Doctors for Choice MALTA

Position Paper on Abortion

And the implications of Malta's complete ban on abortion on women, children, and their doctors

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This Position Paper was produced by Doctors for Choice Malta.

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All authors are active members of Doctors for Choice Malta who advocate for comprehensive sexual and reproductive health and rights (SRHR) and work to achieve better public health outcomes.

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About Us

Doctors for Choice is a non-profit organisation registered in Malta (VO/1816). It is primarily composed of qualified medical professionals from various specialities, and it also enrols medical students as associate members. It may also in the future enrol non-medical professionals as honorary members, in accordance with its statute.

The mission of Doctors for Choice is to advocate for sexual and reproductive healthcare in Malta that is safe, equitable, and accessible. Our main aims are to achieve:

1. Comprehensive sexual and reproductive education
2. Comprehensive and freely accessible contraception
3. Decriminalisation of abortion
4. Changes to the law to allow the provision of safe, equitable, and accessible abortion services

Shortly after its formation in May 2019, Doctors for Choice joined Voice for Choice, a coalition of civil rights organisations and individuals that campaigns for reproductive rights and justice in Malta.

As of 6th December 2019, Doctors for Choice is a partner organisation with Global Doctors for Choice, an international network of physician-advocates who advocate for reproductive rights and access to comprehensive reproductive health care, including safe abortion and contraception, headquartered in New York, USA.

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Aims of the Position Paper

The aim of this position paper is to convey the medical aspects of abortion care, and explain to the general public and stakeholders why abortion care is to be regarded 'an essential area of women's healthcare', as stated by Professor Lesley Regan,[1] past president of the Royal College of Obstetricians and Gynaecologists.

This position paper will also substantiate our call for the decriminalisation of abortion, and for changes to the law to allow the provision of abortion services in Malta.

We will describe the current legal and policy situation on abortion in Malta, and why this is detrimental to pregnant people's health. We will also elucidate the medical reasoning behind why the provision of abortion care within the national health service would be an important measure to safeguard the health of women[2] in our country, and how the criminalisation of abortion is detrimental to the doctor-patient relationship and good patient care.

We will also draw upon medical and scientific literature to dispel common misconceptions about the provision of abortion care, particularly to stress that abortion as a medical or surgical procedure is a very safe procedure for women.

[1] Professor Lesley Regan was the president of the Royal College of Obstetricians and Gynaecologists between 2016-2019.

[2] Whilst using 'woman'/'women' throughout the position paper, we acknowledge that other people who do not identify as such may also become pregnant and need an abortion.

Abortion is Healthcare

Abortion access is an essential part of reproductive healthcare. This is not merely our view as an organisation, but the position of the highest medical institutions worldwide with evidence-based medicine at their core (i.e. they use the highest level of evidence to yield reliable and strong recommendations with the best public health outcomes). These include the World Health Organization (WHO), the International Federation of Gynaecology and Obstetrics (FIGO), the Royal College of Obstetricians and Gynaecologists (RCOG), and the Royal College of General Practitioners (RCGP). It is noteworthy that a number of Maltese medical organisations actually form part of these international institutions (WHO, FIGO), including for example the Malta College of Obstetricians and Gynaecologists (MCOG) which is a member of FIGO. Many obstetricians and gynaecologists in Malta obtain specialist accreditation from the RCOG, and family doctors who undergo training in Malta receive their international membership with the RCGP.

Clearly, Malta's medical community regards these international bodies very highly and respects their standards and their guidance, however not when it comes to the provision of abortion services. In addition, the National Institute for Health and Care Excellence (NICE) guidelines are widely used locally to guide patient management in every field of medicine because these set the highest and safest evidence-based standards. Once again, the NICE guidance sets a benchmark for local practice, but this is not respected when it comes to abortion care.

Our position is that abortion care should be regulated by healthcare policy just like any other medical and surgical procedure, and not by criminal law.

Current Legal Situation in Malta

Abortion (the act of 'causing a miscarriage') is currently illegal in Malta, and the law contemplates no exceptions that would allow a woman or any other person to terminate a pregnancy under any circumstance. The current legislation criminalises both the woman and whoever assists her in the abortion. A person found guilty of procuring an abortion is at risk of serving 18 months to 3 years in prison. Medical doctors and/or other healthcare professionals who do so risk up to 4 years imprisonment as well as being struck off the professional register. The Criminal Code[3] states:

'241 (1) Whosoever, by any food, drink, medicine, or by violence, or by any other means whatsoever, shall cause the miscarriage of any woman with child, whether the woman be consenting or not, shall, on conviction, be liable to imprisonment for a term from eighteen months to three years.

