ARK Policy Brief

Developing policy for a full reproductive health service in NI

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Background/Context

Legal experts have argued for some time that the legal framework regulating abortion needs "fundamental reform to modernize it in line with the clinical science and moral values of the 21st century (Sheldon, 2016). Across the world, governments are under pressure to decriminalise abortion from a series of UN human rights treaty bodies. Abortion was decriminalised in Canada in 1988 and abortion in Canada has been subject only to medical regulation since then. There is no evidence of increased rates of abortion, or of later abortions: over the last 30 years, Canada has had a stable abortion rate 14.5 per 1000 females aged 15-44 years (Shaw and Norman, 2019), compared to a rate of 17.4 per 1,000 women 15-44 years in England and Wales. The statistics published by the Department for Health and Social Care in London only provide a rate for abortion after 22 weeks in England and Wales, which is 0.9%, this compares with the rate for abortion after 20 weeks in Canada, which is 0.6%. (DHSC, 2019; Shaw and Norman, 2019).

Uruguay in 2012 legislated for abortion as a public health issue, rather than a criminal one. In 2014, Luxemburg decriminalised abortion up to 12 weeks (Berer, 2017). In January 2019, the Republic of Ireland passed a law that means no woman can be criminalised for having an abortion (Bardon 2018). In August 2019, New Zealand announced that it is to decriminalise abortion. Announcing the new Bill, the NZ Justice Minister commented 'abortion is the only medical procedure that is still a crime in New Zealand. It's time for this to change" (Roy, 2019). This would bring New Zealand law into line with many other developed countries, he said. The same month saw the lower House of Parliament in New South Wales, Australia vote overwhelmingly to repeal Sections 82, 83 and 84 of the Crimes Act 1900 – a law based on the UK's 1861 Offences Against the Person Act.

On 18th July 2019, the Northern Ireland (Executive Formation) Bill passed in Westminster. A cross-party amendment to this Bill requires that, unless there is a functioning NI Assembly on the 21st October 2019, the Secretary of State for Northern Ireland complies with international Human Rights obligations and implements the UN Committee on the Elimination of Discrimination Against Women (CEDAW) recommendations which state that abortion should be decriminalised in Northern Ireland. On 24th July 2019, the Northern Ireland (Executive Formation) Bill received Royal Assent and is now an Act of Parliament (law). As such, on the 22nd October 2019, in the absence of a functioning NI Assembly, sections 58 and 59 of the Offences Against the Persons Act 1861 will be repealed and criminal sanctions for abortion in NI will be removed. This means that criminal charges can no longer be brought against individuals having an abortion or against qualified medical professional providing abortion.

After 22nd October 2019, there will be a period of consultation on a regulatory framework for abortion which must come into force by 31st March 2020. It is crucial that healthcare professionals discuss the implications of legislative change for women, clinicians and services.

Current Law In NI

Abortion is only permitted in Northern Ireland in very limited circumstances: where a woman's life is at risk or where there is a risk of serious long-term damage to her physical or mental health. As such, abortion law in Northern Ireland is one of the most restrictive in the global North and carries with it the harshest criminal penalties in Europe. It is governed by Offences Against the Person Act 1861. Section 58 makes it a crime for women to cause her own abortion using 'poison or other noxious thing' or instruments; this 'felony' is punishable by up to life in prison. Section 59 forbids assisting a woman

in causing her abortion and this 'misdemeanor' is also punishable by prison; this applies to medical professionals providing abortion as a healthcare treatment in a clinical setting across the UK except where it is carried out under the provisions of the 1967 Abortion Act.

Under Section 5 of the Criminal Law Act (Northern Ireland) 1967, anyone with knowledge of a crime must report it to the police. This applies to medical professionals who gain knowledge of a woman procuring an abortion in NI either through use of abortion medication or other methods. The 2016 guidance on termination of pregnancy in NI states that "Professionals should be clear, however, that patient confidentiality is not a bar to reporting offences to the police" (DHSSPS, 2016, p. 20)

Fatal Fetal Abnormality

Prior to 2013 doctors in NI provided abortion in cases of severe fetal abnormality on the grounds that there is an adverse effect on maternal mental health associated with such a diagnosis. In early 2013, the Attorney General sent a circular advising obstetricians and gynaecologists to ensure they were working within the law and that failure to do so put them at risk of prosecution and imprisonment. Later that year, there was a high-profile case of a woman (Sarah Ewart) who had to travel to England to seek abortion for FFA. Having sought legal advice, her medical team were told they could not legally provide abortion for FFA in Northern Ireland.

