



# **Abortion care in highly restrictive legal regimes: the experiences of health and social care professionals in Malta**

**Briefing Paper**

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## Information about the project

The aim of this project is to investigate health and social care professionals' experiences of providing abortion care within a highly legally restrictive regime. Legal abortion care within the Maltese context includes pre- and post-abortion care, more specifically the provision of information and counselling and the provision of necessary medical care post-abortion. Our study also asked about medical training on abortion and the impact of the law on the provision of care. Due to the timing of interviews, we additionally asked about the impact of COVID-19.

This project was funded by the University of Liverpool and subject to ethical review within the University. The project is managed by the Principal Investigator, Dr Claire Pierson and Research Assistant, Liza Caruana-Finkel. The project comprised of desk-based research and 15 interviews: 11 with a range of health and social care professionals based in Malta, 3 interviews with international providers including the Abortion Support Network, Women Help Women and Women on Web, and 1 interview was undertaken with the Family Planning Advisory Service (FPAS) Malta. Due to restrictions of COVID-19, interviews were conducted online during July 2020. The interview with FPAS Malta was undertaken in April 2021 as the service began in August 2020.

There is a limited amount of research on abortion in Malta, therefore whilst our study is small, it presents the first qualitative study on abortion care in Malta and our findings mirror those found on abortion care in other legally restrictive regimes including the Republic of Ireland and Northern Ireland (Bloomer et al, 2016; Duffy et al, 2018). Although the sample size means that the findings cannot be generalised to all practitioners, the diversity of professional backgrounds and amount of experience mean that the qualitative data can provide an indication of problems created by the current law.

## Terminology

We recognise that not all those seeking abortion identify as women. Whilst the report uses the term 'women', we include women, girls, trans and non-binary people as abortion seekers.

## 1. Background

Malta is a small island nation located in the middle of the Mediterranean Sea. It has a population of half a million, with around 14% non-Maltese citizens (Eurostat, 2019; The Malta Independent, 2019). Catholicism is enshrined in Malta's constitution (Government of Malta, 1964), and the majority of the population identify themselves as Catholic (Sansone, 2018). Despite progressive socio-legal changes in the past 10 years (e.g. divorce, 2011; gender recognition law, 2015; same-sex marriage, 2017), there has been no reform to Malta's archaic abortion legislation, which remains rooted in the 19<sup>th</sup> century.

Malta has one of the most restrictive abortion laws globally. It is the only EU country and the only Commonwealth country with a total ban on abortion. The law pertaining to abortion is found in the Criminal Code of Malta, under Title VIII 'of Crimes against the Person,' Subtitle VII, Articles 241-243A. This legislation criminalises both the person accessing the abortion and whoever assists in the termination. A person found guilty of procuring an abortion risks serving up to 3 years in prison. Health professionals who do so risk up to 4 years imprisonment as well as being struck off their professional register. In the last decade, Malta has received criticism on the state of sexual and reproductive health and rights (SRHR) from international bodies such as the United Nation's Committee on the Elimination of Discrimination Against Women (2010), the United Nation's Committee on the Rights of the Child (2019), and the Council of Europe's Commissioner for Human Rights (Muižnieks, 2017; Council of Europe, 2020). There have been calls for Malta to decriminalise abortion and ensure safe access to abortion and post-abortion care. A lack of sexual and reproductive health education has also been noted by above-mentioned human rights bodies and by participants to our research.

Recent changes in Malta with regards to SRHR include the introduction of emergency contraception in 2016 (however not all pharmacies provide this and pharmacists can act as conscientious objectors), the expansion of Abortion Support Network's services to Malta in 2019, and the launch of the volunteer-run family planning and pregnancy advisory service FPAS Malta in August 2020. There are no state run family planning clinics in Malta and FPAS provide unbiased and accurate information on abortion options, contraception and emergency contraception. They also signpost to reputable services and pro-choice healthcare providers. In their first 6 months of operating (Aug 2020 - Jan 2021) 203 people contacted FPAS, with the majority of queries relating to abortion (FPAS Malta, 2021). Other queries related to the risk of pregnancy after unprotected sex or contraception failure, emergency contraception, and about long-acting reversible contraception such as implants and IUDs (intrauterine devices).

