pressed to find a case where we know definitively what happens to the incidence of abortion before and after a change in the law because of the clandestine nature of abortions before that change. We have seen countries, my own home country of the USA among them, where the abortion rate declines after abortion has been legal for some time and that shift from clandestine to recorded abortions has taken place. It declines because women increasingly start to use contraceptive methods or else to shift from less effective to more effective methods. If there is concern at some point over the numbers of Irish women obtaining abortions then, all of the evidence from other countries suggests that what needs to be looked at is whether or not
something might be preventing these women from using contraception.

Members asked about abortion pills accessed online and how prominent a role these might play as a proportion of total abortions being carried out. When it comes to medical abortion in general, these pills play a large role. The case-loads of online services like Women on Web, from which a woman can be sure she is getting proper pills, proper dosage and proper information, are not in fact very large. In countries with more restrictive laws, however, which are often developing countries, we see large numbers of women obtaining Misoprostal through the black market. Misoprostal is but one of the two drugs that make up that medication abortion regimen and women are obtaining it through a variety of means: from pharmacists; from what they call their “chemists”; and from open-air markets. The drug is often obtained in various doses and thus not necessarily the optimal dose or regimen, and without any guidance or counselling. I do not know if that speaks to Irish concerns in particular but my overall point is that medication abortion in general can play a major role where abortion is clandestine.

**Deputy Jan O’Sullivan:** Generally speaking, however, the issue of whether contraception is freely and easily available is obviously a very significant one. One of our previous sessions here indicated that because Irish women who travel to Britain for abortions do not get the follow-on counselling, they do not always get information on contraception either. Would that be the case in general?

**Dr. Gilda Sedgh:** Yes.

**Ms Leah Hoctor:** It is also very interesting to look at the western European countries featured in Dr. Sedgh’s materials. We can see that some of the lowest rates of abortion are in countries where the family planning and comprehensive sexuality education are quite strong. With regard to the regulation of medical abortion, many European countries have now developed health service protocols. These are not based in legislation but rather are practice guidelines set by medical professional bodies on how medical abortion be provided; how it be rolled out; what requirements there might be for women to have prior consultations with doctors; and whether women would take the pill at the facility itself or perhaps take some of it at home. This matter is properly regulated in most European countries, but within health practice guidelines rather than within legislation.

**Chairman:** I call on Deputy O’Reilly. She has six minutes.

**Deputy Louise O’Reilly:** I will not need the full six minutes as my question is a very simple one. It concerns the word “risk”. We know from the Citizens’ Assembly what it is that we are asked to consider here. The assembly has a gradation of risk or “serious risk” to use its own term. There are various definitions of what does or does not constitute risk. In Dr. Sedgh’s experience, is it possible or even desirable to try to grade risk in legislation? Is it simply a matter of “risk” as determined by medical professionals? Or can or should we consider including a definition of what does or does not constitute sufficient risk? We are being asked to consider the Citizens’ Assembly’s recommendations here and risk is listed as one of the grounds.

The assembly also listed sexual assault among its recommendations, so this too forms part of our deliberations here. Ms Hoctor mentioned that there are some countries which operate through possible prosecution certificates or indeed legal processes. That sounds quite shocking to me. Are these measures on the statute books of those countries without necessarily applying in everyday use? In other words, do these countries have other ways around the matter? Or is it actually the case that such certification has to be obtained? I would like to ask Ms Hoctor to
talk us through the process of how a woman might go about obtaining this as it sound to me like a very tough thing to do. Without wishing to stray outside of Ms Hoctor’s area of expertise, I wonder if she could talk to us briefly about the potential impact that having to obtain such certification might have on a woman who has been the victim of a sexual assault. Finally, what possible implications might that have on time? Legal processes can be long and drawn out - is this a quick process? What are the mechanics of it?

Ms Leah Hoctor: When Deputy O’Reilly talks about “risk”, I presume she means on health grounds. I just want to be clear.

Deputy Louise O’Reilly: Yes. My apologies. I should have been clearer.

Ms Leah Hoctor: Most European countries include an explicit health ground in their law and most do not impose any time limit on that. Some countries do impose such a limit. Some countries do, as the Citizens’ Assembly did, and differentiate between a health risk and a serious health risk. The most common practice, however, is to have a health ground and not to impose any time limit.

I have put together a quick run-down of the terminology involved: “health is at risk”; “damage to women’s health”; “continuation of pregnancy endangers women’s health”; “medical reasons” is also a common terminology; and “necessary to prevent”. Of the 40 European countries we looked at, given that I focused mostly on the green and light yellow countries that also have socio-economic access and access on request, there is no qualification on the risk. Some countries use the language of “serious”, “severe” or “grave” health risk but most, approximately 25 or more of the 40, have no such qualification. That is because, as Deputy O’Reilly mentioned herself, there is a view that best practice in law-making is to treat women’s mental or physical health as a clinical matter for the relevant doctors and physicians and for the woman herself. That is the best practice approach.

In response to Deputy O’Reilly’s other question about sexual assault, it is critical to understand that the 40 countries we looked at by and large allow access to abortion in early pregnancy on a woman’s request or for socio-economic reasons. Where these countries have an explicit assault ground in their law, then, it co-exists as a separate ground side by side with the on request ground. As we saw, only 19 or 20 countries have that explicit ground in their law. I was not around in the 1970s when these countries were in the process of reforming their abortion laws and in the 1980s I was too young to be aware of such matters. I would not be surprised, however, if part of the reason why many European countries have a request ground but no explicit sexual assault ground is because they were concerned about the situations of survivors of sexual assault and thus did not want to set up and then put these women through an onerous certification process. They knew that legalising abortion in early pregnancy would mean that victims of sexual assault could get access to services within that timeframe. Someone would have to actually go back to look at the legislative records in the relevant parliaments, however, to understand whether or not that was a consideration. Also, it is important to understand that where these countries would have a sexual assault explicit ground in co-existence with a non-request ground or a socioeconomic ground, they would have a later term limit usually associated with that. It is quite few that would. In the majority of these countries, the process would involve medical professionals, and sometimes social workers. It would be a similar process to that applied in the situation of a health risk. I cannot give the committee information about how the few that refer to prosecutors or police authorities - these are in the minority - operate in practice. In one country in Europe, Poland, which has legalised access to abortion on grounds of sexual assault but has not legalised access to abortion on request, we see evidence that it is
difficult for survivors of sexual assault to access abortion in practice under that rape ground. I would refer the committee to a case that came before the European Court of Human Rights, called P. and S. v. Poland. That case illustrates, as was mentioned, some of the severe impacts of these kind of certification schemes. Poland is one of the countries that requires a certification from a prosecutor. That case concerned a minor, an adolescent girl who had been raped and who faced very severe impacts and barriers in attempting to gain access to what was a legal service.

**Chairman:** I thank Ms Hoctor.

**Deputy Lisa Chambers:** Most of my questions have been answered. I thank the witnesses for appearing before the committee and for giving us the opportunity to discuss this matter and to ask them questions. That is important for us.

The map made for quite stark viewing. Obviously, Ireland is depicted in bright red. We are not surrounded by any other red countries. Everyone is depicted in green or yellow - very different from the picture here in this country. A picture paints a thousand words, and that is a very powerful one.

Of the other European countries depicted in green and yellow, how recently have they provided these services? Are there any countries within Europe where it is only recently or in the past number of years that they provided these services and was there a debate in the country concerned? What was the process there?

Obviously, Ms Hoctor works not only in Ireland. Is she aware of the perception across Europe of how we are dealing with this situation? Is there a conversation happening? What do people externally think of our current situation and the debate that we are having?

**Ms Leah Hoctor:** To answer the first question, I would say Malta and Andorra, which are small on the map, are also in red. Those are very tiny countries.

**Deputy Lisa Chambers:** Looking closely, I can see them now.

**Ms Leah Hoctor:** It is true that it is a stark picture. Ireland has a number of interesting peers in Europe that have changed their abortion laws and moved from an orange situation or even a red situation to now becoming green. These would be Switzerland, Portugal and Spain. In Switzerland and Portugal, those processes involved a public referendum. I live in Switzerland and I am aware that they vote on everything there - they vote on what side of the road they will drive on. They liberalised, or changed and reformed, their abortion law through a public referendum process. There would have been a legislative proposal put forward to the people of Switzerland by the legislature in 2002.

Spain and Portugal are the most recent. They legalised in 2010 and 2008, respectively. In Portugal, there was a public referendum. It may be also of interest to the committee to look at that process. Then Spain also moved from a restrictive model, from being orange on the map, to now being green. Those are the most recent.

**Deputy Lisa Chambers:** Was there a public vote in Spain?

**Ms Leah Hoctor:** No. It was a legislative process.

**Deputy Lisa Chambers:** Before Ms Hoctor moves on from that, has she any more detail about the process in Switzerland and in Portugal? How did the referenda go? What were the
percentages in terms of vote? In the debate leading up to the referendum, what was the tone and what was the general feeling?

**Ms Leah Hoctor:** This is something that I would like to look into a bit further and come back to the committee on because I think there is information we can give. In Switzerland, the percentage in favour of the change was in the high 60s or up to 70. That is my understanding but I would need to double-check. It is possible we could suggest names of members of the Swiss legislature or Government at the time, and their counterparts in Portugal, who may be able to share this information in more detail. I will certainly look into that and come back to the committee.

**Deputy Lisa Chambers:** I thank Ms Hoctor.

**Ms Leah Hoctor:** On how Europe is looking at this, our sense would be that Europe is watching and waiting. Ireland is a valuable European partner for many European states and there would be a sense of interest in the matter in the hope that Ireland can find a resolution.

**Deputy Lisa Chambers:** I thank Hoctor.

**Chairman:** Senator Ned O’Sullivan has six minutes.

**Senator Ned O’Sullivan:** I have only a couple of brief questions which I will address to Dr. Sedgh. She stated that there are very few unsafe abortions in countries where there is a reasonably open and liberal abortion regime and there is almost a 30-fold increase in unsafe abortions in countries where legislation is very tight. I wonder how does that apply *vis-à-vis* Ireland where we have the right to travel and where we are in such close proximity to the UK. Do those figures hold up for Ireland?

Dr. Sedgh also stated, which surprised me when I saw these figures previously, that 73% of abortions are performed on married women as opposed to 27% on single girls. That would surprise people and raise a lot of eyebrows around the country because the narrative, especially, by those who are very much against abortion, is always centred on helpless young women who are probably confused, etc., whereas, in fact, the vast majority of abortions would seem to involve women who, because they are married, I assume, are older, more settled and more mature. I would like to check that figure with Dr. Sedgh to determine am I right.

Finally, there is one statement Dr. Sedgh made that surprises me and that I cannot rationalise. Russia jumps out on the map as being all green and, therefore, would be, I imagine, very liberal, yet Dr. Sedgh stated there was a reduction of 50% in abortions in Russia since the war or Stalinist period. It does not add up how they are still in the green box. What happened to cause such a reduction?

**Deputy Brid Smith:** Maybe it is a nicer place to live.

**Senator Ned O’Sullivan:** Whatever, but it is a question that interests me. By the way, I welcome the witnesses and thank them for the helpful and informed information.

**Chairman:** Deputy, sorry, Dr. Sedgh first.

**Dr. Gilda Sedgh:** I thank the Chairman for that complimentary mistake.

With respect to this general correlation whereby where abortion law is restrictive abortions tend to be unsafe, Ireland appears to be an anomaly because of its proximity to Great Britain
and to some extent the Netherlands where some women also seem to go for abortions. We do not know all of the women who are having abortions and we do not know all of the conditions in which they are having abortions but it appears to be anomalous.

Senator Ned O’Sullivan’s next question was on the marital status of women having abortions. There is variation across these countries. Across developed countries, it may not be that in all of them the majority of women having an abortion are married but on average it definitely pans out that way. One should bear in mind that married women includes cohabiting women.

It is interesting to me also that the unmarried women are the ones who get so much of the attention. As they get the attention, it gives the impression that they account for the majority of abortions. It makes some sense because it could be argued that the consequences of an unintended pregnancy are greater for a young, unmarried woman who has not yet finished her education and for whom the opportunity costs of having a child might be higher. It could be argued that the stigma of having both an unintended pregnancy and an abortion - having had sex before that - are all compounded. It is useful to be reminded of that statistic because it is surprising.

In Russia and eastern European countries, although I hope life has got better in Russia, abortion rates have decreased because access to family planning services has increased dramatically with the ending of the Cold War and because of increases in trade, exposure to the West and the presence of non-governmental organisations providing services. The number of women using a contraceptive method has increased substantially from 1990 to the present. The prevalence is still not as high as in western and northern Europe and women are not as likely to be using effective methods as women in northern Europe or using them well because of the variability in the quality of service. We still see higher abortion rates in eastern Europe than in the rest of Europe and these are some of the reasons from the evidence we have seen. It comes back again to contraceptive use; it is why rates decline or remain high.

Deputy Bernard J. Durkan: I welcome the delegates and thank them for their participation. In Ireland’s case we are in the area where the purpose of an abortion is to save the woman’s life. It is also true, of course, that it does not necessarily have to be an abortion. My definition of abortion is to terminate the life of the child still to be born to achieve a result. As we know, it is possible to intervene to save a woman’s life without killing the child. Will Dr. Sedgh comment on this?

I am a little confused about the statistics for Germany as compared with those for the United Kingdom, for example. There are liberal or readily available abortion services on socioeconomic grounds, but there are considerable restrictions in Germany related to the provision of counselling and advice. There is a thorough examination of the person presenting, whether she is single, married or whatever the case may be. There seems to be a heavy reliance on counselling and the provision of support services that do not seem to be a feature in the United Kingdom, for example, and certainly are not a feature for Irish women availing of abortions in the United Kingdom. With regard to abortion rates across various countries in which abortion is legal on broad grounds, we can compare the likes of Sweden with Switzerland. There is a dramatic difference in the level of abortions in the two countries. Is that for some reason we have not spotted? There seems to be something obvious that is not jumping up to hit me.

I am a little concerned about the suggestion the European Union is watching us and might be on our case again. There are a number of matters on which we are watching it also. I am a little uneasy about that slant. This is an independent state and we observe EU law in almost every case. In some recent times there has been a tendency for us to feel we must reiterate our
right to exercise our own options. Will the delegates comment on these matters?

Dr. Gilda Sedgh: On the variations in abortion rates across countries or the extremes, I am not interested in a systematic analysis or assessment of what explains the differences in abortion rates across countries. I am aware of research within some countries which indicates that the rate of unintended pregnancies and abortion is higher among minority and disadvantaged women, or women whose access to contraceptive, family planning and reproductive health services might be compromised. It is possible these inequities are more pronounced in some countries than in others. It is also possible the proportion of women who face these barriers or who are disadvantaged in some way is higher in some of these countries than in others. I am uncomfortable in even going there because I am speaking a little beyond the evidence. I am starting with evidence and speculating based on it. Otherwise, I do not know that I can explain well or find evidence to explain the differentials.

I take the point about Germany. These are broad categories with respect to abortion laws in various countries. On the whole, Germany is classified as allowing abortion on broad grounds, as is the United States. In some countries, including these two, restrictions are enacted, including counselling requirements, waiting periods, etc., which allow for cause degradation across countries in which abortion is allowed on broad grounds with respect to ease of access to legal abortion. However, I take the Deputy’s point.

Deputy Bernard J. Durkan: There is the human rights element and there was much reference to human rights. There is the UN Convention on the Rights of the Child, for example, which makes a comment in that regard. The EU Charter on Fundamental Rights also makes a comment. Does Ms. Hoctor wish to comment on either of these? If we are to be even-handed in our debate, we must ask about the human rights of the woman and those of the child.

Ms Leah Hoctor: The important point of which to be aware is that under international human rights law, including the conventions mentioned by the Deputy and other treaties, the right these treaties contain and their provisions do not apply to pre-natal life. They do not apply before birth and only begin once a person is born. That is the starting point for international human rights law. It is very clear from the jurisprudence of all of the adjudicative bodies that oversee implementation of the treaties that they are of the view that women’s human rights are violated or undermined when they are not able to access abortion care safely and legally. That is the legal approach to human rights in this matter.

I will also address the Deputy’s original point about abortion to save the life of a woman. It is very important to understand almost all abortions - perhaps 90% or more - in European countries occur in the first trimester of pregnancy. That is a critical fact to keep in mind. There may be cases later in pregnancy in which women face difficult situations and may need to access abortion care and it is very important that they can do so legally. In Europe the vast majority of abortions take place within the first trimester.

Deputy Bernard J. Durkan: I thank the delegates for their replies. I was a member of the convention on the European Union Charter on Fundamental Rights. We spoke for a long time about a reference before coming to the conclusion that everybody had the right to be born. That is from memory. The UN Convention on the Rights of the Child also states everybody has the right to be born. To be absolutely sure, I would like a comment on that issue.

Ms Leah Hoctor: I believe I addressed this issue earlier as Deputy Clare Daly asked a similar question. The wording in question in the UN Convention on the Rights of the Child is
in a preambular paragraph. It is not in an article or a provision. It states the child “by reason of his physical and mental immaturity, needs special safeguards and care ... before as well as after birth”. It is very clear from the drafting negotiations on the treaty that it was agreed by states that this provision did not mean that there was a right to life that would apply prenatally. It was agreed that Article 1 of the treaty, enshrining the right to life, would apply from the time of birth and that is in line with the language of the Universal Declaration of Human Rights. It may be in a state’s interests to take measures to protect prenatal life but human rights standards and jurisprudence have made it very clear that doing so cannot undermine the human rights of women. It is critical that states take an approach to law and policy around reproductive health care that places women’s health and rights at the centre and works out from there.

I will have to check this but I believe that even the Holy See, in the negotiations of the convention on the rights of the child, understood that the language in the preamble did not prevent states from liberalising and legalising access to abortion care.

Deputy Mattie McGrath: The centre for reproductive rights brought Ireland to court to seek changes to our abortion laws. Does Ms Hoctor consider that the pre-born child has any rights, in particular the right to life?

Ms Leah Hoctor: The centre for reproductive rights represented Amanda Mellet and Siobhan Whelan in their cases to the human rights committee. They were two women who had obtained diagnoses of fatal foetal impairment and were told by doctors and nurses here that they could not legally end their pregnancies here because of Irish law on abortion, so they travelled to the UK where they were able to access medical terminations. These women were of the view that they had suffered grievously in different ways and they wanted to work to ensure that other women would not suffer in the same way. Accordingly, they wanted to take their complaints to the human rights committee and they claimed violations of their human rights, which the committee found.

Deputy Mattie McGrath: The question I asked was, “Does Ms Hoctor consider that the pre-born child has any rights, in particular the right to life?”