In April 2013, the Department of Health issued draft guidelines on abortion which were widely criticised for the use of inappropriate terminology, understating the prevalence and hence need for abortion services in NI and for unnecessarily cautioning against counseling patients on where to access abortion elsewhere in the UK. The latter had no legal basis as the provision of information to women concerning abortion services abroad is protected under article 10 of European Convention of Human Rights. The guideline was subsequently withdrawn and new guidelines published in 2016 (DHSSPS, 2016). UN CEDAW Committee were of the view that the 2016 fails to clarify the circumstances in which abortions are lawful in NI. It places responsibility on health professionals to assess on a case-by-case basis whether an individual's circumstances meet the legal criteria for abortion. The guidance recommends that two doctors with appropriate skills and expertise undertake the assessment but does not provide a framework to guide the assessment. It is indicated in the guideline that "the impact of fetal abnormality on a woman's physical or mental health may be a factor to be taken into account when a health professional makes an assessment of a woman's clinical condition and recommends options for her ongoing care". However, it does not clarify whether abortion is an option.

Since 2013 there has been a "chilling effect", with doctors left unsure of where the balance of risk lies and reluctant to perform abortions which could leave them facing prosecution. Women with a FFA diagnosis now travel to Great Britain to access abortion, incurring financial and emotional costs undergoing a painful and stressful experience away from home and without the support of family. Those who opt for post mortems may need to spend longer away from home and may face difficulties in repatriating the fetal remains, further compounding what is already a very distressing situation.

Current situation for women in NI

Between 1970 and 2015, at least 61,314 women traveled from NI to Great Britain (GB) to access abortion (Bloomer et al, 2017). Abortions during this time period were self-funded and not available on the NHS to women with NI addresses. Since 2017 NI women have been granted free access to abortion services in GB, a development that has seen a marked increase in the number of women giving NI addresses seeking abortion in Britain, from 724 in 2016 to 1053 in 2018 (DHSC, 2019). However, the Economic and Social Research Council funded research at Ulster University found that significant barriers to travel remain. The principal barriers were time off work and child care; those at the lower end of the labour market told researchers they could not afford to take time off (Horgan, 2019). Women in controlling or abusive relationships, young women and girls and those living in rural areas with poor transport links may find traveling impossible while asylum seekers and refugees may have

visa requirements that forbid them leaving the region. In addition, women with complex physical or mental health needs may not be fit to travel or may need specialist hospital care which can be difficult to access without a referral from a consultant.

Because of barriers to travel, women are still accessing abortion medication online. The precise number is unknown due to the existence of multiple online sources. The two reputable sites, Women on Web and Women Help Women, both of which are provide an online consultation with a doctor are estimated between them to provide about 700 each year to Northern Ireland. While mifepristone and misoprostol have an excellent safety record, this is based on the pregnant woman being able to access medical assistance if required. The Ulster University research suggests that, since the prosecutions for using pills began, some women, especially younger ones are unlikely to seek medical help for fear of arrest.

Women who access abortion, either through travelling to GB or through abortion medication bought online, may experience significant barriers in accessing appropriate abortion after-care in NI including referral for psychological support and contraception. This is despite 2016 DOH guidance stating that women should be offered post-termination follow-up, including counselling and aftercare for complications, regardless of where the abortion was carried out.

Public support for legislative change

Studies suggest that the majority of NI public support legislative change on abortion. This support has risen significantly since the public became aware that women were being prosecuted for abortion.

The NILT findings also reveal is strong support for abortion reform in Northern Ireland across voters for all the main political parties here. In cases of fatal or serious fetal abnormality, where the life or health of the mother is at serious risk and in cases of rape and incest, the overwhelming majority of supporters of each of the main parties said that in their view abortion should definitely or probably be legal. For example, 80% of DUP voters stated abortion should be permitted in context of fatal fetal abnormality (Gray et al, 2018).

The tables below show results for NI Life and Times Survey questions on abortion (2016 and 2018).

Abortion should be a matter for medical regulation and not criminal law

2016	Strongly agree 23%	Agree 48%	Agree in total 71%
2018	Strongly agree 44%	Agree 38%	Agree in total 82%

A woman should never go to prison for having an abortion

2016	Strongly agree 31%	Agree 40%	Agree in total 71%
2018	Strongly agree 57%	Agree 32%	Agree in total 89%

It is a woman's right to choose whether or not to have an abortion

2016	Strongly agree 25%	Agree 38%	Agree in total 63%
2018	Strongly agree 39%	Agree 32%	Agree in total 71%

Support for legislative change from medical community:

A 2009 study of attitudes and practice of gynaecologists towards abortion in NI found that 57% were in favour of liberalisation of abortion law (Francome and Savage, 2011).