Malta has only recently seen a vocal pro-choice movement emerge. The pro-choice coalition Voice for Choice was created in 2019, with current members including the Women's Rights Foundation, Doctors for Choice, and Allied Healthcare for Choice. The emergence of a pro-choice movement led to an increase in abortion discourse in the public sphere. Platforms such as Break the Taboo Malta provide a space for those who have had abortions to tell their stories, similar to In Her Shoes in Ireland, which published abortion stories approaching the 2018 referendum.

Despite these developments, abortion remains a highly stigmatised topic in Malta, with misinformation spread through social media, traditional media, religious institutions, schools, as well as higher education and professional entities. There is still a predominant anti-abortion sentiment on the island, deepened by over 20 years of a Christian-democratic, conservative government (until 2013). The two main political parties – The Labour Party (currently in

government) and the Nationalist Party – have made public anti-abortion statements. Volt Malta became the first pro-choice political party in Malta in 2021 (Volt, 2021). At the time of publishing this paper (May 2021) an independent Maltese MP has just presented a bill to decriminalise abortion (Vella, 2021c). Following this, the ADPD party endorsed the decriminalisation of abortion and said abortion should be available in certain circumstances (Vella, 2021a).

A number of surveys have examined public sentiment on abortion. Despite problematic language used and certain limitations in most Maltese surveys on abortion, they show that age and level of education are predictors of personal views on abortion, with young and more highly educated people more likely to support abortion access (Sansone, 2019; Gauci Cunningham, 2020; Vassallo, 2020) and the decriminalisation of abortion (Vella, 2021b). The latest survey (Vella, 2021b), which focused on the current criminal penalties attached to abortion, found that a relative majority of 46.9% of respondents did not agree with women being imprisoned for terminating pregnancies. 38.7% agreed with the conviction, while 14.4% said they did not know. Participants were less lenient towards medical professionals, with 55.0% agreeing with their imprisonment for assisting with or providing abortions. Participants aged 18-35 and/or with a tertiary level of education were more opposed to the criminalisation of abortion than those aged 65+ and/or with a primary education. A survey with medical doctors in Malta (Gravino and Caruana-Finkel, 2019) showed that the majority disagreed with the total ban on abortion and agreed with the legalisation of abortion, at least in some circumstances.

## 2. How abortion is accessed by people living in Malta

Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion is about the same (Sedgh et al, 2012). Criminalising abortion does not stop it but displaces it outside of formal healthcare settings. Malta is no different in this regard. Women and pregnant people living in Malta access abortion via travel to other jurisdictions including Sicily, mainland Italy, the UK, and the Netherlands. Others access pills online through providers such as Women Help Women and Women on Web and self-manage their abortion at home. It was also reported by several participants to this research that vulnerable populations may procure abortions through unsafe methods. It is impossible to provide fully accurate numbers of women accessing abortion in legally restrictive regimes. The Women's Rights Foundation in Malta estimate that approximately 500 Maltese residents per year are accessing abortion in some form (2018).

### Abortion travel

Statistics from the English Department of Health show that on average between 2015-2019, 55 women per year from Malta accessed abortion in England (UK Government, 2019). Other jurisdictions do not gather statistics on nationality. The Abortion Support Network (an organisation based in England which provides practical information, funds, and accommodation for abortion travel) began providing services to residents of Malta in February 2019. In the first year they received calls from 82 people, an average of 7 per month. They funded 10 of these. Numbers have risen this year with an average of 9 calls per month between April 2020 and April 2021.

### Abortion pills

Women on Web statistics show that between 2009 and 2019, over 600 people based in Malta contacted them about accessing abortions. Between March 2020 to March 2021, they provided 227 abortion pill kits to women in Malta (Doctors for Choice, 2021). Women Help Women do not provide statistics but confirmed via interview that numbers of people from Malta contacting them had risen since the beginning of the pandemic.

### Unsafe methods

The World Health Organization (WHO) describe unsafe abortion procedures such as '*insertion of an object or substance (root, twig or catheter or traditional concoction) into the uterus; dilatation and curettage performed incorrectly by an unskilled provider; ingestion of harmful substances; and application of external force*' (2012). Whilst it is probable that the majority of women access abortion through travel or procurement of pills from reputable sources online, four participants to the project noted that they had engaged with women who had attempted abortion through potentially unsafe methods. These included women attempting to self-harm to induce miscarriage, buying pills from fake sites, or having complications from what are described as 'back-street' abortions. As one participant told us:

*"...they would open up about attempts at...at doing an abortion at home. So I had people trying to fall down stairs, people hitting themselves in the stomach, taking lots of alcohol and pills."*<sup>1</sup>