Ms Leah Hoctor: As I said to Deputy Durkan, under international human rights law the right to life, as enshrined, for example, in the international covenant on civil and political rights, is a right that accrues from birth and does not apply to prenatal life.

Deputy Mattie McGrath: That answers the question but I do not agree with Ms Hoctor. The United Nations committee on the rights of persons with disabilities stated that legalising abortion on disability grounds was a violation of the human rights of people with disabilities under the convention on the rights of persons with disabilities. I travelled with some people to the UN in 2015 and attended the committee. What comment does Ms Hoctor have to make on that point?

Ms Leah Hoctor: I think the material referred to by the Deputy is a submission to the committee on the rights of people with disabilities from a few weeks ago. My understanding is that the committee on the rights of people with disabilities has never said that women who received diagnoses of severe fatal foetal impairments should not be allowed legally to access abortion care in their countries, or that a state should prohibit women’s access on these grounds.

The committee raised concerns regarding the legislative modality through which a state does that and gave its view that states should not include explicit legal terms in their laws re-
regarding foetal impairment. The committee has never expressed any concern about a woman being legally allowed to access abortion care and services. Some countries in Europe, such as Switzerland and Sweden, have a health ground in their law but no explicit ground for access to abortion for foetal impairment. Germany also has such a ground but in all these countries women obtain legal abortion services when they receive a diagnosis of fatal foetal impairment and the committee on the rights of people with disabilities has never expressed any concern with the laws of these countries. In fact, along with all the other human rights mechanisms, the committee has stressed how important it is that women can access sexual reproductive health care, including access to abortion care. The committee’s concern is around the legislative modality, as opposed to whether women who are suffering due to diagnoses of fatal foetal impairment should be allowed legally to access care.

Deputy Mattie McGrath: I attended a meeting of the committee and one of the women present had had a fatal foetal diagnosis but her child is now aged 11 and was with us. The committee made a statement on this quite recently, though the presentation was made in 2015. Two weeks ago, a UN committee also stated that “fatal” and “incompatible with life” were terms that should not be used.

Ms Leah Hoctor: Those terms are used by clinicians and physicians and are common in medical practice. The committee on the rights of disabilities did not state that women should not be allowed to access services when they receive a diagnosis of fatal foetal impairment - it simply raised the question of how the law does that and how the law should enable women to make decisions in the course of a pregnancy with a fatal foetal impairment. It also discussed whether or not the law should include an explicit term around foetal impairment.

Deputy Mattie McGrath: I profoundly disagree. The HSE has issued new guidelines in recent times, discontinuing the use of the terms “fatal foetal” and “incompatible with life” and using softer terminology. I have brought forward a Private Members’ Bill on the issue but the HSE has acquiesced already, with more compassionate and sensitive language on pregnant mothers or couples presented with such diagnoses. There is a clear conflict with what the committee has stated and the quotations Ms Hoctor has given from the United Nations. I do not accept her answers and I totally discount her answer to Deputy Durkan’s questions to the effect that no life exists before birth.

Deputy Bríd Smith: The statistics given by Dr. Sedgh were very useful. They included the statistic that the majority of abortions are requested by married women, that more than half of women are between 20 and 29 years old, that most women who have abortions have at least one other child and that most abortions happen by the ninth week. These are very important scientific statistics that show that there is a lot of myth from those who oppose people’s right to abortion in this country. We stick out like a sore thumb on the map, as an island isolated from the rest of Europe in this area.

Dr. Sedgh said we had no way of knowing exactly what the statistics are for Irish women seeking abortions abroad. Many Irish women go to Britain but many of them do not give Irish addresses and this is probably also true of Irish women who go to Holland. We have no way of gathering real statistics around women, abortion and this country. Dr. Sedgh is not a health professional but she informs health professionals. Does she, as a scientist, believe that not having absolutely correct and full statistical knowledge of how abortion impacts on Irish women is not a good thing for the health of Irish women? Does she believe that it is not good from the point of view of getting a full picture of the full reproductive health of Irish women or for informing ourselves as legislators? As a scientist, does Dr. Sedgh believe it is unhealthy not to
have knowledge of the full statistics?

I have questions for Ms Hoctor about the availability of abortion services. She talked about the stress and distress caused in having to leave one’s country to have an abortion elsewhere, regardless of the reasons involved. As the doctor showed, there is a huge variety of reasons women seek to terminate a pregnancy. Having to leave one’s country and suffer distress is a big issue when it comes to where Ireland falls down in protecting women’s rights and, therefore, compensating them. Can Ms Hoctor add to that aspect? Importantly, statistics here prove that socioeconomic reasons are another huge factor for women. In other words, if one is poor or does not have the financial resources required, one will often, as the doctor said, be subject to procuring an abortion much later rather than as early as possible in the pregnancy. One is also put under much more stress and strain by having to get onto an aeroplane or a ferry and stay overnight in accommodation. On top of this, one cannot take one’s partner or pal along because that would cause further stress and financial strain. Does Ms Hoctor think the socioeconomic reasons we are considering in women seeking to have an abortion are a big element in terms of the countries that allow women to access abortion services?

Dr. Gilda Sedgh: I thank the Deputy for her comments and questions. Before I discuss what we do not know and how useful it would be to know more, I acknowledge that for the women who travel to Britain for an abortion and admit that they are from Ireland, we have statistics for their ages and the gestational age at which they have an abortion. A very small share are obtained by adolescents and they are mostly performed within the first 13 weeks. I work in an organisation the mission of which is to conduct policy-relevant research and to support evidence-based policies. From that perspective, yes, it is unfortunate that we do not have direct evidence within Ireland on the reasons Irish women have an abortion, the numbers of Irish women who have an abortion and the circumstances in which they have them.

I have mentioned that Ireland seems to be an anomaly with respect to the proportion of abortions that are unsafe. We do not know how many of the clandestine abortions are performed by a trained person. Even among those who have an abortion that is medically safe, we do not know what proportion of women who have an abortion experience stress related to the stigma they experience having had an abortion or the stigma they are afraid they will experience. I have mentioned a review of 14 papers that comment on the pervasiveness of that experience among women who have had an abortion. In the absence of this evidence directly from Ireland, I hope evidence from other countries in the region and the developed world can help us to get a sense of the circumstances experienced in Ireland. To the extent that the Deputy’s question is also a comment, I appreciate her comment that we need evidence to inform policies both here and throughout the world.

Ms Leah Hoctor: On the question of social inequality, it was something to which the UN Human Rights Committee pointed in its decision in the Amanda Mellet case as one of its considerations in what it termed the Irish law’s failure to take account of her socioeconomic circumstances and the difficulties she would have faced in travelling to another country to access services there. It was a component part of the cruel and inhuman treatment the committee found she had suffered. It was also a component part of the finding of the committee of inequality before the law that she faced discrimination because of her socioeconomic status.

I refer the committee - I do not have the exact page number - to the World Health Organization’s guidelines on safe and legal abortion. The WHO also specifies very clearly that one of the results of restrictive abortion laws is the creation of social inequalities.
Deputy Peter Fitzpatrick: I welcome the delegates for whom I have two questions, the first of which is for Ms Hoctor. I note that all of her comments were focused on making the case for abortion. Therefore, it would be fair for me to say hers is a campaigning organisation.

Ms Leah Hoctor: No.

Deputy Peter Fitzpatrick: Has the organisation ever criticised any aspect of the abortion industry? I do not expect Ms Hoctor to comment on specifics, but she may be aware, for example, that in recent weeks the Care Quality Commission in the United Kingdom brought to light information that Marie Stopes International gave bonuses to its staff members for convincing women to go through with an abortion, even in situations where they had decided not to go through with it. That is appalling behaviour in the name of choice. I assume that Ms Hoctor is aware of some horrifying stories from the United States, but I will not go into graphic detail. As a multi-million dollar organisation that campaigns on the issue, has the centre ever commented on cases such as the one I have cited involving Marie Stopes International or is the abortion industry always given a free pass?

Ms Leah Hoctor: As I said in my opening statement, the Center for Reproductive Rights is an organisation that seeks through its legal and legal advocacy work to advance women’s reproductive health and rights. It is important for me to clarify that it is a legal advocacy organisation which uses the law to advance women’s reproductive health and rights which include access to safe and legal abortion care, quality maternal care for women who are in labour and access to affordable contraception services. We also work to prevent child marriage and forced sterilisation.

Deputy Peter Fitzpatrick: Has the center ever criticised anybody?

Ms Leah Hoctor: No; I am not aware of anyone.

Deputy Peter Fitzpatrick: Is Ms Hoctor aware of the organisation-----

Ms Leah Hoctor: Yes; I work for it.

Deputy Peter Fitzpatrick: No; is Ms Hoctor aware of the organisation that pays its staff members bonuses?

Ms Leah Hoctor: Is the Deputy referring to the report of the Care Quality Commission in the United Kingdom?

Deputy Peter Fitzpatrick: Yes.

Ms Leah Hoctor: What is really critical about the example given by the Deputy is that it is the regulatory body in the United Kingdom that regulates and oversees medical practice. It is critical to understand all western European countries have highly effective regulatory bodies in place that oversee and monitor the provision of health care, including reproductive health care and abortion services. Also, if there are allegations of or concerns about malpractice or inappropriate service provision, the relevant regulatory body should investigate. That is what the regulatory body in the United Kingdom is engaged in, which is an appropriate response. That is why there are such bodies.

Deputy Peter Fitzpatrick: I have referred to vulnerable women who had made up their mind not to have an abortion, yet bonuses are paid to staff members who convince the women in question to change their mind. The centre must criticise such a practice. It cannot stand for
it for one moment. To me, such a practice is totally and utterly wrong. Committee members have said women leave Ireland and spend a lot of money in travelling to the United Kingdom. However, staff members have been paid bonuses to encourage women to have an abortion.

Ms Leah Hoctor: I am not aware of the specific report or allegations mentioned by the Deputy. As I am not aware of them, I would not like to comment on or address them further.

Chairman: In that sense and from a procedural point of view, it is important for Ms Hoctor not to comment on them.

Deputy Peter Fitzpatrick: I must leave to attend the meeting of the Select Committee on Finance, Public Expenditure and Reform, and Taoiseach which is taking place next door at which a vote will take place. I will return in about five minutes to ask Dr. Sedgh my final question. Is that okay?

Chairman: Senator Paul Gavan has indicated that he wishes to make a comment. Of course, I will accommodate Deputy Peter Fitzpatrick if he makes it back. Deputy Kate O’Connell may want to ask a question too.

Senator Paul Gavan: I thank the witnesses for their presentations. Today again validates the process we are going through. We are here to listen to facts and evidence. I do not think anyone can question that we are receiving an awful lot of good information, hard evidence and facts here today. I welcome that. Frankly, all my questions have been answered apart from one, which I will highlight. With regard to the sixth slide of Dr. Sedgh’s presentation, some people will find it fascinating, although I was not surprised, that in the countries where abortion is prohibited, 37 out of 1,000 women have abortions while in the countries where abortion is available on request, that number is 34. In other words, there is a lower level of abortion where it is legally available. That might come as a surprise to some members of the committee. I know Dr. Sedgh has touched on this point already, but will she elucidate why abortion rates are lower in countries where it is available as against countries where it is prohibited?

Dr. Gilda Sedgh: I thank the Senator. The statisticians on our team would say that I was remiss if I did not point out that there is no statistically significant difference in the abortion rate of countries with restrictive abortion laws and those with liberal abortion laws because of the margins of error. Having said that, the Senator is correct. The point estimate is such that the abortion rate is actually lower on average in countries in which it is allowed on request. It is probably worth reinforcing what seems to be behind what we are seeing. First of all, in countries in which abortion is allowed without restriction as to reason we see some of the lowest abortion rates on record and also some of the highest rates on record. Those are the countries in eastern Europe and the average rate comes out to approximately 34. What differentiates the countries with high abortion rates from those with low abortion rates is not the legal status of abortion in those countries, but the level of unmet need for contraception or the proportion of women who wish to avoid getting pregnant and are not using a method of contraception. We would see a completely different chart if, along the bottom axis, one was looking at the level of unmet need for contraception. One would see very different abortion rates in those groups of countries. I hope that makes sense.

Senator Paul Gavan: It does. One other point occurred to me. Dr. Sedgh or Ms Hoctor pointed out, rightly, earlier that there was quite an unusual situation in the Soviet Union and the other eastern countries, and that is why we have seen this dramatic reduction in the abortion rates. Allowing for that and assuming the rate continues to drop, the differential between lower
rates of abortion will actually be larger between countries with freely available abortion and those where it is prohibited. Would that be a fair comment?

**Dr. Gilda Sedgh:** If the abortion rate were to decline further in eastern Europe, we would see an even lower abortion rate in the group of countries where abortion is allowed on request, yes.

**Senator Paul Gavan:** I thank Dr. Sedgh.

**Deputy Kate O’Connell:** I have just a few quick questions. I apologise if I am repeating anything which was asked recently, I was in the Chamber for another matter. Is there any other country in Europe where there is this constant argument or discussion about the life of the live mother, who is walking around pregnant, being given equal weighting to the life of the unborn child? It seems to be a constant discussion in this country. Have other countries dealt with the same issue and, if so, how did they get through it?

On the ninth week of pregnancy, is Dr. Sedgh counting from conception, implantation or date of last period? Will she clarify that? When we look at the hard copy of Ms Hoctor’s presentation, particularly the slide on time limits for unrestricted access, do all these countries use the same standard? Do they use either conception point or date of last period? Perhaps the witnesses could clarify that. I have noted from some of the documentation that perhaps we are comparing apples and oranges in some cases. For this chart to be truly, factually correct for the committee, the starting point needs to be the same. We do not want the committee to fall out over the number of weeks. If we are doing this, we want to do it correctly.

**Ms Leah Hoctor:** We have sent copies of all the relevant laws which are referenced in the chart to all members of the committee and we have hard copies here. It would be possible to check which countries have the ten week limit, for example, and to assess where the starting point for that limit is. The practice across Europe differs significantly in respect of the starting point.

**Deputy Kate O’Connell:** What I am really getting at it is whether a ten week limit could actually be a 12 week limit, depending on where one begins to count from. Does Ms Hoctor understand what I am saying?

**Ms Leah Hoctor:** We would need to check but we can do that for the Deputy.

**Deputy Kate O’Connell:** It would be helpful so that we would not have to deal with so many starting points.

**Dr. Gilda Sedgh:** It would be better to wait until Ms Hoctor is able to check but, from what I recall, it is more common for the clock to start at the last missed period. Therefore it might be that a ten week limit is actually an eight week limit. It is more likely that abortions are happening at an even earlier gestation than is shown in these charts.

**Deputy Kate O’Connell:** That is what I take from the information myself, but I would like the witnesses to clarify it if they have the capacity to do so. It would be helpful to the committee to know if one country’s limit is 12 weeks, but that it is actually ten. Will the witnesses comment on the balancing of the rights of the woman walking around pregnant and the unborn child? How have other countries dealt with that?

**Ms Leah Hoctor:** No other country in Europe has a constitutional provision like that. An-
dorra, Malta and San Marino, which are very small countries on the map, have highly restrictive abortion laws and do not allow abortion at all or only to protect a woman’s life. Of those, I believe only Andorra has any form of constitutional provision on the question but it does not equate the right to life of a woman with the right to life prior to birth. It just speaks about recognising the right to life and protecting it in its different phases. There is no equation of the rights. My understanding is that the Phillipines may be the only country in the world to have a similar provision to the Irish Constitution. Again, we would have to check this and come back to the Deputy. I believe that provision was adopted after the provision in the Irish Constitution was.

**Chairman:** I would like to thank both witnesses very sincerely for their time here today. It has been very helpful and will help the committee with its work.

**Deputy Jonathan O’Brien:** I should point out that Deputy Fitzpatrick wanted to come back in if he had returned. I will perhaps try to delay by asking a question.

**Chairman:** Okay.

**Deputy Jonathan O’Brien:** Just in the interests of Deputy Fitzpatrick. I would not want him coming in in----

**Chairman:** I thank Deputy O’Brien for extending the session.

**Deputy Jonathan O’Brien:** I will have to come up with a question now off the top of my head. Somebody better give Deputy Fitzpatrick a shout and tell him that we are finished in two minutes. He is at the Select Committee on Finance, Public Expenditure and Reform, and Taoiseach.

**Chairman:** He is here.

**Deputy Jonathan O’Brien:** That is grand. I will ask the question anyway. There has been a lot of talk around equating the right to life of the mother to that of the unborn child. I think we sometimes get away from what is in the best interests of women’s health. That is what the committee should be looking at in my opinion. If we were to start with what is in the best interests of women’s health and women’s health care, in Ms Hoctor’s expert opinion would it be fair to say that standards of women’s health care are better in countries where there is a more liberal regime in respect of terminations than in countries where there is a very restrictive regime? Would that be a fair assessment in Ms Hoctor’s expert opinion?

**Ms Leah Hoctor:** In my expert opinion, when one takes a global perspective, yes. As a general rule, countries that allow abortion on a woman’s request or on broad socioeconomic grounds, which are mainly countries in Europe or other OECD countries, do not see high rates of unsafe abortion or of maternal mortality. In countries where there are highly restrictive laws and which do not take a women-centred approach to law-making around reproductive health and abortion, which are largely countries outside of Europe, there are often much higher rates of unsafe abortion and maternal mortality and morbidity.

**Deputy Jonathan O’Brien:** That is grand. I will ask the question anyway. There has been a lot of talk around equating the right to life of the mother to that of the unborn child. I think we sometimes get away from what is in the best interests of women’s health. That is what the committee should be looking at in my opinion. If we were to start with what is in the best interests of women’s health and women’s health care, in Ms Hoctor’s expert opinion would it be fair to say that standards of women’s health care are better in countries where there is a more liberal regime in respect of terminations than in countries where there is a very restrictive regime? Would that be a fair assessment in Ms Hoctor’s expert opinion?

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**Deputy Jonathan O’Brien:** I am not differentiating between physical or mental health but, for the general health care of a woman, it would be better to have termination on request up to a certain point.

**Ms Leah Hoctor:** Most European laws we looked at, and we looked at 40 countries in some detail, would have a general provision on health. In almost all cases mental health would either
be explicitly listed there, together with physical health, or else implicitly interpreted into the ground.

Chairman: Thank you. On a point to Deputy Fitzpatrick, the Marie Stopes organisation has a statement on its website with regard to what Deputy Fitzpatrick had referred to earlier. It is up to the witness whether she wishes to respond. The Deputy can take up where he left off.

Dr. Gilda Sedgh: The Deputy was going to move on to ask a question of me. I think Ms Hoctor had answered his question to the best of her ability at that point.