Positions of professional bodies on decriminalisation:

Decriminalisation of abortion is supported by most medical professional bodies including RCOG, RCGP, FSRH, RCM, RCN and the BMA.

Regulation of abortion post-decriminalisation (BMA, 2019)

As the position paper from the British Medical Association (2019) points out, decriminalisation does not mean deregulation. Abortion would be regulated in the same way as other healthcare treatments and the following legal, professional and regulatory controls would apply. The BMA points out that there would continue to be strict controls on sale and supply of medicines including abortifacients; only registered and licensed medical practitioners with the appropriate training would be able legally to perform surgical abortions; serious and persistent failures to follow GMC guidance would place a medical professional's registration at risk. GMC guidance on consent, safeguarding and prescribing will still apply and the Criminal Justice Act 1945 will still outlaw the destruction of a "child capable of being born alive". The Westminster government has said that the viability times set out in the 1945 Act will be amended to 24 weeks.

Healthcare providers will be regulated by the Regulation and Improvement Authority (RQIA). It inspects services across four domains: is care safe, effective, compassionate and well-led? Further, civil and criminal laws that apply to other healthcare treatments will continue to apply to abortion, including protections to ensure informed consent, data protection and confidentiality and to protect against assault, wilful neglect or ill-treatment, medical negligence and gross negligence manslaughter.

Models of care:

Across these islands there are currently three models of care in operation; all have one thing in common – over 80% of all abortions are carried out via Early Medical Abortion. In the Republic of Ireland, EMA abortion services are provided by GPs and Family Planning clinics; in Scotland EMA is provided mainly via NHS-run Sexual Health Clinics to which women can self-refer; in England and Wales, most EMA is provided through the independent sector, but funded by the NHS. The other 20% of abortions in RoI and Scotland are provided by hospitals while in England and Wales, only those with clear medical issues are cared for in a hospital setting.

Over the last decade, hundreds of women each year have availed of the telemedicine abortion service provided by the feminist websites Women Help Women and Women on Web. Ulster University's study of the experiences of those women, compared with women in Scotland who had EMA via the NHS, found that both sets of women self-managed the EMA successful. Instructions for use were not followed by three of the 15 NI women interviewed but by all of the Scottish women. The three NI women explained that panic and fear led them to misread the instructions (or not read them at all).

The women in Scotland all had an ultrasound to confirm dates but none of the NI women did; in the RoI only a minority of women seeking EMA have an ultrasound, usually if there is a query about dates. The women in both NI and Scotland knew within hours that the abortion had been successful even if they weren't sure if they had passed the embryonic sac. Only the fear of prosecution put the women in NI at any risk.

Here in Northern Ireland, there is a good spread of Contraception and Sexual Health (CASH) services and these could be upgraded to include provision of EMA. Currently, there is a daily clinic in Derry city and weekly or twice weekly clinics in Omagh, Limavady, Strabane and Enniskillen. These clinics are in Health Centres or attached to a hospital, which is similar to the Scottish model. This was very important to the women in the Scottish study, as it means women are not having to announce that they are seeking an abortion when they attend the clinic – they could be accessing contraception or other health services.

The telemedicine that delivers pills to women in NI now could provide a model for CASH services to provide EMA in more rural areas. The CASH service could provide consultations by phone or skype and, if there are no contraindications, email the prescription to her local pharmacy.

Models of Care in Second Trimester

Surgical Abortions under 14 weeks can be provided in a hospital setting or in independent clinics, as a

day case procedure under local anaesthesia, sedation or general anaesthesia. These may be via Electric Vacuum Aspiration or Manual Vacuum Aspiration

Abortions after 14 weeks in Britain are either medical abortions, using mifepristone and misoprostol or D & E (Dilatation and Evacuation). Surgeons need to be trained in this technique, have necessary instruments and have sufficient caseload to maintain skills. D+E is most common method in non-NHS abortion services in England.

Abortions greater than 21+6

The RCOG recommend feticide by intracardiac injection of KCl by skilled fetal medicine specialist in tertiary referral centre unless fatal fetal abnormality where baby is not expected to survive birth. In 2018, of the 1,856 abortions performed in England & Wales at 22 weeks and over, 51% were reported as preceded by a feticide and a further 45% were performed by a method whereby the fetal heart is stopped as part of the procedure. 23 (1.2%) of abortions at 22 weeks or beyond were confirmed as having no feticide. For the remaining 51 cases (3%), the Department of Health & Social Care had no further details available (DHSC, 2019).

