DÁIL ÉIREANN

AN COMHCHOISTE UM AN OCHTÚ LEASÚ AR AN MBUNREACHT

JOINT COMMITTEE ON THE EIGHTH AMENDMENT OF THE CONSTITUTION

Déardaoin, 23 Samhain 2017

Thursday, 23 November 2017

Tháinig an Comhchoiste le chéile ag 2 p.m.

The Joint Committee met at 2 p.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Lisa Chambers,	Jerry Buttimer,
Clare Daly,	Paul Gavan,
Peter Fitzpatrick,	Rónán Mullen,
Billy Kelleher,	Ned O'Sullivan,
Mattie McGrath,	Lynn Ruane.
Catherine Murphy,	
Hildegarde Naughton,	
Jonathan O'Brien,	
Kate O'Connell,	
Louise O'Reilly,	
Jan O'Sullivan,	
Anne Rabbitte,	
Bríd Smith.	

Teachta / Deputy Bernard J. Durkan sa Chathaoir / in the Chair.

Obstetric Medicine in the Netherlands: Professor Sjef Gevers and Professor Eva Pajkrt, University of Amsterdam

Acting Chairman (Deputy Bernard J. Durkan): In the absence on business of the Chairman, members must put up with me for the day. I welcome television viewers to the proceedings. We will try to get through as much business as possible although it will be difficult because there will be several votes in the Dáil during the course of the day. Members should try to keep their work within confines and do their best to avoid overlaps. I appeal to members of the committee for their help and co-operation in that regard.

I welcome our witnesses, Professor Eva Pajkrt and Professor Sjef Gevers.

Members are requested to turn off their mobile phones as even when in silent mode they interrupt, and play havoc with, the recording.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

In addition we like, and try, to conduct our business in a non-confrontational way both in our dealings with witnesses and with each other, in accordance with the best parliamentary practice.

I call on whichever of our witnesses wishes to proceed first to make his or her opening statement.

Professor Sjef Gevers: I thank the Chairman. I will start with a short introduction to myself and my background. I have a background in law and sociology. I was professor of health law for more than 20 years in the University of Amsterdam in the faculties of law and medicine, in the academic medical centre where my colleague, Professor Pajkrt, also works. I was a former editor-in-chief of a European journal of health law and of the Dutch journal of health law. For more than 25 years I was a member of the Dutch health council advising the government on health and the ethical and legal aspects of health care, and, in relation to today's subject, I was responsible for the first evaluation of the abortion Act in the Netherlands which took place in 2005, 20 years after it was issued in 1985. We conducted a nationwide study of how it was applied and functioned.

I thank the committee for the invitation to inform it about abortion law and practice in the Netherlands. We have already given the committee an overview of the Dutch situation in our joint paper. In this opening statement we will briefly summarise this paper, focusing first on the law, which I will do, and then on the practice in the Netherlands, which my colleague, Professor Pajkrt, will do.

I will say a few words first on the termination of pregnancy Act as it was enacted in 1984. Terminating a pregnancy is a crime under Article 296 of the Dutch penal code. The abortion Act is based on the criminal law and abortion is an exception to the basic prohibition in the criminal law. According to the fifth paragraph of Article 296, abortion will not be punished if carried out by a doctor in a hospital or abortion clinic with a licence in accordance with the termination of pregnancy Act. The Act is known in common or lay terms as the abortion Act and I will use this term in the rest of my contribution. The Act was adopted in 1981 and, as I stated, it came into force in 1984 after a long history and more than ten years of public and political debate. Several Bills were introduced in Parliament and only the last Bill was narrowly accepted with a voting margin of 38 in favour and 37 against. The two conflicting values that had to be accommodated in the legislation were clearly expressed by the Government of the Netherlands during parliamentary proceedings. The Government stated:

> The Bill is based on the view that women, who are in a situation of emergency due to an unwanted pregnancy, should receive help. But we consider the termination of unborn human life as such a serious act, that it is only acceptable if unavoidable because of that emergency. This means that the physician, the woman and others that may be involved before the decision to terminate, need to act with utmost care and in awareness of their responsibility towards unborn human life and of the consequences for the woman.

At the moment, 93 hospitals and 15 clinics have a licence to terminate pregnancies within the limits set by the abortion Act. Licences are granted by the Minister of health to establishments that satisfy statutory requirements relating to the quality of treatment in terms of medical competence and facilities as well as psychological care. The directors of these establishments must submit periodic reports to the Health Care Inspectorate about the number of patients they have treated and some characteristics of these patients. The figures are published in the inspectorate's annual report. It is important to stress that abortion is not seen as a routine medical procedure but as one that may only be carried out at the request of the woman if her circumstances leave her no other alternative.

I will say a few words about the key provisions of the abortion Act, which relate to careful decision-making, because this is the substance of the Act. Termination may only take place if a situation of emergency of the woman makes this inevitable. An emergency refers to the psychological state of mind of the woman due to an unwanted pregnancy and does not require the risk of physical or mental injury. The Act does not provide substantive, general criteria for assessing whether the situation of the woman amounts to an emergency. The legislator has adopted this approach because the decision to terminate a pregnancy must be taken with due regard for the individual circumstances of each case.

Both the woman and the doctor are responsible for the process of reaching a decision, although the decision as such is ultimately made by the woman. The physician shall assist the woman requesting an abortion in making up her mind. For that purpose, the doctor must provide the woman with appropriate information about other solutions to her situation and see to it that her request is made and maintained freely and without undue pressure from other persons. The doctor must also see to it that the woman insists on her request only after careful consideration. To ensure sufficient reflection, the Act requires a reflection period of five days between the initial request of the woman and the eventual termination of her pregnancy. An exception to this requirement is only possible when the health or life of the woman is at risk.

I will not elaborate much on other provisions of the abortion Act. One important point,

however, is that health professionals are never obliged and cannot be obliged, for instance, by employers or other persons, to perform an abortion and conscientious objections must always be respected. Furthermore, physicians carrying out abortions must keep medical records on the reasons in each case they decided to terminate a pregnancy. If requested, they must give the inspectorate access to these data. Mention should also be made of the obligation to provide adequate care after the termination has been performed. This includes not only a medical check and psycho-social assistance, if needed, but an obligation on the establishment where the abortion takes place to provide information and education concerning the prevention of undesired pregnancies.

I will now say a few words on what does not fall under the abortion Act. I refer to three different interventions. First, so-called morning after methods, such as the use of a morning after pill, are not considered to be a way to induce an abortion and are, therefore, not covered by the Act. The reason is that these are methods to prevent conception, which means there will be no pregnancy. The second circumstance that does not fall within the Act is when abortion takes place as an unavoidable side-effect of a necessary medical intervention or if continuation of the pregnancy would endanger the life of the mother. Although formally such an abortion still comes under the penal code, no prosecution will take place because the doctor is considered to have acted in a situation of *force majeure* and he or she can invoke the defence of necessity in legal terms, resulting from a conflict of duties. Criminal proceedings will not be taken in such circumstances.

The third intervention is slightly more complicated and relates to inducing an abortion within 44 days after the first day of the last menstrual period, that is, where menstruation is 16 days overdue. This circumstance does not fall within the provisions of the abortion Act and is, if I may say so, a bit special. It means that although the abortion must still be performed in a hospital or an abortion clinic with a licence, formally, the provisions of the abortion Act, including the statutory waiting and reflection period, do not apply. This interpretation of the Act dates to the beginning of the 1980s when the abortion Act was adopted and came into force. At that time, it was not yet possible to confirm the existence of an early pregnancy beyond doubt. Although this is no longer the case - we now have far better medical methods, on which Professor Pajkrt will elaborate, if necessary - this restrictive interpretation of the scope of the Act has survived until today. In practice, however, the requirements of the Act relating to careful decision-making are usually observed in such cases of early pregnancy.

While the abortion Act does not set a time limit for abortion, the penal code does. According to Article 82a of the code, abortion amounts to a crime against human life if the unborn child has developed to the point where it is able to survive outside the womb. This is known as foetal viability. On the basis of current medical opinion, this is after 24 weeks of gestation. In practice, however, a period of 22 weeks is used, if I am correct. After this time limit, the doctor involved can only defend himself or herself by invoking a situation of necessity or a conflict of duties.

If I may, I will conclude by saying a few words on the evaluation of the abortion Act which took place in 2005. Many health laws in the Netherlands are evaluated after four or five years. The idea is that we should have a look at whether they work in practice, whether they are complied with, whether they achieve their goals, etc. There was no such obligation within the abortion Act itself. Perhaps that is because it was already enacted in the 1980s. The way it operates in practice, however, is closely followed, in particular, by pro-life groups - of course, we have them in the Netherlands - and some of the political parties which are concerned that

our legislation is applied too liberally. To address these concerns, when a new coalition was formed in 2002, it was agreed that the application of the abortion Act would be the subject of a nationwide study.

In 2005, as I said, the evaluation report was published. Its overall conclusion is that the compliance by clinics and hospitals with the Act was satisfactory and that health professionals did what the law required of them to ensure that decisions concerning abortion were taken in a careful way. Furthermore, the report concludes that abortion services are available and accessible where needed and that, in general, they are of good quality.

One interesting point we found relates to the interviews we held with many women who had gone through this process of requesting an abortion and having one. I picked this out of the 250-page report to put it forward here. According to the women who were interviewed, the reasons for requesting an abortion are quite diverse. They range from financial and housing constraints, to age, the fact that the family is already complete, a broken or fragile relationship, lack of possibilities to raise a child, and then, of course, sometimes medical reasons in the strict sense of the word. Most often, there is more than one reason to request abortion. This is also confirmed in a later study conducted in 2012 by the University of Utrecht and commissioned by the Ministry of Health in the Netherlands. The outcome was that most women who were interviewed said that their final decision was the result of a number of reasons and should be seen against the background of their present situation in life. All of them, according to the report, experienced the decision to terminate their pregnancies as a hard one, and some of them experienced it as the most difficult decision in their lives.

Finally, last year, a new evaluation of the abortion Act was planned. It should have taken place this year but has been postponed because the Government fell. It was replaced last month by a new Government and the Parliament decided to allow the latter to decide on how this new evaluation of the Act should proceed.

Acting Chairman (Deputy Bernard J. Durkan): I thank Professor Gevers. Does Professor Pajkrt wish to make her opening statement now?

Professor Eva Pajkrt: My name is Eva Pajkrt. I am a professor in obstetrics, in particular, prenatal diagnosis and obstetric ultrasound, at the academic medical centre of the University of Amsterdam. I was trained as a gynaecologist at Medical Centre Alkmaar, which is a general hospital, and afterwards in the Academic Medical Centre in Amsterdam, which is a tertiary referral centre. I was trained as a general gynaecologist in all aspects of the specialty. Before and during my residency, I did my PhD on prenatal screening for chromosome anomalies and I worked later and contributed to the national introduction of prenatal screening in the Netherlands. Following my residency, I did a two-year clinical fellowship in foetal medicine at University College London Hospital. Once I came back to the Netherlands in 2005, I started working again at the Academic Medical Centre as a consultant in foetal and maternal medicine. I have been head of the foetal medicine unit since 2010 and was appointed professor in 2016.