Ms Leah Hoctor: Yes, I felt I would not be in a position to comment.

Deputy Peter Fitzpatrick: I apologise to the Chair but there was an issue with the Finance Bill.

My question is for Dr. Sedgh. I know that in recent years she has severed her links officially with the International Planned Parenthood Federation, IPPF, but I think I am right in saying she has a long historical link with that group, which is one of the largest abortion providers in the world. I note that, in her presentation, she talks a lot of facts and figures but she does not talk about how many people have been saved by the eighth amendment. My question to her is this: does she think anyone has been saved by the eighth amendment?

Dr. Gilda Sedgh: I appreciate the Deputy bringing up our relationship with Planned Parenthood Federation of America, PPFA. That is on our website, the information is available and I am happy to make it available here. When the institute was founded in 1968, we were housed in the corporate structure of PPFA. In 1977 we became an independent organisation with an independent board of directors and our affiliation with PPFA was eventually dissolved.

I am familiar with estimates or assumptions about how many abortions have been averted by virtue of restrictive abortion law in Ireland. I think the assumptions on which those numbers are based are dubious. I could get into that if one wanted me to.

Deputy Peter Fitzpatrick: The question I am asking is whether Dr. Sedgh thinks any lives were saved by the eighth amendment. It is not a hard question.

Dr. Gilda Sedgh: I am trying to comment on whether abortions have been averted and I am not sure the extent to which abortions have been averted by virtue of the eighth amendment. I think that is my answer to the Deputy’s question.

Deputy Peter Fitzpatrick: Sorry, I do not understand. What is the answer - yes or no? Have any lives been saved by the eighth amendment?

Dr. Gilda Sedgh: I think the Deputy is asking me to take a position on whether a terminated pregnancy is the end of a life and that is not something on which the institute has taken a position. The position of the institute is that there are a lot of perspectives on when life begins and that women’s reproductive health is best ensured when women are able to make decisions regarding their reproductive lives and reproductive health in consultation with their partners, with their faith leaders and with their health care providers. That is the position of the institute and I think that is what the Deputy is asking me.

Deputy Peter Fitzpatrick: As a bottom line, there could be one, two or 100,000. Dr. Sedgh just does not know.
Dr. Gilda Sedgh: I cannot speculate on that.

Deputy Peter Fitzpatrick: But she has severed her links with the International Planned Parenthood Federation. That is gone a good while now.

Dr. Gilda Sedgh: Planned Parenthood Federation of America. Yes, we are no longer with affiliated with PPFA and we are not affiliated with IPPF.

Deputy Peter Fitzpatrick: I am very disappointed that the two organisations present will not give me any comment about the eighth amendment. They seem to know everything else and seem to have answers for everything else. I just asked a simple question about the eighth amendment, which is a massive issue here in Ireland. In fairness, we invited both here today and I am sure they knew the main issue was the eighth amendment. One would think they would have done some kind of investigation into the eighth amendment. The taxpayer pays for these people here today. I am asking a simple question and I cannot get a simple answer.

Chairman: In fairness, there is no obligation on a witness to give a “yes or no” answer under fair procedures. I think they can answer the questions in whichever way they wish. Perhaps it is an area of speculation that we would like the witnesses to venture into. In fairness to them, I think they have answered in the way they wish to answer. Deputy O’Brien has a point of clarification.

Deputy Jonathan O’Brien: I think it is fair to say claims have been made that lives have been saved as a result of the eighth amendment. I think we have a group coming in who made that-----

Deputy Peter Fitzpatrick: In fairness, I did not ask the Deputy. I asked the two witnesses this question.

Deputy Jonathan O’Brien: I am not talking about the Deputy. I am not even commenting on what he is saying.

Chairman: Deputy O’Brien did not ask a question so that Deputy Fitzpatrick could ask his question. He did not use all his time so I was allowing him back in, to be fair.

Deputy Peter Fitzpatrick: That is fair enough.

Deputy Jonathan O’Brien: I believe a group is coming before the committee whereby we will get the opportunity to discuss the methodology they use in their claims. I think we should reserve judgment until we get to question them.

Chairman: They are not coming.

Deputy Jonathan O’Brien: They are not coming so we will not get to question their methodology. However, it is also fair to say it is beyond dispute, given the evidence we have heard before this committee from people in the medical profession, that the eighth amendment has actually cost people their lives as well. I think that should also be put on the record. That is the only evidence that has been presented before this committee which I can stand over, namely, that the eighth amendment has actually cost at least one life and we do not know how many others. I have not heard any evidence before this committee that the eighth amendment has actually saved any lives. If somebody wants to come forward and present that evidence, I am sure the committee will be more than happy to deal with it.
Chairman: We will be more than happy but I will not ask the witnesses to comment on that because it is in the area of speculation to some degree. I thank Dr. Sedgh and Ms Hoctor most sincerely. We will suspend before calling Dr. Fletcher.

Sitting suspended at 4.28 p.m. and resumed at 4.30 p.m.

Medical Law Review: Dr. Ruth Fletcher, Queen Mary University London

Chairman: I again welcome viewers to the committee proceedings. On behalf of the committee, I extend a warm welcome to Dr. Ruth Fletcher, senior lecturer in medical law, Queen Mary University in London. Is Dr. Fletcher aware of the laws around privilege and qualified privilege the reference to which I read earlier? Although I have no difficulty in doing so, is she happy for me not to read through it again?

Dr. Ruth Fletcher: That is fine.

Chairman: I now call on Dr. Fletcher to make her presentation.

Dr. Ruth Fletcher: Thank you, Chairman. I thank the members of the committee for the invitation. It is a great pleasure to be able to draw on the research and teaching I have been doing in the area of medical law to think practically about how we might build on the insights of the Citizens’ Assembly and how we can practically translate that into legislation.

I thought in this presentation I would select some key points from the submission I made. Before I get to focusing on how we might translate the Citizens’ Assembly recommendations in regard to both on-request models and criteria for access in the later stages of pregnancy, there are two framing issues on which I wish to focus.

The first is in regard to the trend towards decriminalisation and the significance of decriminalisation. That that is an option open to the committee members in order to progress the framework within which the Citizens’ Assembly recommendations might take effect. Basically, as I am sure the committee will be aware, decriminalisation of abortion is part of an international trend. Even though there are significant criminal prohibitions in many different countries, we are seeing a trend towards taking the criminal law out of the regulation of reproductive health care, in particular, abortion, partly because it is about having the right tool for the job. In a sense, criminal law is not the right regulatory tool for regulating reproductive health care and the main argument around decriminalisation of abortion health care at present is about taking the punitive aspect of law out of the regulatory tool box that is available for different kinds of abortion care.

One key reason people find it persuasive to take that punishment element out of the regulation of abortion care is because it is having a chilling effect on professionals providing quality abortion care and health care, and because it stigmatises this kind of reproductive health care and because it has an impact in the sense that we have seen individual prosecutions and there is fear and stigma then attached to that for individual users of abortion care. However, it is important to remember that taking the criminal law out of the regulation of abortion care and reproductive health care, that is decriminalising, is not about deregulation or full legalisation. Decriminalisation is about, as I say, removing the punitive element but there are still many other legal tools available to ensure that good practice is promoted and that poor practice is held to account. That would be the function of the civil law, for example, in regard to the tort of negligence, and
it would also be the function of professional regulation. In medical law, we have other legal tools available to hold good practice to account and to promote that good practice. Criminal law does not need to do it.

The second key point is that decriminalising does not necessarily mean one is fully legalising something. One can still adopt criteria that make certain kinds of abortion care lawful and unlawful. It is merely that one might use other sorts of public tools, such as incentive measures and funding measures, and even information, in order to monitor that boundary between what is lawful and what is unlawful. That is the first key framing issue that we might want to think about a bit more that might help implement the recommendations of the Citizens’ Assembly.

The second is the guarantee of access that I have proposed in the third part of provisions that might implement the Citizens’ Assembly objectives. That is about making clear that there is a public responsibility to provide abortion care to the highest attainable standards. One has two framing measures with regard to the statutory provisions in a possible Bill that would implement the Citizens’ Assembly, namely, decriminalisation, and a positive guarantee of access to make sure that it is the Minister for Health - the public system - which is responsible for ensuring access and for implementing principles around non-discrimination. Not only does it seek to make sure there is a level of public responsibility for delivery of a quality service but it also attempts to redress the previous situation in the sense that we know that the negative effect of abortion restriction has been most keenly felt by those who are most disadvantaged, so we can address that by making a guarantee of access as clear as possible. Those are the two framing points on which I would be delighted to take questions and comments.

I will now focus on what I am recommending in terms of the actual grounds themselves and what might be the best and clearest way to implement the recommendations of the Citizens’ Assembly. The first is on language that might implement the on-request model. There are three main reasons parliaments and people have found on-request models persuasive. Two of them are related to women-centred arguments but one is related to a more foetal life-centred argument. On-request models have received public support because they take women’s wishes seriously and that is one of the key reasons. A second key reason is because they make it easier. By that I mean there is less obstruction or less harm for the particularly vulnerable cases. Making abortion available on request means that the barriers and scrutiny that might come with particular pathways for rape victims or women who have serious health conditions are reduced in terms of facilitating access for that vulnerable group of women seeking abortion.

The third reason is because on-request models, as committee members have heard, tend to have the impact that abortions are more likely to be availed of at an earlier stage. There is a way, therefore, in which, in effect, if one takes the view that foetal life develops more value in a gradual way over time and if one does not have an absolutist value on foetal life, and many people think foetal life deserves some respect but just does not deserve the same kind of legal recognition women’s lives do, there are ways in which many different legal regimes have recognised that foetal, prenatal, life deserves some sort of respect. On-request models can deliver on that to some extent in the sense that they make it more likely that abortion would be earlier rather than later. The effect of them is also to speak to people’s concerns that prenatal life should have some respect but just not in the same way that women’s lives would have.

The other issues to think about in relation to abortion on request, and I have recommended that we follow the Citizens’ Assembly recommendations, is by providing that a person who is not more than 12 weeks pregnant may access abortion on request and without the need to demonstrate indications other than her own wishes. Again, the woman’s wishes would be the
main criteria for accessing an abortion on an on-request ground. One thing to think about in relation to that is that it might be possible, given what the Citizens’ Assembly recommended, and given the recommendations based on the World Health Organization guidelines and the kind of variety the committee has been looking at in the earlier sessions, to extend that period from 12 weeks up until something more like 22 weeks, which 44% of the Citizens’ Assembly recommended.

The final point is in relation to how to translate the types of recommendations that speak to making access available later in a pregnancy for especially vulnerable groups. What I have recommended in relation to that is that we have a ground which would allow a person who is between 12 and 22 weeks pregnant, for example, to access an abortion where an appropriately qualified medical practitioner determines that the abortion is appropriate in all the circumstances and then in making that determination the practitioner shall have regard to the pregnant person’s own wishes, feelings and thoughts on her current and future circumstances. There is a way of making sure that the pregnant woman’s concerns are part of that process but where one still has an approval process for later terminations. An appropriately qualified medical practitioner could include nurses and midwives, for example. We could expand the provision and enhance a local service in that regard.

For pregnancies that are of longer duration than 22 weeks, where the Citizens’ Assembly wanted access at that point to be still available where there was risk to the person’s life or a risk to health or in cases of fatal foetal anomaly, the idea would be that the appropriately qualified medical practitioner could consult a second appropriately qualified practitioner but that one would make it available on the legal pathway of a risk to a pregnant person’s life or health. There is a difference between the reasons people have, in particular in vulnerable situations, in terms of serious risks to health, rape or carrying a pregnancy with a serious anomaly. Those are the reasons particularly vulnerable people might have for wanting access to abortion later in pregnancy but we do not necessarily have to use that language in the law. The language we use in the law can be a more open ground such as risk to health or life. In that way one removes the ways in which criteria such as rape grounds, anomaly grounds or a finding of serious risk can be an obstruction and instead one puts the details around what circumstances might qualify into the code of practice or into guidelines. Those are really the main points I wanted to emphasise in relation to the submission. I look forward to discussing them in more detail.

Chairman: I thank Dr. Fletcher. I now call Senator Rónán Mullen. He has about three or four minutes but I will give him six minutes.

Senator Rónán Mullen: I will only take about half of that if that is okay. Is infanticide still criminalised in Britain and Northern Ireland?

Dr. Ruth Fletcher: Yes.

Senator Rónán Mullen: Does Dr. Fletcher have a different view on whether infanticide should remain a criminal offence? It is clearly her view that abortion ought to be decriminalised. Does she take the same view of infanticide?

Dr. Ruth Fletcher: That is an interesting question. I do not take the same view of infanticide. That is because I think birth is a very significant social and legal event which should mark the differentiation.

Senator Rónán Mullen: Does Dr. Fletcher think the unborn baby has any rights before
Dr. Ruth Fletcher: The way I would phrase it, and other countries have done this, which is one of the points I have been trying to make in my work for a while, is that we see there is value in prenatal life. There is an objective value in that life in that it has potentiality to go on and become a person and because we as human beings invest in the significance of that life and the work of reproduction is an important social role. Therefore, yes, I do think it has value but I do not think we need to translate that value into positive rights in the same way-----

Senator Rónán Mullen: Does Dr. Fletcher mean value only to the extent that another human being invests value in it? Is that her position?

Dr. Ruth Fletcher: That would be one of the reasons it has value but that is not the only reason. It also has symbolic value and a kind of potentiality.

Senator Rónán Mullen: I thank Dr. Fletcher. I was struck by her rationale when speaking about on-request abortion. I do not know whether this is her view but she appeared to cite the view with approval. It struck me that there was something Sir Humphrey-like about the idea that an on-request basis for abortion in some way offers some respect to the unborn because it might be argued in certain cases, but I do not think the difference is that stark, that people might have abortions earlier if it is available on request. Given that the death of the child is what results, it does not seem like an awful lot of respect for the unborn. It is a fairly tortured sop to the unborn. Is Dr. Fletcher not engaging in a kind of strategic argument that there is something here that she can call in some way pro-life by making abortion on demand?

Dr. Ruth Fletcher: No, I am not engaging in a strategic argument in that way at all. I am trying to deliver on what is a complex range of people’s wishes that are not black and white in terms of the relationship of reproduction in which a pregnant woman and a foetus are involved. I accept that people who are against all abortions would not accept that rationale.

Senator Rónán Mullen: Would Dr. Fletcher accept that from the point of view that the unborn baby has rights as a human being, decriminalisation does not make sense?

Dr. Ruth Fletcher: Yes, as I said earlier, my point is that prenatal life has an objective value but that is not the same value as a full living born person.

Senator Rónán Mullen: I might say in passing by way of some kind of compliment that Dr. Fletcher is an example of an expert that has a very particular, definite view as opposed to being an advocacy group. Professor Fionnuala McAuliffe, the then head of the Institute of Obstetricians and Gynaecologists, said in hearings here in 2013 that regardless of the legislation being discussed, she and her colleagues would continue their existing practice of trying to get every pregnancy to a stage at which the baby would survive, if it were medically safe to do so. Dr. Rhona Mahony said at the time that obstetricians are not in the business of killing foetuses and so on. Is it not the case that Dr. Fletcher and others with whom she works within a legal group, through her activism and the production of draft legislation, are proposing a radical departure from any notion that there could ever be a reason for delaying an abortion?

Dr. Ruth Fletcher: I am trying to work out what the Senator might be speculating about in asking that question. To pick up what he was saying earlier about delayed access to abortion and how it has happened in some cases that professionals have sought to continue the pregnancy in order that a live child could be delivered------
Senator Rónán Mullen: Provided it is medically safe to do so.

Dr. Ruth Fletcher: What does “medically safe” mean? If it means detaining a woman against her will or inflicting degrading treatment on her, then those are forms of treatment that are not sustainable and not rights-respecting.

Senator Rónán Mullen: Does Dr. Fletcher accept that to speak of abortion care, as she does repeatedly, does not make sense if one is thinking also in terms of the unborn baby as an entity that deserves protection?

Dr. Ruth Fletcher: Again, the unborn baby, to use the Senator’s term, does not exist in some sort of independent state. Abortion care, like all forms of reproductive health and medical care, has to address relationships. The prenatal life is being sustained by the pregnant woman and, so, in the context of delivering abortion care for the pregnant woman-----

Senator Rónán Mullen: But not for the baby?

Dr. Ruth Fletcher: There is not a way to provide care for foetal life without reducing the pregnant woman-----

Senator Rónán Mullen: We have been doing it very successfully for years in this country, caring for both mothers and babies, as our medical history attests.

Dr. Ruth Fletcher: That is contested.

Deputy Hildegarde Naughton: If this committee did nothing else but decriminalise abortion, what effect would that have?

Dr. Ruth Fletcher: The committee would have to do more than decriminalise abortion to deliver on the recommendations and ensure a safe, timely service is made available. Decriminalisation is one good tool that would take the punishment element away, but there would need to be some clarity about the terms on which an abortion service is provided. Given the history of having outsourced provision, there is not an institutional history of developing the service. The transition from a situation in this country where abortion care has not been integrated into the provision will require positive legislation to guide the terms on which the service would be provided. Decriminalisation is an important tool that would help to deliver that service, but not the only necessary tool.

Deputy Hildegarde Naughton: How does medical law and policy interact with future developments in medicine? As we know, medicine is progressing all the time. What does Dr. Fletcher consider the most effective way for legislators to make law that is able to respond to future changes in medicine?

Dr. Ruth Fletcher: As I made clear, if there is a guarantee of access in the provisions, it would be the responsibility of the Minister for Health to review and deliver an abortion care service to the highest attainable standards. That type of language is meant to work in tandem with scientific developments and allow for a review of public regulation of the service in order that it can accommodate scientific developments such as the development of the abortion Bill, for instance, but also low-tech developments. A particular trend we are seeing internationally in medicine and science technology, one which the committee does not seem to have picked up on in a significant way, is the increasing involvement of nurses and midwives in the delivery of care, because such involvement helps to deliver a quality local service. There are both low-tech
and high-tech ways in which the guarantee of access can seek to maximise the capacity of the law and regulation to respond well to scientific developments.

**Deputy Hildegarde Naughton:** We heard in previous sessions about prenatal life. What is the legal position of prenatal life, if any, under medical law?

**Dr. Ruth Fletcher:** There are a variety of positions. As I am not a comparative lawyer, I am somewhat straining my expertise in responding to this question. Certainly in medical law we do see different ways employed by which a kind of constitutional value of prenatal life is devised which is not, however, equivalent to the value accorded to persons eligible for full rights-bearing protection. In Spain, for example, the statutory language refers to the desire to respect prenatal life but states that the best way to achieve that is by providing quality reproductive health care and positive guarantees around maternity. The respect for foetal life is channelled in particular ways. We see these attempts at characterising a value in prenatal life because, as I said, people invest in and care for that life and because it is seen as having a symbolic and potential value for the future. Those ethical concerns get translated into this type of category of a legal or constitutional value that is lesser in weight than that of a full rights-bearing person.