Challenges in providing second trimester abortions in England

NHS Workforce issues: During 2007-2017 only 33 doctors completed the RCOG Abortion Care ATSM. Only 20 doctors have completed FSRH Special Skills module in abortion care (Dunn, 2017). The low numbers may be attributed to a variety of factors. The bulk of abortion care being provided in independent sector is leading to few consultant role models and less exposure to abortion. Stigma associated with providing abortion care may also be deterring doctors from seeking career paths in this area.

High-risk cases: Difficulties have arisen where women with complex co-morbidities at later gestations require abortion in hospital setting. Due to abortions largely being commissioned and performed in the independent sector, there are dwindling numbers of consultants in NHS hospitals with the skill-set to perform late gestation abortions. The independent providers have the expertise but do not have the facilities to care for women with complex co-morbidities.

Challenges in providing second trimester abortions in Scotland

The vast majority of these are medical abortions meaning there is less skill and expertise in D&E. There is a lack of provision to perform abortions greater than 20 weeks (18 weeks in some areas). Currently, women seeking late gestation abortions travel to England, however, clinicians in Scotland are currently working on providing a service up to 24 weeks within Scotland (SACP, 2019)

Roundtable Discussion

A roundtable, organised by ARK in partnership with Doctors for Choice, well attended by consultants and registrars in Ob/Gyn and smaller numbers of GPs and nurses/midwives, was held on 24th September in Altnagelvin Hospital, Derry-Londonderry. The roundtable discussion was held under the Chatham House Rule, starting with the background to legislative change being outlined. It was noted that there would be a consultation period which would be led by NIO/ Westminster officials. It was agreed that the key focus should be on shaping a service which is women centred.

Insight from Republic of Ireland (ROI) on how the new service has been structured and is operating

A GP described the current position in the RoI. Access to EMA is through GP services if less than 9 weeks gestation. If gestation is between 9 and 12 weeks GP will refer the woman to secondary care. The legislation does not state that 9 weeks is the cut off point for GPs to provide EMA – it is 12 weeks. But the 9 weeks is the result of an agreement between GPs and secondary care. There was an excellent awareness raising campaign by HSE to ensure that everyone knew about the central booking system – MyOptions.ie which made things a lot easier for the GPs.

The process requires women to visit the GP twice; on first visit, the GP completes the necessary form and

then the woman has to return 3 days later (this is known as the cooling off period) before the procedure can take place. Following the procedure there is a 3rd contact – this can be by phone. There is no evidence base to support a 'cooling off' period and the three day wait greatly increases difficulties for those who have to travel to see the GP. GPs in the Republic are advised that they must wait at least 72 hours before being able to provide the abortion, which can cause real difficulties.

One of the GPs present noted that the phone call follow up is successful – with her able to make contact with 20 out of 22 patients. The medication is ordered by GPs from pharmacists and it is delivered to GP practices. The first tablet is given in the presence of a doctor.

Abortion is available over 12 weeks for more limited circumstances – it has to be signed off by two obstetricians.

There is geographic variability in terms of number of GPs on the list in different parts of the Republic, two counties have no GP providers. Some practices took their names off the list due to being targeted by anti-choice protesters, while others provide a service but never had their names on the list. There has been some push back from GPs who have been unwilling to refer on. Some hospitals are not participating (including Letterkenny) – but they will do scans and anti-D injections where required. There has been an impact on the workload of participating GPs - with cost implications but the service is well funded. GPs would counsel patients attending for abortion about contraception but, in the Republic, most have to pay to access contraception e.g. a Mirena coil can cost 240 euro to have inserted.

ESRC funded research on NI and Scotland

Goretti Horgan described the research phases and key findings from the quantitative and qualitative results. There was interest from the doctors present in what could be learned in terms of telemedicine from the experience of on-line pill providers and experiences of women taking the pill. It was noted that most women contacted on-line providers at an early stage in the pregnancy – on average 6 weeks. There were some differences in experiences between those who had previously given birth and those who had not, with the latter being more worried about the level of bleeding and more likely to experience higher pain levels.

There was a question about how providers could be sure that dates given by women were reliable. It was recognised that there was a need to trust women; that most provided accurate information and in the rare circumstances where pregnancy was at a later stage there was a recognition on the part of the women that this incurred a risk and that they needed to seek medical attention.

There was also some discussion on whether all women would be able to access and understand information available on-line and therefore to provide informed consent. It was explained that the information provided was very accessible. It was also noted that if telemedicine were to be used in NI it was also likely there would be a telephone conversation.

Consent

The more general debates about the capacity of a patient, to give informed consent for contraception for example, also apply here. The GP from the RoI noted that the Gillick principle is applied; that under 15s would generally need to be referred to social services.