241 (2) The same punishment shall be awarded against any woman who shall procure her own miscarriage, or who shall have consented to the use of the means by which the miscarriage is procured.'

'243 Any physician, surgeon, obstetrician, or apothecary, who shall have knowingly prescribed or administered the means whereby the miscarriage is procured, shall, on conviction, be liable to imprisonment for a term from eighteen months to four years, and to perpetual interdiction from the exercise of his profession.'

Currently the law prohibits abortion in situations where a woman's physical and/or mental health are jeopardised by pregnancy, and the law does not recognise exceptions for when the woman's life is at risk from complications directly arising from the pregnancy. There are also no provisions to allow abortion in cases where the pregnancy results from rape or incest.

These restrictions make Malta's prohibition of abortion the most stringent across the 27 member states of the European Union (as of February 2020). Poland, which is regarded as having the second most restrictive abortion law in the EU after Malta, legally allows the procedure in cases of risk to the woman's life, fetal anomaly, and in cases of pregnancy resulting from rape or incest.

[3] Government of Malta. (1854). Criminal Code of the Republic of Malta. [Online]. Available: http://www.justiceservices.gov.mt/downloaddocument.aspx?app=lom&itemid=8574

In June 2019, the UN's Committee on the Rights of the Child called on Malta to ensure safe access to abortion and post-abortion services for adolescent girls, and to decriminalise abortion in all circumstances.[4] In 2017, the Commissioner for Human Rights from the Council of Europe stated that Malta needed to reform its abortion laws.[5] He specified that the laws need to be changed on the grounds of human rights, right to health, and equality. He urged Malta to bring its legislation in line with 'international human rights standards and regional best practices' in the domain of sexual and reproductive health and rights. According to international and European human rights law, European States have the duty to ensure that women's sexual and reproductive health and rights are protected and respected.[6] The UN Convention on the Elimination of All Forms of Discrimination against Women has also spoken out about the situation in Malta, noting in 2010 that women's health was an area of concern due to 'insufficient access to reproductive health-care services for women'.[7]

[4] United Nations' Committee on the Rights of the Child. (2019). *Concluding observations on the combined third to sixth reports of Malta*. United Nations High Commissioner for Human Rights.
[5] Muižnieks N. (2017). *Letter from the Commissioner of Human Rights, Council of Europe, to Prime Minister of Malta*.
[6] Council of Europe. (2017). *Women's sexual and reproductive health and rights in Europe.* COE.
[7] Committee on the Elimination of Discrimination against Women. (2010). *Consideration of reports submitted by States parties under article 18 of the Convention: Concluding observations of the Committee on the Elimination of Discrimination against Women – Malta*. United Nations. CEDAW.

Abortion Ban: The Impact on Doctors' Work

A local study[8] published in 2019 assessed the views of doctors in Malta regarding abortion. The results of this first ever study of 454 registered medical doctors shows that the majority of medical doctors in Malta do not agree with a total legal ban on abortion and support its legalisation in limited circumstances.[9] There were clear majorities favouring legalisation when a woman's life in danger and in cases of non-viable fetal anomalies. There was also support, albeit to a lesser extent, in other circumstances such as rape (or incest), to preserve physical and mental health.

Notwithstanding this preliminary data, our position is that the majority opinion of medical doctors or even that of the general public should not dictate whether abortion becomes legal or not. Any essential health care provision (as clearly stated by international bodies such as WHO, FIGO, RCOG and NICE) should not be left up to any majority. However, the views of medical doctors on this issue remain important since the complete ban on abortion impacts their work. The following scenarios do invariably happen, even if abortion is illegal:

1. Advising pregnant women

A woman seeking advice about an unwanted pregnancy or even a wanted pregnancy that is complicated (by poor health of the woman or a fetal anomaly) should be well informed about all available options. Unfortunately, many doctors in Malta are not aware that it is ***not*** actually illegal to give information to their patients about the option of procuring an abortion legally abroad and to refer patients to organisations such as the Abortion Support Network (ASN). We have received reports of medical students and junior doctors being warned by some of their senior mentors not to mention abortion to patients as this could lead to the loss of their medical licence possibly because they genuinely believe this to be true. This false idea appears to have been effortlessly passed on from one generation of doctors to another, acting as a deterrent to even bring up the