I am involved in numerous committees of the Dutch Society of Obstetrics and Gynaecology. Since the introduction of the prenatal screening programme, I have been a member on several working parties concerned with the quality of care of the programme and I have been advising the Ministry of Health on several abortion issues.

My presence here has been requested to answer the committee's question about Dutch abortion care. The abortion care is imbedded within the ethical framework of patient autonomy and

is completely woman centred. The objective of Dutch abortion care is to have a thorough and comprehensive process without creating any obstacles.

I will briefly take the committee through the statement it has already received. I will not go through it extensively but I understand some of the people are following this online only and they do not have the statement. I will skip certain parts and if the committee cannot follow me, that is why.

Since 2016, there has been a national co-operation agreement between the Dutch Association of Abortion Specialists, the Dutch psycho-social counselling service for questions of unintended pregnancy, adoption and abortion, the Dutch Society of Obstetrics and Gynaecology and the Royal Dutch Organisation of Midwives. The Dutch College of General Practitioners, which is not listed, is also involved in this agreement. Women with an unplanned or undesirable pregnancies and doubts about continuation of their pregnancies will generally go to their general practitioners - this is about which professionals are involved.

In 56% of cases, the general practitioner will be the first contact. He or she may counsel the woman about her options and may refer her to an abortion clinic, a gynaecologist or for further psychological counselling. General practitioners have their own national guidelines. There is an English version which is available. In 25% of cases, women go directly to the abortion clinic and it is the first contact. The abortion clinic doctor may counsel the woman about her options. They may perform the procedure or they may refer the woman for further counselling. The other 25% either go to a midwife, a gynaecologist or some other professional. If the pregnant woman goes to the midwife, the midwife never will be the referring physician. The midwife is not legally a doctor and should refer the woman, and then the GP or gynaecologist has to refer the woman. The first contact may be a gynaecologist or other doctors. For example, the doctors of women with a cardiac problem in which it is unsafe to have a ongoing pregnancy may also refer them.

There are general considerations in cases of unplanned and undesirable pregnancy. One of the first questions one asks is whether there was a pregnancy test performed and whether there should be a repeat test. Then one should always ask if the pregnancy was planned or unplanned. That seems contradictory but it is, of course, not always so. A planned pregnancy may become undesirable and an unplanned pregnancy may become desirable. Ask about the circumstances leading to the pregnancy and whether or not the woman was on contraceptives. Mention there is always a choice and a dilemma in case of unplanned pregnancy. Ask about a dating with a scan. If there has not been one, please have one performed, preferably transvaginally. If the woman is determined to have an abortion, she should mention that on her request to the person performing the scan. Is the partner present at the consultation? If so, explore whether the woman was not forced by the partner or the person sitting beside her and that it is a voluntary request. Explore whether there has been any sexual abuse. Be aware of cultural and religious factors. Ask whether there would be a risk of genital tract infections, but in case of abortions on request as opposed to abortions due to prenatal diagnosis, we always test for sexually transmitted diseases in the Netherlands. We always discuss contraceptives - what kind of contraceptives the woman will use after she has had the abortion. Is the request consistent or does the woman seem to be in a state of panic and, as a result, would she potentially benefit from more time to make a decision? If so, refer woman for further counselling. When referring a woman for an abortion, always document the first date of the abortion request. Of course, there are several websites and I have included the address of one. Women can go online. There is a help choice and they can go through it.

There are also some questions one should always ask, including, "Are you certain about your decision?" It seems obvious but one has to ask. The others are: "How did you reach this decision?"; "Is this your own choice?"; "Have you considered other options?"; "Would you like me to explain the options?"; and "Do you need help to make a proper decision?" If the partner is present, the partner also should be asked. In case of ambivalence, it is important that the woman understands that she is responsible for her own choice. Ultimately, she has to make the decision. Nobody is going to make that decision for her. The woman should not be forced into making a decision; rather she should be helped to make a choice. It is important not to blame the woman for being ambivalent and that the emergency situation of the woman is considered. If the woman remains ambivalent, she should be referred for further counselling. In the Netherlands women are also referred to FIOM, which is the Dutch agency that helps women who give consideration to or opt to have their child adopted.

Time is important in any case of unplanned pregnancy in view of the method of abortion. Once a woman is referred, a quick appointment is mandatory, preferably within a week or, at least, within ten days. From the moment the woman indicates she is considering an abortion and the actual treatment, a reflection time of at least five completed days is mandatory in the Netherlands. This reflection time is not mandatory until a gestational age of six weeks plus two days, which is the 44 days after the first day of the last menstrual period. However, 65% of these women do have a reflection period of more than five days.

There are several ways to terminate a pregnancy. A woman can have a surgical termination, a medical termination or a combined termination, which involves the use of medication followed by a surgical procedure. Women may choose where to have an abortion and what type of abortion they would like, although their choice is, of course, dependent on gestational age. Women over 16 years of age do not need parental consent. Women between 12 and 16 years do require parental consent but we may withhold it if we believe it is a reasonable argument.

Approximately 90% of abortions in the Netherlands are carried out in abortion clinics. The Dutch Health Care Inspectorate produces an annual report with statistical information on terminations performed in the Netherlands in the preceding year. The last report was in 2015. As the data in the report are aggregated data, it is not possible to correlate between the different components of the abortion registration. In 2015, approximately 30,000 abortions were carried out in the Netherlands, almost 4,000, 13%, of which were on behalf of women from a foreign country. Of these 30,000 abortions, 8,500, 28%, were carried out before 44 days and as such these terminations are not considered under the abortion Act. Approximately 16,000, 50%, were performed before seven weeks gestation, while almost 9,000, 29%, were performed between seven and 12 weeks gestation. Thus, 80%, of all the abortions were performed in the first trimester, before 13 weeks.

The majority of women undergoing an abortion were between 25 and 30 years of age. Only 83 pregnancies were terminated in women under 15 years. In 2015, the total number of pregnancy terminations in teenagers was 3,079. This number has been decreasing slowly over the last couple of years. This is reflected in the percentage of teenage pregnancies that go to term. This is very low in comparison with other European countries.

Since 2007, all pregnant women in the Netherlands may undergo pre-natal screening. They are offered a combined test for screening for Down's syndrome, Edward's syndrome and Patau syndrome. As of 2017, non-invasive pre-natal testing, NIPT, has been added as a first trier test to screen for the above mentioned trisomies. Moreover, every women is offered a 20 week scan. Since 2011, it is possible to address whether an abortion is the result of pre-natal diag-

nosis. In 2015, a little over 1,000 of all abortions were performed after pre-natal diagnosis, the majority of which were carried out in a hospital. We know from the aggregated data that more than 30% of the abortions in hospitals are due to pre-natal diagnosis, compared with only 0.5% in abortion clinics. However, we do not have any knowledge on diagnosis nor is it possible to correlate the date with gestational age. It is likely that abortion due to pre-natal diagnosis will be carried out in the second trimester due to the time it takes to get a definite diagnosis. Thus, we can assume that around 20% of the second trimester abortions is due to pre-natal diagnosis.

Of all women undergoing abortion, 75% leave the clinic or hospital with a prescription for contraceptives. Since 2012, it is mandatory to provide sexual education to all schoolgoing children. This starts in elementary school. Up to 2011, contraceptives were reimbursed for every woman. Since 2011, only women up to 21 years are reimbursed. In the Netherlands, abortion is free for everyone who is legal and has a social security number. It is subsidised care. The costs are not reimbursed by the insurance companies but are subsidised by the ministry of health. For foreigners or people living illegally in the Netherlands, the cost varies, between €380 and €940. Particular centres, such as the Academic Medical Center, are subsidised separately by the ministry of health to take care of these women. For women who are in a really difficult position and cannot afford an abortion our hospital will provide an abortion, for which the hospital receives a subsidy, although I am not sure about how reimbursement in this regard is regulated.

Acting Chairman (Deputy Bernard J. Durkan): I thank Professor Pajkrt for her opening statement. We very much appreciate the witnesses being here and giving us of their time. To be helpful to everybody, and because our witnesses are not everyday English speakers, I ask members to speak slowly to accommodate their understanding. I will try to accommodate everybody in every way possible in terms of time. It might be best if we operate on a single question and an answer basis.

Senator Jerry Buttimer: I thank the witnesses for being here today. Perhaps Professor Pajkrt would explain the job of a consultant in foetal medicine.

Professor Eva Pajkrt: I spend a lot of time in the ultrasound department. Women who have been scanned elsewhere are referred to me because there is a suspicion of a foetal anomaly. I either rule out or confirm that there is a foetal anomaly and then I counsel parents about which additional tests could be performed to achieve a final diagnosis. Once we have a final diagnosis I spend a lot of time counselling people about how to proceed with their pregnancy.

Senator Jerry Buttimer: I thank Professor Pajkrt. Professor Gevers referred in his presentation to a prenatal screening programme. Perhaps he would elaborate on how the programme operates and the outcomes of screening.

Professor Sjef Gevers: Professor Pajkrt is more competent to answer that question.

Senator Jerry Buttimer: I ask the witness to explain how the prenatal screening programme works and the outcomes of screening. I ask her to expand a little on her presentation.

Professor Eva Pajkrt: We were actually quite late in introducing a prenatal screening programme in the Netherlands. We introduced our programme in 2007. There are two elements to the programme. Women are first asked if they want to receive information about prenatal screening. If the answer is affirmative, we offer the information but women have a right not to know. It is a strong belief that if women do not want all of the information, we should not give it to them. If the woman says that she would like to have the information, she is counselled about

the fact that there is a possibility of being screened for chromosomal anomalies. That used to be done via the combined test. We still have the combined test but since April 2017, we now offer the non-invasive prenatal test, known as the NIPT, a blood test which determines if it is likely that the baby has trisomy 21, 18 and 13. The NIPT is more sensitive than the combined test in detecting foetal trisomies. However, it lacks the ability to see other problems in the foetus at an early stage. Every woman is counselled about the 20 week scan and is offered such a scan, which we actually try to perform at around 19 weeks. We do this because we feel that if there is an anomaly, one needs time to do further investigations. Such investigations take time and it is better if one has a little bit more time so that women do not have to rush into making decisions.

The uptake of screening in the Netherlands for the combined test has always been around 40%. However, it is very regionally dependent. In Amsterdam, where we work, it is quite high but in more rural areas, the uptake is lower. It is also quite low in the north of Holland. It depends a little on where one lives. We thought that once we introduced NIPT in the Netherlands that women would just rush to have it but that has not happened. The uptake has stayed more or less the same. It may be a little bit higher but it is not something that everyone is rushing into. One of the arguments put forward to explain this is that the combined test and the NIPT are not free in the Netherlands. One must pay €169 for the entire combined test or €175 for NIPT. The rest of the cost of NIPT, which is more expensive than that, is paid for by the Ministry of Health. It is a study so it is under a study protocol and the licence runs to 1 April 2020. It will be evaluated then to determine how well it is working. Women have to pay for that. However, the 20 week scan is free. If one has health care in the Netherlands and one receives a treatment, one must pay the first €385 but there are certain treatments not included in that. The 20 week scan is one such treatment. If that is the only treatment one receives in a year, the health insurance companies will pay for it. The uptake of the 20 week scan is quite difficult to determine. We have everyone in a database who has the scan but it is more difficult to figure out who is not in the database. We estimate, however, that the uptake is around 95%.