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<sup>1</sup> Participant 6, Medical doctor in family medicine

### 3. Pathways for seeking abortion care

In legally restrictive regimes, the limits of the law and the stigma associated with abortion can delay or stop health seeking behaviour within normal care routes. This was suggested by our international healthcare providers in particular, as one international abortion pill provider said, “*I can remember several cases from the Republic of Ireland where people said ‘my doctor can’t help me’ or something like that. And I have never seen that in Malta.*”<sup>2</sup> Our interview with a representative of FPAS Malta indicated a mixed response from health and social care providers including anonymous referrals, those who had been in contact with rogue crisis pregnancy agencies, and those who had been turned away by health providers. It is likely that restrictive legislation and fear of prosecution is affecting patient disclosure and inhibiting full and open conversations within formal healthcare settings. As the Abortion Support Network told us with regards to fetal anomaly:

*“We heard from a couple in Malta – they had a family history of fetal abnormalities or genetic conditions and they were like ‘ok we’re pregnant but we don’t want to have this baby if it has this [condition], so we don’t know what to do. Can we go to the hospital in Malta and even register the pregnancy? Or should we go for the tests to another country?’ Imagine that level of fear.”*<sup>3</sup>

Those who do seek abortion care may turn to friends and contacts working in healthcare known to be pro-choice and therefore less likely to exhibit stigmatising behaviour or potentially report them for seeking abortions. Whilst the provision of information is legal, there is confusion over the legality of providing information about abortion services. Another international provider told us, “*we know that they’re contacting Doctors for Choice. But there was no Doctors for Choice a year ago.*”<sup>4</sup>

Examples where contact with health and social care professionals may exist are in cases of fetal anomaly as the diagnosis is made by clinicians, or in cases where a pregnant woman may be in contact with a social worker or counsellor. In our interviews with health and social care professionals based in these fields we were told that cases would be dealt with in an ad hoc and case by case basis without a standard route for pre- or after care put in place. For example, one interviewee based in social work told us that with one client who wished to access abortion “*we simply stopped calling her for a couple of days. And that gave her time to go and come back to Malta.*”<sup>5</sup> Another participant, who works in paediatrics, noted that in terms of following up with people who may have opted for abortion, “*I don’t know why we didn’t find out what happened to those...to that baby that didn’t materialise. For all I know it could have been a spontaneous miscarriage. I have no idea.*”<sup>6</sup>

Official and standardised pathways for abortion care are therefore non-existent in Malta. These could be particularly helpful for those seeking information and clarity on their legal rights (for example the legality of abortion travel) and for those seeking post-abortion care. For people seeking abortions in circumstances which may be important to future pregnancies, for example in the case of fetal anomaly, pathways of care become even more important to allow for full disclosure and testing.

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<sup>2</sup> Participant 11, Women Help Women

<sup>3</sup> Participant 14, Abortion Support Network

<sup>4</sup> Participant 12, Women on Waves

<sup>5</sup> Participant 7, Social worker

<sup>6</sup> Participant 5, Medical doctor in paediatrics

## 4. Experiences of providing care in a legally restrictive regime

Our study was confined to examining the situations when abortion care can take place – in a highly restrictive regime this obviously excludes the act of abortion. However, aspects of abortion care can take place, for example giving information on abortion, providing counselling before or after, and providing post-abortion care. This section describes our findings on these themes, in particular participants' understandings of their own ability to provide this care within legal limits. One point that was frequently mentioned was that providing abortion care is equally about protecting care providers or the fetus, as providing care to the pregnant person. As one participant said, abortion care is *“more like taking care of myself rather than the client.”*<sup>7</sup> Another noted that *“the law of abortion, really and truly, revolves around the unborn child, right?”*<sup>8</sup>

### Pre-abortion care

Pre-abortion care begins with establishing pregnancy and gestation, then the provision of information and counselling if needed to decide on options and to choose the best method of abortion. Interviews with international care providers indicated that poor levels of sex education and public health information on pregnancy mean that Maltese women may not know how to count gestation, or the circumstances when contraception is likely to fail.