[8] Gravino G and Caruana-Finkel L. (2019). Abortion and methods of reproductive planning: the views of Malta's medical doctor cohort. *Sexual and Reproductive Health Matters*, 27(1). [Online]. Available: https://tandfonline.com/doi/full/10.1080/26410397.2019.1683127

[9] 1578 out of a total of 2468 medical doctors registered in Malta in 2018 were invited for an anonymous survey. The response rate was 28.8% ($n = 454$), guaranteeing a maximum margin of error of 4.16% assuming a 95% confidence level.

subject for discussion within the profession. Indications for abortion do not feature in Malta's medical students' training, deviating from internationally recognised standards of training. Hence, abortion has remained a taboo in the local medical community as much as it has in the general population (if not to a greater extent).

We strongly believe that the current restrictive laws create uncertainty, reluctance, and inadequate consultations. Doctors in these situations should not be in a position where they fear being criminalised and losing their license. This leads to women being poorly informed by their doctors, having no access to such services, and potentially resorting to unsafe abortion methods with the risk of severe consequences.

2. Providing post-abortion care

Women in Malta *do* procure abortion either by travelling abroad, purchasing medical abortion pills online, or attempting unsafe non-recommended methods. Estimates by WRF suggest that every year around 200 women purchase abortion pills online (despite being illegal to consume in Malta), whilst around 370 travel abroad for an abortion.[10] These women are reluctant to seek medical help if they experience difficulties or complications (out of fear of being criminalised). If they do eventually seek help, they do so at a later than ideal stage, and even then, they are reluctant to disclose all the information which would normally help doctors manage the patient safely. Note that the WHO guidance states that medical abortion pills (Mifepristone and Misoprostol regimen) can be safely used at home up to 12 weeks gestation, provided that the woman has access to a healthcare provider should she need or want it at any stage during the process.[11] FIGO provides evidence showing that properly performed abortions are safer to women than term deliveries, particularly during the first trimester.[12]

3. Doctor-Patient relationship

Many GPs have a very good relationship with their patients. Some would have known their patients from childhood and would be intimately acquainted with

[10] Women's Rights Foundation. (2018). *Women's Sexual and Reproductive Health and Rights - Malta: Position Paper 2018*. [Online]. Available: https://www.wrf.org.mt/post/women-s-sexual-and-reproductive-health-and-rights-malta
[11] World Health Organization. (2018). Medical management of abortion. [Online]. Available: https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/
[12] International Federation of Gynecology and Obstetrics. (2012). *Ethical issues in obstetrics and gynecology*. FIGO.

the whole family. Yet, women considering having an abortion hesitate to speak to their GP about it since there is still strong opposition to abortion by doctors in Malta. Despite a strong GP-patient relationship, women are afraid that they will be judged by an anti-choice doctor and try to look for solutions elsewhere. They may opt to go to a public health centre to maintain anonymity, but it is very likely that they will be turned away. This means that at times of great need of help, women considering an abortion will be left to their own devices. The lack of accessibility to professionals who are willing to help them make their own informed decisions may lead to options of sub-standard or unsafe procedures. Women who do succeed in finding the support needed through a GPs recommendation to contact ASN, would still have to undergo the procedure abroad without the help of a trusted doctor.

Abortion Ban: A Risk to Women's Lives

The Criminal Code has no provision for abortion under *any* circumstance, not even when a woman's life is imminently at risk of death as a result of a pregnancy. Current local medical practice generally applies the ethical 'principle of double-effect' in order to protect such women. The ethical principle stipulates that it is permissible to do something 'morally good' that has a 'morally bad' side-effect, providing the latter was not the intention, even if it was foreseen. By applying this principle (in the context of Maltese law which considers Catholic teaching as the normative value), doctors can only save the woman when the life of the fetus is terminated indirectly (e.g. treating an ectopic pregnancy by surgically removing a fallopian tube or administering chemotherapy aimed at curing cancer in a pregnant woman). However, there are a number of problems with relying on this approach when managing patients.

The 'principle of double-effect' is an ethical concept that originated in Catholic philosophy (note that neither all doctors nor all patients identify as Catholics in the diverse community that Malta has become), and it should certainly not be considered the same as a law. Although it may be considered a guiding ethical principle, this does not provide clear grounds on how to act in certain sensitive situations. For example, it may result in treatment being delayed (as precious time can be wasted waiting for the condition of the woman and/or fetus to improve or deteriorate), thereby possibly endangering a woman's life. Furthermore, we cannot wait for women to be at imminent risk of death to try and save her life because this may very well be too late. Our position is that women should be given the option of contributing to the management plan of their own pregnancy in a timely manner.

