ARK (Access, Research Knowledge- www.ark.ac.uk) is a joint Ulster university, Queen's University Belfast, Research Centre. ARK welcomes the opportunity to respond to this consultation. Much of the evidence in this response to the consultation is from an Economic and Social Research Council funded study (Principal Investigator: Goretti Horgan) into public attitudes to abortion in Northern Ireland and the experiences of women in the region who take abortion pills obtained from the internet. In addition, we append two policy briefs based on roundtables held with clinicians across Northern Ireland. The first roundtable was held with Obstetricians, Gynaecologists and GPs in anticipation of a change in the law, the second was held to facilitate health professionals working in the Sexual and Reproductive Health areas to develop a response to the consultation and to envision the kind of service that should be developed in Northern Ireland.

Introduction

The consultation seeks to develop "a new framework for access to abortion services in Northern Ireland that is consistent with the recommendations of the 2018 United Nations Committee on the Elimination of Discrimination Against Women Report, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women". We welcome this approach but an important point to highlight is that the CEDAW report is not only about abortion; it also makes recommendations in relation to sex education and to contraception services. Section C of the CEDAW Inquiry Report focuses on the *Inadequacy of Family Planning Support*. It notes that: *Women attested to difficulties in obtaining modern forms of contraception, inter alia, emergency (morning-after pill), oral, long term (intrauterine) and permanent (sterilisation). Testimonies revealed that women were refused sterilisation if deemed too young or unmarried, including pharmacists' reluctance to dispense or provide information about emergency contraception*. (CEDAW 2018, para 46) and *The Committee concludes that NI women and girls are frustrated in their efforts to access the information and services necessary to enjoy their sexual and reproductive health and rights* (para 47).

We know that enabling women to access a contraceptive method that works for them helps prevent unplanned pregnancies and improve public health outcomes. The Department of Health in England's *Framework for Sexual Health Improvement in*

England estimated that, every £1 invested in contraception saves £11 in averted health outcomes (DoH, 2013).

In spite of this, we know that contraception and sexual health services in Northern Ireland, and across the UK, have been affected by cuts to the public health budget. We do not have figures for contacts with SRH services in Northern Ireland but, according to NHS Digital statistics, there has been a drop of 25% in the numbers contacting family planning services in England since cuts started in 2014-15; in 2018-19, nearly 800,000 women and girls accessed SRH services for contraception, a drop of 15% since 2014-15, when in-year cuts to the Public Health budget were introduced (NHS Digital, 2019). There is no reason to suggest that services in Northern Ireland have done any better.

The CEDAW Inquiry Report recommended that the state party:

(a) Provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, ***including on all methods of contraception*** *and access to abortion;*

(b) Ensure accessibility and affordability of sexual and reproductive health services and products, ***including on safe and modern contraception, including oral and emergency, long term or permanent*** *and adopt a protocol to facilitate access at pharmacies, clinics and hospitals;*

(c) Provide women with access to high quality abortion and post-abortion care in all public health facilities, and adopt guidance on doctor-patient confidentiality in this area;

(d) Make age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health and rights a compulsory curriculum component for adolescents, covering early pregnancy prevention and access to abortion, and monitor its implementation;

(e) Intensify awareness-raising campaigns on sexual and reproductive health rights and services, ***including on access to modern contraception****;*

(f) Adopt a strategy to combat gender-based stereotypes regarding women's primary role as mothers; and

(g) Protect women from harassment by anti-abortion protestors by investigating complaints, prosecuting and punishing perpetrators. (CEDAW 2018, para 86, emphasis authors).

Public support for legislative change

It is important to stress that, despite a narrative that Northern Ireland is largely anti-abortion, 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 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%	71% agree in total
2018	Strongly agree 44%	Agree 38%	82% agree in total

A woman should never go to prison for having an abortion

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

While support for decriminalisation is very high, there is also support for the idea that the question of whether or not to continue an unintended pregnancy should be left to the individual woman herself. Again, the support for the contention that "it is a woman's right to choose whether or not to have an abortion" grew between the 2016 and 2018 Life and Times Surveys.

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%

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 foetal 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 foetal abnormality (Gray et al, 2018).