There are no guidelines in Malta on the provision of information about abortion. Whilst providing information is legal, some of our participants were unsure of how much information they could provide and indicated that this was a common concern among colleagues:

*“...if you did speak to your colleagues about this then they'd say, 'no, no, no you can't give advice about this.' It's a 'no-go' area. Don't go there. And I admit I did not challenge that.”*<sup>9</sup>

*“But even I would not send an email, or a link by SMS. As I said, I would sit next to the person and help her search and spell out a link...because we are afraid of being prosecuted.”*<sup>10</sup>

*“...the first 3 years of practice in my life, I remember distinctly when, if someone mentioned abortion, we used to hand out pro-life leaflets rather than information on abortion...we don't do that anymore, at least here.”*<sup>11</sup>

Some indicated that they kept a list of sources to provide. The phone number of the Abortion Support Network was mentioned as the key contact provided to anyone seeking information on abortion, and one participant noted signposting women to the Women's Rights Foundation. FPAS Malta recorded some anonymous referrals indicating healthcare providers are aware of independent services. A minority also reported a fear that if they were asked for information, the conversation may be recorded as part of anti-abortion campaigning.

It was clear that participants involved in pro-choice activism (through Doctors for Choice) had much clearer knowledge on the legality of pre- and post-abortion care. Some of these participants explained how they became aware of the legality of information provision very recently, through informal knowledge exchange via Doctors for Choice and the Voice for Choice coalition.

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<sup>7</sup> Participant 3, Counsellor

<sup>8</sup> Participant 7, Social worker

<sup>9</sup> Participant 1, Medical doctor in obstetrics & gynaecology

<sup>10</sup> Participant 4, Medical doctor

<sup>11</sup> Participant 7, Social worker

Counselling can be part of effective pre- and post-abortion care. The WHO advises that counselling services are an important step in making informed decisions free from any pressure, and indicates that counselling should be ‘*voluntary, confidential, non-directive and by a trained person*’ (WHO, 2012). In interviews with those working in areas of counselling and social work, the provision of counselling raised questions as to whether health and social care professionals then had a duty to report to authorities that they knew an abortion might take place. Three participants (a counsellor, a family therapist, and a social worker) mentioned *The Minor Protection (Alternative Care) Act*, a piece of legislation which came into force in July 2020, and which they believed meant that they had a duty to report on any potential harm to a child, including the fetus. One told us:

*“In my profession, being a family therapist, in Malta, that binds us...as it stands today, it binds us to report. So if someone comes to me before the abortion has happened, then I am legally bound, because as of 1<sup>st</sup> July there is also a new law which came into effect, which also binds us as a professional...not only from an ethical but a legal position, that if I know a woman or a couple...is planning to do an abortion, I have to report to the authorities. So it’s a legal obligation that I have. If not, I am liable and I will definitely lose my job.”<sup>12</sup>*

A belief in a duty to report that someone plans to have an abortion presents an obvious chill factor to the provision of counselling and informed decision-making, which will be discussed further below.

### Post-abortion care

Post-abortion care may not be necessary for the majority of those who have abortions in safe conditions, however it may include emergency care or a general check-up or counselling. Participants were clear that if asked to provide post-abortion care, they were legally allowed to do so and were under a duty to do so:

*“Whatever it is, after the abortion you take care of the woman, you are not involved in her decision or in the abortion, so you care for her, that’s our obligation.”<sup>13</sup>*

*“There are no provisions that prevent medical practitioners from providing post termination care especially in the presence of complications – I would actually think that the doctor would be legally liable if he/she refuses to provide this care.”<sup>14</sup>*

The provision of post-abortion care will either be in an emergency basis in hospital settings or as a routine check-up. In non-emergency cases participants noted that women may approach private gynaecologists or ask people they know if they can provide the details of trusted contacts who would not judge them. Again, they may use friends or family in some cases, as one participant told us, *“in my personal experience, I’ve had calls from friends again saying, ‘I’ve had an abortion, I’m bleeding, is this normal?’”<sup>15</sup>* Another participant noted that she had provided scans to women after an abortion to confirm that the abortion had been successful. FPAS Malta also recorded several women contacting them about post-abortion care.