Senator Jerry Buttimer: I have one last question which is linked. Professor Pajkrt spoke about the regulatory system that is in operation. I ask her to explain the regulatory regime. Does it serve the doctors well in terms of dealing with female patients? Can Professor Pajkrt identify any issues with the current law in the Netherlands that may limit practice? What would she do if she could improve it? I note that there is a vote in the Dáil.

Acting Chairman (Deputy Bernard J. Durkan): I am sorry but a vote has been called in the House.

Professor Eva Pajkrt: Ah yes, the bell.

Acting Chairman (Deputy Bernard J. Durkan): I apologise for that. We were not aware that this might happen. In theory, we could continue with only half of the members participating but that could give rise to questions later on so in the circumstances, we will suspend the meeting.

Sitting suspended at 2.44 p.m. and resumed at 3.04 p.m.

Acting Chairman (Deputy Bernard Durkan): Had Senator Buttimer concluded?

Senator Jerry Buttimer: I have a question about the regulatory system. Will the witnesses explain the system and how it operates in the context of the outcomes and the way women are looked after under that regime? Also, will the witnesses identify any issues with the current law

under the Dutch model? Does it limit practice or how could it be improved? What can we take from that? I thank them for their presentation and I thank Dr. Pajkrt for explaining the work she does. It is important that we place this in the context of her role and competence in terms of foetal medicine. Perhaps our country should consider making that more visible and explain it in simpler terms to people so they can understand the competence and professionalism of people such as Professor Pajkrt.

Professor Sjef Gevers: I thank the Senator for his questions. He asked how the regulatory system operates and, if I understood him correctly, what position it places physicians in, if they can go along with it and what problems they may encounter with the current system. At first sight, it might seem that our law could deter doctors because abortion is still a crime and perhaps one could expect that they would be afraid of performing an abortion. However, the abortion law has been in place for more than 30 years and is broadly accepted. It has been an accepted practice. The provision in the criminal code is not a deterrent as long as one remains within the well defined limits of the abortion Act. The further question was whether it is easy for doctors to operate and proceed within those limits. Basically it is, because there is so much emphasis on the procedure of coming to a good decision. We do not have a system with substantive criteria, for instance, whether in this case there is a medical problem, how serious it is and whether the life of the mother is in danger. No, the system is open to a large extent but there must be a counselling process aimed at careful decision-making. That allows doctors to take on board different reasons and motives for abortion and different individual situations. That does not make the decision less serious and far-reaching, but basically it is an open system that does not confine doctors to certain pre-defined situations.

Acting Chairman (Deputy Bernard Durkan): The next questioner is Senator Mullen.

Senator Rónán Mullen: I thank the witnesses for attending and for their very interesting presentation, which brought to light something I had not realised, namely, that the number of Irish women having abortions in the Netherlands is very small. There has been a narrative in this country that while 3,000 to 3,500 Irish women go to Britain for abortions, we are often reminded that there are more going to the Netherlands and so forth. I had not realised the number is so small and does not, to any significant degree, impact on Irish abortion rates abroad.

I will start by asking about the Dutch abortion figures. The Netherlands is presented as a country that has very low abortion rates. However, from what I can see, it is more accurate to say that Britain, France and other such countries are in the highest tier and that the abortion rates in the Netherlands more resemble those of Italy and Portugal, in that it is in a second tier of abortion rates. The figures presented to the Citizens' Assembly, using the UN approach, put the Dutch rate at 9.7 per 1,000, which would be more than twice the Irish rate of 4.5 per 1,000. However, the British Office for National Statistics calculates abortions as a percentage of total pregnancies. Do the witnesses ever use that approach to avoid things that may change from country to country, such as fertility rates? If one looks at the rate of abortions out of total pregnancies, taking out the 4,000 German and French abortions, it was at 27,000 in 2015 out of the total of 170,000 pregnancies, so the Netherlands seems to have a rate of 13% or 14% whereas in Ireland, we have one in 20, a rate of 5%. Before we examine the Dutch figures, is the third category which is not included in them, the early abortions, included in the figures the witnesses are giving us?

Professor Eva Pajkrt: Yes.

Senator Rónán Mullen: Would the witnesses have any idea of the post-24 week number

of abortions? Are they included in the figures the witnesses have given us?

Professor Eva Pajkrt: No.

Senator Rónán Mullen: Will the witnesses give us an idea of the total number of abortions that take place after 24 weeks?

Professor Eva Pajkrt: With the introduction of prenatal screening, there has been a decrease in the Netherlands. We have two categories for late pregnancy termination. The first category is for lethal cases where the infant, once born, will never survive. The second category is where we feel that if the baby is born, no medical treatment would be warranted because it would be felt that it would be inhumane, unnecessary or however one frames it. We had 18 cases of the first category in 2004, it has dropped to three in 2015 and the 2016 report, while it is not here, notes two cases. The rate has dramatically decreased with the introduction of prenatal screening, mainly because many of the diagnoses were of trisomy 18 and trisomy 13 and are now picked up by prenatal screening. The number in the second category has also dropped, but it is more likely to be one or two per year.

Senator Rónán Mullen: Being born or aborted?

Professor Eva Pajkrt: Terminated.

Senator Rónán Mullen: How many pregnancies over 24 weeks are terminated in a year?

Professor Eva Pajkrt: Two or three.

Senator Rónán Mullen: A very small number. We have a tradition here in Ireland where children with Down's syndrome are perhaps more cherished than in many other countries. We are very proud of our international Special Olympics. Many people testify to the joy that Down's syndrome children bring into their lives and how the children change their lives in a positive way. There has been much concern and debate about the fact that, in Britain, over 90% of children diagnosed with Down's syndrome in pregnancy are aborted. Iceland has reached 100%. The great and the good in Denmark plan to be Down's syndrome free by 2030 - that is the quasi-official position. Has Professor Pajkrt figures for what percentage of children diagnosed with Down's syndrome *in utero* are aborted in the Netherlands?

Professor Eva Pajkrt: I have the figures but there is a problem with our database. It is a national screening programme and I am sorry about it but it is still not working properly, so we do not have all the outcomes. As I said before, the uptake of prenatal screening in the Netherlands has been approximately 35%. That is for screening in the first trimester for foetal trisomies. We have done a study and, if the Senator wants, I can send him the paper, by Bakker et al., which I was involved in. We asked women their reasons. One reason was that many women in the Netherlands felt that Down's syndrome was not something we should screen for. I think that reflects our way of counselling women and giving them their own choice. Our health care is based on patient autonomy and what women want. We do not force anything on them. If a foetus is diagnosed with Down's syndrome, generally among women who want screening, the termination rate would be approximately 90%.

Senator Rónán Mullen: Some 90%? I thank Professor Pajkrt. She refers, going through the guidelines of the general considerations, to asking if the pregnancy has been correctly dated with a scan and that, in case of doubt, a scan should be performed. The guidelines state that when referring for a scan, it should be mentioned whether it is an undesirable pregnancy. Many

people in this country, not just people of faith, contrary to what Professor Pajkrt has heard, have a human rights vision that includes born and unborn and would regard the language of "undesirable pregnancy" as shockingly euphemistic with fairly chilling historic parallels. That is my view. I will not be the first to have said that to Professor Pajkrt. Why, when referring for a scan, is it relevant to mention whether it is an undesirable pregnancy?

Professor Eva Pajkrt: We have said that, in making decisions, we focus more on what women want. I say women since I am a gynaecologist and do not generally deal with men. If one knows that a woman has become pregnant and is considering a termination, it is good medical practice to ask the woman whether or not she wants to see the scan. If one knows as a general practitioner, GP, that the woman is maybe considering an abortion, it is good medical practice to inform the professional one is referring to with as many details as medically necessary about that woman.

Senator Rónán Mullen: Surely the woman should be given the straight option of seeing the scan? It might save a life.

Professor Eva Pajkrt: Yes, but it could also be a very traumatic experience. I think that is speculation.

Senator Rónán Mullen: Abortion rates in the Netherlands are somewhere between two and three times our rate, depending on how one counts them. Is it not the case that the system is to provide abortion on request? Professor Pajkrt pitches it with regard to emergencies, but is anybody ever refused an abortion? Does she have figures on that?

Professor Eva Pajkrt: We have no figures on that. I think we do have abortion on request.

Senator Rónán Mullen: What Professor Pajkrt is really talking about-----

Professor Eva Pajkrt: I would like to add something to that. I have been doing this work for a very long time and I have never come across a woman who makes the request lightly. These women have many difficulties. There are not cases of women saying they are going on a vacation and that the pregnancy does not suit them. I seriously object to the statement that abortion on request is just something that people do, because there is always a bigger argument. They have problems, whether financial, housing or whatever else. The decision to have an abortion is not a light one.

Senator Rónán Mullen: Is it not fair to say that nobody really claims that abortion is a light decision? Most people who speak about this issue, whether they see two lives to protect or just one, will acknowledge that this is a crisis. The last speaker in before Professor Pajkrt, yesterday evening, was a person who opposes abortion and has a child with severe disability. She spoke empathically about how every case is different and there are so many crises. In the end, is it not the case that Professor Pajkrt only sees one life to be protected? As long as the abortion is wanted, she really does not see herself as having any duty of care to the unborn child.

Professor Eva Pajkrt: Is that a question?

Senator Rónán Mullen: Yes. Do the witnesses acknowledge that is the stark truth of their position?

Professor Sjef Gevers: I think we have a duty of care to the unborn in that the decision to have or perform an abortion-----

Senator Rónán Mullen: Even though-----

Professor Sjef Gevers: -----should not be taken lightly and should be taken with due care and after a due process of consideration.

Senator Rónán Mullen: The professor is talking about ending a life. He is really saying that it is an entirely subjective test. As long as the person insists that it is an emergency surely there is no reality to the doctors' duty of care to the unborn if all that is asked of the woman is "please make sure that you have made up your mind". She is not even offered sight of a scan.

Professor Sjef Gevers: I do not know about offering of scans.

Acting Chairman (Deputy Bernard Durkan): This must be the last reply Senator as we are running in to the time of the next speaker. Does the witness wish to reply?

Professor Eva Pajkrt: I have answered the question about the scan, so I do not believe I will have to go into that again.

Acting Chairman (Deputy Bernard Durkan): I thank the witness. Our next speaker is Senator Gavan.

Senator Paul Gavan: I thank both of the witnesses for their presentations. I found them absolutely full of facts and with a broad and detailed setting of the health framework relating to terminations in the Netherlands.