In practice, there is a a great deal more to consider about the 'principle of double-effect':

1. The criminal code states that '*whosoever*' and by '*whatsoever*' means shall '*cause the miscarriage*' will be liable to punishment. It makes no mention of this principle and makes no distinction between 'direct' and 'indirect' termination (or any differences in the 'intention'), condemning all forms of termination irrespective of whether it is a 'direct' or 'indirect' abortion. That most medical doctors ignore this in their treatment of ectopic pregnancy clearly means that they are not in compliance with the law.

2. In practice it is very unclear what constitutes 'direct' vs 'indirect' termination of pregnancy. This makes the 'principle of double-effect' a poor tool for medical practitioners. This issue has also been highlighted by Prof. Pierre Mallia, a professor in family medicine, patients' rights and bioethics at the University of Malta: 'In fact, [the principle of] double effect has a weakness because it is not clear what is considered direct and so "we cannot give it as a tool to medical practitioners" […] "This is why there should be a law that states that if the mother's life is in danger, then she has a right to decide," [he stated].'[13]

3. Even if the boundary between 'direct' and 'indirect' were to be made clear, the principle would not allow 'direct' termination, according to the law not even if a woman's life is in danger. Traditionally, ectopic pregnancy has been treated by surgical removal of the fallopian tube containing the non-viable fetus (this is usually regarded as 'indirect' termination). A more modern approach for selected cases would involve the administration of a medicine called Methotrexate which terminates the non-viable pregnancy in a way that is more 'direct', with the benefit of potentially preserving the fallopian tube to facilitate future pregnancies. If regarded as 'direct', the nature of this preferable approach means that it cannot be carried out under the 'principle of double-effect'.

4. Relying on this principle to save the life of a patient who is dying has its own problems. At which point does the status of an ill patient change from being 'very sick' to 'dying'? This is not only unclear but entirely arbitrary. In a recent seminar, Dr Rhona Mahony, a prominent obstetrician and gynaecologist who argued for the removal of the constitutional ban in Ireland, spoke about a 'medical roulette'. This refers to certain sensitive situations where decisions based on attempts to quantify risk may result in compromising women's health.[14] In the context of a country where abortion is illegal, a patient who is at risk of serious medical complications is not given the option to decide for themselves if (and when) they wish to terminate the pregnancy. Instead, the medical team is required to use the 'principle of double-effect' as a loophole, wait until the situation is deemed serious and grievous enough (such as the patient being in medical shock[15]), and then intervene in some way to prevent

[13] Cilia R. (2018). Abortions carried out in certain circumstances in Malta. The Independent. 16 December. [Online]. Available: https://www.independent.com.mt/articles/2018-12-16/local-news/When-abortions-are-carried-out-in-certain-circumstances-in-Malta-6736200899

[14] Mahony R. (2019). 'Advances in reproductive health care in Ireland', *Sexual and Reproductive Health and Rights Conference*, Malta, 12 Oct 2019.

[15] In medicine, shock refers to a major medical emergency involving a critical condition that is brought on by a sudden drop in blood flow through the body with the circulatory system being unable to supply adequate blood flow and Oxygen to vital organs.

maternal death (when it may well be too late). Even then, medical professionals performing a life-saving termination of pregnancy in Malta are inevitably technically performing a criminal act (even if in practice this does not lead to criminal conviction). The law, as it currently stands is clearly being violated each time doctors utilise the 'principle of double-effect' to save a woman's life.

The lack of a clear legal framework as well as the lack of policy guidelines on when the 'principle of double-effect' can be invoked, can have a huge impact on patient care. It may also lead to medical professionals being reluctant to make clinically sound decisions to terminate a pregnancy which is threatening a woman's life.