Emergency care, whilst legal, was also noted by participants to raise questions of reporting. Participants noted that women would arrive in the A&E department but would usually not

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<sup>12</sup> Participant 9, Family therapist

<sup>13</sup> Participant 8, Midwife

<sup>14</sup> Participant 13, Medical doctor in obstetrics & gynaecology

<sup>15</sup> Participant 4, Medical doctor



disclose or be asked if they had accessed abortions. More recently, however, two participants reported that patients were being asked directly if they had had an abortion and they feared that this may lead to reporting to the police. One told us:

*“Someone did try...unsuccessfully, and she was reported to the police. And I actually had a fight with...with the staff. ... And ... I had to go do a report at the police station. I mean come on this is ridiculous.”*<sup>16</sup>

### Chill factors

In a legally restrictive regime there are factors which inhibit the provision of abortion care within the law – these can result from a lack of understanding and clarity around the law and a lack of regulations. We have noted several examples of this above. The criminalisation of abortion creates a chilling effect in professionals as well as people seeking and accessing abortions. The fear of potential legal repercussions may jeopardise access to accurate information and care, potentially endangering people’s health and lives.

Anti-abortion laws, abortion stigma, and misinformation on the subject may affect anyone who is pregnant, regardless of whether they intend to continue with the pregnancy or not. This was exemplified in a case from 2020, where a pregnant victim/survivor of domestic abuse was faced with a provisional injunction placed on her person, prohibiting her from travelling, following false allegations by her abusive ex-partner that she planned to travel abroad for an abortion (Calleja, 2020). This happened despite the fact that she wished to continue the pregnancy, and that it is not illegal to have an abortion outside of Maltese jurisdiction. This case led to public outrage and protests in solidarity with the victim of this injustice. The warrant on the woman's ability to travel was eventually revoked. However, the police were in possession of her passport for 8 days.

The ultimate chill factor over the provision of abortion care is that the health and social care provider is modifying their provision of care to ensure they protect themselves. A lack of clear guidance on pre- and post-abortion care inhibits care provision. As one participant noted, *“I would like to provide [care] and I would like the know how. Even more concrete guidelines, because the fact that there are no guidelines... It’s quite concerning actually, that I don’t know.”*<sup>17</sup> There was also a perception amongst participants that hospitals were beginning to ask women who presented for aftercare if they had had abortions and whether this presented a duty to report them.

Several participants to our research indicated that the chill factor around providing abortion care had been increasing due to a perception that there may be a duty to report in certain cases, including a new piece of legislation, *The Minor Protection (Alternative Care) Act*, which was viewed to include the fetus within the definition of ‘child’. One participant (a counsellor) mentioned receiving training in relation to this Act, where *“they kind of emphasised that if we don’t report, actually we can face charges ourselves ... we were informed to report to Child Protection ... because there is kind of potential harm to the unborn child.”*<sup>18</sup> Another participant (also a counsellor) mentioned being ‘duty bound’ to report to Child Protection Services, even if the client planned to have a (legal) abortion abroad. The research team spoke to two professionals in Malta (one lawyer and one academic) who confirmed that the Act does not include the fetus

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<sup>16</sup> Participant 2, Medical doctor in obstetrics & gynaecology

<sup>17</sup> Participant 3, Counsellor

<sup>18</sup> Participant 3, Counsellor

under the term ‘child’ and indicated that the Act is being interpreted too broadly in some circumstances.

## Training

The majority of participants stated that they had had no training around abortion in Malta. Those who had trained abroad in sexual and reproductive health fields (many doctors will undertake part of their training abroad, commonly in the UK) had exposure to abortion services and some stated that this had changed their own personal perspective on abortion.

As the FPAS Malta volunteer noted, there is “*a big gap in knowledge, because abortion is happening anyway and we would need to know how to manage it.*”<sup>19</sup> Despite the illegality of abortion, there is a need to be trained in how to provide pre- and post-abortion care and in methods of abortion. Participants noted that in some cases abortion was taught as part of medical ethics training which lacked a practical aspect: “*Everything is kind of too theoretical rather than practical, and when it comes to practice you kind of have to find out yourself and look for stuff yourself.*”<sup>20</sup>

One participant told the research team that, in the past, a British lecturer had provided midwifery training in Malta that did include information on abortion. The participant stated that this was received with hostility by students; therefore, they have since made it explicit in job adverts that lecturers must teach “*in accordance with Maltese law.*”<sup>21</sup>

The lack of training means that whilst health and social care professionals may know that abortion is illegal, they may believe that there are circumstances when abortion is legal. We were told, “*so you get all kinds of questions, like for instance ‘I thought we did perform abortions when a mother’s life is at risk’ or ‘I thought we did perform abortions on children with fetal abnormalities’. You know, those kind of questions...misconceptions. And I say ‘no, absolutely not.’ And giving this type of information has changed a few of my colleagues’ minds for sure.*”<sup>22</sup>

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<sup>19</sup> Participant 15, FPAS Malta

<sup>20</sup> Participant 3, Counsellor

<sup>21</sup> Participant 8, Midwife

<sup>22</sup> Participant 10, Medical doctor

## 5. Rogue crisis pregnancy agencies

Rogue crisis pregnancy agencies exist to prevent women accessing abortions. They do this through a variety of mechanisms, including misinformation, misleading advice, and in some cases intimidation. These mechanisms are obviously designed to delay women seeking care, and therefore by the time they realise that these agencies do not provide services, they may have passed the gestational limit for abortion.