Before I ask my questions I wish to correct one aspect. The previous speaker, Senator Mullen, has given the impression that we know the numbers of terminations from Ireland. In fact we do not. The reason we do not is because while we have a figure for the number of women who register in Britain - which is around 3,500 - that figure does not include the number of women who take abortion pills. Estimates vary on this number but it seems to be some 1,500 women. The total figure also gives no account of the women who do not give their true address. A number of women do this and they have a good reason to do this; if they give a UK address they may be able to access treatments without having to pay. To be frank, we do not know the abortion figures for Ireland. We do know that thousands of women travel each year. I just wanted to correct that point.

The first thing that struck me is that there is a very ethical framework in place in the Netherlands. Will the witnesses explain to the committee how abortion health care is viewed by the Dutch population as a whole? How are women considered in all of this?

Professor Sjef Gevers: There is a wide acceptance of the system we have. When the abortion Act was enacted in the 1980s it was a very narrow, tight vote. We were very happy that we achieved something in this field and that there was at least a minimum of consensus. I think it is fair to say that nowadays a large part of the population, a majority, are satisfied with the system we have. At the same time, it remains an issue of political debate and this is illustrated by the fact that the annual report of the health inspectorate, as we have previously mentioned, is debated in parliament every year. The same questions always come up about how the system is operating, whether it is in accordance with the intention of the legislation and so on. I have already spoken of the plans to have a second evaluation and a debate around what the main focus should be etc. There is continual debate and concern about how it works and how it should work. While it remains a controversial question, in practice we have a system that is widely accepted.

Professor Eva Pajkrt: As with the ethical framework we spoke of earlier, it is regarded by most people, men and women, that it is really the female's decision to make. It is a women-centred decision and the women should have the right to make reproductive choices. This includes abortion.

Senator Paul Gavan: So in effect the Netherlands' system is based on a principle of trusting women.

Professor Eva Pajkrt: I think so, yes.

Senator Paul Gavan: Can the witnesses give the committee some information about the health outcomes for women who access abortion health care in the Netherlands?

Professor Eva Pajkrt: I find the question difficult to understand. What does the Senator mean by "outcomes"? Does he mean "is it safe" or "how is it done"?

Senator Paul Gavan: Yes. I shall explain the context of the question. There is an argument from a strange minority that abortion is somehow overwhelmingly bad for women's health and has long-lasting consequences, such as on mental health for example.

Professor Eva Pajkrt: I believe that abortion is a very safe procedure. There are different methods. There are the pills and the surgical methods. It has been found that in the surgical procedure we have to dilate the cervix a little bit. Now, more and more, they prep the cervix first with medication and then they perform the surgical procedure. All of these procedures are relatively safe. Of course, if the woman has progressed a little bit later in gestation, there are complications. This issue is addressed in the annual report. This complication mainly has to do with the fact that if the gestation is further along, say at 20 weeks, there is a 20% chance that the placenta will be retained. The woman would have to go to the emergency room to have the placenta removed. It is not very clear to hospitals how to register that. It registers as a complication when in fact it is just the procedure and how it is. I believe that abortion is a relatively safe procedure. To my knowledge I do not believe we have had any maternal deaths from the procedure.

Senator Paul Gavan: I am curious to know, if the witnesses have the information, about the Irish women that visit abortion service providers. We are familiar with the situation of women who are forced to go to Britain, and while the numbers of women who travel from Ireland to the Netherlands is smaller, do the witnesses have any data on them?

Professor Eva Pajkrt: We do not. The problem is that it is all aggregated data. I am trying to convince them to compile the numbers differently so we could actually correlate. For instance, if an abortion was because of a prenatal diagnosis, we would like to know more around the abortion so that we would know a little bit more about what is going on. The only thing we can do at the moment is make assumptions. If there were around 35 women from Ireland out of some 30,000, I do not know where they are in those figures.

Senator Paul Gavan: I understand that. My last question is on a subject about which many people, I am sure, have thought. We are struck by the low rate of abortion in the Netherlands. The witnesses have related to us the very extensive programme of education and contraception. Could Professor Pajkrt expand on this? Clearly, whatever is being done in the Netherlands is very successful and there are lessons for us in Ireland.

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Professor Eva Pajkrt: To be honest I believe that maybe we could do even better if I could reflect on our own system and consider improvements. I believe that prevention is better than having to treat an issue and I do not believe that anyone disagrees with this. In that regard, contraceptives should be reimbursed or be free for everybody whether a person is 40 or 18. Health and sexual education is very important because if we do not do it children will go online anyway. Everybody has a smart phone now and sometimes what we see on social media is not how we want our kids to be educated about sex. It is very good that we have a system in the Netherlands where sex education is mandatory - it is not discretionary. In elementary school there is a programme. We need to show it to people and we need to see what we are teaching kids. Parents are involved. I was asked by the school to give a sexual education course. My kids told me that if I did it they would never go back to school again, so I did not dare to go in. I did, however, volunteer to tell them a little bit. You just explain it to them, and it helps.

Senator Paul Gavan: I thank Professor Pajkrt.

Senator Ned O'Sullivan: I welcome both of the witnesses and thank them for coming before the committee. Their presentations were frank and informative. I especially welcome the statement from Professor Pajkrt that in the Netherlands the whole question of abortion is women-centred. This is the way it should be. It is the mindset that is starting to gain momentum in Ireland, although rather belatedly.

I have two questions. One has to do with the legislative situation in the Netherlands, and Senator Mullen may have referred to it earlier. There is a lot of very strong, even harsh language in the 1981 Act, which I understand has survived any reviews that have taken place, referring to abortion as being a crime punishable only as a last resort. At the same time, there is quite clearly a very liberal abortion regime in the Netherlands. I am trying to put those two things together. Does this language reflect some sort of social divide on the question? Has the 1981 Act ever been endorsed by the people of the Netherlands by way of a referendum?

Professor Sjef Gevers: There has not been a referendum on the abortion Act. I think if there was one, as I have tried to say before, it would be widely endorsed. The Senator says the language is harsh. To some extent it is. I think in several countries, maybe most countries of Europe, the criminal code is still the basis when we talk about abortion. Abortion is only allowed within specific circumstances spelled out in national laws. In the Netherlands, we have this concept of emergency, which was already mentioned. An important issue in the parliamentary debates in the 1980s was how this concept should be applied. The final agreement was that the law should not go into further detail when one could say that an emergency existed. This was done deliberately to take account of the fact that the situations in which a woman might be in a situation of despair because of an unwanted or unplanned pregnancy might be so diverse. The Legislature refrained from going into substantive criteria because of this. That explains why so many different situations can be taken into account, provided that the decision is made in due care and after good reflection and so on. The procedural aspect of the law is more important than substantive reasons. They are not to be found in the law except for the very general concept of emergency.

Senator Ned O'Sullivan: I will not pursue that issue. I suppose it is a matter for philosophy rather than anything else. On the legislation, I think I am correct in saying that an abortion will not be allowed to a young person between the ages of 12 and 16 without parental consent. However, should a reasonable argument be put forward by the woman in question, abortion would be allowed. I am somewhat surprised that a 12 year old, pre-teen girl would be allowed to argue that kind of a case. Does it happen often in practice and is Professor Gevers comfort-

able with that?

Professor Sjef Gevers: Let me say something about the legal situation. Professor Pajkrt may follow up and talk about practice. In our law on patient rights, which is a more general law, we have a majority age for health care decisions of 16 years. When one is 16, one is entitled to decide for one's self without parental consent. Between 12 and 16, we have a dual system. For an intervention, we must have the consent of the minor and his or her parents.

In the context of abortion, that law might say that abortion can only take place if the parents of the pregnant person are also in agreement with it. However, we have an exception, not only for abortion but also for other medical procedures, in cases where a minor continues to insist that he or she wants to have it. For instance, a couple of months ago we had a very controversial case about a young cancer patient who refused further treatment. This exception came into the debate also. The judge of the court that had to decide on the case agreed that in such a case, if a minor between 12 and 16 insists on having or not having a certain procedure, the voice of the minor prevails. That applies also to abortion cases.

The problem, of course, is that even if parents do not have to consent, they usually will have to be informed. I guess in practice the person who is requested to perform an abortion will have a discussion with the minor about why she does not want her parents to be informed and will suggest it might be better if they were informed. If there is a strong argument not to inform them, and if this is strongly in the interests of the minor, the law makes it possible that the procedure remains confidential and the parents are not involved. This will only take place after long discussion and careful decision.

Professor Eva Pajkrt: We have no data on that. I think it is set up that way as a protection for the minor. It is not so much about the parents not consenting. It is more a question of whether the minor wants her parents to know. If we feel there is a situation that would basically endanger the life of the minor, we might consider doing an abortion without informing the parents. It is all very speculative and we do not have any figures.

Senator Ned O'Sullivan: Senator Gavan has already referred to my next point. Obviously the Irish cohort is so small there have not been any studies of it. There was a dip in 2013 and a very small number of Irish women travelling to the Netherlands in that year. Do the witnesses have any idea why that happened? Also, is there any after-care regime in place for foreign women generally or Irish women in particular who have abortions in the Netherlands?

Professor Eva Pajkrt: I do not think there is an after-care programme. There is one for Dutch women because they are referred back to the person who referred them to the abortion clinic in the first place. I know that of the women who go to an abortion clinic, 25% will address the abortion clinic directly. They will be referred back to their GP, who has to know that they have had an abortion. Sometimes they are referred back to the GP to discuss contraceptives. There is that kind of after-care but I am not sure about what is provided for foreign women. Generally, the women just go back to the country they are from and do not attend our services any more.

Deputy Peter Fitzpatrick: I welcome the witnesses. One of the main concerns many people have regarding abortion is that we would end up like England and Wales, where 90% of babies diagnosed with Down's syndrome are being aborted. The witness's paper talks about how prenatal screening is being offered to women from 2017 in order that there is a better chance of detecting Down's syndrome in the womb. We know from countries like the UK that

increases in screening usually mean that more babies with Down's syndrome are aborted. A recent article on the *Huffington Post* news website discussed how more and more babies with Down's syndrome are being aborted. It mentioned Denmark, where 98% of babies with the condition are aborted, and Iceland, where that figure rises to 100%. The same article describes how the Dutch Minister for health at the time was asked if she planned to take any steps in the Netherlands to ensure that the same situation does not happen there. Her response was that if freedom of choice results in a situation that nearly no children with Down's syndrome are being born, society should accept that. Do the witnesses agree with this statement? Do they think that the idea of a choice is more important than the life of a baby with Down's syndrome?

Acting Chairman (Deputy Bernard J. Durkan): Who wishes to proceed first?

Professor Eva Pajkrt: I have been listening. The first question was whether I agree with our Minister for health. Is that correct?

Deputy Peter Fitzpatrick: I was talking about choice. Does Professor Pajkrt believe that choice is more important than the life of a baby with Down's syndrome?

Acting Chairman (Deputy Bernard J. Durkan): The right to have a choice?