**Senator Lynn Ruane:** I thank Dr. Fletcher for her presentation, which was very practical and useful in the way it is laid out in possible heads of Bill. It could be very helpful to the Department of Health, which is currently looking at drafting legislation.

The point regarding objective value versus societal value is a very interesting one. Will Dr. Fletcher expand on it? There is a great deal of confusion as to how societal value lines up against the human rights of an actual individual in the world, experiencing life, with family, friends and a job. The societal value placed on foetal life is very different from that and it is a distinction worth examining.

Dr. Fletcher noted that our work presents a good opportunity to learn from the implementation and operation of the Protection of Life During Pregnancy Act. From a medical law perspective, what does she consider the most important lessons to be learned from that legislation?

The witness mentioned that accommodation will have to be made for conscientious objection in abortion services provision. How best can we create a legislative model that includes such accommodation, and is there a country we might look to in so doing?

Dr. Fletcher made an interesting point around abortion access on foetal anomaly grounds and rape grounds and including them under a different category or classification, which would be risk to health. Why does she consider that classification superior to creating one or more specific grounds or categories in themselves?

**Dr. Ruth Fletcher:** On the question of societal value versus objective value in respect of foetal life, we must bear in mind that law is a complex toolbox and there are different ways in which we can respond to the fact there are pluralities in society and people have very different views, but those views are not black and white. The law can work in a way that is layered and complicated in attempting to respond to the different interests people have.

This development of a recognising of a value in foetal life is an effort to respond to that plurality but also to say that there are things we want to do such as provide good maternity care, miscarriage care and education around reproductive health and sexual health. There are things we can do which have an impact on the value of reproduction and the contribution which reproduction makes. It is a kind of public value and societal value in the reproductive contributions.
that are made. Within that model, prenatal life has some weight. However, as it does not meet the same criteria or have the same social history or social relationships as born, living, feeling, thinking women, it is not the same weight and would always be subject to the protection of the full human rights of pregnant people. However, there is still a way we can try to promote that public interest in doing the best we can in terms of the provision of reproductive health care. That is one of the reasons on-request models have found support not just among pro-choice constituencies in other jurisdictions but among constituencies where people are perhaps not against abortion entirely but they have concerns about it. Those concerns can be addressed by saying that the effect of an on-request model will make it easier for pregnant people to access abortion at earlier stages, and the views of those who adopt a kind of gradualist model of pregnancy can be accommodated in that way.

The point about learning from the Protection of Life During Pregnancy Act is an important one. Medical law would normally have audit, research and reflection into legal processes and it would be a good idea to build that into our statutory processes in this area, as in any area of law. In some areas it happens more than others. We have seen with the Protection of Life During Pregnancy Act some non-delivery of abortion care that seemed to meet legal grounds, for instance, the cases of Ms Y and the woman who was detained under the Mental Health Act. There is definitely lessons to be learned there. Even though formal legal grounds can be created for accessing abortion and making it lawful, the interpretation of those grounds needs to be guided by professional regulation and perhaps a code of practice to ensure that they are implemented fully. Those are the main areas. We can learn from what did not work as well as was expected with the Protection of Life During Pregnancy Act. Life exceptionalism - the right to life-saving abortion - can be interpreted in a more positive and human rights-respecting way to enhance the dignity of the woman whose life is threatened, for example. We see that in some Latin American countries but it does not seem to have happened in this case. That is therefore an interesting lesson to learn.

In terms of conscientious objection, my recommendation would be to recognise conscientious refusal to provide abortion care. That is out of an interest in recognising plural opinions and wanting to build a system in which there is public trust. It is not good for pregnant people accessing services if they are coming up against people who do not want to provide the care to them. There are good reasons to have a protection of conscientious refusal to provide abortion care but it has to be implemented in a way that respects the rights of the pregnant woman. There has to be a referral, for example, and it has to come under the guarantee of access in the sense that she has to get a safe and timely service, even though there is that particular conscientious refusal. It also has to be clear that it does not apply to institutions, for example, as that would be contradictory. It is supposed to protect individuals. If an institution is protected, individuals in an institution do not get their right to differentiate from the institution.

In terms of thinking about different ways in which we could implement access when pregnant women need it at later stages of pregnancy on grounds of rape or foetal anomaly, if we use the term “rape” or a diagnosis of “foetal anomaly” in the law specifically as the reason, it generates problems, as the committee has been hearing. Let me tackle the rape one first. We do not need to have the rape ground specifically in the legislation. It can be the set of circumstances which generate the risk to the woman’s health. It is a set of circumstances that generate the qualification on the legal ground. That is a typical way of addressing the issue. Then we do not have the sort of problems around requiring women to engage with the criminal justice system when they are not ready to or the proof problems the committee has been hearing about.
On foetal anomaly, we are trying to think about what is the best way of achieving legal criteria to implement the Citizens’ Assembly’s objectives. In a sense, often we have conflicting objectives. Here we are trying to avoid a stigmatisation around disability or vulnerability, for example. People have concerns that we stigmatise disability or vulnerability if we specify “foetal anomaly” in legislation. The idea is to avoid the legal stigmatisation by recognising that those are circumstances which can generate a risk to health and the ground is one that is focused on the woman or pregnant person rather than one that is focused on the anomaly of the foetus. Again, a code of practice would be used to make that clear.

Chairman: I call Deputy Durkan. I ask him to be mindful that we are quite tight on time and that another witness will be in after this. There is a lot of work to get through, not to belittle any of the comments or questions or anything of that nature.

Deputy Bernard J. Durkan: I thank Dr. Fletcher for coming before the committee and for her responses. Following on from Deputy Naughton’s line of questioning, if nothing else but decriminalisation happens, how does Dr. Fletcher see the situation developing? Would it be legislation to protect the medical sector? Alternatively, would it be left entirely to the medical sector? Would that be wise given the litigious nature of our society nowadays?

Abortion on-request with space for ongoing counselling has been raised and provision appears to be urgently needed in respect of counselling. Some countries have it and some countries do not. One of the things adduced at this committee in the past couple of weeks was that in some situations the pregnant woman changes her mind during the course of the pregnancy. How does one determine at which stage in the pregnancy it is correct to proceed in a particular fashion and to go for termination or not to go for termination given her natural tendency to change her mind in the course of the pregnancy?

Dr. Ruth Fletcher: I will deal with the last issue first and work backwards. As with any medical procedure, people often need a chance to deliberate and think about their options. The question does not point to any concerns that apply specifically to abortion care. I guess it is a question around consent and when a decision has been made about a particular health care treatment. If the person has not had the treatment, he or she can withdraw the consent or change his or her mind at any point. That is a normal part of engaging in health care options. The whole point of consent in health care is that one has the right to change one’s mind. It is part of the deliberation counselling process and this deliberative process is supported by counselling and good information. Once the pregnant person comes to the point of making a decision and going ahead with the treatment, that is the key point at which the consent operates.

Deputy Bernard J. Durkan: I ask because we also have statistics from Professor Aiken, and a graph showing the feelings of women post-abortion, which appear to confirm that women changed their minds or had some concerns afterwards. I emphasise the need for counselling and professional support for women who have a crisis pregnancy. A considerable percentage - 46% - of people who had an abortion had concerns afterwards, ranging from feelings of being alone to being isolated, feeling lost and sad, etc.

Dr. Ruth Fletcher: I am not aware of research showing that regret over abortion is significant. There tend to be relief and positive emotions.

Chairman: We are looking for the information to which the Deputy refers so that we can be clear about it.
**Dr. Ruth Fletcher:** The Deputy is concerned about people who might feel regret but that is usually associated not with the abortion, but with the set of circumstances in which they got pregnant in the first place. These are complex experiences and varied emotional responses are not a reflection on the decision to have a termination of pregnancy. We have to differentiate between changing one’s mind on the decision and having regrets about other things. It is about how we address the small number of cases where people might have-----

**Chairman:** The graph is on the screen.

**Deputy Bernard J. Durkan:** I agree but there is a need for counselling and advice beforehand where a woman or girl feels isolated and in need of such advice. In Germany that advice is available more readily than in any other country, including those where abortion is available on demand. The responses include feeling relieved, satisfied, happy, pleased, guilty and sad. A total of 10% said they felt confident and almost 10% were empowered but there were also feelings of loss. There is a considerable proportion of people in that category when one adds them all up.

**Deputy Brid Smith:** What category?

**Deputy Bernard J. Durkan:** I am asking questions. I mean no disrespect to anybody behind me. The questions relate to the total number in the group - 46% of respondents, which is a sizeable number. It states that there is no 100% as the same group is listed under both headings.

**Chairman:** I am not interrupting. I am the Chair and I do not interrupt. I clarify issues and ask for matters to be clarified. The women could have felt a number of the emotions to which the Deputy referred at the same time.

**Deputy Bernard J. Durkan:** I accept and understand that.

**Chairman:** The Deputy mentioned percentages and I do not think that is a fair reflection of the situation.

**Deputy Bernard J. Durkan:** They all fall within the category of women who had abortions. The statistics reflect the variations of their feelings afterwards.

**Dr. Ruth Fletcher:** They do not indicate a need to stray from the principle of consent in relation to abortion treatment but they might indicate a complex range of reactions which coexist. This means we need good quality counselling services and support measures and there is, through the HSE, public funding of counselling and support, both pre and post abortion care. This can be built on as the abortion care service develops. There are different regulatory tools for different purposes and public funding of counselling and information would address the Deputy’s concerns.

**Chairman:** Deputy O’Sullivan has six minutes

**Deputy Jan O’Sullivan:** It is unfortunate that, in the area of medical law, we do not have the opportunity to ask detailed forensic questions such as Senator Mullen was able to ask of Professor McCaffrey. I read his document on prenatal counselling but we have been deprived of the opportunity to ask questions of people who have a different view and it is extremely unfortunate, particularly in the context of what Dr. Fletcher said.

I reiterate what Senator Ruane said as to the usefulness of giving us advice on how the State might proceed if there was a referendum, either to amend or repeal the eighth amendment, be-
cause we do not yet know what the wording is going to be. Dr. Fletcher suggested we should proceed on the basis of a new piece of legislation rather than trying to amend previous legislation. Can she expand a little on that?

**Dr. Ruth Fletcher:** There is a very practical reason in the sense that if one has to adopt legislation which amends an earlier piece of legislation, one ends up working with two Acts. It might be simpler to repeal in its entirety and replace it with a new Act and this would satisfy the basic objective of simplifying the statutory structure. A second reason is that the transition from a legal regime which has taken an exceptional approach to abortion care - in that it is only available when the life of a woman is at risk - to a system which allows abortion on request, to some extent, is a major one. They are two very different regimes so the transition would be better marked by adopting an Act that did not have limitations relating to life-saving exceptionalism as the Protection of Life During Pregnancy Act has. Does that answer the question?

**Deputy Jan O’Sullivan:** Yes. Thank you.

**Deputy Catherine Murphy:** I thank Dr. Fletcher for her paper, which was very clear and helpful. Are there any other jurisdictions where there is a legal system which is not based on primary law? I am thinking of the Canadian model.

**Dr. Ruth Fletcher:** The Deputy is asking about places where there might be an absence of criminal law.

**Deputy Catherine Murphy:** Yes.

**Dr. Ruth Fletcher:** Did the Deputy say “primary law”?

**Deputy Catherine Murphy:** I said “primary legislation”.

**Dr. Ruth Fletcher:** There are such examples and Canada, where abortion care is regulated under the health act, is one. Decriminalisation came with the striking down of the criminal provisions by the Supreme Court. This might not translate particularly well into the Irish environment because we might need more than the striking down of the criminal provisions. Obviously, that is something to be debated and considered.

**Deputy Catherine Murphy:** The witness obviously based her paper on the Citizens’ Assembly. There were two elements to it. Undoubtedly, a change to the Constitution was envisaged by the assembly. I hope that it will be a straightforward repeal, although that decision has yet to be made, even by this committee. The second phase related to legislation and it cannot predate the referendum. The assembly identified a number of issues, for example, rape and incest, which we have discussed in the committee, that are incredibly difficult to incorporate into law. The on-request provision would take care of some of that up to the first trimester, for example. However, incorporating it afterwards means it could be provided for if there are other sets of circumstances. What are the other circumstances one would have to provide for specifically to cater for that?

**Dr. Ruth Fletcher:** The legal ground would be a risk to health. The circumstances where somebody is pregnant through rape and is distressed and vulnerable and does not want to continue that pregnancy clearly can constitute a risk to her psychological health. It is to continue the pregnancy against her will in circumstances where she is pregnant through a violation in that way. There are different circumstances. That set of circumstances relating to her experience of pregnancy through rape can constitute the risk to health. That would be the legal ground
specified in the legislation. The rape circumstance is the risk to health legal ground in statute. Then there would be a code of practice or regulation to join the pathway between the two.

**Deputy Catherine Murphy:** Would one use medical professionals to adjudicate on this?

**Dr. Ruth Fletcher:** One would guide their adjudication of it with something like a public policy document. One would not leave it entirely to the professionals. One has the option of not leaving it entirely either to professional practice or professional guidelines. The link between those two can be made more explicit by Department of Health guidance. In that sense it would be State public policy rather than professional guidance.

**Deputy Catherine Murphy:** With regard to health in the second trimester, the Citizens’ Assembly considered serious risk and risk to health. Is that something one can adjudicate on?

**Dr. Ruth Fletcher:** This is why I did not use the word “serious”. We have a history of the term “real and substantial” operating as a barrier. To the same point, if one adds something such as “serious” into a ground like risk to health, that could potentially become an obstruction or barrier in respect of what counts as serious. The empirical research on pregnant people’s reasons for abortion at later stages tells us that they have very serious reasons, by and large. We do not have an evidence base that would suggest a need for requiring that seriousness in statutory language. It is there already in the practice of abortion seeking. That is one reason we do not need it. The more negative reason is that it can operate as a restriction or barrier in some instances. If we want to move towards a policy and practice which is led by removal of barriers which might have an impact on the health and human rights of pregnant people we should avoid qualifying language such as “serious”.

**Deputy Clare Daly:** Dr. Fletcher’s input was clear and helpful, which minimises our need to ask questions. A number of questions have been asked already but I wish to raise a few matters. The witness has given a good insight into how some or all of the Citizens’ Assembly recommendations might be recommended. We can probably take it as a given that even if we did not implement some of them, new legislation will require that the Protection of Life During Pregnancy Act will have to go. I wish to explore the decriminalisation issue. That is the only legislation on the Statute Book at present that criminalises abortion outside the narrow circumstances where there is a danger to a woman’s life. It would be necessary to remove that legislation, therefore it is not legal or illegal. It is just there. The regulation of the abortion pill would be through normal health regulation of products in a pharmacy or how all of that is regulated for and administered by one’s pharmacist, nurse, midwife or whatever. It is a little like the morning after pill. It would be part of the health service, not with conditions laid down in law. It is just a medical product that is licensed in Ireland. Could that be done in the context of getting rid of the Protection of Life During Pregnancy Act post-repeal?

**Dr. Ruth Fletcher:** Yes, one could do that. One of the options would be to repeal the Protection of Life During Pregnancy Act and to integrate abortion care into existing regulation. There is much to be said for that. Given that it is a big transition and that it will have an impact on the professional delivery of care, a statute would lay out things such as the guarantee of access. We are used to thinking of legislation as being restrictive but we could switch and think about legislation that can be promotional of good practice. That would be the reason a statute might be a good thing to replace that Act, to make it clear that it is a reproductive health statute, to decriminalise and to promote public provision.

**Deputy Clare Daly:** There could be legislation which would provide for the broader
grounds in later pregnancy and regulate the earlier one.

**Dr. Ruth Fletcher:** I thank the Deputy for raising that, because I left that part out in my response. The legislation is making clear the criteria for lawful abortions. As it is clarifying those terms that makes it easier for implementation.

**Deputy Clare Daly:** That is helpful. We have a great deal of evidence, and we know ourselves, that nobody wants women or practitioners being criminalised for this. Access is a key issue. It has been a thread today. Even for people who might have reservations and who would say they are not in favour of unlimited access to abortion, the best way of guaranteeing access is through early availability for the first trimester. Perhaps the witness would elaborate on that point. I believe Senator Mullen was a little unfair to her earlier in the comments about her point, which was, in effect, that this would respect the view of some citizens on prenatal life. My interpretation of what the witness meant, although I might be wrong, was that people would view access to abortion on request up to 12 weeks as dealing with what at that stage, as anybody who has had a miscarriage knows, is like a heavy period. It is a little blood clotting and perhaps a little cramping. It is not the same as a fully grown woman. People recognise that there is a difference between that up to the first trimester and a foetus on the point of viability. By distinguishing in that way and making abortion available on request in the early term one is accommodating that. Perhaps the witness would expand on that.

**Dr. Ruth Fletcher:** Absolutely. There are probably two key points in respect of thinking about how on request models can accommodate different people’s beliefs around the value of prenatal life. One would be where people have a type of gradualist approach, that in the early stages it is not as significant in value as it might be in the later stages. Adopting an on request model because it makes it more likely that people would access abortion at earlier stages means, in effect, one is achieving that goal of gradualist protection. Another point is that the lack of access in the prohibition does not have the effect of stopping abortions, so one is not achieving protection of prenatal life when one prohibits it in that way. The two work as either side of a coin. People who do not take a gradualist perspective, whose perspective may be about the symbolic or potential value of foetal life and it would not necessarily vary for them but again it would have less weight than the sentient woman, will be accommodated by a system which balances the different interests at issue by allowing earlier access and fewer obstacles to access in the earlier stages. I would encourage the committee to think about whether they want to stick with the 12 week limitation, given the variety that is available in other jurisdictions and given the size of the vote in the Citizens’ Assembly, which was 44% in favour versus 48% against. If the Citizens’ Assembly got to the point of thinking about how to remove barriers to access and thinking about how to apply an on-request model in various ways, with 44% supporting abortion until 22 weeks, that is a lesson for us in terms of the impact of evidence and public education on support for those models.

**Chairman:** That concludes this session. I thank Dr. Fletcher for her attendance as it has been very helpful.

*Sitting suspended at 5.30 p.m. and resumed at 6.15 p.m.*

**Risks to Mental Health:** Dr. Anthony McCarthy, National Maternity Hospital, Holles Street

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Chairman: We will resume in public session. I welcome back members and viewers who are tuned in on Oireachtas television. I welcome Professor Anthony McCarthy, consultant perinatal psychiatrist, National Maternity Hospital in Holles Street, to this evening’s meeting. Ordinarily, I would read the note on privilege and the Defamation Act 2009. Is Professor McCarthy familiar with that or would he like me to go through it?