Legally restrictive regimes where information on abortion is sparse and high levels of stigma silence conversations on abortion mean that such agencies can often be a first point of contact for women and other pregnant people. The Abortion Support Network, British Pregnancy Advisory Service (BPAS), and Voice for Choice published a statement in 2019 detailing tactics used in Malta, including misleading information, impersonating services, sharing personal information and contact details, and sending abusive text messages (ASN, 2019). International providers and FPAS Malta indicated that interactions with these groups provided highly negative outcomes for women seeking abortions.

*“The rogue crisis pregnancy centres over there are out of control. And we put out a press release over the summer about the situation that we’d seen where a group had been lying to women, pretending to be BPAS, telling people they had to go for scans, taking them to ‘their doctor,’ who would then give them articles about how women die from abortions, and then saying they need to get a 4D scan, which they couldn’t get for 2 months, and just like really crazy, crazy, awful stuff.”<sup>23</sup>*

Participants to our study named the Life Network as the main group operating in Malta. Their tactics were named as similar to those noted above. The Life Network take part in Agenda Europe summits. Agenda Europe is a network of conservative and religious campaigners from the United States and several European countries who aim to reverse human rights for sexual and reproductive health in Europe (Hudson, 2018). Despite this, the Ministry for Social Justice and Solidarity, the Family and Children’s Rights in Malta donated €130,000 to a shelter for those considering an abortion which is administered by the Life Network (Azzopardi, 2020).

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<sup>23</sup> Participant 14, Abortion Support Network

## 6. The impact of COVID-19

The critical situation in Malta became more perceptible during the COVID-19 pandemic (Caruana-Finkel, 2020), when lockdown measures and travel restrictions resulted in very limited movement within and between countries. In April 2020, the European Parliament voted on an action plan to combat the pandemic and its consequences (European Parliament, 2020). Among its resolutions is a call on member states to guarantee safe and timely access to SRHR during the COVID-19 pandemic, namely contraception (including emergency contraception) and abortion care. Only one Maltese Member of the European Parliament (MEP) voted in favour of this specific resolution. However, all six Maltese MEPs voted in favour of the final version of the document, which included the amendment to protect SRHR.

In May 2020, the Council of Europe's Commissioner for Human Rights stated that the situation is particularly worrying for countries like Malta, where people had trouble accessing abortion care abroad: *'while abortion care is essential and time-sensitive, access to it has become more difficult in states that have imposed a lockdown and travel restrictions. This situation is particularly worrying for women and girls who live in the few European states where abortion is illegal or severely restricted and who cannot travel abroad to seek assistance and care, as reported in Malta'* (Council of Europe, 2020).

International providers all noted an increase in requests from Malta after the onset of the pandemic and increased travel restrictions (see figures above, page 5). Whilst abortion pills were sent to Malta, international shipping was disrupted and packages were taking around an extra week to arrive, causing stress to those waiting on the pills. The increase in demand for abortion pills has also been demonstrated in a study by Aiken et al (2021) who note that in countries where abortion is not accessible legally (their case studies were Malta and Northern Ireland) there has been a statistically significant rise in requests for the abortion pills. It is unclear what those with later gestations (who cannot safely use the abortion pills) have done.

The continued effects of the pandemic were noted by FPAS Malta:

*"...It's been a major problem... borders got closed. Sometimes just to cross the border at all you have to do all kinds of tests and some COVID tests cost hundreds normally. So there has been a lack of flights, so basically low cost flights are gone now. You just get a few flights with national carriers, which cost several thousands of pounds. This is something that Abortion Support Network has really highlighted – increased bureaucracy, the number of forms that they have to fill in for their clients, the costs in our flights have gotten into thousands. And then you have quarantines when you arrive, so you have to stay in hotels, they might be a bit more expensive than usual, and then you might have to pay for other tests... COVID is becoming a huge nightmare."*<sup>24</sup>

Some of our participants stated that they had seen an increase in international residents asking for information about abortion since March 2020. It was believed that prior to travel restrictions, international residents would travel back to their home country, but had to seek alternative methods due to travel restrictions. Participants also noted a general rise in women asking about abortion, which they attributed to the pandemic and to the visible increase in abortion activism and publicity around groups such as Doctors for Choice.