Prior to the repeal of the 8th Constitutional Amendment in the Republic of Ireland, doctors in that jurisdiction similarly relied on the 'principle of double-effect' when faced with cases of life-threatening complications in pregnancy. The tragic case of Savita Halappanavar, who lost her life due to sepsis following a second trimester premature rupture of membranes, is widely regarded to be a consequence of restrictive abortion laws and their powerful impact on medical decisions. The Arulkumaran report,[16] commissioned by Ireland's Health Service Executive as part of an inquiry into Savita's death, stated:

'There are no accepted clear local, national or international guidelines on the management of inevitable early second trimester miscarriage (i.e. less than 24 weeks) including the management of miscarriage where there is prolonged rupture of the membranes. The reason for the absence of such guidelines may be that clinical practice in other jurisdictions would have led to an early termination of pregnancy in equivalent clinical circumstances. It is recommended that such guidelines be developed for such patients as a matter of urgency and they should be explicit in the guidance given as to when one should offer termination based on symptoms and signs of infection implying increasing health risk to the mother which may even threaten her life.

We recognise that such guidelines must be consistent with applicable law and that the guidance so urged may require legal change.'

[16] Health Service Executive. (2013). *Report of the investigation into the death of Ms Savita Halappanavar*. [Online]. Available: https://www.hse.ie/eng/services/news/media/pressrel/newsarchive/2013archive/jun13/savitareport.html

Given the close similarities between pre-repeal law in the Republic of Ireland and the current law in Malta, our position is that the guidance of the above report should be regarded as being directly applicable to Malta as well.

Our position is that the absolute prohibition of abortion leads to a reluctance to terminate a complicated pregnancy until those complications present a clear and imminent risk to the woman's life. This inevitably leads to women in such situations being subjected to an increased and unnecessary risk to their lives. There is no possibility for women in Malta to opt for an elective termination of pregnancy when faced with a risk to their lives. We believe this is an infringement to women's right to life as protected by Article 2 of the European Convention on Human Rights.

Abortion Ban: A Risk to Women's Physical and Mental Health

Importantly, death is an immensely low bar to set when discussing maternal health, since pregnancy can potentially involve life-changing complications, especially for those who are at high risk. Abortion also needs to be an option when a woman's physical and mental health are at risk (e.g. women suffering from heart defects, high risk underage pregnancies, suicidal ideation, *etc*.).

Unintended pregnancies or complications of intended pregnancies can have negative consequences on women's physical and mental health, and the lack of provision of termination of pregnancy services perpetuates this harm. Women who do not get help may resort to dangerous options, including poisoning themselves with dangerous medicines, drinking excessive amounts of alcohol, use of dishwashing liquids and other forms of self-harm.

The Turnaway study,[17] a prospective longitudinal study conducted in the US between 2008 and 2015, examined the consequences of being denied an abortion (hence the study's name) on women's physical and mental health. The study conducted interviews with women who had a (1) first trimester abortion or a (2) near limit abortion, and women who (3) sought an abortion but were found to have been over the limit and therefore turned away. Comparisons made between the abortion and non-abortion groups of women found that those who were denied an abortion were more likely to:

- Experience serious complications from the end of pregnancy including eclampsia and death
- Stay tethered to abusive partners
- Suffer anxiety and loss of self-esteem in the short
- Not have aspirational life plans for the coming year

This study was the first of its kind. Unlike previous studies that had looked at outcome differences between women who had an abortion and those who did not, the Turnaway study's non-abortion group consisted of women who were denied an abortion rather than those who chose to continue with their pregnancy. Therefore, the Turnaway study is considered to more accurately

[17] Details about the Turnaway study and related the publications by the Advanced New Standards in Reproductive Health (ANSIRH) are available here [Online]: https://www.ansirh.org/research/turnaway-study

reflect the consequences of the lack of abortion access on women who request such a service.

The results of the Turnaway study demonstrate that denying women abortion care has detrimental effects on their physical and mental health. Comparisons can be made with the situation of women who live in Malta. Unlike women in the US, which is where the Turnaway study was conducted, women in Malta are likely to be effectively denied an abortion if they are unable to travel abroad for abortion care, e.g. due to financial and/or Visa issues. There is likely to be a very significant cohort of women in Malta who are denied abortion care and therefore are likely to be suffering similar adverse physical and mental consequences as those reported by the Turnaway study.

Even those who do travel to obtain the help they need, are still not receiving the care they deserve. For example, they face unnecessary stress in an already difficult situation (financial difficulties; being away from family when they need it the most; a healthcare system that they do not know and that does not know them; and no opportunity for proper follow-up). Therefore, any impression that the system in Malta is satisfactory because women (including those with intended but complicated pregnancies such as fatal fetal anomalies) can travel abroad is fallacious and simply masks the shortcomings of our healthcare system.