The results of the recent General Election show that the public are happy to endorse those political parties that have been progressive on the issue of abortion, while the two parties that anti-abortionists urged the public to support did not fare well. The DUP's vote fell by 6.7% while Aontú, failed to gain more than 4% of the votes in any constituency.

An Integrated Sexual and Reproductive Health Service

Given the rural nature of much of NI and the pressures that already exist in the health service in the jurisdiction, it is imperative that the service delivery model for Early Medical Abortion in NI is flexible and evidence based. If it is also to be local, with women not having to travel long distances, then providing it through the current network of SRH /CASH clinics would assist in ensuring provision across the region, not just in urban areas. This would also help in reducing stigma and make it more difficult for anti-choice forces to protest. Without the constraints of the 1967 Abortion Act, there is no reason why the majority of SRH services cannot be provided by health care professionals other than doctors. While nurses have long been able to prescribe most contraceptives, only doctors have been able to prescribe the drugs used for medical abortion e.g. mifepristone and misoprostol.

There is ample international evidence to indicate that a wide range of healthcare professionals, not only doctors, should be able to provide early medical abortion (EMA). The World Health Organisation's 2015 Guidance on *Health Workers' Roles in Providing Safe Abortion Care and Post Abortion Contraception* recommends that first trimester medical abortions can be safely provided by nurses, midwives, auxiliary nurses and auxiliary nurse midwives, non-specialist doctors and doctors of complementary medicine (WHO, 2015). The guidance also indicates that pharmacists and lay health workers can assess eligibility for EMA and administer the medication. See Table 2 for the WHO recommendations in relation to roles across a range of healthcare workers.

The new service could include the use of telemedicine in the provision of Early Medical Abortion, this could be particularly useful for those living in isolated rural areas. Telemedicine is providing diagnoses and even help with surgery in a wide range of specialisms from neurology to orthopaedic surgery. In the provision of EMA, it has been widely used by women in Northern Ireland in the absence of any provision of abortion by the Health Service. Despite evidence of about 1,000 women a year in Northern Ireland obtaining abortion pills via telemedicine for the last decade or so, there have been no reported serious adverse incidents (Aiken et al, 2017; Horgan, 2019).

In the USA, there are now 15 states that allow EMA to be provided via telemedicine and others where telemedicine is used to meet some of the regulatory barriers that have been imposed in recent years (Ekland et al, 2010; Grossman et al, 2011; Grindley et al, 2013; Grindley et al 2017). A recent systematic review of studies on the use of telemedicine in the provision of EMA found that "medical abortion through telemedicine seems to be highly acceptable to women and providers, success rate and safety outcomes are similar to those reported in literature for in-person abortion care" (Endler et al, 2019).

One of the findings of the qualitative research with women in Northern Ireland self-managing EMA using medication obtained via the internet is the importance of their being able to decide when they took the pills. The timing of when mifepristone is taken is crucial to this since that decides when she takes time off work, gets her children looked after etc in order to take the misoprostol (Horgan, 2019). As well as the evidence from within Northern Ireland of women's ability to use the pills effectively and safely, there have been international studies confirming this. In a study of 290 women in Kazakhstan who were given the option of taking the mifepristone, as well as misoprostol, at home the majority (64%) chose to self-administer the mifepristone at home; there were no adverse incidents and 99% of abortions were completed successfully, with 1% (n=3) requiring intervention because of incomplete abortion (Platais, 2016).

SRH centres could also provide a way for GPs who have a conscientious commitment to providing an abortion service to be able to do so. This idea was suggested at a roundtable discussion regarding a future service model for abortion provision in Northern Ireland held by ARK and Doctors For Choice NI (DFCNI) in September 2019 (Horgan et al, 2019). This was well-attended by obstetricians and gynaecologists, midwives, nurses and GPs. The possibility of a multidisciplinary service model encompassing primary care, existing community sexual health services, telemedicine and secondary care was explored.

There was consensus that a multi-disciplinary approach would be preferable in order to optimise access, provide clinical exposure and training, destigmatise abortion and avoid a focal point at which protestors can gather. Barriers to GP participation in the service were considered; these included the high costs of self-funding additional indemnity insurance, the possibility of protests outside GP practices and the need for agreement amongst practice partners prior to offering the service. It was considered that GPs could deliver early medical abortion (EMA) sessions either at existing SRH or from home via telemedicine; these proposals offer a better approach as they overcome many of the aforementioned barriers. It would be particularly attractive to GPs if indemnity insurance was also covered by the commissioning organisation.