Dr. Anthony McCarthy: I have spoken at committees previously.

Chairman: I figured as much. I just have to check. I am saving everybody having to listen to me say the same thing three or four times a day. I now call on Professor McCarthy to make his presentation.

Dr. Anthony McCarthy: I thank the committee for inviting me to address the committee. I hope to be able to answer any questions which members might like to ask by bringing the benefit of my experience and expertise, and my knowledge of the research in the field of pregnancy and mental health and illness. I have worked as a consultant perinatal psychiatrist at the National Maternity Hospital in Holles Street for the past 21 years where more than 500 women attend the clinic each year. Women are seen who are pregnant or who are in the first six months post pregnancy, which includes pregnancy loss, and where a significant mental health issue is involved. Women attending may have a previous mental health history or a significant new crisis may develop during or after the pregnancy. Among those who attend will be many who have suffered a miscarriage. Others may have had a stillbirth or may have a baby diagnosed with a significant abnormality of varying levels of severity, may have had a previous termination or may be considering a termination.

I have previously spoken as an expert witness at the two Oireachtas hearings which led to the introduction of the Protection of Life During Pregnancy Act 2013. I was also invited to speak as an expert witness to the Citizens’ Assembly. I am also an expert assessor for the Confidential Enquiry into Maternal Deaths in the UK and Ireland. This involves detailed study of the records of women who have died during pregnancy or in the first year afterwards, as a result of suicide or other mental health causes.

What I can say now after all of these years of working in this area, and from my understanding of relevant research and of history, is that while having a baby is, hopefully, and fortunately for many, one of the most joyful, rewarding and meaningful experiences of their lives, as the committee members all will be aware, it is also unfortunately so often not like this. The committee members will know this from their own lives, those of their families and friends, and of course, also from listening to many of the stories told here to this committee and to the Citizens’ Assembly. Most of the committee members will have heard of, or personally witnessed, stories of depression or distress, of unwanted pregnancies, of rape, or the discovery of major foetal abnormalities, or of the termination of pregnancies in the UK and here in Ireland. These are stories heard so regularly in my clinic in Holles Street.

In an ideal world, abortion would never be needed or requested, but even if we exclude medical emergencies and severe life threatening indications, we cannot wish abortion away. It has been a part of the history of every country, including Ireland, and before it became legally available in the UK 50 years ago, and therefore available for thousands of Irish women every year since, it was illegally available here in Ireland for those who could pay. Of course, there was infanticide, too, which was such a widespread practice. I would urge anyone who is unaware of the nature and extent of this to read Dr. Clíona Rattigan’s seminal history, *What Else Could I Do?*, a detailed study of hundreds of cases of infanticide in Ireland between 1900
and 1950, or the work of Dr. Elaine Farrell, who studied 4,645 infanticides in Ireland between 1850 and 1900 and published her work, entitled *A Most Diabolical Deed*. Dr. Rattigan quoted a judge in County Clare in the 1930s who described the “epidemic of infanticide cases” he had to hear. Both studies emphasise that these numbers were an underestimate of the true scale of infanticide in Ireland at that time. We do not want to go back to an era of illegal back street abortions and infanticide.

In my clinical work, of course, most of the women who I see for whom a termination of pregnancy is an issue are seeing me because of their or their partner’s concern about their mental health. Sometimes that termination could potentially be very damaging for them. For example, a woman who has a planned and much wanted pregnancy, but who develops severe depression which is clearly clouding her judgment about everything in her life, and not just the pregnancy, keeps thinking she should terminate because she would be a bad or evil mother. She needs expert help for her depression. A termination is almost certainly not what she wants and could be very damaging to her mental health long term. For another, however, she is clear that she cannot continue the pregnancy, she cannot cope and continuing the pregnancy would destroy her life. She is in no way mentally unwell but she may be terrified of becoming unwell.

How any woman responds to a pregnancy is personal to her and how she visualises and imagines what is or is not growing inside her is unique. For example, one woman who has an early miscarriage will say that what she lost was a just pregnancy for her, not a baby, that she knows it happens in 20% of all pregnancies, and it is just nature’s way. It was just like a heavy period. For another, she may have a huge sense of loss of a baby, name it and grieve for it, even if the scan actually showed a so-called empty sac, or even if she has had a rare molar pregnancy where there was only ever placental tissue and no foetus but her pregnancy tests were repeatedly positive and she may grieve as though it was a baby.

These sorts of inner perceptions and beliefs and imaginings that determine so much, and often more so than any biological reality. It is part of what makes us human. One woman with a baby with a fatal foetal abnormality may decide that she or they want to continue the pregnancy because she wants to hold on to that baby inside her as long as possible, and she hopes that the baby will die inside her and not shortly after, as it is safe and warm inside of her. Another will feel she cannot bear to think of the baby suffocating inside her or being in pain, or the distress of it dying inside her. She loves that baby but she will want a termination and she will love it afterwards. Another woman will say she wants the baby delivered early and hopefully alive still so that she or they will be able to hold the baby for a few minutes before it dies, and may bring the pregnancy on early for that reason. As doctors we must be aware of the complexities involved for everyone, and listen and not prejudge.

I now turn to mental health outcomes after induced abortion and the research evidence in this area. It has been mentioned by members of the committee and some speakers in earlier sessions. It is important to note that no significant research on this subject has been completed in Ireland. Research from the UK, the USA and Australia, for instance, may not be applicable here or may only be in a very limited way because it is different here. There are many other limitations to most of the research in this area, which include researcher bias, inadequate control for confounding variables and inappropriate control groups, and the failure to control for previous mental health problems. My advice, particularly for those unused to reading medical papers, is to read any such research in a critical, informed and objective way.

The best overall publication in this area was by the Academy of Medical Royal Colleges in the UK which published a systematic review of the mental health outcomes of induced abortion.
in which they reviewed all of the research evidence available and critically analysed all published research which reached basic scientific standards. The key findings of this overview of all studies were as follows. An unwanted pregnancy in itself is associated with an increased risk of mental health problems. The rates of mental health problems in unwanted pregnancies were the same after termination or after giving birth. The most reliable predictor of post-abortion mental health problems was having mental health problems before the pregnancy or abortion. Women who were pressurised to have a termination and women who were exposed to strongly negative attitudes towards abortion in general and to her personal experience were likely to have long-term mental health problems.

For any and every woman who might seek mental health advice in this situation, it will be the specifics of her individual situation - her distress, history, and personal beliefs and wishes - and often that of her partner which must be listened to and understood. The research evidence is helpful in general but never specific to any individual life situation. The dilemmas for women in such difficult situations will always be painful and distressing. I consider it my responsibility as a psychiatrist in Holles Street not to add to their pain and distress. I hope the committee will be of the same view.

**Chairman:** We do not have any lead speakers as their time ran out so if anyone wishes to speak, they should indicate.

**Senator Rónán Mullen:** I thank Dr. McCarthy for his presentation. I will start by drawing his attention to his remarks regarding his not wanting to return to an era of illegal back street abortions and infanticide. Any reasonable person would shudder at the thought of living in such an era. Would Dr. McCarthy say that a scenario that is as horrific is that in modern Britain where there is an abortion rate which we estimate is four times that of the Irish rate, if we judge by the numbers of Irish women who go abroad? In that case there is no protection in law for unborn babies up to 24 weeks and no protection where there is any kind of disability, including mild disability. Does Dr. McCarthy agree that also presents an horrific scenario to a fair-minded, reasonable, caring doctor if they had two patients in mind?

**Dr. Anthony McCarthy:** I raised the matter of infanticide because I am very aware of history. I am also aware, particularly as a psychiatrist, of the history of psychiatry, women who were pregnant, and the control and often the severe things that psychiatry was involved in and responsible for during their pregnancies. I do not want to go back to anything in history. In my practice in Holles Street, my responsibility to anyone who comes to me is to make the best decision for them. When someone comes to see me, I am certainly not there to encourage them to have a termination if, in helping them to come to a decision, that is the worst thing to do. Those circumstances would have a very negative outcome. I am equally not there to bring any personal view to her decision. From my work in the confidential inquiry into maternal deaths, it was evident that so often, when women kill themselves, they do so while pregnant, sometimes with one baby or two, or there is infanticide afterwards. There is a hierarchy of ideals. An ideal is where everyone is happy with pregnancy and everything is wonderful. If I must have a choice between infanticide, back street abortion and abortion in an everyday way, my hierarchy is to go for the least damaging option. That is a personal view. My professional responsibility is to deal with the individual woman before me, and maybe her partner, to help her or them come to the decision that is right for her or them.

**Senator Rónán Mullen:** Is that a yes or no to the British scenario being somewhat horrific?

**Dr. Anthony McCarthy:** It is not my responsibility to deal with that. When I see a dead
woman, when I read a file of 750 pages that begins with the day she became pregnant, and maybe she wanted to be pregnant, and I know that on the second last page I will read the post mortem report for her, that is what informs my way of thinking about these things.

Senator Rónán Mullen: When Dr. McCarthy speaks of them, is he thinking about two patients including the baby, irrespective of how welcome he or she might be then? Does he feel he has a duty of care to the baby?

Dr. Anthony McCarthy: There is clearly a duty of care to the baby. As the Senator will know, it is enshrined in the Protection of Life During Pregnancy Act, for example.

Senator Rónán Mullen: What about ethically? What is Dr. McCarthy’s own outlook?

Dr. Anthony McCarthy: Each time I see a woman in pregnancy, I am involved in having to think of the baby also. Most women who come to see me during pregnancy do so for advice regarding the safety of taking medication. They may have a previous mental health illness and want to know if the medication they take is likely to damage the pregnancy. I have to take considerable time on this. Sometimes I have to look at medication, the women may not be taking it or they might be drinking or smoking and they are damaging their baby. I have to spend considerable time thinking about the damage that maybe done to babies in pregnancy. I have seen women who have taken abortion pills -----

Senator Rónán Mullen: I suppose I mean requests for abortion and the British law. We will move on as we are stuck for time. That really is the big problem with our work. Dr. McCarthy referred to research. We all agree that good quality research is necessary for normal functioning of the law and we cannot ignore it. I draw Dr. McCarthy’s attention to the work of Professor David Fergusson. I am sure we agree that he is one of the most highly published mental health professionals globally and that he would not have skin in the game when it comes to coming down on either ideological side. Professor Fergusson has published a piece in 2013 in the Australian & New Zealand Journal of Psychiatry in which he reviewed the four best studies from the place which Dr. McCarthy correctly said is the place to go. Its conclusion was that there is no available evidence to suggest that abortion has therapeutic effects in reducing mental health risks of unwanted or intended pregnancy. There is suggestive evidence that abortion may be associated with small to moderate increases in risks of some mental health problems, and there are particular circumstances in which that might arise, such as previous mental health history. That being the case, does Dr. McCarthy agree that it would be unconscionable that any jurisdiction providing abortion would not be in the business of checking if a woman has a prior mental health history, that it would be under a duty to advise of the potential risks if there was any evidence of mental history, and that should be mandatory practice across the board?

Dr. Anthony McCarthy: The paper to which the Senator referred is a very good paper. It agrees with the basic assessment point I made, namely, that the mental health outcomes after termination or pregnancy are similar. In both cases, the risk is increased. Pregnancy itself is a risk to mental health. The reason I have a very busy service in the National Maternity Hospital is because of the mental health problems associated with the complications of pregnancy.

If a woman has a termination, she is equally likely to have mental health problems and no less or no more than a woman who does not have a termination and goes on to have a baby. Both are vulnerable. It is the single most vulnerable time in a woman’s life. A woman is 19 times more likely to be admitted to a psychiatric hospital in the first six weeks after the birth of a baby than in any other six-week period in her life.
There are certain circumstances, in particular in the case of women who have previous serious mental health problems, where women are more vulnerable to having problems whether they have a termination or go on to have a baby.

**Senator Rónán Mullen:** Professor McCarthy referred to it by implication.

**Dr. Anthony McCarthy:** There is an idea that everybody should have counselling and be assessed for serious mental health problems. One of the major challenges in my clinic is that many women come to my service who do not want to have any counselling whatsoever. First, what is a mental health problem? Is it stress after an exam when I was 15? Is it somebody who had anorexia? Is it somebody who had a major depression after bereavement? Something may have happened ten or 15 years ago. Are we going to insist that a person has to talk to a counsellor or expert or psychiatrist in some form? That would be absolutely impossible. We know from our work that if somebody wants to have counselling, he or she will get counselling.

**Senator Rónán Mullen:** We are shot for time. Counselling is one thing. Given that there is at least one life at stake, and potentially two, the gravity involved, the culture of informed consent which applies in other areas of medicine and the duty of care involved, surely it is not excessive to expect a basic investigation to see what type of person is before one?

I refer to a study from Professor Ferguson. The ground has moved. In 1994, the Royal College of Psychiatrists found that the risk to psychological health from termination of pregnancy in the first trimester was much less than the risks associated with proceeding with a pregnancy which is clearly harming the mother’s mental health. Professor Ferguson described a big shift from that ground of seeing potential benefits to a situation where nobody is now talking about the mental health benefits of abortion. Rather, it is case equal. The only question is whether it causes mental health problems in certain cases. He is very cautious in his studies. In 2008, he noted that the specific issue of whether induced abortion has harmful effects on women’s mental health remains to be fully resolved. There is a movement away from seeing any kind of benefit on mental health grounds.

Dr. Ruth Fletcher argued that the concept of health should be used to encompass situations like the claim for abortion on the grounds of foetal anomaly or cases of rape, and that health could be used as a grounds to avoid legal stigmatisation. She stated such circumstances could contribute to a risk to health. I presume she was talking about mental health.

The work of Professor Ferguson, which has analysed other work, seems to suggest that one does not go there on mental health grounds. Would Dr. McCarthy agree?

**Dr. Anthony McCarthy:** Some 20% of women will have a mental health problem at some stage in their lives. The figure is lower in men, and there is a very interesting discussion as to why that is. Some feminists would say that women’s mental health problems have been caused by men. Women come to psychiatrists----

**Senator Rónán Mullen:** Let us say some men.

**Dr. Anthony McCarthy:** Women go to psychiatrists. Men go to prison with their violence. There is almost an attitude nowadays that no matter what happens in people’s lives they need counselling. It is rubbish to suggest that someone who has been bereaved needs counselling. Most people, following bereavement, want to be silent or talk to their partner, spouse, mother or friend. They do not need counselling. After major trauma there is a notion that people need to be debriefed in some way. The reality is that often a debriefing does more harm than good.
People who want counselling will seek out a counsellor and talk. People who do not, but are forced to, will tell a counsellor nothing. The session will be empty and useless and the person will resent it. In fact, one may do people more harm by forcing them into a process which de-means them.

The women who come to see me in Holles Street for advice want that advice and, therefore, are very open and tend to bring up all of the key questions. As the committee knows, it will be a very long time before we have enough psychiatrists in Ireland to see everyone. I currently have 1.5 days a week in Holles Street and have two colleagues in the other Dublin maternity hospitals. There are no such specialists anywhere outside of Dublin. The idea that women would have to undergo counselling is impractical. More truthfully, the idea that every woman who ever had a mental health problem should have that assessed by a psychiatrist before she can have a termination is an insult to women.

Senator Rónán Mullen: Is Professor McCarthy agreeing with me that it would be wrong to invoke health as grounds for termination? Professor Ferguson said his conclusions have important, if uncomfortable, implications for clinical practice and the law in its interpretation in jurisdictions which require abortion to be authorised on medical grounds. He went on to state his view was that the growing evidence suggesting that abortion does not have therapeutic benefits cannot be ignored indefinitely and it is unacceptable for clinicians to authorise large numbers of abortions on grounds for which there is currently no scientific evidence. Does Professor McCarthy agree that there has been a shift away from invoking mental health?

Dr. Anthony McCarthy: I understand why Senator Mullen is asking that question.

Senator Rónán Mullen: Do not mind why I am asking it. The question is important.

Dr. Anthony McCarthy: Should we, therefore, insist that before any woman becomes pregnant she sees a psychiatrist to have her mental health assessed?

Senator Rónán Mullen: Could Professor McCarthy repeat that?

Dr. Anthony McCarthy: Should we insist that a woman should see a psychiatrist before she becomes pregnant in the first place? That might be equally damaging to her mental health.

Senator Rónán Mullen: Yes. In other words, mental health is not to be invoked. Does Professor McCarthy accept what Professor Ferguson said?

Dr. Anthony McCarthy: Did Senator Mullen hear my answer? Does he realise what he answered? I said we are accepting that termination of pregnancy and pregnancy are both serious threats to a woman’s mental health. Therefore, we should develop a system where women, before they get pregnant, should see a psychiatrist to have their mental health assessed before they can have a baby or termination.

Senator Rónán Mullen: Professor McCarthy is arguing an absurd proposition-----

Dr. Anthony McCarthy: Exactly.

Senator Rónán Mullen: -----for rhetorical effect. He appears not to be uncomfortable with the question I have put.

Dr. Anthony McCarthy: I am not uncomfortable with the question. It is a ludicrous idea to suggest compulsory counselling. The term “mental health” is broad. It includes mild anxiety,
a phobia, serious depression-----

**Senator Rónán Mullen:** Professor McCarthy should not blame me. That is the British abortion law. I asked him earlier if he had any problems with the British abortion law and he declined any expression of disapproval. Do not blame me for the British abortion law.

**Dr. Anthony McCarthy:** I am not.

**Senator Rónán Mullen:** I thank Professor McCarthy.

**Chairman:** I have allowed you 13 minutes.

**Senator Rónán Mullen:** I hope people found it useful. We could do with 30 minutes each.

**Chairman:** Excuse me. I have given you more time. I think you have asked questions that need to be asked. I appreciate that. Thank you.

**Senator Paul Gavan:** I thank Professor McCarthy for his presentation. I found it fascinating when I read it yesterday. I was particularly struck by the history of infanticide in our country. I was not aware of it and it is another indicator of what a dark place this country was for women so long. It is to be hoped we are involved in a process which will move us all to a better place. I thank him for that.

I am tempted to repeat one line from his presentation, namely, “We cannot wish abortion away”. Some of us may need to think about that. He said that fears about the enactment of the 2013 Act would lead to significant numbers of pregnant women trying to fool clinicians into granting abortions by threatening suicide have not been borne out in real life and were never going to be. Could he speak a little more about that, as a professional in the area?