Another situation that concerns us as an organisation is the fact that hundreds of women in Malta each year procure medical abortion pills (Mifepristone and Misoprostol) and consume these pills to terminate their pregnancy in Malta, effectively committing a criminal offence.[18]

We are concerned that some women are procuring medical abortion pills without receiving enough information about potential complications. We are also concerned that due to the illegality of taking abortion pills, such women may be reluctant to seek medical help in Malta if they develop complications.

In the light of this situation, we believe that the abortion ban in Malta is being circumvented sufficiently to render it somewhat ineffective, but it is nonetheless increasing the risk of harm to women in our country.

[18] The assertion that hundreds of women are procuring these pills each year is based on information made available to us by organisations that support and provide abortion access, including Women on Web and Abortion Support Network.

Our position is that the ban on abortion is harming women's physical and mental health in two main ways. Firstly, it is a clear barrier to accessing abortion care, and as demonstrated by the Turnaway study women denied abortions are more likely to have adverse health outcomes than those who are permitted to have abortions. Secondly, it compels women to take abortion inducing medication without adequate medical supervision and follow-up care, which places their health at unnecessary risk.

Abortion Ban: A Risk to Children's Lives

A total and absolute ban on access to abortion services also negatively impacts the lives of children. As per WHO data,[19,20] we recognise that adolescents have an increased risk of developing obstetric complications from a pregnancy compared to women aged 20-24 years. Internationally, 3.9 million girls undergo unsafe abortions annually. Research shows that pregnancy and giving birth at a young age is associated with significantly increased risk of high blood pressure, severe infections and depression, all with possible long-term consequences. Adolescent pregnancies also have higher risks of preterm delivery, low birthweight, severe neonatal conditions and infant death.

The right to life is described in the United Nations Convention on the Rights of the Child[21] (Article 6) and also in the International Covenant on Civil and Political Rights.[22] The right to life is elaborated upon in the OHCHR comments on the latter[23] (Remark 1.8): *'restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering'.*

The United Nations Convention on the Rights of the Child goes on to say *'adolescents should have access to short- and long- term contraceptive methods, including condoms, hormonal contraceptives and emergency contraception; safe abortion and post-abortion care services, irrespective of whether abortion itself is legal; and maternal health services*'.[24]

Our position is that the prohibitive and restrictive legal framework in Malta currently forces adolescents into higher risk pregnancies or unsafe abortions due to a total ban on this service. This also promotes social inequality and stifles social mobility; overseas services may be accessed against payment, which constitutes a clear obstacle for girls of lower socioeconomic groups in their efforts to utilise these services. This is compounded by international restrictions

[19] World Health Organization. (2016). *Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015*. WHO.
[20] Ganchimeg T, *et al*. (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study. *International Journal of Obstetrics and Gynaecology*,121(S Suppl 1):40-8.
[21] United Nations. (1989). *The United Nations Convention on the Rights of the Child*. UN.
[22] Office of the United Nations High Commissioner for Human Rights. (1966). *International Covenant on Civil and Political Rights*. OHCHR.
[23] Office of the United Nations High Commissioner for Human Rights. (2018). *The United Nations Rights Committee General Comment on the Right to Life and the Right to Abortion*. OHCHR.
[24] Committee on the Rights of the Child. (2013). *On the right of the child to the enjoyment of the highest attainable standard of health*. UN.

on movement of minors and lack of financial independence by virtue of being of school-age. Teenage pregnancy itself has significant implications on educational and employment opportunities, perpetuating cycles of poverty; this itself is associated with adverse health outcomes.

According to the European Union Statistics Office (Eurostat) recent data, Malta's rate for teenage pregnancy was the 9th highest within the European Union.[25,26] Our position is that a total ban on abortion services harms the physical, mental, and social health of children in Malta. Therefore, this leaves our children in poorer circumstances than their European counterparts, resulting in detrimental long-term outcomes. We also note that this ban can push children to access unsafe and illegal services out of desperation, further putting them at risk of harm. The current ban is an infringement on the rights of the child as outlined above.

[25] Caruana C. (2018). Teenage pregnancy still among Europe's highest. Times of Malta. 2 April. [Online]. Available: https://timesofmalta.com/articles/view/teenage-pregnancy-still-among-europes-highest.675132

[26] European Union Statistics Office (Eurostat): https://ec.europa.eu/eurostat

Our Aim: Decriminalisation of Abortion in Malta

Our primary legislative aim is the repeal of Article 241 of the Criminal Code, and any other such legislation that may be related to the criminal sanctioning of abortion.