Professor Eva Pajkrt: The right to choose? My view is that the woman should have the reproductive choice, yes.

Deputy Peter Fitzpatrick: Professor Pajkrt mentioned a very strong word earlier, namely, protection. She said there should be protection. I also believe there should be protection for the unborn baby. My concern is that when there is screening, such as in the UK, there are more and more incidences of abortion. In Ireland approximately 120 babies are born with Down's syndrome annually. They are loveable children. I have spoken to parent after parent, and not one would give that child up.

Professor Eva Pajkrt: In the Netherlands, studies have shown that the number of children born with Down's syndrome has been stable. It has not decreased at all with the introduction of screening. Many people were scared that the number of Down's syndrome babies was going to fall but that has not been the case. One reason is that although there has been an increase in uptake in prenatal screening, mothers have become older and older women may make different choices than younger women. We do not know. Younger women do not screen because they think that they are young and it will not happen to them. We have about 250 born with Down's syndrome annually, and the rate is a flat line.

Deputy Peter Fitzpatrick: Does Professor Pajkrt agree with the Minister's statement?

Professor Eva Pajkrt: I agree with the Minister's statement, and I agree because she is speaking from the same framework as the one from which I refer. Ultimately, it is the choice of the parents. It is the choice of the mother and of the father. We are speaking as though it is only the women who want these things, but fathers also have clear ideas about how they will live their lives and what fits into their lives.

When one says they believe in patient autonomy and they should be the ones who have the choice, it is not that I wish everyone should have an abortion. We believe that people should be informed, know what their options are and should be counselled. If someone has a child with a disability, whether it is Down's syndrome or otherwise, there should be provisions for them, and we should live in a society where there is enough medical care for disabled children, and

not a situation such as the United States where having a child with a disability is a huge burden and can ruin someone financially. A country has to look at itself and ask what kind of country it wishes to be. I think the Netherlands is a country where we care for everybody but the parents have the choice, and it is not a case where because they have been unlucky to have a baby with one type of disability or another, they must deal with it because others feel that they should have to be the ones to deal with it.

Deputy Peter Fitzpatrick: I have spoken here of the need for us to examine positive alternatives to abortion such as providing better support to families and the need to improve the adoption process. I am disappointed that we do not seem to be interested in ways to save babies' lives while at the same time providing better supports to women. Professor Pajkrt's paper referred to how women seeking abortions should be asked if they are aware of other options and have considered them. She has spoken here of how abortion law has developed in the Netherlands since it was first introduced. Will she now balance her contribution by explaining how the law has developed to provide and improve on alternatives to abortion such as adoption?

Professor Eva Pajkrt: There is something of a contradiction over whether one should ask a woman about options because there is a belief that if a woman comes with a request, one should focus on that rather than coming up with alternatives that the woman is likely to have considered already. I have no idea how we should change the law to facilitate adoption. I do not work in adoption and am not the person who should comment on it.

Acting Chairman (Deputy Bernard J. Durkan): There is another vote in the Dáil. It is an interruption over which we have no control whatever. Deputy Fitzpatrick is coming near the end of his contribution.

Deputy Peter Fitzpatrick: We can continue when we come back. I am near the end.

Acting Chairman (Deputy Bernard J. Durkan): The Deputy may do so but we are coming near the end.

Deputy Peter Fitzpatrick: I have just one question left.

Acting Chairman (Deputy Bernard J. Durkan): The Deputy may do so but we are coming near the end and he should keep that in mind.

Deputy Peter Fitzpatrick: I know that. I thank the Chairman.

Sitting suspended at 3.46 p.m. and resumed at 4.03 p.m.

Acting Chairman (Deputy Bernard J. Durkan): We are back in session. Deputy Fitzpatrick was in possession. Has he concluded his question?

Deputy Peter Fitzpatrick: My second question, yes, but I am on my third question now. There seems to be a contradiction in what Professor Gevers is saying. On the one hand, the law in the Netherlands states that abortion is a serious matter and is not seen as a routine medical procedure. As such, there is something different about it. On the other hand, the baby's life is still ended by abortion. Does Professor Gevers think that an unborn baby has value? Science shows that the baby is separate to the mother. Should the baby, therefore, get separate protection? Professor Gevers is probably aware that last Friday was World Prematurity Day, which is celebrated in Ireland and the Netherlands. Does Professor Gevers agree that there is a real contradiction in that we are living in a world that ends a baby's life through abortion while, at

the same time, we try to save other babies that are born prematurely?

Professor Sjef Gevers: We have formal rules about the law, as it stands, in the Netherlands. I take the Deputy's question to be whether there is a contradiction in it. He referred to what I was saying about it not being a routine medical procedure. I think there is no contradiction because it is not considered, in law or in practice, as a normal medical procedure, as a routine, which is only a question of medical expertise, technique and norms. In my discipline of health law, we say that not everything doctors do can be regulated only by their own norms. Some things must be considered by society. Abortion is an example in this regard because there is more at stake than only medical intervention to solve a medical problem. In that sense, it is not routine or normal. That is why we have kept and will keep the basic prohibition on abortion in our criminal law and it is why we have a time limit in our penal code to say that after 24 weeks of gestation, only in very exceptional circumstances, the numbers on which were set out half an hour or so ago, can abortion take place. As such, there is protection of unborn life and respect for unborn life, but the choice of the woman remains in the centre. Perhaps, our system will have more protection of unborn life than others which do not respect the choice of the women concerned.

Deputy Peter Fitzpatrick: Does Professor Gevers agree that there are two people involved, namely, the unborn and the mother?

Professor Sjef Gevers: We do not consider the unborn as a person in the sense of the law. In our law, there is increasing protection of unborn life as it grows in the womb of the mother, but it is only considered a person after birth. Then, it has the full rights a person has. Before that, there is some degree of protection, but not the same as after birth.

Senator Lynn Ruane: I thank both witnesses for the presentation. When I was reading it, it was very refreshing to see just how woman-centred the legislation is. Yesterday, we had a presentation where a witness said our bodies are not only ours and asked, given that our hormones are all over the place during pregnancy, how we could make a decision. It was, therefore, nice and refreshing to have this follow today to cancel out yesterday's nonsense. While I can see how woman-centred the legislation is, I wonder if the five-day waiting period creates a conflict in the circumstances of some women. If a woman from a certain socioeconomic background or who has experienced domestic violence has only one opportunity to get to the clinic at all, what happens? Does the five-day waiting period have a negative impact on some women? I can ask all three questions together.

Acting Chairman (Deputy Bernard J. Durkan): We will take them one at a time.

Senator Lynn Ruane: As long as I get the three.

Professor Eva Pajkrt: I can answer this question. In cases where the 44-day option is not available - after the 44-day period in which no reflection time is required - 97% of women have a reflection time of more than five days. In cases where the 44-day option is availed of, 65% of women reflect for more than five days. Some 35% of women in such cases make an earlier decision because they want to have this simple procedure without waiting until the pregnancy is further advanced. In cases where women are further on in their pregnancies, 3% have abortions. There is an escape. I will explain how this is done. If one says that one has reflected for two or three days, one will be asked about one's reasons on the form one has to fill in, but those reasons are not included in the report. I have no idea of the reasons in such cases. I do not know what they are. My assumption is that physicians will always listen to women. If they

see an emergency, they will help the woman.

Senator Lynn Ruane: That is great. My next question follows on from that. An anomaly exists in the legislation in the cases of earlier abortions within the 44-day waiting period. There are two cohorts of women involved. Some women are required to have a waiting period and mandatory counselling, but other women are not. I wonder whether any research has been done to gain an understanding of how this process is experienced by both cohorts of women.

Professor Eva Pajkrt: We do not have any data on that. Counselling is not mandatory.

Senator Lynn Ruane: Okay.

Professor Eva Pajkrt: When we interact with women, we have to ask questions to figure out whether they need more help. We know, from the literature and personal experience, that abortion is always a very difficult decision. If a woman has her arguments very straight before the event, it is easier for her to cope with it afterwards. In that respect, the reflection time gives each woman an opportunity to get her act together and think about all the pros and cons. This is especially true for a woman who is confronted with structural or chromosomal anomalies. If she is considering termination, her first reaction is always "My baby has this and I want a termination now". I always advise such a woman not to do it while she is going through loop after loop on a rollercoaster. When the rollercoaster finally stops at the end of the day, if she has had a termination and has returned home, she will think about what has happened and it will really hit her. The grieving process has to start before a woman rushes into an abortion. I do not have data or psychological studies on that, but I have been counselling women for many years and not once has a woman come back to me to say it was inhuman of me to make her wait. Women tend to tell me it was nice for them and their partners to have a great weekend together to do something nice, to think about it, to discuss it, to talk to their families and to make the decision. Although they are very sad about their circumstances, they tend to think they have made the only right choice.

Professor Sjef Gevers: I would like to comment on the legal aspects of the 44-day period. The 2005 evaluation of the abortion Act that I mentioned earlier specified that an anomaly exists in this regard. It recommended that the law should be adapted to bring the 44-day period within the scope of the law now that we can be certain about whether there is a pregnancy. The Dutch Government agreed with that recommendation, but it did not take many measures to implement it. It was scared to make any change because it was worried about compromising the delicate law in this area. In 2016, the health minister submitted a Bill to the Dutch Parliament that would allow GPs to offer abortion pills to women who request them. We referred to this in our position paper. There has been a lot of debate about the Bill. It will not go further because the new Government does not like it. The proposed Bill would legalise the current 44-day arrangement, so to speak, by bringing it under the scope of the abortion Act. Maybe it will be advanced at some point in the future.

Senator Lynn Ruane: My final question ties in with the next body of work this committee will take on, which pertains to the auxiliary recommendations of the Citizens' Assembly. In their presentation, the witnesses mentioned mandatory sex education, which is something I support in theory. In Ireland, the Catholic church unfortunately still has a monopoly over schools and, therefore, sex education. I have to remove my ten year old daughter from participating in the lessons given by some organisations that come to her school. Could the witnesses give us a small bit of insight into who provides mandatory sex education in Dutch schools? What is the curriculum based on?

Professor Eva Pajkrt: As I am not a teacher, I will talk from personal experience of how it was brought to us as parents. The teachers get their programmes from the people who make the programmes. They are facilitated in providing sex education in the classroom.

Senator Lynn Ruane: I suppose it would be different from Ireland because sex education here is based on religion. I think sex education should be about positive sexual experiences and negotiated sexual consent.

Professor Eva Pajkrt: Some elementary schools in the Netherlands have a religious background. I refer to Catholic, Protestant, Jewish and Islamic schools. I have no idea whether they all do it the way they actually should. I know this is one of the items to be ticked off when schools are visited by inspectors. Schools are asked to state whether they have sexual programmes.

Senator Lynn Ruane: I thank Professor Pajkrt and Professor Gevers.

Acting Chairman (Deputy Bernard J. Durkan): Deputy Kelleher is next but he has not yet returned from voting in the Dáil. He told me not to be surprised if he was delayed. Therefore, I call Deputy Hildegarde Naughton.