Culture, context and attitudes of medical staff: impact of new legislation and new structures

There was a discussion around how the more stringent DHSS guidelines had resulted in a reduction in the number of abortions in NI for fetal abnormality and resultant risk to mother's health, especially after 2013. This had been very noticeable with clinicians much more cautious and more likely to advise patients to seek terminations in Britain. This carries additional stress and problems re post mortems etc. Ob/Gyn consultants said that more women have been seeking termination due to fetal abnormality and this will definitely increase from the end of October.

There was concern that clinicians will struggle to see patients quickly enough – there was much discussion of the need for this new service to be appropriately funded and structured.

The issue of conscientious objection was discussed.

Medical staff are awaiting guidance from Dept of Health. It was noted that the BMA had published a useful paper on decriminalisation. With regard to gestation limits it was noted that with regard to NI, 24 weeks was being discussed at gestational limit – on the basis of viability. There was also discussion of specific (and complex) scenarios; for example in the case of severe fetal anomaly, when does an abortion become an early induction? It was noted that (pre new legislation) when one clinician had sought legal advice from the Department, the advice was that if the intention was to shorten the pregnancy then it would be a termination and illegal.

The background of funding shortage and difficulties recruiting staff in the health service generally is a concerning context. Funding will be needed for additional ultrasound scans or, as in RoI, scans paid for in private scanning centres (for EMA). There was a strong view that consultants and other medical and nursing staff need to be supported. There has to be clear structures in place. This will help staff to be more confident and more able to support patients.

The view was expressed that there may be an issue of some practitioners using conscientious objection to opt out simply because they are so busy and also have concerns about resources. There were questions about whether so many opt outs could mean that there are insufficient staff to provide the service. In response, participants were reminded that GMC guidance prohibits action which obstructs ensuring a woman's health. A question also raised about whether staff could opt out of some procedures while agreeing to participate in others. There was some discussion of the problematic nature of this and issues of discrimination. It was noted that the most complex cases were likely to be rare and should be carried out in one or two units within NI. But clinicians certainly were clear about the need for guidance on late terminations.

Model for NI

There was agreement that ideally the services should be provided by NHS facilities. This was seen as important in minimising stigma. The majority of abortions will be pre 12 week gestation. Abortions for reasons of severe fetal anomaly require a multidisciplinary model of care and it is important that this is at the centre of a model of provision. This would also help to ensure staff are appropriately supported.

It was noted that services not previously commissioned in NI will need to be bought. For example, there is currently no screening for Trisotomy conditions. It is possible that the discussion taking place about private providers setting up a clinic in NI could be being seen as way of circumventing some commissioning issues but there is a concern that this would increase stigma and chances of protests.

It is likely that demand will be c2,000 pa or higher. There is the additional issue of whether some women in the RoI may access services in NI. With 80% of abortions before 10 weeks, that will mean c400 after 10 weeks; in GB about 1.9% of abortions are after 20 weeks – that would mean 40 - 50 a year in NI.

In its most recent guidance on medical abortion, the World Health Organisation now recommend that pills are safe for self-management of abortion up to 12 weeks (84 days). Is this something the RCOG should be arguing for?

A new model for NI will also have to consider scanning locations and staffing. Within secondary care it was proposed that the best model would be dedicated units with ring fenced funding- not all hospitals would have to be provider units but coverage needs to be appropriate – possibly 2/3 across the region.

There was discussion regarding the use of family planning clinics and a consensus that these are very accessible services, attendance does not carry stigma and they are less likely to attract protests. It was pointed out that they currently face resource challenges and struggle to get adequate medical staff. However, GPs do provide sessional cover in these – so even where a practice is unwilling to provide the service for whatever reason, individual GPs could contribute to a new service in this way.

The concluding points were that the roundtable facilitates participation and input into the consultation process at an early stage since its discussion can be shared with NIO/ Westminster officials. There was a strong consensus that alongside changes to abortion provision, the opportunity

needs to be taken to argue to improve contraception services and sex education and to get these embedded at the same time. It is important also to note that this was a key recommendation of the CEDAW's Committee's Inquiry into reproductive rights in NI (CEDAW, 2018).

There was also a consensus that the focus of clinicians should be on looking after women and making sure they have choice. As the roundtable drew to a close, the question was asked what if 'a magic wand' was waved, then those around the table wanted to see:

- a community-based EMA service provided in expanded and properly resourced CASH/Family Planning clinics where LARCs could be provided at the same time as the EMA;
- after ten weeks, there would be a number of funded day clinics in 2/3 hospitals to cover the entire region.

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