Several countries have historically legalised some forms of abortion care by amending legislation to allow for elective induced abortion if certain criteria, usually relating to gestational age and reasons why the abortion is requested, are met. Such laws usually impose criminal sanctions on those women and healthcare professionals who induce a miscarriage outside the parameters of the law.

Such an approach has come under criticism by reputable medical organisations, who maintain that since abortion is a medical or surgical procedure, it should be regulated just as any other medical or surgical procedure as a matter of healthcare policy and professional regulation. The Royal College of Obstetricians and Gynaecologists, and the Royal College of General Practitioners, have both adopted this view as official policy and have stated that the UK should amend its laws to decriminalise abortion.

Our Aim: Changes to Law and Policy to Allow the Provision of Abortion Services in Malta

As a matter of principle, we believe that the choice of whether to carry a pregnancy to term should be made by the pregnant person. This is also reflected in the name of our organisation. Impartial medical advice can help women inform their decision, but women should be the ones to make a final decision about their pregnancy.

There should be no legal hindrance to termination of pregnancy at any stage (i.e. no gestational age limit) if a serious risk to the woman's life develops and termination of pregnancy could alleviate that risk.

There should also be no legal hindrance to termination of pregnancy at any stage if a fatal fetal anomaly[27] is discovered, such as in anencephaly[28].

In the absence of risk to the woman's life or a fatal fetal abnormality, there are important considerations to make when it comes to setting a gestational age limit. Fetal consciousness and viability are central to this issue.

Here we make reference to the research presented by the Royal College of Obstetricians and Gynaecologists titled *'Fetal Awareness: Review of Research and Recommendations for Practice'*[29]:

'In reviewing the neuroanatomical and physiological evidence in the fetus, it was apparent that connections from the periphery to the cortex are not intact before 24 weeks of gestation and, as most neuroscientists believe that the cortex is necessary for pain perception, it can be concluded that the fetus cannot experience pain in any sense prior to this gestation. After 24 weeks there is continuing development and elaboration of intracortical networks such that noxious stimuli in newborn preterm infants produce cortical responses. Such

[27] Fatal fetal anomaly refres to a non-viable fetus which is incompatible with life and would result in stillbirth or a neonate that dies hours or days after being born.
[28] Anencephaly is an incurable serious fetal defect in which the major parts of the brain, scalp and skull of the fetus do not form completely.
[29] Royal College of Obstetricians and Gynaecologists. (2010). *Fetal Awareness: Review of Research and Recommendations for Practice*. [Online]. Available: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/fetal-awareness---review-of-research-and-recommendations-for-practice/

connections to the cortex are necessary for pain experience but not sufficient, as experience of external stimuli requires consciousness.

Furthermore, there is increasing evidence that the fetus never experiences a state of true wakefulness in utero and is kept, by the presence of its chemical environment, in a continuous sleep-like unconsciousness or sedation. This state can suppress higher cortical activation in the presence of intrusive external stimuli. This observation highlights the important differences between fetal and neonatal life and the difficulties of extrapolating from observations made in newborn preterm infants to the fetus.'

Regarding the issue of viability, at present, medical authorities generally regard 24 weeks as the lower limit of viability (i.e. ability to survive). Of relevance to this issue is the publication by the Nuffield Council titled *'Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues'*.[30] The discussion in this publication revolves around 24 weeks as the age at which survival without impairment becomes more likely and, with the acceptance that survival without serious impairment or disability is highly unusual at 22 weeks of gestation, this has led to the conclusion that there is no obligation to attempt resuscitation at a gestational age of 23 weeks or less.

[30] Nuffield Council on Bioethics. (2006). *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues*. [Online]. Available: https://www.nuffieldbioethics.org/publications/neonatal-medicine-and-care

Medical Evidence: Abortion is a Very Safe Procedure

Modern abortion care involves the induction of a miscarriage either through medications or through a simple surgical procedure. There is enough medical evidence to conclude that modern methods of abortion have very low rates of morbidity and mortality, and it is statistically more likely for women to have an adverse health event, including death, in relation to childbirth than as a consequence of abortion.[31]

Medical abortion involves the use of two types of medication, Mifepristone followed by Misoprostol. This will antagonise the effects of pregnancy hormones such that the pregnancy cannot continue and cause the lining of the womb to breakdown with bleeding and loss of the pregnancy. As per WHO guidance, this regimen can be safely used at home up to 12 weeks gestation provided all the relevant recommendations are followed.