Deputy Hildegarde Naughton: I thank Professor Pajkrt and Professor Gevers for their presentations. I would like to follow up on Senator Ruane's questions about better sex education and the importance of contraception awareness. Do the witnesses believe that there have been reductions in the numbers of teenage pregnancies and teenage abortions in the Netherlands? I note that the majority of those who seek abortions are older women. Can the witnesses confirm that the numbers of teenage pregnancies and teenage abortions have decreased as a direct result of the improvements in sex education? Do they believe such a correlation exists?

Professor Eva Pajkrt: Yes. In recent years, talking about sex in the media has become a natural and normal thing. On television, for example, a prominent sexologist has been constantly repeating that it is important for people to have sex education, not just to prevent abortion and unplanned pregnancy but also so that adults can experience a good, nice and healthy sexual life. It is important in one's life to be happy and to have all these facilities. One needs to know a little bit about it if one wants to appreciate it. Once he was there, more and more sexologists started to come forward and advocate in a similar manner. It is a very natural thing to discuss, whether in a classroom or at home, with family or friends. It is not a taboo.

Deputy Hildegarde Naughton: Many of my questions have been answered but I have just one more question. I thank Professor Pajkrt for her very comprehensive presentation today. While I know the professor does not have data on the five-day waiting period, if an Irish woman travels to the Netherlands for an abortion, how would the five-day waiting period work for her if she had only one or two days?

Professor Eva Pajkrt: The woman will have to make an appointment. If she is here and calls the clinic or sends an email to say she would really like to have an abortion, she will make up the five-day waiting period by the time she arrives in the Netherlands. It is not the case that she has to be physically present to say she wants to have an abortion. It starts on the day she requests an abortion. The clinics know this and they say fine and they will book her in. If the woman shows up on the day, she has apparently been thinking about it, and she is consistent in her request, the clinic will proceed with the abortion.

Deputy Kate O'Connell: I thank both witnesses for coming over here to attempt to edu-

cate us here in Ireland. Following Deputy Naughton's question, I was interested in how the Netherlands demystified human reproduction and conversations around sex. Have they any suggestions on how we might try to do that in this country? I am not sure how familiar they are with our legacy of incarcerating females in this country and the trade in illegitimate children to homes in Ireland and abroad. We have a damning history when it comes to women's rights. I agree with Senator Ruane that it probably stems from the hold of the Catholic Church on our State and our ovaries and all things related to sex. Have the witnesses any advice for us? I think that if I went to the Minister for Health and said I wanted a team of sexologists, he would say he would not know how to deal with that. The witnesses might be able to help us in that regard.

It seems to be very difficult for some people here to separate the moral from the medical, as the witnesses have surely seen from the questions put to them. We constantly hear conversations about the rights of the unborn child and that somehow, by removing the eighth amendment, women will take a turn at 36 weeks and say they do not even want a child, that they have changed their minds. Where did the moral pressure come from when the witnesses were doing this back in the day? Have they any advice for us on that?

Professor Eva Pajkrt: Before there was the legislation there were abortions. It always starts the way Ireland is starting. There are always a couple of people who think they have a strong case, that they should fight for it and stand up to do something about it. We had an abortion clinic and while the academic medical centre did not exist, it resulted from that movement. There were very strong advocates for abortion. They had been performing abortion before it was legalised. This is Holland. We go along with the flow until the issue becomes so big that everybody is talking about it and everybody is ready, then we get a law. It starts with a couple of people who will go against what maybe they should be doing but who feel strongly that they should change things. That is basically what Ireland is doing now. There is such a strong feeling that things should change. Ireland cannot come from where it is now to our system. It will never work that way. It will be a very slow and long process and the fighters will be needed. They may be the politicians but they will also be medical people, maybe volunteers, or women who had an abortion, maybe women who never had an abortion but really feel strongly about it, or maybe men who think that way. It will go. I do not know how else to tell the Irish what to do. I do not have the solution to hand.

Deputy Kate O'Connell: I may have picked the point up wrong in the presentation but how did the witnesses decide not to distinguish between first and second trimester?

Professor Eva Pajkrt: We do.

Deputy Kate O'Connell: I picked that up wrong. I am sorry.

Professor Eva Pajkrt: The report distinguishes between first and second trimester. I do not know why. It distinguishes the gestational age at which there can be termination and when there is foetal viability, which is 24 weeks. Abortion clinics, however, will terminate up to 22 weeks. That stems from the days when we did not have any very accurate dating. We now have far more accurate dating scans, they are scanned with the variation, but if they went beyond 22 weeks they might be terminating a foetus that was further progressed. In the Netherlands the majority of the terminations are performed in abortion clinics, but at 23 weeks they are performed in hospitals. There were only 127 cases last year and we assume they were because of foetal anomalies.

Professor Sjef Gevers: There is also another difference between the first and second trimes-

ter in our law. Abortion clinics need a special licence to be allowed to perform abortions in the second trimester. That has mainly to do with the medical complications and the skills and the facilities necessary to do it safely.

Deputy Kate O'Connell: Professor Gevers said the law deters doctors, and used the phrase "broadly accepted practice". What happens if it is a broadly accepted practice and somehow a very conservative government comes to power? How would that affect the practice if doctors behave in a way that is broadly accepted but is against the law? Professor Gevers probably has not thought about that and I probably should not worry about Holland.

Professor Sjef Gevers: Every law can be changed. It is more difficult to change the constitution of course but we do not have anything in the Dutch constitution about abortion. The law can be changed. Theoretically, I agree the law could be much more restrictive than it is now. It is unlikely that will happen because we have had many different coalition governments in the past 35 years and, for instance, the Christian Democratic Party led for part of that time and forms part of the present coalition. Those parties have always respected the balance or the compromise that has been achieved in the abortion Act. I do not expect this will change. The majority of the Dutch public would be opposed to that.

Deputy Louise O'Reilly: I thank the witnesses. Before asking questions, I very much welcome Deputy O'Connell's suggestion regarding a team of sexologists. I would like to attend any such meeting, as I expect all members would.

With regard to the five-day waiting period, is it the case that a woman is not required to visit a doctor beforehand and may express a wish to have an abortion by email and visit the doctor five days later?

With regard to issues of geography and the availability of services, an ever increasing number of Irish women are accessing abortion pills online via the *womenonweb.org* website. In some cases, their reason for doing so is that they do not have the wherewithal to travel or they find out early that they are pregnant. Do women in the Netherlands access the services of *womenonweb.org* or is this not necessary because there is sufficient provision in the State system? In terms of geography, how do women access clinics? Is it through their general practitioner? Obviously, isolation can be an issue for women living outside cities and towns, even in countries where abortion care is readily available. What has been the witnesses' experience in this regard?

Professor Eva Pajkrt: We are well aware of the *womenonweb.org* website but I have no idea about numbers or how many people are accessing it. All the abortion clinics in the Netherlands have a contract with a hospital. If there is a complication, the individual will be able to refer to a hospital that can deal with the complication. I do not believe there will be any boundaries for women who have access to pills via the Internet. If they have a complication, they can freely walk into a hospital and we will manage the situation.

Deputy Louise O'Reilly: In respect of the five-day waiting period, are women offered counselling? Professor Pajkrt correctly pointed out that this is not an easy decision. Obviously, the decision is made significantly more difficult for women in some countries. Is it mandatory to offer women counselling? Do women have to seek counselling and, if so, is it available?

Professor Eva Pajkrt: Counselling is always available. It is not mandatory. If the Deputy gives me a moment, I will provide the figures but the percentage of women who have counsel-

ling is much less than 100%.

Deputy Louise O'Reilly: Is it mandatory to offer counselling?

Professor Eva Pajkrt: It depends a little on where one works. In our hospital, we have a rule that it is mandatory but that is not because we believe the woman has to go through some sort of panel to be able to have an abortion. We believe it is good medical practice and that counselling will help later on to deal with the situation.

Deputy Louise O'Reilly: I refer to a number of points raised earlier and I am sorry the person who made them is no longer here. With regard to the directive that would be issued or the information that would be given when a woman may wish to date the pregnancy and to avail of a scan, a suggestion was made that the woman would not be able to look at the scan. I presume women can ask to see the scan. I am giving Professor Pajkrt an opportunity to correct what I believe was misinformation. My understanding of Professor Pajkrt's words, which may have been misinterpreted by another member, is that the note to the person performing the scan sets out the reason the woman is having the scan and that she may not wish to look at the scan. I presume if the woman wanted to see the scan, for whatever reason, it would be fine for her to make that choice.

Professor Eva Pajkrt: Absolutely.

Deputy Louise O'Reilly: It is good that we cleared up that matter.

I did a quick Google search after a previous speaker saluted Ireland for all the work done here on the Special Olympics. It is important to place on record that the Special Olympics is an international movement that is as vibrant in the Netherlands as it is elsewhere.

Deputy Catherine Murphy: I thank the witnesses for their presentation. It is very useful to hear different perspectives. A statement was made that Irish people would be horrified by the use of the term "undesirable pregnancy". We are used to the term "crisis pregnancy". This is simply a language issue and I am not arrogant enough to presume to speak for the entire Irish nation. Opinion polls certainly show a desire to change the highly restrictive abortion regime in place here, which permits abortion only on the basis of an equal right to life. The current regime brings the legal profession into the treatment rooms. I wonder why the choice was made to embed the Dutch legislation in criminal law as opposed to the whole health care area.

Professor Sjef Gevers: It is embedded in the whole health care area in the sense that much health legislation applies to abortion services, for instance, legislation on patients' rights, quality and safety in health care and the medical professions. In that sense, it is part of health care. When we had the evaluation of the abortion Act in 2005, some of the abortion specialists or physicians who came forward sent us a letter asking us to consider in our recommendations that they were already subject to so much other legislation. They asked why they could not be removed from the criminal system and if we really needed to have this criminal code context. We did not make such a recommendation in our study. If we had done so, I am sure it would not have been accepted by politics and the Dutch Parliament and Government because, as I stated, under Dutch law, unborn life is considered to deserve some degree of protection. It makes sense that this protection is also provided by means of criminal law. I would be very surprised if this position changed in the foreseeable future and abortion was taken out of the criminal law. At the same time, abortion, as it is performed in practice, does not have the burden or association of a criminal act, which the Deputy may have understood from what we said.

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Deputy Catherine Murphy: I understand that and there is a very clear difference between the position described and what happens here. The majority of abortions in the Netherlands take place in abortion clinics. In hindsight, does this create problems? We have heard from psychologists about stigma and protests outside abortion clinics. Do clinics in the Netherlands attract protests? Would it be better to embed abortion services in hospitals? Has this been the experience in the Netherlands?

Professor Eva Pajkrt: No. I have a daughter who lives in Texas and there are always people protesting outside the abortion clinic. I have not seen a protest in front of an abortion clinic for ages and I live very close to one. As Professor Gevers stated, abortion is embedded in the criminal law but women are not criminalised, which may be contradictory. Let us say the Deputy and I were to meet at a party where we discussed the fact that we were at this meeting. I could easily say - if it was the case - that I had an abortion. It is not something that someone would be judged on. It is like people saying they had a miscarriage.