**Dr. Anthony McCarthy:** That is not part of my presentation from today. When I spoke before the Seanad in the sessions that led to the development of that Act, I know people were saying there would be bus loads of such people. I remember being asked if buses of psychiatrists would be coming in from elsewhere or women would be queuing to come to psychiatrists and lie to us or fool us by saying they are suicidal, etc. I put it on the line and said it was ludicrous and it would never happen. Could he speak a little more about that, as a professional in the area?

**Dr. Anthony McCarthy:** That is not part of my presentation from today. When I spoke before the Seanad in the sessions that led to the development of that Act, I know people were saying there would be bus loads of such people. I remember being asked if buses of psychiatrists would be coming in from elsewhere or women would be queuing to come to psychiatrists and lie to us or fool us by saying they are suicidal, etc. I put it on the line and said it was ludicrous and it would never happen. In the years since the Act was established, I have seen one woman in Holles Street in that circumstance.

There was the idea that women would somehow invent these stories but the women I see are genuinely distressed, whether they have a termination or keep the baby. It is a genuine and real problem. They are in desperation by the time they come to see somebody like me. There is the phrase, “Sometimes the world is more full of weeping than you can understand”, and it might be over my office door because of some of the stories I hear. The idea that pregnant women would come in to see psychiatrists to fool them into thinking they are suicidal is not how it works in the real world. It was somebody’s fantasy that this would happen.

**Senator Paul Gavan:** In the real world I am very conscious that right now women must travel and leave the country if they need a termination. Is that a good thing?

**Dr. Anthony McCarthy:** How could it be a good thing? I see women who come back afterwards as well, and they have a level of distress. The committee has heard the stories and I do not need to repeat them. How could any human being react listening to women describing taking the boat rather than the plane and bringing the foetus in a bag? I will sometimes have seen them before the termination. They will show love for the foetus and have a photograph of
it. It is a baby they loved but this was the only way for them to deal with the matter. They are hurt, outraged or upset that they had to go to the UK.

**Senator Paul Gavan:** Is it not horrific that women have to face that at this point? How is the 2013 Act working? I know this was not part of Dr. McCarthy’s presentation but it is relevant for decisions we must make on legislation. Do the current procedures under the Act provide dignity to patients? Are they workable across the country? Do they ensure pregnant women and girls who may need an abortion due to risk of suicide would be able to access the service? Are they necessitated and could another pathway be considered?

**Dr. Anthony McCarthy:** As the Senator was speaking I was thinking about what Senator Mullen asked. My views on abortion, to a certain extent, do not matter as the women I see who are going to have an abortion are having them anyway. It is such an irrelevant question for me in my practice. The women will have it here, buying their tablets on the Internet, or they will travel. I do not even think about what is happening in the UK except that people have to travel there. They are losing their babies anyway. It is happening.

To answer the Senator’s question, as he knows there have been very few such cases. A woman has to see two psychiatrists, who have to agree, and one obstetrician. If everybody agrees on the case, that is it. It is a problem and I know cases have been highlighted where things went very poorly. Some of the psychiatrists who saw patients in those circumstances had never previously dealt with a mental health problem in a pregnant women or seen women in those circumstances. Some of the decisions made led to court orders and various other processes because those who did the assessment never did the work in a daily way before. Of course, there is no adequate provision of psychiatry services around the country.

Fortunately, there is a perinatal mental health strategy that is about to come out and it recommends that there should be full-time psychiatrists in every large maternity unit in the country. It argues there should liaison psychiatry at least part-time in every maternity hospital around the country. It is coming. Fortunately, I was right in that the demand was never going to be there; it has amounted to a trickle. Some of those women have had very faulty assessments as those who saw them had no training in the field.

**Senator Lynn Ruane:** I thank the witness for the presentation. When I read it I could tell how person-centred it was and I appreciated how human it was as well. I am sure that translates into how the witness treats women when they come to him. I got some solace from that in reading the presentation. Senator Gavan posed the questions I wanted to ask so I will some comments instead.

Senator Mullen upset me when he used the words, “what type of person is before one”. I am not really sure what that meant. The Senator said in reference to someone arriving and having mental health issues, and whether the person would have had mental health issues before arriving. The phrase used was “what type of person is before one”. I do not know the Senator’s intent. I took it to mean that if a person has a mental health issue before coming pregnant, somehow this would undermine the woman’s capacity, as a person, to have autonomy and view of life and who she is. I did not appreciate it. As a woman and mother who sought help during my second pregnancy from the witness’s counterpart in the Rotunda, I found the comment very distressing. I will stand corrected if the intent was not there but I suggest that the Senator read the debate. He referred to “what type of person is before one”. She would be the same person and the continuity remains the same.
If caring about women entering an office and women’s health in general is ideological, I thank the witness for his ideology.

Chairman: Does Senator Mullen have a point of order?

Senator Rónán Mullen: I ask you to please impose some kind of structure and fairness here when a person is attacked, as I was when seeking to tease out matters. I thought I was being reasonably clear. Senator Ruane has responded in a personal way and implied some kind of motivation or attitude in me that certainly is not there. How can we have a fair process here if, once one has finished trying to respectfully elicit information and answers, one is attacked in a frontal and emotional way by a colleague? It is making a farce of this procedure. Anybody listening would know of my bona fides in my line of questioning. It would be a great regret to me if Senator Ruane was upset but I cannot remember anything I said that would have been objectionable. I was trying to deal with complex mental health grounds for abortion and people with a history of mental health issues being particularly vulnerable.

First, I clarify there was certainly nothing of bad intent in what I say. Second, I should not need to make such a clarification. To be taken on in this way by a colleague with no chance other than by seeking a point of order to respond does not auger well for this process. We have had problems of this kind on countless other occasions.

Chairman: The Senator’s comments are very much noted. The Senator said what she had to say.

Senator Rónán Mullen: I would appreciate your ruling on it.

Chairman: There is no ruling to be made.

Senator Rónán Mullen: Suppose I had gone from the room. The media would be left with some notion that I had some kind of bad attitude.

Chairman: I was very aware of the fact you were in the room, which is why I allowed the Senator to make a comment and you to respond. I will not get involved.

Senator Rónán Mullen: You could be more generous in your defence of every member’s right to try to tease out complex matters in a respectful way without being sniped at by colleagues. I never do it.

Chairman: I reiterate the comments I have made on numerous occasions. I want this to be a place where people feel they can make comments and ask questions. It is a very difficult and divisive matter. In so far as it is possible for me as a referee, I have allowed the process to unfold. Unless people stray into an area that is not allowed-----

Senator Rónán Mullen: I think the Chairman allowed it. She saw where it was going. It was very personalised.

Chairman: I did not see anything of the sort. I have given the Senator the opportunity to respond but it seems I am still wrong. Could we move on?

Senator Lynn Ruane: Up to now we could not apparently use words like “mesmerise” but when a person on the committee wishes to express her distress-----

Chairman: Senator-----
Senator Lynn Ruane: The Senator has a problem with a woman making such an expression. We are talking about the experience of pregnant women. I happen to have been one of them and my comments are valid.

Chairman: Please, if you want to have a row, take it outside.

Senator Rónán Mullen: Only one of us sought a row. I only sought to defend my good name.

Chairman: I directed that to Senator Ruane.

Senator Rónán Mullen: If you were not speaking in the plural, that is okay. Thank you.

Chairman: I call Deputy O’Brien. Sorry, it is Deputy O’Reilly. I wrote down Deputy O’Brien, I wrote down the wrong name for some reason.

Deputy Louise O’Reilly: That is fine. To return to one of the points made by Senator Ruane, I do think there has to be a certain amount of respect given to those of us on the committee when we are discussing pregnancy related issues who have had that very personal experience. I found the content of some of what was said quite disrespectful. I do not intend to get into a row with anybody about it. In fact, the more people who see it, the more the disrespect is evident.

With regard to the perinatal mental health strategy, we appreciate that it is to be introduced. That will require a significant amount of investment and upskilling of personnel. It is also going to require access right across the country. We would welcome the fact that it is on its way but what we are discussing is the grounds as laid down by the Citizens’ Assembly. One of those is the mental health of the pregnant woman. As things stand we are clearly struggling in that area. It is true to say there is a huge amount of compassion and it is radiating from the evidence we have heard. That is very much to be welcomed.

Does Dr. McCarthy agree with me that the added stress and trauma for a pregnant woman in terms of what the 2013 Act places on her is compounded by the lack of resources? While we are considering the issue around access to termination on the grounds of mental health, we must also consider the resources and the implications for that. That is going to be important for us.

We are considering risk. I have asked this question of every single witness. I appreciate that I usually get the same answer but it is important that we have it on the record. My understanding is that it is quite tough for us as legislators using legalistic terminology to hand the medical professionals a piece of paperwork and ask them to make medical decisions based on it. We use terms such as “grave risk” and “serious risk”. Will Dr. McCarthy indicate whether such terms are in use in the medical profession or is it more likely that there is just risk, that there are not categories such as “grave” and “serious”? What kind of terminology is used? I am conscious that what we are doing is trying to devise a legalistic framework, but when that is finished, we hand it to the medical profession. How easy will it be to translate that? I am conscious of the 2013 Act and the necessary complications that arise out of that, and the fact that all of the available evidence suggests, as was pointed out by a lot of people in advance of it, that it is fairly unworkable for most people. We know the result of that. We use legalistic terms in listing the gradation of the risk. Is there anything we can do to help to translate that for practical use?

Dr. Anthony McCarthy: First, I will make a brief response to the first part of what Deputy O’Reilly said, which echoed what Senator Ruane said. Just because a woman has had a mental health problem in the vast majority of cases, it does not in any way affect her capacity to make
decisions for herself. That is the response to the question on capacity. In the vast majority of women it is not a question of capacity whatsoever. I wish to make that point.

As regards the 2013 Act, as I said at the outset, before the legislation was enacted, the reality is that for the vast majority of women who are depressed and suicidal in pregnancy, they do not want a termination. However, the vast majority of women who want a termination are not depressed. They do not need to see a psychiatrist. For the majority of those women who are depressed in pregnancy and want a termination, they are not going to go through an Irish process. Why would they? They are going to go to the UK anyway or they are going to order pills over the Internet. Even if there were psychiatrists all over the country, most of them do not feel they need to see a psychiatrist. Most of them do not think they need to see one psychiatrist let alone two psychiatrists. That ill was the result of saying that, whatever about general medical illnesses, in terms of psychiatry it was not going to be about serious risk or moderate risk but about one issue only, and that was the question of suicide, the probability that a woman was going to commit suicide, and if termination was the only possible solution for that, then it followed. Therefore, it is no wonder that for the vast majority of women in this country it is an irrelevancy.

Suicide at least was at the extreme end. On the idea that psychiatrists or anybody - psychologists, counsellors or parliamentarians - would discuss the gradations of a woman’s mental health, that would be an impossible one for clinicians. When we are talking about mental health, we can accept a clinician trying to make the best estimate possible over a suicide risk, but bringing it down to an assessment of a woman’s mental health, bar excluding the very small group of women who may not have capacity, for the vast majority of women the idea that we could have some system where they all had to go to see a psychiatrist to have a score on their mental health is not going to work.

Deputy Peter Fitzpatrick: I thank Dr. McCarthy for coming before the committee. I am aware of a number of stories where abortion turned out to be a bad decision for the woman involved and where it carried long-term psychological after-effects. Many personal stories have been told to that effect. One well-known public story is that of Miss C who was brought to England as a minor for an abortion and then spoke publicly about how much she regretted the abortion. Sometimes a person thinks they know what is best for the vulnerable person in question but the decision turns out to be wrong.

Does Dr. McCarthy think women considering abortion, in particular those predisposed to mental health issues, should be told about the possible negative consequences of abortion before the procedure takes place? Am I correct in saying that does not happen at present?

Dr. Anthony McCarthy: I have seen women who regretted having abortions. I have seen women who have had long-term mental health problems following abortions. Every time I think about that, I think of particular individuals. I have seen huge numbers of women who have had abortions and that has not been the case.

The vast majority of women are aware that an abortion could be negative to their mental health. The vast majority of women struggle with that and they are ambivalent. Those who have mental health problems already are the ones who are most aware. They are also aware that if they go on to have a baby, there is a risk to their mental health.

I was perhaps being slightly mischievous with Senator Mullen in asking whether we should get women to see a psychiatrist before they ever get pregnant. To a certain extent it is the same
question. There are women who regret not having had a termination. There are women who regret the failure of the morning-after pill. There are women who regret both. Most people have the knowledge that an abortion may be damaging to their mental health. That is often the reason for their ambivalence. In terms of the idea that there is a message out there that abortion is good for one’s mental health always, with happy smiling faces, that is not how it is on the ground. There will always be people who will regret serious decisions. Becoming pregnant is a very emotional time. A straight answer as to whether women should be aware there are potential mental health difficulties following abortion is, yes, of course, as there are after pregnancy.

Deputy Peter Fitzpatrick: My question is whether they are being made aware of it, as such, to Dr. McCarthy’s knowledge.

Dr. Anthony McCarthy: I do not work in any pregnancy advice centre. I do not do that. The women who come to me are aware from the beginning. They are seeing me because of concerns about their mental health or because they have a mental health issue already or they are incredibly distressed because they have just discovered they have a baby with a fatal foetal abnormality or whatever the circumstances might be. They are very distressed already, so I am there helping them to weigh it up, but those who are seeing me know that already. I cannot say what happens in every single pregnancy advice centre but there certainly should be a general awareness that an abortion presents a risk for the woman.

Deputy Kate O’Connell: It is a pity the people who were quoting the Dr. Ferguson study have left the room. Dr. Ferguson clarified the position on his research on our national broadcaster four years ago. The man who is continually quoting him says the interpretation of Dr. Ferguson’s data is that abortion is bad for mental health. Dr. Ferguson stated that he had completed a review of the evidence and his view was that there was no evidence that abortion mitigated any mental health risks of unwanted pregnancy. That was based upon a review of the limited research and he said that the first point was that the research was not particularly good and any conclusion drawn should be made cautiously. That was his major conclusion; he could not find any evidence of benefits. He went on to say that abortion does not improve mental health of women and, has no mental health benefits and poses more risks for unwanted pregnancy. That is on the record. Dr. Ferguson also said that research has found that abortion has no therapeutic value in reducing the mental health risk. Instead, the evidence suggests that abortion may be associated with an increased risk of some mental health problems. Dr. Ferguson said that statement was true. He found that he compared women who had an abortion with equivalent groups of women who had unwanted pregnancies or intended pregnancies, the women having abortions had slightly higher rates of mental health. Basically, what he said about his study was that there are limitations in it. My take is that Dr. Ferguson is not happy about the conclusions that have been continually drawn by certain groups on his work to be drawn on his work. It is important that when someone is being quoted as saying X, but is actually saying Y, then it has to be called out. Anyway, I thank the professor for coming in to us. It has been helpful and in particular his statement has been helpful to me.

The Child Care Law Reporting Project published known facts recently in the case of a pregnant girl who sought an abortion under the Protection of Life During Pregnancy Act on the suicide ground. Instead, she was briefly detained under the Mental Health Act. Ultimately, she was denied the abortion she requested. It appears that, instead, her pregnancy was terminated via early induction or delivery. This is being claimed by some groups as a good outcome. These are people who want to retain the eighth amendment, even though it was determined that it was indeed her informed decision to end her pregnancy. Does this raise any concerns for Professor
Dr. Anthony McCarthy: I will reply first to Deputy McConnell’s question about the Ferguson report. It is a pretty good study but it has major limitations. As I highlighted, almost every study has serious limitations. That is why the meta-analysis or systematic review done by putting everything together came out with the conclusions. The conclusion of that study and the first part of what Senator Mullen said is that abortion is not good for women’s mental health - but neither pregnancy nor marriage are good for women’s mental health either, as we know. We have to know these things.

I heard the same interview with Dr. Ferguson on “Morning Ireland” on RTÉ Radio 1 when he said that his study was being selectively quoted. There was nothing actually that I could hear from what Senator Mullen said that he was selectively misquoting. Dr. Ferguson said we should not take too much out of the study. He said there were major doubts and gaps.

In my opening statement I referred to the notion of control groups. This is the single biggest flaw. I am unsure how many of the scientists here do research. Anyway, what do we mean by control groups? I was trying to think of an analogy. Let us suppose I did a study on people who get lung cancer and I examined whether they got stressed and whether that caused the lung cancer. Let us suppose I asked all of them whether they got stressed before they got lung cancer. I would find that 80% said they were stressed before they got lung cancer. We might think in consequence that stress equals lung cancer. However, if we have not compared those who smoke to those who do not smoke, we completely miss the key fact. Many of these studies are not looking at comparing only women with unplanned pregnancy or women who have been pressurised to have a termination. In other words, it is not comparing the key or important variables at all. It is altogether selective. It does not even examine the gestation of the pregnancy. Many other factors are involved that are missed in the vast majority of studies. Dr. Ferguson was honest. He pleaded for people not to quote him suggesting the conclusions were absolute fact. He was being misquoted. The actual words Senator Mullen used today are in his study, but there are major flaws to it.

Deputy McConnell asked about a particular case. Obviously, I cannot talk about specific cases, but a woman cannot have a termination of pregnancy past 24 weeks. There is a responsibility for all doctors to consider the health of the foetus. Of the few cases that have arisen, I am aware of one case where a woman was actively seeking a termination and was detained. Actually, she could not have a termination anyway, because she was past that term.

We only detain a woman if she has lost her capacity or if she has a mental illness. I was not involved in that case but, as far as I understand it, if the woman did not have a mental illness, then it was absolutely wrong to detain her. First, I have no doubt that those involved in the circumstances almost certainly do not work in this area. Second, they were highly anxious. If a woman is hitting her stomach with her hands, literally pounding into her stomach, and saying that she wants a termination of pregnancy, then people will sometimes not be able to stand back. They may panic and take the view that they must do something and then decide to use the Mental Health Act. Psychiatry has a dangerous history in that regard, one I am acutely aware of. Anyway, that is a major error. If a woman does not have a psychiatric illness – this girl clearly did not and that is why the court lifted the order shortly afterwards - then it was a major mistake to detain her in the first place.
Deputy Kate O'Connell: A point was made earlier about the abortion rate in the UK being four times as high as the Irish rate. Did someone get clarity on that in my absence? I thought we heard earlier today that there is no such thing as data in areas that have no abortions or where people seek illegal abortions. That was being quoted here but we do not actually know the official rate. It is important to clarify that point on the figure. Technically, we do not know the rate here. It is being bandied around here.

Chairman: If there is any clarification that can be brought to bear on it based on what we have heard thus far, I will highlight it.

Deputy Kate O'Connell: There are views from people we have heard from.

Deputy Catherine Murphy: I thank Professor McCarthy for his paper. I too found it interesting. I could see the humanity in it as well, something I appreciate.