Surgical methods of abortion include vacuum aspiration, usually recommended up to fifteen weeks gestation, and dilatation and evacuation (D&E) being recommended beyond 15 weeks gestation. In 2018, vacuum aspiration was the method for 24% of all abortions in England and Wales, whilst D&E was the method for only 5% of all abortions.

Statistics from high income countries consistently show that the vast majority of abortions happen at less than ten weeks gestational age. In England and Wales, more than 80% of all abortions performed in 2018 were during the first ten gestational weeks.[32] Medical abortion using Mifepristone and Misoprostol accounted for 71% of all abortions.

Complications after abortion in high income countries are rare, with England and Wales reporting a rate of complications of 1.7 per 1,000 abortions in 2018. The rate of complications increases consistently with the gestational age at abortion. The rate of complications for surgical abortions at all gestational ages was

[31] Raymond EG and Grimes DA. (2012). The comparative safety of legal induced abortion and childbirth in the United States. *Obstetrics and Gynecology*, 119:215-219.
[32] Department of Health and Social Care (UK). *Abortion statistics for England and Wales: (2018)*. [Online]. Available: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018?fbclid=IwAR3Z95Yv47vx7YlitOwws7Y0ua13rph4uehirbsjDTn8OhZsZXQ8pfLHYGg

marginally lower than that for medical abortions at all gestational ages (1.4 per 1,000 and 1.8 per 1,000 respectively).

Concern is often raised about the impact abortion might have on the mental wellbeing of women. Meta-analysis and systematic reviews are regarded as the highest level of scientific evidence on the basis of methodological quality, validity and applicability to patient care. Three large meta-analyses and critical reviews investigating the association between abortion and mental health problems are those conducted by the Academy of Medical Royal Colleges,[33] the American Psychological Association[34] and Charles reviews,[35] all of which have concluded that there is no significant association. Mental health problems correlated with abortion were not causally linked, i.e. not caused by the abortion itself but relate to substantial confounding social factors. Therefore, the widely quoted notion in Malta that abortion causes mental illness is completely unsupported by clinical evidence.

A more recent longitudinal study conducted in the US and published in 2015 followed a cohort of 667 women who had an abortion and asked them whether in hindsight they felt their decision to have an abortion was the right one, and whether they had any positive or negative emotions associated with their abortion. The study found that over 95% of respondents felt that their decision to have an abortion was the right one. Amongst the minority who reported negative emotions, the intensity of the negative emotions lessened over the study's follow up period of three years.[36]

Therefore, as an organisation we believe that there is ample scientific evidence to conclude that abortion is a very safe procedure, with a low physical complication rate, and a low rate of psychiatric morbidity. Claims that abortion, if legalised, could lead to negative effects on the physical and mental health of women are not founded in any medical or scientific evidence.

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[33] Academy of Medical Royal Colleges. (2011). *A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors*. National Collaborating Centre for Mental Health, London.

[34] American Psychological Association. (2009). Abortion and mental health: evaluating the evidence. *American Psychologist*, 64:863-890.

[35] Charles VE, Polis CB, Sridhara SK, and Blum RW. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception*, 78:436-450.

[36] Rocca CH, *et al*. (2015). Decision rightness and emotional responses to abortion in the United States: A longitudinal study. PLoS One. [Online]. Available: https://journals.plos.org/plosone/article/related?id=10.1371/journal.pone.0128832

Conclusion

We acknowledge that there are some who would wish to continue with their pregnancy even in cases of unfavourable situations, and these women should certainly be well supported by social services. At the same time, we also acknowledge that this will not be everyone's choice and those who need access to abortion should also be helped and supported.

Abortion should be regulated under healthcare policy and not under criminal law. The lack of a clear legal framework and policy guidelines for when a woman's life is at risk is particularly worrying and should be changed to clearly reflect the absolute protection of women in Malta. Due to the lack of abortion services, Malta's medical authorities are falling short of best-practice and the highest standards recommended by international guidelines which are based on evidence-based medicine. We have provided evidence that despite abortion being illegal, people in Malta still seek and obtain abortions both locally and abroad. Therefore, doctors inevitably deal with issues related to abortion and it is undesirable for them not to be well-informed and well-trained on these matters.