Deputy Catherine Murphy: That is fine; I just wondered about that.

We spoke yesterday with witnesses from the British Pregnancy Advisory Service. Essentially, they said that even though there is a regime in place and lots of centres available to people, women are availing of abortion medication online. Is there any experience of that in the Netherlands?

Professor Eva Pajkrt: I have no numbers for that. I really do not know.

Deputy Clare Daly: I thank the Chair and I thank the witnesses for coming in. They have given us a very different view. The woman centred approach in the Netherlands is striking but at the same time, there are some things that seem a little bit contradictory.

There has been a consistent attempt at this committee, and we saw evidence of it again today, to use disabled people or people with disabilities in order to support an anti-abortion stance. The witnesses' figures on Down's syndrome were quite good. I ask Professor Pajkrt to go over the statistics she gave again because there has also been an attempt to portray prenatal screening as an attempt to eliminate anyone with a disability. My reading of the figures she gave, however, is that prenatal diagnosis has had no impact on the abortion rate but has had an impact on late abortions. Would that be a correct reading of it?

Professor Eva Pajkrt: Yes. I think the Deputy reads it correctly. That is why I would like the numbers to be better. I would like to be able to correlate the numbers and say, this is the level of prenatal diagnosis and this was the result. All we can do is say, as the graph shows, that we have seen an increase in late, second trimester abortions. The only assumption that we can make is that it might be due to the 20-week scan because that is when the anomalies are picked up. If it is a severe anomaly, parents will consider termination and we see that reflected in the numbers.

Deputy Clare Daly: I think the statistics show that 3.3% of the abortions take place after a scan. Scanning is used-----

Professor Eva Pajkrt: No, in terms of the figure of 3.3%, I was saying that it was out of 1,000-----

Deputy Clare Daly: It is just a figure that illustrates that in 2015, of all of the abortions-----

Professor Eva Pajkrt: Only 3.3%-----

Deputy Clare Daly: Of all of them, only 3.3% of them were after a scan. In other words, the impact-----

Professor Eva Pajkrt: We do not know when they were but only 3.3% were after prenatal diagnosis. We can only assume that-----

Deputy Clare Daly: -----it was after the 20-week scan.

Professor Eva Pajkrt: The report actually says that we can only assume that the prenatal diagnosis was not made in those first 44 days, so thus the number of pregnancies is 74.6%. I do not think that is the correct way of looking at things because I work out there and I know how long it takes to make a prenatal diagnosis. Before one actually gets a diagnosis, one is possibly 12 weeks but most likely 13 weeks. I think, therefore, that those terminations are all late terminations.

Deputy Clare Daly: While we have to use statistics in evidence, in terms of comparisons, the Dutch model is quite different from the British one, which is the one with which we are more familiar here. The figure we have been given for Britain is 92% of terminations taking place at less than 13 weeks, while the figure for the Netherlands is 81%. I know that there is a very high number in Holland that take place at less than seven weeks but is there a reason for that difference? How would we explain that difference?

Professor Eva Pajkrt: Which difference is the Deputy referring to - the 81% versus 92%?

Deputy Clare Daly: More terminations take place at less than 13 weeks in the UK than in the Netherlands.

Professor Eva Pajkrt: We have 81%-----

Deputy Clare Daly: Yes, and in the UK, the rate is 92%.

Professor Eva Pajkrt: I do not know why that is the case. I think that for women who are considering an abortion, it is easy today. One can get a pregnancy test anywhere so women can know very early that they are pregnant. If they are considering an abortion, they will do it as soon as possible. I do not know why there is a 10% difference between Britain and the

Netherlands.

Deputy Clare Daly: I was just curious. Briefly, on the criminalisation issue-----

Professor Sjef Gevers: We did an evaluation in 2005 and we found that the number of second trimester abortions was relatively high. It was not high in absolute numbers but was relatively high because of women coming from countries where there was a strict 12 week limit. In terms of the statistics we have now, it is difficult to say whether this is still the case but it may be.

Deputy Clare Daly: Just in terms of the whole area of criminalisation, the need to decriminalise in Ireland has been a regular feature at this committee. Evidence has been given, across the board, from the medical profession that it has a real chilling effect on medical practice here. That does not seem to exist in the Netherlands. Is there any sanction? Basically, what the witnesses are saying is that it is criminal but it is not really so. It is only criminal if it takes place outside of a licensed premises.

Professor Eva Pajkrt: Actually, it is embedded within the criminal law to protect the women. If there are doctors out there who were doing stuff that is illegal or not within the medical ethical framework, we can actually deal with those doctors. It is not within the criminal arena for the woman but it is for the doctor. It is a completely different way of doing it. We doctors do it in a nice and licensed way. It is not to criminalise the woman but more to protect the woman from potential-----

Deputy Clare Daly: It is criminalising illegal abortions or back street abortions.

Professor Sjef Gevers: Yes, very much so.

Professor Eva Pajkrt: Yes.

Deputy Clare Daly: It provides a certain protection for women in that there is no sanction-----

Professor Eva Pajkrt: For women? No, never.

Deputy Clare Daly: That is important because I think the Dutch model, which is striking, is based on the idea of careful decision making, which is timely in light of what we discussed here yesterday. I was struck by the point that everybody's circumstances are different. The witnesses identified, which supports this as being a really good model, the importance of having non-specific language. How does one include in a law all the myriad, sometimes conflicting or competing reasons? Is that something the witnesses would recommend to us? Have they found great benefit from having that non-specific language?

Professor Sjef Gevers: It is difficult to make recommendations for others and we are reluctant to do so. What is important is that the system we have is more responsive to the many different situations in which women can find themselves, in situations of despair and so on.

Professor Eva Pajkrt: That is how it is written down. It is actually illegal unless there is a crisis for the woman. The request comes from the woman and she is in despair. It is written down but I do not know how one would translate it. It is like a woman saying that she is in an emergency or crisis and does not see any other way out. It is taking the whole state of the woman into account, medical and psychological. Psychological pressures can be a huge burden.

Deputy Clare Daly: An emergency is a very individual thing. What is an emergency for one person is not for another.

Professor Eva Pajkrt: Yes.

Deputy Clare Daly: The issue of consent is key here. Medical treatment is based on the consent of the patient or the person at the heart of it, a willingness to accept treatment or indeed, a right to refuse it.

Professor Sjef Gevers: Yes, very much so.

Deputy Clare Daly: In Ireland, our medical ethics are based on that, with the exception, which is specified in our health policy, of pregnant women in cases where it is perceived that there is a risk to the foetus. Midwives and other representatives of our health service have told us that this has created a climate of fear in terms of the provision of medical care and so on and has coerced the medical profession into seeking a legal opinion on their patients. Is that something that the witnesses have ever come across in any scenario?

Professor Eva Pajkrt: I do not know if I understand the Deputy correctly. A physician or gynaecologist has his or her own ethical framework. If a physician is opposed to abortion and a woman comes to him or her with a request for an abortion, he or she does not have to personally carry it out but must refer the woman to a professional who is willing to help her. Does that answer the Deputy's question?

Deputy Clare Daly: If the witness were my doctor and I were pregnant and she wanted me to have a caesarean section but I wanted a natural delivery, could she, as my doctor, tell me she believed I might be jeopardising the baby's life and, therefore, compel me to have a caesarean section?

Professor Eva Pajkrt: I could not do that. As the Deputy may know, in the United Kingdom it is possible to relieve a woman of parental custody for an hour or so if there is a big danger to the life of the foetus in cases involving psychiatric patients or similar, such as patients who are seeing Jesus in the room. I am aware of that happening on a couple of occasions while I was working in the United Kingdom. That is the only situation in which such action might be permitted. A doctor may not carry out a caesarean section if a woman does not want the procedure, even if not having it would result in the death of the baby.

Deputy Clare Daly: That is very helpful. I thank Professor Pajkrt.

Acting Chairman (Deputy Bernard J. Durkan): There are two members still to speak. I am watching the clock because our situation is becoming precarious in that regard.

Deputy Bríd Smith: I will try to be as quick as possible in order to prevent any more precariousness in the room. I was interested by Professor Pajkrt's submission on reasons for abortion. Women make difficult decisions about whether to have abortions. I was interested in the list of reasons the witness provided, such as financial considerations, housing, age, whether one's family is complete, broken or fragile relationships and the lack of possibilities regarding raising a child. In the committee's discussions on the future of abortion rights in this country, we classified such reasons as being socioeconomic in nature. I was very interested that Professor Pajkrt did not list some of the issues that have caused most discussion in this country, such as rape, incest, fatal foetal abnormality, a risk to the life or health of a woman or suicidal ideation. As an obstetrician, does Professor Pajkrt consider the latter risks to almost automati-

cally be grounds for an abortion? Is it true to say that in the case of a woman who said she had been raped and wanted an abortion, a young girl who became pregnant as a result of incest in a family or a woman presenting with a fatal foetal abnormality, there would be no discussion of whether an abortion is warranted? Can Professor Pajkrt say how one measures up against the other? Having listened to all the experts who have come before the committee, some of whom have been fantastic, the evidence has been that women mainly choose to terminate a pregnancy for socioeconomic reasons and that reasons such as those relating to rape, incest and fatal foetal abnormality are thankfully the exception. That is also borne out in my experience. Therefore, if a society is to liberalise the availability of abortion and give women choice in that regard, socioeconomic reasons for termination must be strongly considered.

Professor Eva Pajkrt: I absolutely agree. The Deputy has made a couple of points. In Holland, we call such terminations medical abortions but the use of the word "medical" is potentially confusing. It is more accurate to call it an abortion for medical reasons. Such abortions can arise if the foetus or the mother has a medical condition and it would be unsafe to carry on with the pregnancy. If a woman has psychiatric difficulties or is suicidal, that could also be a reason. There has been a long discussion about the latter reason in terms of when the mother's life is really in danger. In the latest evaluation, that is now outside of the criminal law. If it is mandatory to perform an abortion in order to save the woman's life, a doctor does not have to blink or wait but can just do it and there will be no repercussions whatsoever.

We call the other reasons for terminations social indications. The Deputy may call them socioeconomic reasons; we call them social indications. Reasons such as rape, incest, housing and so on all come under social indications.

Deputy Bríd Smith: Rape comes under socioeconomic reasons as well as housing, work and so on.

Professor Eva Pajkrt: Yes. In terms of the Deputy asking whether psychological help is mandatory, in a case involving rape or incest, we would do the abortion and would strongly insist that the woman be helped to get counselling, youth care or whatever assistance she needed.

Deputy Bríd Smith: Intervention.

Professor Eva Pajkrt: Absolutely. One wants to prevent it from happening again and also protect the woman from going back to the------

Deputy Bríd Smith: Abusive place.

Professor Eva Pajkrt: -----abusive environment. We would, therefore, put all effort into helping such a woman and would not just send her to an abortion clinic to be given a pill and told to get it over with and go on and deal with her life.