Professor McCarthy quoted from the Academy of Medical Royal Colleges in the UK. He noted cases of women who are exposed to strongly negative attitudes towards abortion in general and whose personal experiences are likely to have worse outcomes. I have said before at this committee and elsewhere that I accompanied a group. It was around the time of the Protection of Life During Pregnancy Bill. I went to Liverpool Women’s Hospital with Doctors for Choice Ireland. It was specifically around the area of fatal abnormalities. I got some indication of the way women were treated in that hospital and environment. They were treated with great humanity and care. That made me feel very ashamed because they did not get that here. One person who was on that visit asked whether there was a difference between Irish women and women from the UK in how they were treated or how they felt. The instant response from the people who took care of those women was that what differentiated Irish women was that they felt judged. I suspect that is exactly the same whether it is a fatal abnormality or a requirement to leave the jurisdiction. They feel different by virtue of the fact that they were forced to leave the country. Those strongly negative attitudes and presumably the very fact that people have to leave the jurisdiction would feed into those poorer outcomes. Would that be a fair assumption and does the witness see people when they come back who would express views like that afterwards?

Dr. Anthony McCarthy: In terms of the evidence, the research papers that have highlighted that have been predominantly from the United States. We have to be careful about what we might think as human beings and what research evidence states. The research evidence that is based on tends to be from the United States where people are going into clinics where there might be crowds outside abusing them as they go in and where there may be threats as they go in. The research evidence is in that. That is the general attitude coming across. In terms of the individual ones it is very clear that particularly pressure from a spouse to have a termination can be a problem if an individual does not want one. Equally, a very strong family opposition to it, when a person still goes ahead, can be damaging. That is at a very personal level. I am not aware of any study that has been done specifically looking at the Irish question. Do I hear people in my office saying that? I do not see that many coming back. One woman said it was bizarre, it was dreadful, here she was terminating her much wanted baby and she thought it was going to be the worst day of my life but compared to the many weeks beforehand it was an extraordinarily kind occasion. She said it was almost lovely the way she was cared for and looked after, and people were so non-judgmental. She was comparing it specifically to how her family had responded to it. Yes, at human level I can say that. I do hear those stories but the research evidence is from America.
Deputy Catherine Murphy: Dr. McCarthy says 500 women a year attend the clinic. Is that number broken down into those who are pregnant? Does the witness look after women in the year after pregnancy or what part of the health service would look after women?

Dr. Anthony McCarthy: I see them for up to six months after the birth of a baby. With the small size of my team it would be impossible beyond that. We also sometimes see women even before pregnancy particularly if they have a major mental health problem or mental illness and are concerned about pregnancy and concerned about the medication they are going to have. We do see women even before pregnancy or maybe they have had some particularly difficult stillbirth before or a sudden infant death. Breaking it down, there are so many different categories that I would not give the figures here. We will see people for up to six months afterwards including if it has been a miscarriage or a termination or a stillbirth. We will be compassionate about that as well. It does not necessarily stop exactly at six months.

Deputy Catherine Murphy: Some of the 500 women would be referred to Holles Street or would they be patients of Holles Street?

Dr. Anthony McCarthy: They would be patients of Holles Street.

Deputy Catherine Murphy: Right, okay, that is fine.

Dr. Anthony McCarthy: With 9,500 deliveries per year we are extremely busy and if I were to take women from outside of Holles Street I would never go home.

Chairman: Thank you. I call on Deputy McGrath, who has six minutes.

Deputy Mattie McGrath: I thank Dr. McCarthy for coming in. I have to take him up on something he said earlier about people saying back in 2013 or 2012 in the committee that I was a member of that there would be bus loads of psychiatrists coming in to allow abortions if the 2013 legislation went through. Can the witness enlighten us as to who claimed that or is he quoting from the records? I do not remember anyone claiming that at the committee at that time.

Dr. Anthony McCarthy: Truthfully, I cannot remember who said it to me but I do know it was said in the room when I was there.

Deputy Mattie McGrath: In the committee?

Dr. Anthony McCarthy: In the committee.

Deputy Mattie McGrath: In the hearings?

Dr. Anthony McCarthy: Oh yes. In either the first or the second set of hearings. I cannot remember which but I was invited to both.

Deputy Mattie McGrath: Perhaps Dr. McCarthy could check the record and respond to me later.

Dr. Anthony McCarthy: I will.

Deputy Mattie McGrath: I was a member of the committee and I do not remember it being said.

Chairman: We can check that.
Deputy Mattie McGrath: There was no evidence for the suicides. It was remarked that threat could be grounds for abortion. Roughly, I believe, seven lives have been lost, seven too many as far as I am concerned, on the alleged threat of suicide. The floodgates did not open to use Dr. McCarthy’s own words. On whether the abortion happens here or abroad, it was put to the witness that in Ireland the much lower rate suggests the law has a protection effect. Does he accept that?

Dr. Anthony McCarthy: I do not understand the question.

Deputy Mattie McGrath: The witness was claiming it was irrelevant whether the abortions were here or abroad. I am putting it to him that is an indication that the legislation here has a prohibiting effect on the number of abortions. When compared with the numbers in England, and I am not going to get into a debate with Deputy O’Connell about the numbers, but they are much higher in England than here.

Dr. Anthony McCarthy: I am not an expert on the number of women in Ireland having abortions. That is not my job. My job is to see women-----

Chairman: Would the witness speak into the microphone please?

Dr. Anthony McCarthy: I am not an expert on the numbers issues at all. I was not aware that there were any great numbers. I also know that the numbers are unreliable anyway because I see women sometimes who have had terminations at home taking tablets and I know women who have gone to England for a termination and given an English address. I am not sure how important numbers are in all of this in terms of the reality of the work that I do. The reality of the work is that the women I am seeing who decide to have a termination of pregnancy - and many as I say do not - are going to the UK to have it. I have not yet met a woman who has not had a termination because she had to stay in Ireland. I have not had that experience. I know of other situations where women have not been able to afford to go to the UK and I know of one case in particular. I know there are issues with children or with refugees but it has not been a personal experience of mine. All I can tell the Deputy is my own personal experience and what I come across. I am not sure what the Deputy’s question is that would specifically address that.

Deputy Kate O’Connell: For clarification, I am afraid I may have misheard Deputy McGrath. Did the Deputy say, and maybe I heard it wrong, that seven lives too many were saved?

Chairman: I do not think he did.

(Interjections).

Deputy Kate O’Connell: I am not sure that I heard it right.

Deputy Mattie McGrath: No, the Deputy did not. I did not say that. I would not say something like that.

Deputy Kate O’Connell: Seven “whats” too many?

Chairman: Sorry, we can clarify it there is a requirement for that.

Deputy Mattie McGrath: Professor, I know that the situation can arise during pregnancy where women suffer depression or mental health disorder and that we need to ensure that women are cared for in the best way possible. Would the witness agree that the optimal outcome would be that a woman, a mother, gets the support and treatment that she needs and that both
she and her baby are safely delivered of the pregnancy?

**Dr. Anthony McCarthy:** If that is possible.

**Deputy Mattie McGrath:** The professor’s comments are interesting. I respect totally his professionalism but was he being flippant with his comments about mental health because we had a witness in last week who said that every man, woman and child’s mental health was affected by the amendment? Can I assume Dr. McCarthy was being flippant when he referred to mental health and marriage? Was the witness just being flippant when he spoke about the mental health of people who are married or pregnant or not pregnant? I am a proud parent of eight children and I was put through all the pregnancies with my good wife and indeed both Senator Mullen and myself were the result of pregnancies ourselves, thankfully.

*(Interruptions).*

**Deputy Mattie McGrath:** I do not scoff and laugh at anybody else. It is totally ignorant.

**Chairman:** In fairness Deputy McGrath-----

**Deputy Mattie McGrath:** It is ignorant and disparaging.

**Chairman:** People felt that the Deputy was making a joke.

**Deputy Mattie McGrath:** I did not make a joke. I would like to continue without the sideshows and the ignorant comments please.

**Chairman:** Could we please let the Deputy have the floor?

**Deputy Mattie McGrath:** This is why the committee is such a charade. I do not interrupt anyone. It is a total charade. I am on several committees in this House and none of them behaves in this way. None of them. I am in and out of the finance committee all day.

**Chairman:** Deputy, sorry, just one second. We will come back to housekeeping issues in a few moments. Please ask the questions that you want to ask and let the witness answer them and we will move on.

**Deputy Mattie McGrath:** I did ask. I asked if the witness was being flippant.

**Chairman:** Will the Deputy allow him to answer?

**Deputy Mattie McGrath:** I was just clarifying but people think it is very funny. I am clarifying that he mentioned marriage having a bad effect on mental health. Maybe it has some certainly but not in the vast majority of married couples in this country.

**Dr. Anthony McCarthy:** I was making a flippant comment.

**Deputy Mattie McGrath:** The witness was being flippant.

**Dr. Anthony McCarthy:** Of course. I was making a flippant comment. When we look at what is good for people in their lives - some are looking into it - we note that pregnancy in general is not good for women’s mental health. Termination is not good for women’s mental health, but it is no worse and no better than pregnancy. I was flippantly adding that if we were to have women assessed for their capacity before consenting to decisions in their lives, be it to have a termination, get pregnant in the first place or even get married, all of which have nega-
tive consequences for them, the psychiatrists would be very busy. The research does show that
the mental health of women in general - not in the case of the Deputy, obviously - is best when
they are single and worst when they are married. Men’s mental health is best if they are married
and worst if they are single. That is the research evidence.

**Deputy Mattie McGrath:** From where is that evidence? Will Dr. McCarthy clarify from
where he got it?

**Chairman:** That is very interesting, but it is for another day.

**Deputy Mattie McGrath:** It has been given. From where did Dr. McCarthy get it?

**Chairman:** As I said, it is very interesting, but it is for another day.

**Deputy Mattie McGrath:** I do not find it interesting; I find it strange.

**Chairman:** We are not going to get into a debate at this committee about whether marriage
makes one happy or unhappy.

**Deputy Mattie McGrath:** I find it a bit bizarre.

**Chairman:** We are talking about the topic of abortion. In fairness to Dr. McCarthy, he
made a light-hearted comment, as did the Deputy. That happens in life. We will move on.

**Deputy Mattie McGrath:** I did because-----

**Chairman:** We know that it is not a light-hearted topic.

**Deputy Mattie McGrath:** That is why I am surprised-----

**Chairman:** The light-hearted comment was well meaning, with which I do not believe
there is any problem. The Deputy did the same. Can we move on to the next person, please?

**Deputy Mattie McGrath:** With respect, I asked Dr. McCarthy to clarify whether he was
being flippant. He has now said he was. This is not a matter on which to be very flippant.

**Chairman:** In fairness, I have to defend Dr. McCarthy, although he is well able to defend
himself. He was making a light-hearted comment in difficult circumstances. There are many
people who would say that the day on which one cannot make a light-hearted comment in very
difficult circumstances is the one on which one is really finished.

**Deputy Mattie McGrath:** I am one of those.

**Chairman:** I call Deputy Bríd Smith to ask her questions.

**Deputy Bríd Smith:** I will definitely read the studies of infanticide. It was amazing to
compare the lives of women and what it was like to live in Ireland with an unwanted pregnancy
before the 1967 Act with what it was like afterwards. Dr. McCarthy rightly referred in his
presentation to the 1967 Act as the Irish abortion Act. Without it, we would never have had
abortions in this country. It was illustrated that this was an island on which there was no access
to abortion services. There is a limited number of abortions. There are variations on a theme
across Europe. If one were in Poland and needed help, one could get on a train and travel to
Germany or Austria. In Ireland, being an isolated island that was poor for a long time and
which is now quite wealthy, we are still in the Dark Ages. I will definitely read the studies and
thank Dr. McCarthy for pointing me in their direction.

Anecdotally, I believe there have been more ways than one to skin a cat in the history of this country. I was on a walking holiday in County Donegal learning the names of plants in the Irish language when I noted there was a lovely little plant that traditionally had been picked to make a tea in order to abort an unwanted pregnancy. This has been occurring for hundreds of years. The plant had a beautiful old Irish name and I brought home lots of it if anybody wants to have a cup of tea. I am letting anybody who needs help know about it.

I want to quiz Dr. McCarthy about the Protection of Life During Pregnancy Act and the barrier of two psychiatrists and an obstetrician a woman has to get through if she needs an abortion because she is suicidal. Dr. McCarthy has mentioned that most psychiatrists, or some of them, had never done this kind of work. By that, I believe he meant they had not seen pregnant women with mental health issues. That is the professor’s job and he has been doing this work in Holles Street with hundreds of women every year. The psychiatrists who are now doing this work under the Act would not have been used to it. Is the Act fit for purpose if practitioners such as psychiatrists are doing a job they never did before in very serious circumstances involving women whose lives are at risk? Obviously, if one does a job for a long time, one gets used to it, but if one is starting from a position in which one is not used to dealing with pregnant women with mental health issues who request an abortion because they feel suicidal, it is a different matter. Does Dr. McCarthy believe the Act is fit for purpose if the two psychiatrists whom a woman must see are not used to the work, given the stretched resources available in the country? Do the psychiatrists have a choice in doing that work? Are they forced to do it? Are they told on the day by the HSE that they must interview two women who are suicidal because they are employed by it? Can they opt out if they do not want to do that work?

Rather than going to two psychiatrists and an obstetrician and having to go through the hoops and over the jumps the ridiculous Act has forced on women with mental health issues, would it be easier for a woman to travel to Britain to have an abortion? Who, in the main, has to go through all of this? Is it girls? Is it women who are below the age of independence or women who are not capable of having financial independence? Is it very poor women? Is it refugee women, in particular, or women in direct provision accommodation who cannot leave the country? Does this reflect badly on the country? As well as penalising all women by not giving them a choice in respect of their own reproductive systems, we further penalise a cohort of women, particularly those who cannot leave the country because of their immigration or refugee status.

Dr. Anthony McCarthy: There were a few questions, but I will start by talking about having a sense of humour. I am sorry that Deputy Mattie McGrath has left. Having a sense of humour is very important in my job. After talking about a very distressing matter, being able to share a joke and a laugh is sometimes one of the best things we can do. Even laughing and joking after some painful losses, including pregnancy loss, is part of the process. It is a little like being at a funeral; people will laugh and joke. That is part of the human response in situations such as this. It is healthy rather than something about which to be offended, I hope.

Obviously, the legislation was enacted at the time with the best of intentions to try to deal with all of the results of the directions of the European Court of Justice. It was trying to address some of the issues involved. Mental health issues had to be involved and, in those circumstances, suicide was the most controversial aspect of the legislation, as the Deputy knows. I remember being on radio at one stage when there was a suggestion there should be 12 professionals involved. One of my children says it was a relatively proud moment to see my name on an
Evening Herald poster on Pearse Street. It read: “Psychiatrist calls this idea a joke.” I believed originally that the figure of 12 was a joke. The number was eventually reduced to three. All along I said there were simply not enough people available to do the work. I questioned how it would work and how it would be appropriate.

There is an acknowledgement that there are not enough psychiatrists in the country. Of course, there are psychiatrists. The three Dublin maternity hospitals have part-time psychiatrists. The major unit in Cork has a liaison psychiatrist who does a lot of work in this area. Throughout the country, however, there are very few. The requirement is that a psychiatrist must have treated a woman with mental health problems in pregnancy to be allowed to do this work. He or she has to be a consultant and to have treated a woman. That is the pragmatism of the legislation based on the problem of having enough people. Of course, there are not enough people available with the required training. A requirement was included afterwards that they be trained. One of the key issues is the nature of the training provided. There is none working in maternity hospitals. I might see a woman who wishes to terminate a pregnancy but who will have no idea of gestation or the difference between an emergency caesarean section at 24 weeks and the scar that will be on her body and a different procedure altogether if she waits a few more weeks. She will have no idea of various things. Equally, the assessing doctor will not either. The amount of experience and time it takes to deal with that issue is considerable. There is simply not enough training provided and not enough people used to doing this work. For all of the theoretical training, it is actually a matter of practice. I learn every day from the patients I am seeing. That is how we learn. Unequivocally, the system really does not work. Since it is so clumsy, the vast majority of women will come nowhere near us, appropriately so. It is just an unnecessary and unhelpful procedure. Therefore, women have to travel.

I do not have a breakdown of the very small number of women who find themselves in the circumstances to which the Deputy referred. Some of the cases that were very much highlighted have some involved younger people and at least one refugee. I have not seen a breakdown of the numbers involved simply because I have not been involved.

**Deputy Bríd Smith:** Are doctors obliged to do this work?

**Dr. Anthony McCarthy:** No. Everybody can opt out if he or she so wishes. A number of doctors have opted out because they felt they did not have the qualifications or experience or simply did not want to do it. There are real difficulties in finding a second psychiatrist, or two psychiatrists if the first psychiatrist does not want to certify. It is a real problem.

**Deputy Jan O’Sullivan:** I have one very practical question. Can Professor McCarthy treat those aged under 18 years who are pregnant? Is there a distinction between child and adolescent psychiatry in that situation?

**Dr. Anthony McCarthy:** Pragmatically, if they are in Holles Street and expecting a baby I am not worried what age they are. If there was a case of termination, I would want a child and adolescent psychiatrist to come in.

**Deputy Jan O’Sullivan:** I was struck by the humanity of Professor McCarthy’s presentation and the fact he clearly understands and listens to individual women. He said that over the past 21 years more than 500 women attended the clinic each year. That goes back quite a long way. Would societal changes and attitudes to abortion have affected how women can talk about it? Has it changed how they feel about asking for or considering a termination? We know from opinion polls that attitudes have changed. A few of us here campaigned back in 1983 and we
have seen a difference in public attitudes. Would that be reflected in Professor McCarthy’s experience?

**Dr. Anthony McCarthy:** In my initial years after I came back from the UK I saw women who may not have told their obstetricians they had had terminations. They would come into the hospital and say they had one child or no children. On the second or third time I would see them, they would then tell me about a termination they had. Now, I am much more likely to hear such information at the very beginning. Of course there are changes. When I first came back, women with fatal foetal abnormalities got no information and got no support from my obstetric colleagues. Now there is a completely different culture and attitude towards that.

**Deputy Jan O’Sullivan:** Has that improved the ability of women to deal with mental health situations?

**Dr. Anthony McCarthy:** I am always aware of the difference between giving an opinion and giving research evidence. As a human being, how can it not be better for someone to have a compassionate and supportive experience, and not feel judged in a hospital and that they cannot talk about something? There has been no formal published research on that, however.