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<sup>24</sup> Participant 15, FPAS Malta

## 7. Conclusions and Recommendations

It is clear that the legal restrictions on abortion provide a barrier to providing care in Malta. This barrier often presents as fear of prosecution due to a lack of clarity around what is legal and what is not, and a fear of patients being reported for accessing or wanting to access abortions. The silence and stigma that surround abortion means that many women and pregnant people seeking abortions will have minimal or no contact with health providers in Malta.

The parameters of this project were to investigate abortion care that can be provided within the law. It is obvious that abortion laws in Malta are not stopping abortions, and as such a change to the law is necessary. Care pathways in Malta are fragmented, with numerous gaps and no systematic management of the care pregnant people receive. This lack of co-ordination results in women not being cared for, not being directed to services (such as counselling and post-abortion care), and exploitation by rogue agencies.

Our recommendations are informed by the WHO guidance on safe abortion care. Any changes to abortion care in Malta should be informed by the experiences of those who have sought abortions and developed through engagement with a range of health and social care practitioners across specialisms.

### **Recommendation One: Decriminalise abortion**

The decriminalisation of abortion in Malta has been called for by a number of human rights bodies. A bill was presented to the Maltese Parliament in May 2021 to decriminalise abortion (Vella, 2021c). Fear of criminal action inhibits health seeking behaviour and the provision of abortion care. Decriminalisation means that people self-managing their abortion will no longer be liable for prosecution and it will ease the chilling effect on health and social care providers in terms of providing information, counselling, or post-abortion care. Decriminalisation also contributes towards breaking down the stigma and silence that surrounds abortion.

### **Recommendation Two: Create guidelines for health and social care professionals on abortion law and pre- and post-abortion care**

Whilst abortion is illegal, there is a general lack of understanding around the provision of information and counselling, whether there is a duty to report abortion to authorities either before or after it has occurred and the legality of abortion travel. This encourages a chill factor around the provision of care and will inhibit those seeking abortions to contact healthcare providers. Guidelines on care that can be provided pre- and post-abortion are necessary to provide full clarity to health and social care professionals and to decrease fear around reporting. These guidelines should emphasise neutrality, confidentiality, and non-stigmatising attitudes to facilitate disclosure by patients and clients.

### **Recommendation Three: Create public health information for people seeking abortion care**

The 'movement' of patients is not regulated, and the onus is on women to navigate their own care. As a result of legal prohibitions, women are frequently accessing services without support or advice from the health service. As a consequence, they do not always receive all necessary pre- and post-abortion care. There is no way to ensure safe and quality assured services. Those seeking abortion are relying on finding information themselves or relying on trusted contacts in healthcare or volunteer services. The creation of public health information on abortion access outside Malta and on accessing pre- and post-abortion care within Malta is urgently required, in particular to ensure that rogue crisis pregnancy agencies are not the first point of contact for

abortion seekers. For those who are in contact with healthcare professionals (for example in fetal anomaly cases), the creation of more formalised care pathways, in particular post-abortion care, is necessary.

#### **Recommendation Four: Health and social care training**

Abortion is happening in Malta whether it is legal or not. Training on abortion care methods and attitudes towards abortion is needed both to ensure professionals are trained to provide modern healthcare but also to challenge the silence and stigma that exists around talking about abortion in health and social care settings. Such training needs to be provided to those already working in the health and social services as well as those who are currently studying, and should be included in the core curriculum (alongside other sexual and reproductive health topics). This training must be provided in an unbiased and neutral manner.

#### **Recommendation Five: Rogue crisis pregnancy agencies should be regulated**

Rogue crisis pregnancy agencies are known to be operating in Malta and were cited as a means by which women and pregnant people were blocked in accessing abortion services. These agencies receive government funding but provide misinformation and misuse personal details of those who use their service. There is an urgent need for these agencies to be regulated through ensuring they must make clear to anyone using their service that they do not provide abortion services, and by monitoring the information that they provide.

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