In 2013, RQIA recommended an SRH consultant to cover the whole of NI, although our population profile would suggest we need an SRH consultant in every Trust if the gross inequalities in the health of women and girls is to be reduced (RCOG, 2019, *Better for Women)*. However, there has been no movement on the RQIA recommendation, and the clinicians present noted that one of the main reasons adduced for not having a consultant was that Northern Ireland did not have an abortion service.

The Northern Trust has started to develop some integrated SRH services, as highlighted in the RCOG's *Better for Women* report. However, there are real problems recruiting doctors to work in SRH services because the sessional rate for a GP session is almost double that of a SRH one and doctors, understandably, are

less likely to choose the lower rate. This pay differential was seen as one of the obstacles to a fully integrated service in NI, since it meant that doctors were less likely to train in the specialism.

Funding is clearly the main issue. If we are to develop fully integrated services across NI, with an SRH consultant in each Trust, then the service would need significant funding. However, it was emphasised that this would be cost effective in the long term since such services will save the NHS considerably more. Indeed, contraception is considered the single most cost-effective intervention in healthcare (Cleland et al, 2013). Public Health England has more recently estimated that every £1.00 invested in the provision of contraception achieves a £9.00 saving across the public sector. (PHE, 2018).

Workforce issues and planning

There was some discussion at both the roundtables about how to meet the workforce needs of a proper SRH service for NI and about the need for a new service to be properly funded. Hospital doctors especially commented on how it was currently impossible to meet the demands of the maternity service in a timely manner; to add those who did not want to continue pregnancies and whose position is, by definition, an emergency one would be impossible without separate funding to provide a day clinic service for those who needed hospital care when terminating their pregnancy. There was a concern that some practitioners may use conscientious objection to opt out simply because they are so busy and also have concerns about resources.

It was pointed out that in England SRH centres tend to have approximately six GP trainees and two FY2 trainees who can provide most of the service except for the most complex cases. However, the pressures on GP services in NI are so great that they rely on their allocation of trainee GPs therefore the SRH services may not be able to access any.

It was emphasised that there needs to be an SRH training programme as part of medical students' training, not just a mention of the speciality as part of the O&G rotation. Including SRH in the rotation, would help in this regard. The lack of workforce planning in SRH was a matter of concern and it was pointed out that many existing medical and nursing staff are due to retire in the next few years, so this is becoming an urgent issue.

Without the constraints of the 1967 Abortion Act, there is now scope to develop a fully nurse-led early medical abortion service within SRH services in NI. There is a proposal in the consultation for flexible model of service delivery, whereby trained and competent health professionals could provide abortion treatment and, if approved as part of the regulatory framework, would be hugely advantageous in improving access and providing a cost-effective service. Nurses can also be trained to independently provide LARC, an important aspect of abortion care.

To improve access in rural areas, a telemedicine approach would be ideal. Telemedicine is already used in NI for some SRH services eg the current pilot in partnership with SH24 where online testing is available for STIs, including HIV. It was agreed that, in the absence of the kind of integrated SRH services that we see in other parts of the UK, telemedicine would be a useful way to provide an EMA service from March 2020 since it may take at least two years to fully develop the kind of services we need.

It was noted at both roundtables that those living in GB may not fully understand the political context in NI or the 'chilling' effect of having parties in government that take a very biblical approach to matters of sex and sexuality and, as a result, strong advocacy on behalf of clinicians and patients in NI is essential. In order to address workforce issues and effect a cultural shift towards destigmatisation, it was felt that the provision of training, support and guidance from FSRH would not only be welcomed but would be hugely beneficial.

The main message coming from both roundtables was that the opportunity ought to be grasped, when introducing a new abortion service, to ensure that any EMA service would be community-based and provided in expanded and *properly resourced* CASH/SRH clinics where LARCs could be provided at the same time as the EMA. Additional funding will be required to ensure that those whose pregnancy gestation is greater than 10 weeks or who have medical needs that require hospital treatment will be able to access terminations in a timely manner.

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