**Deputy Jonathan O’Brien:** In his contribution, Professor McCarthy referred to mental health outcomes after induced abortion and research evidence in the area. He pointed out that there is no significant research in Ireland. He gave the caveat that the advice he would give is that any research be looked at in a critical, informed and objective manner. He then spoke about the review of the mental health outcomes of induced abortions from the Academy of Medical Royal Colleges in the UK. He went through the key findings. I want to focus on the last finding.

**Chairman:** There is a vote in the Dáil. I am hesitant to suspend, but we will have to because there are still a number of questions. I ask people to come straight back.

**Deputy Jonathan O’Brien:** I can finish my question. We have eight minutes.

**Chairman:** That is a matter for yourself.

**Deputy Jonathan O’Brien:** Professor McCarthy said that the findings showed that an unwanted pregnancy was associated with increased risk to mental health, but the rates of mental health problems in unwanted pregnancies were the same after termination or whether a woman gave birth. I presume the research was carried out in countries with very liberal regimes. We heard evidence today that Ireland, Andorra and, I understand, Malta are the only countries in the vicinity which have very restrictive regimes.

Professor McCarthy, quoting women’s personal experiences, said women who were exposed to strongly negative attitudes towards abortion in general were likely to have worse outcomes. My question may be unfair, but I will ask it. Would it be fair to say a very restrictive abortion regime, where there are constitutional provisions almost preventing women from having choice, would portray a very negative attitude towards women who wish to choose whether to have a termination?

Would it be fair to say that in very restrictive countries where abortion is almost impossible to obtain that would have a more detrimental effect on a woman’s mental health if she then chose to have an abortion? If somebody had to travel or obtained pills on the Internet and had an abortion, would a restrictive regime be a factor in somebody’s mental health?
Dr. Anthony McCarthy: Should I not answer the question until after the vote?

Chairman: You can answer. Deputy O’Brien is a cool customer because he is not a bit worried. He will probably leg it. If he would rather the answer after the vote, it will give Professor McCarthy a chance to think about the response. We have to come back anyway.

Sitting suspended at 7.35 p.m. and resumed at 7.55 p.m.

Chairman: We are in public session.

Deputy Jonathan O’Brien: Finding (d) in Dr. McCarthy’s presentation states “… women who were exposed to strongly negative attitudes towards abortion in general and to her personal experience, were likely to have worse outcomes”. What could Dr. McCarthy extrapolate from that? In a country with a very restrictive abortion regime and very negative attitudes to women, for instance we criminalise women who have terminations, could he say whether the outcomes for women who go and obtain a termination are likely to be worse?

Dr. Anthony McCarthy: Again there is no professional evidence on the basis of professional research.

Deputy Jonathan O’Brien: Based on Dr. McCarthy’s experience - - - - -

Dr. Anthony McCarthy: In general because of how we are as a society and have been for such a long time, people are not really thinking about that issue. I would not want to generalise, but it is for the individual person and whether she is really thinking in that way. What is really likely to matter is the views of those who are close to them or if there was some really publicly severe opinion. What comes out in research is that if her partner or a family member is really critical of them, that can be very difficult. If there is an argument, and sometimes I will witness argument and a lot of conflict from a parent or from a partner, that is likely to add to the emotional distress that is involved. This research has never been conducted in Ireland, but we have American research looking at those going to abortion clinics in the US, where there is very public protest with people outside these clinics protesting and trying to stop abortions. For the person who is desperate or wants a termination, that sort of protest will not help them, or help their mental health. We know that if women have a mental health problem as a result of that experience, even in any future pregnancy, that mental health issue may become relevant again.

Deputy Jonathan O’Brien: My follow-up question arises from Dr. McCarthy’s public comments during the Protection of Life During Pregnancy Bill. One of his comments was why would any woman want to put herself through the process of having to go before a panel and almost have their mental health questioned. If we were to get to a position where we had a more liberal regime for terminations, where mental health was one of the grounds for it, I presume that analysis would stand no matter whether we had terminations in all circumstances. If somebody had to go before a panel of psychiatrists and almost prove that she had mental health issues, does it make a difference whether it is a very restrictive or a very relaxed liberal regime? I do not know how one would deal with having to put a woman through a process that is obviously going to be distressing for her. From the evidence we have heard today, would it be correct to presume that one of the ways one would deal with it is by on-request terminations up to a certain period? What would Dr. McCarthy’s opinion be in terms of women’s mental health? I presume Dr. McCarthy would say that it would never be good to have a woman almost have to prove her mental health status before she could access a termination, regardless of whether the regime is very restrictive or very liberal.
**Dr. Anthony McCarthy:** Irrespective of the issue of termination, I am unsure of how someone attending a psychiatrist could prove a negative or how the psychiatrist could determine it. When someone comes to see me or any psychiatrist, the first and most important element will be the relationship in the room. Can that person talk to me? Does she feel heard and listened to? That is the key starting point.

I attended a lecture some years ago given by Professor Aidan Halligan, who was an Irish paediatrician and the deputy head of the NHS in England. Speaking about medicine, surgery or any specialty, he said that the first thing any patient attending any doctor wanted to know was whether the doctor cared. If the doctor cared, then it was likely that the patient would be heard. Even where there was a cardiac complaint, the patient would know that the doctor was listening. The doctor would take a proper history and hear the person’s story. If a doctor is not interested, he or she will miss things and, often, the patient will not tell him or her things. This is particularly the case in mental health. For someone to tell me personal, difficult things about herself, her history, her feelings and her previous experiences requires a sense of trust. If that appointment is imposed on her or I approach the matter in some judgmental way or bring my personal attitudes or history to it in either direction, it will be a failure of an appointment. Insisting that a woman go through a particular process where she must see a series of psychiatrists, or even just one, when she is clear on the situation in her own mind will be a waste of an appointment and abusive of her and she will be unlikely to talk about what matters because she is being forced into a situation that is not helpful. It would waste her time and my time and be damaging.

**Deputy Jonathan O’Brien:** Could it have a more negative impact on her?

**Dr. Anthony McCarthy:** Of course.

**Deputy James Browne:** I thank Dr. McCarthy for his evidence. It has been most helpful. I apologise for missing some of it, but I had to speak in the Chamber. Since some of my questions may have been answered, I will try to move through them quickly.

What percentage of women suffer from perinatal mental health issues during or post pregnancy? Is there any indication of that figure?

**Dr. Anthony McCarthy:** The terms “mental health problems” and “mental illness” are broad. In general, 11% of women get what is called postnatal depression. It is not a thing, but a label to highlight that after the birth of the baby is an extremely vulnerable time for a woman’s mental health. It is a peak time for many reasons. I could spend an hour telling the Deputy about why it is such a poignant and vulnerable time for women with mental health problems.

According to some research, if women are asked to fill in a questionnaire during pregnancy, a higher percentage, perhaps 20%, will say that they are struggling. The most important message is that there is no decrease in mental health difficulties during pregnancy. In general, between 5% and 7% of women will have a significant mental health problem at that time. That does not lessen or increase overall. It may get much worse for an individual woman but much better for another. After the birth of the baby, the figure increases to approximately 11%. They have what is called postnatal depression, but for 3.5%, it is a serious problem.

**Deputy James Browne:** How many perinatal psychiatrists are there in Ireland?

**Dr. Anthony McCarthy:** There is a little bit of me in Holles Street, a little bit of one of my colleagues in the Rotunda and a little bit of another colleague in the Coombe employed specifi-
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cally in that role. There is none outside of Dublin. Professor O’Keane, who works in Tallaght hospital, addressed the committee. She has a long history of having worked in perinatal psychiatry, but she does not do that anymore. She is not working in a maternity hospital.

Outside of Dublin, there are no specialists and hardly any psychiatric input in some maternity hospitals except where, for example, a very small number of women become acutely psychotic or unwell. As to seeing women during pregnancy for assessments or afterwards in general, however, there is almost nothing outside of Dublin in terms of specialists.

**Deputy James Browne:** Effectively, there are three part-time perinatal psychiatrists in Dublin and none outside. Is it fair to say that there is no designated mother and baby unit for mothers suffering from mental health problems?

**Dr. Anthony McCarthy:** Correct. I hope that my business managers are listening. It is to be hoped I will be a full-time psychiatrist in Holles Street in the near future. There are plans under the national perinatal strategy for mother and baby units, with one in St. Vincent’s hospital when the National Maternity Hospital moves to that site. It would be for the whole of the city. As the committee knows, however, that move is some way off. Currently, there is no mother and baby unit in the country.

**Deputy James Browne:** My next question is on perinatal mental health in general. What is the impact of having only a limited service?

**Dr. Anthony McCarthy:** One of the most important points about perinatal mental health services in general is that they are preventative. We are trying to prevent mental health problems in the mother or treat them early. In this way, ongoing bonding issues, attachment issues and mental health problems for the children are prevented. If we do not intervene, then the mother is badly depressed or anxious and not getting help, which can have a negative effect on children. That would perpetuate problems through the generations.

**Deputy James Browne:** Would it be fair to say that the lack of extensive perinatal mental health care is putting women at risk?

**Dr. Anthony McCarthy:** Of course.

**Deputy James Browne:** What kinds of mental health problems arise in pregnancy? What are the associated risks for the mother and the unborn?

**Dr. Anthony McCarthy:** For the mother, there is a panoply of issues. She may have had a major mental health problem previously, for example, schizophrenia, bipolar illness, anorexia nervosa, obsessive compulsive disorder, OCD, anxiety, depression, etc. For others, something new might emerge during pregnancy, for example, anxiety or depression. It could be any mental health difficulty. Some women will start drinking in pregnancy. Some will cope in unhealthy ways. For example, I have had patients tell me that they stopped taking their antidepressants because they were fearful of damaging their babies, but because they could not sleep at night, they were drinking four glasses of wine. Women who may have controlled their eating disorders suddenly become pregnant. The challenges to their bodies, such as the challenge of having something inside them, can trigger a relapse of a serious problem. Women who have managed or controlled their obsessive concerns may become completely obsessed and suffer a relapse of OCD during pregnancy that affects their anxiety and checking behaviour, perhaps because of reducing their medication or the responsibility of something being inside them. They are checking movements multiple times. They cannot sleep at night because they
are double-checking, triple-checking and worrying about it. Maybe they have had a foetal loss before and cannot relax during pregnancy because of that. Maybe they are depressed. There are a range of issues.

**Deputy James Browne:** What is the appropriate level of availability of mental health care for pregnant women in maternity hospitals? What should the management protocols be?

**Dr. Anthony McCarthy:** The Deputy should see the perinatal mental health strategy, which is about to be published by the HSE. I could be here all day discussing this. It will be attached to the national maternity strategy. If its recommendations come true, we will have mother and baby units around the country. We will have psychiatric services, not just involving psychiatrists, but also psychologists, social workers and occupational therapists. We will have teams in maternity hospitals, which would be good.

**Deputy James Browne:** Is an independent analysis of the mental health outcomes of terminations necessary for Ireland?

**Dr. Anthony McCarthy:** It is unavailable at the moment. Terminations are not happening in Ireland, so how could one conduct research?

**Chairman:** I wish to ask a brief question about a matter on which Deputy Browne and Dr. McCarthy touched, namely, patients currently in psychiatric services. I am unsure as to when they would attend. If they anticipate a pregnancy, would they have access to perinatal psychiatry at that stage to plan the medication aspect? It is a major concern for some women who have an ongoing mental illness. How is that managed? At what point do they move over to perinatal psychiatry? Do they need to be pregnant? What is involved in the planning? I would be interested in Dr. McCarthy’s comments. For people with existing conditions, for example, bipolar illness, which is manageable in many cases, anxiety about reducing or going off their medications during pregnancy can cause their illnesses to return, etc.

**Dr. Anthony McCarthy:** Any doctor seeing any woman of child-bearing age, no matter what her medical or psychiatric condition, should keep in mind that she could become pregnant. Therefore, when prescribing, for example, a broad pressure, anti-asthmatic or epilepsy tablet, the doctor should be aware of that information. In the mental health area, particularly in complex medical regimes and specifically when there are complicating obstetric issues, women very often want to get specialists’ advice. Some of my colleagues will sometimes want me to give specialist advice. To answer the Chairman’s question, we see a small number of women before pregnancy specifically to provide this advice. Some women may already have obtained this information when they became pregnant by googling it or looking it up on a website. They may be perfectly happy with the local services available and may not feel a need to see me. Others will definitely want to see me, particularly those who have a bipolar illness and are on lithium. These women need very careful change monitoring. The change dynamics of pregnancy and the change in renal function - all sorts of issue in pregnancy - make the situation much more complicated. It is very much individual to the woman who will make up her mind, with the advice of her doctor, etc., on whether she should come to see us.

**Chairman:** I thank Dr. McCarthy for his attendance.
Chairman: We must now attend to a housekeeping matter. I return to an issue which was raised with me earlier. Letters may be read into the record in limited circumstances only, as, for example, in the case of Ms Cora Sherlock where clarification was necessary. I am reliably informed that it is a matter for the Chair, rather than individual members, to decide how correspondence is handled. I have proposed that the correspondence in question be placed on the committee’s website. That is my decision and it is one on which I will not be challenged. Individual members may not demand a decision or question the decision of the Chair. This applies to the Dáil, the Seanad and all committees. If any member wishes to table a substantive motion in respect of a ruling of the Chair, he or she is free to do so, provided he or she gives adequate notice to the committee. That is the position. My sincerely held view is that if someone is scheduled to attend and subsequently decides not to do so, it is not appropriate to read statements from him or her into the record. If we were to allow this, many people would not attend meetings. I have made my final decision on the matter.

Senator Rónán Mullen: May I seek clarification?

Chairman: Yes.

Senator Rónán Mullen: The Chair gave us her sincerely held view that my request would not make sense. She then gave a ruling that it was a matter for the Chair to decide and said that she had been reliably informed that it was only done in certain circumstances. What is the source of her authority in this matter?

Chairman: As Chair of the committee, I have decided that letters sent to the committee by persons who were due to attend will not be read into the record. I am happy to read into the record clarification. It would also be reasonable to do so if an issue arose subsequent to a person’s appearance. It would not set a good precedent to allow individuals who were due to attend but did not do so to write to the committee and have their statement placed on the record. We could spend all day doing so.

Senator Rónán Mullen: I am clear on the Chair’s personal view on what is the appropriate approach to take and that she believes it is her right, as Chair, to make a decision on the matter. What is the source of her authority to make this ruling now, as opposed to expressing this view as a member who happens to be Chair? I am merely seeking clarification on a couple of points.

Chairman: It is not incumbent on the Chair to quote Standing Orders or precedents or give a reason for a ruling.

Senator Rónán Mullen: From what is the Chair reading?

Chairman: I am reading from the handbook, Salient Rulings of the Chair, fourth edition, Dáil Éireann. I can provide the Senator with a copy. It sets out accepted precedent.

Senator Rónán Mullen: The Chair is relying on precedent and stating a written set of precedents allows the Chair to make a decision.

Chairman: The Senator is questioning me. I have made a ruling on the matter.

Senator Rónán Mullen: I am seeking information. I am not questioning the merits of the Chair’s decision.

Chairman: It is not appropriate.
Senator Rónán Mullen: I am exercising my right to find out from exactly where the Chair sources her authority in this matter. This is in everyone’s interests. Perhaps we should all know that this authority is provided for in what the Chair referred to as the salient rulings of the Chair. Can I also establish that while she stated she was relying on the salient rulings of the Chair to make this, as it were, extempore and ad hoc decision, certain letters can be read out and certain letters may not?

Chairman: It is not an ad hoc decision.

Senator Rónán Mullen: It is because the Chair stated she had relied on the salient rulings of the Chair in advising members that she had formed the view that in certain cases, it could be-----

Chairman: The Senator-----

Senator Rónán Mullen: I am not questioning the Chair’s authority. I am seeking clarification and following the matter to a conclusion.

Chairman: The Senator is trying to undermine me.

Senator Rónán Mullen: No, I am not. If the Chair regards seeking clarity on the source of her authority and seeking to understand the logical basis of her explanation as undermining her, she does not understand democracy.

Chairman: Now it seems I do not understand democracy.

Senator Rónán Mullen: I am entitled to seek full particulars in this matter because where I am leading is that the Chair has conceded that, on notice, a motion can be tabled to seek to overturn the ruling of the Chair and have letters read into the record. Is that what she said?

Chairman: If there is a problem with a particular ruling that I make, a member is free to table a motion. The Senator should do so, if he wishes.

Senator Rónán Mullen: In that case, the Chairman accepts the point.

Deputy Mattie McGrath: I will table a motion.

Chairman: I am an extremely patient person, but I find this inappropriate at this point. I made a ruling on the matter and set out in detail my rationale in respect of the letters in question. It is only fair that we leave the matter at that, unless an additional point needs to be made.

Deputy Catherine Murphy: The same set of rulings applies to all committees.

Chairman: It applies to the committees and the Houses.

Deputy Catherine Murphy: The same practice applies and there has been no deviation from it. Is such a deviation being sought?

Chairman: I am allowing too much discussion on this issue.

Deputy Catherine Murphy: I agree. The discussion should conclude at this point.

Chairman: I have seen this happen in the Seanad on numerous occasions. I have been generous and patient in allowing this discussion.
Senator Rónán Mullen: We do not owe the Chairman any gratitude for doing her job.

Chairman: I am not looking for thanks.

Senator Rónán Mullen: We are entitled to clarification on the source of the Chair’s authority. For the Chair to regard as a concession a period devoted to debate on the source is a completely unacceptable approach to her role.

Chairman: To be honest, I find the Senator’s approach unacceptable.

Deputy Jonathan O’Brien: The letter was read out at approximately 3.30 p.m. This is a joke and I am starting to lose my temper.

Chairman: That is the end of the matter.

Senator Rónán Mullen: Deputy Jonathan O’Brien would not be the first person to lose his temper. We are the only members who do not lose their tempers and who try to maintain logic.

Deputy Jonathan O’Brien: At 3.30 p.m., while the committee was sitting, the Senator went outside to speak to the media about this issue. He undermines the Chair at every opportunity.

Deputy Mattie McGrath: If this is not intimidation, I do not know what is. May I speak, please?

Chairman: No, not unless the Deputy has something different to say.

Deputy Mattie McGrath: I indicated that I wished to speak. We are not disrespecting the Chair’s ruling. We waited all day for her to obtain advice, which is fair enough and which we accept, but for her to take umbrage at us questioning the reasons behind-----

Chairman: I am not taking umbrage.

Deputy Mattie McGrath: Yes, you are.

Chairman: I am adjourning the meeting.

Deputy Mattie McGrath: Someone threatened to lose his temper. Will we be intimidated? Will we be kneecapped or something? That is disgraceful.

The joint committee adjourned at 8.20 p.m. until 1.30 p.m. on Wednesday, 16 November 2017.