Deputy Bríd Smith: It is hoped by all members currently in the room that Ireland will move to a situation where it will be possible to get rid of the constitutional ban on abortion. I am sure Professor Pajkrt, as a lawyer, is aware of that constitutional ban. If it is removed, legislation will then have to be considered. I am trying to tease out the distinction between what we call socioeconomic reasons and what the witness refers to as social reasons and those in the other horrible and hopefully very rare cases. If abortion were only to be allowed in such horrible and, hopefully, very rare cases, there would still be an extremely prohibitive abortion regime. Does Professor Pajkrt agree with that view?

Professor Eva Pajkrt: Yes, because otherwise one is trying to is come up with why one reason is better than another. For example, for a woman of 45 who suddenly discovers she is pregnant, having five children who are all in university could be a very good reason not to want to start over again. Another example could be a woman experiencing extreme poverty who has two small children and lives in a tiny one-bedroom apartment. This is what one comes across. They are desperate stories. One does not encounter people who have taken the decision lightly. As I outlined in my opening statement, there is a difference between unplanned and unwanted. Some women get pregnant and go to their doctor and tell him or her that the pregnancy is unplanned but very wanted. People deal with unexpected situations; they do not all run across the road and have an abortion.

Deputy Bríd Smith: If one did not need to have an abortion, one would not have it.

Professor Eva Pajkrt: Yes.

Deputy Bríd Smith: I want to explore what those who are anti-choice would argue is an abortion industry. The majority of Irish people who currently go to the Netherlands for an abortion attend CASA clinics. There are seven or eight such clinics and they are currently bankrupt. They charge between €350 and €500 for an abortion. Some people in Ireland say there is an abortion industry which is targeting vulnerable women. Being targeted by the abortion industry has not been cited as a reason for an abortion in any of the material members have read or that has been set before the committee. Women in Holland are entitled to free abortions as long as they are insured and legally in the country. If there is an abortion industry in Holland, it is currently bankrupt and possibly carrying out many abortions for free. Perhaps there is a lot of corruption there.

Professor Eva Pajkrt: Those companies are bankrupt because they had to pay back a lot of money related to billing. We do not know what happened and the matter is under investigation. I have no more data than the Deputy or what has been printed in newspapers. The only thing I know is that a couple of those clinics have to close and it is putting an enormous stress on all the other ones. We are seeing that. One could say it is an industry in that there is what is called upbilling. The practitioner gets a certain amount of money for a certain procedure. I have listed all the procedures. This is what I think and it is an assumption; one procedure is a bit more expensive than the other one and they said they did A while they were doing B. It has nothing to do with their professionalism or how they were doing it. There is no malpractice there.

Deputy Bríd Smith: I thank the witness for that. Early abortions are most common; 81% are performed at under 13 weeks, which is very good. Is that largely due to increased use of the abortion pill, in the sense that the woman can take a pill early on and does not have to go through surgical abortion? Would the professors distinguish between the two things in those statistics?

I do not suspect the witnesses will want to answer my next question but I want to ask it. If they closed their eyes and just landed here, without knowing they had to come to speak to a parliamentary committee about our future in Ireland, what would they think about the state of abortion care for women in this country? What would be their impressions as a professor in law and a professor in obstetrics?

Professor Eva Pajkrt: It is difficult.

Professor Sjef Gevers: I cannot give an opinion about the state of abortion care because

I am not familiar with it. What I can see is the legal context. Compared with other countries in Europe, the provision in Ireland is very restrictive. The European Convention on Human Rights and the court decisions that have been taken over the course of the years show that the European court has been very reluctant to go into the issue of whether the choice of the woman or the protection of the unborn life should prevail. Even so, there is a growing consensus in Europe that there should be more openness and possibility for a woman to have an abortion in certain circumstances. We also have discussion of socioeconomic reasons, which the Deputy mentioned. Maybe Ireland will move towards a more moderate regime in the future. I cannot say.

Deputy Bríd Smith: And what would Ms Pajkrt think, as a professor of obstetrics?

Professor Eva Pajkrt: Of how abortion care should be organised?

Deputy Bríd Smith: Or the lack of it. What does she think of the Irish abortion system?

Professor Eva Pajkrt: I think I do not have to say that out loud. I think the Deputy probably knows what I feel about it. I am a very strong believer, as I have said, in a woman's choice and in women's reproductive choices. I really think that women are the only people ... I am not disrespecting the men in this whole thing but I do feel that it is a female thing.

Acting Chairman (Deputy Bernard J. Durkan): We have two more speakers, Deputies Anne Rabbitte and Lisa Chambers.

Deputy Anne Rabbitte: I am going to lead on from where Deputy Smith was in respect of socioeconomic factors. It is a question I would have asked of previous witnesses. It has to do with children in foster or residential care. How are those issues addressed through the legal framework in the witnesses' country? If a teenager or young adult finds herself pregnant and there is a care order for her, in this country, if she wishes to have an abortion there has to be a full court sitting.

Professor Eva Pajkrt: They have the same rights as everybody else, whether it is a parent, guardian or whatever.

Deputy Anne Rabbitte: In this country, according to Ms Justice Laffoy and the other senior counsel we had in, they have to go before the courts. That brings gestation times into it. It was a question I raised a number of weeks ago. I am spokesperson for children in my party. We have 6,300 children in care in Ireland and somebody has to articulate these questions on their behalf. How are we to address that legal side of it? There are guardianships but there are also different court orders in place as to how their care can be administered. Have the witnesses come across that in their country and how is it addressed?

Professor Sjef Gevers: To my knowledge, we do not come across this. I can see how it may be an issue. We do not have special rules for this. In our legislation in general, a request for abortion is looked upon as a highly personal decision. The main issue would be whether the woman or girl in question would be competent. If she is, and she is 12 years old or more, she is entitled to make a request. If she has a guardian who does not agree, it depends very much on the circumstances. If she insists on that request and the health professional feels that he can go along with her request, she will have this abortion. It is the same provision as the one for minors for whom parental consent is not needed in special circumstances.

Professor Eva Pajkrt: One does not have to go to court. Someone who has a guardian does

not have to go to court in order to get an abortion.

Acting Chairman (Deputy Bernard J. Durkan): The reason she would have to go to court here is that there is a ban on abortion. The State has a ban on abortion except in certain circumstances. That is the origin of the Deputy's question.

Deputy Clare Daly: These are children who do not have the freedom to travel. Anybody else in a similar crisis situation would travel.

Professor Eva Pajkrt: Once there is legislation, they would fall under those provisions, right? They would have the same rights as anyone else.

Deputy Anne Rabbitte: It is just one of those loopholes. I think there is going to be a huge challenge around it. It has to do with children in care. The last day, when we had our own legal professionals before the committee, they clearly told me the process at present. I do not know from a legislative point of view how we can address this anomaly in the system. It is going to be a huge issue.

I found the witnesses' presentation very shocking. Maybe it is the reality. It is, because the witnesses are after telling me so. Children at 12 or 14 years of age making decisions about abortion without having the support or telling their parents or anything like that - that they can make the choice without permission or without the engagement factor - I find that-----

Professor Eva Pajkrt: May I comment on that?

Deputy Anne Rabbitte: I would like Professor Pajkrt to do so.

Professor Eva Pajkrt: I would like to comment on that in the same way as I commented on the issues of incest and rape. If, as doctors, we see these young girls, we always try to address these things. We had 83 teenagers under 15 last year. It is below 100 and has been dropping. If we think there is a problem, we will always seek assistance or will try to figure out what is going on and see if there is a way of helping the girl. If the girl in question has actually been the victim of incest, for instance, and there is a threat to her life if she comes out with it or if she says she is pregnant - this is what we are talking about. The majority of girls under 15 will probably come with their mum or dad or both. There are scenarios, however. I think the Deputy can imagine them as well as I can. In such scenarios, the doctor really thinks that if he discloses the matter to the outside world it will endanger the life of the girl. In such a scenario, that danger outweighs the possible benefit of seeking help, advice and support from the parents or guardians.

Deputy Anne Rabbitte: I thank Professor Pajkrt for expanding on that. My final question is really just a comment. Many witnesses have appeared before us. They have talked about people being coerced or persuaded into seeking or avoiding terminations. When women present at Professor Pajkrt's clinic, does it persuade them that going through with it is the right decision? What is her clinic's involvement?

Professor Eva Pajkrt: Our counselling is very neutral. I always say something to parents when we offer counselling - it is not that we think they are crazy or need counselling, but it is important for them to balance all of the pros and cons in order to make an informed decision. It is all about informed choice. It does not matter what I think. I am just the health care provider. That is what we are doing.

Deputy Anne Rabbitte: I thank Professor Pajkrt.

Acting Chairman (Deputy Bernard J. Durkan): Deputy Lisa Chambers is the very last, but someone had to be.

Deputy Lisa Chambers: Yes, and it is me today. I thank the witnesses for travelling to be with us, making their presentations and taking questions. Professor Gevers might put on his legal hat. As he knows, our law guarantees the equal right to life of the mother and the unborn. What is his legal opinion as to the difficulties that poses or why would he not agree with that equation legally?

Acting Chairman (Deputy Bernard J. Durkan): Since there is a vote coming up, and if no one objects, we will try to conclude proceedings.

Professor Sjef Gevers: I do not agree with this equation. We do not consider the unborn a person. While the unborn's life is entitled to some degree of protection, and more at a further stage of development, only after birth does he or she receive the full protection that a person receives. No such equation would be accepted.

Deputy Lisa Chambers: It is not that the Netherlands disregards the unborn. Gestational limits are in place, there is a regulated service, counselling is offered and there is a reflection period of five days. Obviously, checks and balances are in place to ensure that things are done properly.

Professor Sjef Gevers: And a time limit for abortion of 24 weeks.

Deputy Lisa Chambers: Of course. I thank Professor Gevers.

Acting Chairman (Deputy Bernard J. Durkan): I thank our visiting witnesses, particularly for being so patient during the numerous interruptions. We are much indebted to them for their replies to the various questions that were asked.

Deputy Anne Rabbitte: May I ask a question on the statistics? Professor Pajkrt mentioned that as many people did not abort as did when they discovered that their children had Down's syndrome. Does she have statistics on that?

Professor Eva Pajkrt: No. I only looked them up for my own region. We have those data. Where a baby is diagnosed with Down's syndrome, a little more than 80% will be terminated, 10% will decease during pregnancy - even if people carry on, some of their babies will die before they are born - and 10% will be live born. I was referring to a group of people who wanted screening. There is a large group of people who, even if we say that a baby shows signs of Down's syndrome, will just say "Okay". They do not want an intervention or a prenatal diagnosis. They will just go along with it. Our maternal age has been increasing, so maybe we have been terminating more Down's syndrome babies, but it is stable.

Acting Chairman (Deputy Bernard J. Durkan): I thank the witnesses. Likewise, I thank members for their questions and contributions.

The joint committee adjourned at 5.15 p.m. until 1.30 p.m. on Wednesday, 29 November 2017.