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# Report on Sexual and Reproductive Health in Northern Ireland

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MARCH 2021

## Our Vision

We have a vision that every child in Northern Ireland is born into a family that has both the will and means to support their needs and nurture their development, with support from the state as needed.

It is our vision that all children and young people should be provided with a high-quality education that teaches about healthy relationships, consent, sexuality and the ability to decide when, and if, to start a family.

We believe that all young people and adults should be educated about the benefits and effectiveness of different methods of contraception.

Women and girls should be empowered to take control of their fertility and contraception should be easily accessible and freely available.

When a pregnancy is unintended, women and girls should be supported with decision-making in a way that is unbiased, non-judgemental and devoid of stigma.

Where abortion is needed, services should be accessible, high-quality and designed to deliver safe compassionate care within the NHS.

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# List of Abbreviations

**ARK**

Access Research Knowledge

**BMA**

The British Medical Association

**BPAS**

The British Pregnancy Advisory Service

**CCEA**

The Council for Curriculum, Examinations and Assessment

**CEDAW**

The United Nations Convention on the Elimination of all forms of Discrimination Against Women

**DFCNI**

Doctors for Choice NI

**DHSC**

The Department of Health and Social Care (England and Wales)

**DOH**

The Department of Health (Northern Ireland)

**DOJ**

The Department of Justice (Northern Ireland)

**EMA**

Early Medical Abortion

**FFA**

Fatal Fetal Abnormality

**FSRH**

The Faculty of Sexual and Reproductive Healthcare

**GMC**

The General Medical Council

**GUM**

Genito-Urinary Medicine

**HCPC**

Health and Care Professions Council

**HSCNI**

Health and Social Care Northern Ireland

**ICNI**

Informing Choices NI

**ICTU**

The Irish Congress of Trade Unions

**IUCD**

Intrauterine Contraceptive Device

**LARC**

Long-Acting Reversible Contraception

**MHRA**

Medicines and Healthcare Products Regulatory Agency

**NIACT**

The Northern Ireland Abortion and Contraception Taskgroup

**NICE**

The National Institute for Health and Care Excellence

**NMC**

The Nursing and Midwifery Council

**OCN**

Open College Network

**PHA**

The Public Health Agency

**PHE**

Public Health England

**POP**

The Progestogen-Only Pill

**RCGP**

The Royal College of General Practitioners

**RCM**

The Royal College of Midwives

**RCN**

The Royal College of Nursing

**RCOG**

The Royal College of Obstetricians and Gynaecologists

**RQIA**

The Regulation and Quality Improvement Authority

**RSE**

Relationships and Sexuality Education

**SRH**

Sexual and Reproductive Health

**STI**

Sexually Transmitted Infection

**TOPFA**

Termination of Pregnancy for Fetal Abnormality

**TUC**

Trade Union Congress

**UCL**

University College London

**UNESCO**

The United Nations Educational, Scientific and Cultural Organization

**WoW**

Women on Web

**WHW**

Women Help Women



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# Report on Sexual and Reproductive Health in Northern Ireland

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## Executive Summary

## 1 Introduction

The Northern Ireland Abortion and Contraception Taskgroup (NIACT) is a group of multidisciplinary professionals formed in response to the Abortion (Northern Ireland) Regulations 2020 to give professional guidance on bringing about the conditions and services required to minimise the need for abortion in Northern Ireland and, when it is required, to provide a compassionate and caring abortion service within the framework of the Regulations. The purpose of this report is to provide an evidence base to inform the funding and commissioning of Relationships and Sexuality Education (RSE) provision, and integrated sexual and reproductive healthcare for the population of Northern Ireland.

## 2 Relationships and sexuality education

There is a significant body of robust evidence that curriculum-based sexuality education programmes contribute to delaying the age of first sexual intercourse, reducing the number of sexual partners, increasing the use of condoms to prevent sexually transmitted infections, and increasing the use of contraception.

There is also compelling evidence that programmes which promote abstinence-only relationships are ineffective. RSE has the greatest impact when school-based programmes are backed up by initiatives within the community. Recent research in Northern Ireland showed that young people were not impressed with the quality of RSE they received in school, and we believe that a complete overhaul is required with RSE being mandated and monitored by the Department of Education. We would support the use of online resources such as the Scottish relationships, sexual health and parenthood (RSHP) website, and those provided by Informing Choices NI (ICNI) and Common Youth. We also advocate better funding and provision of RSE in community settings.

### 3 Sexual and Reproductive Health Services in Northern Ireland

The introduction of the new legal framework for abortion services in Northern Ireland provides a unique opportunity to develop an integrated sexual and reproductive health (SRH) service for the region. We know that enabling women to access a contraceptive method that suits them, helps prevent unplanned pregnancies and allows healthy pregnancy spacing, which improves maternal health outcomes and public health. It is thus clear that investment in contraception is good for both public health and the public purse.

Contraception service provision and accessibility varies significantly between trusts in Northern Ireland, but all trusts have staffing shortages due to a lack of workforce planning. The Southern Trust does not have any SRH doctors, but has a limited nurse led service. There is no consultant in SRH in the whole of Northern Ireland, and this was highlighted as an issue in 2013 in The Regulation and Quality Improvement Authority (RQIA) Review of Specialist Sexual Health Services in Northern Ireland. As a consequence of this, it has not been possible to develop a comprehensive SRH training programme in Northern Ireland, so currently any doctor wishing to become a consultant in SRH needs to access a 6 year training programme in other parts of the UK. There is also a need to ensure appropriate career pathways for specialist nurses.

Northern Ireland has seen a lack of commitment to sexual health from policy makers, service commissioners and HSC trusts. There is an out of date strategy, the Sexual Health Promotion Strategy and Action Plan 2008-2013 (and an addendum which expired in December 2015), which set out “to improve, protect and promote the sexual health and wellbeing of the population”. An update is long awaited and has left current provision struggling without direction in the face of ever-increasing demand. It is clear that there is a pressing need for investment in the recruitment and training of the staff required to provide a comprehensive SRH service in Northern Ireland alongside the development of a new strategy.

The needs of young people are particularly important when considering access to SRH services. In keeping with Department of Health recommendations, we would advocate involving young people in the design of services, and we would emphasise the need for confidentiality and making them feel welcome.

## 4 Contraception

Access to effective contraception has a profound positive effect on the health of women, and has revolutionised women's lives by supporting them in taking control of their reproductive health and the future of their families. In public health terms it is an extremely cost effective intervention; the cost implications of unintended pregnancy to the NHS are estimated to be in the region of one billion pounds per year. Increased provision of easily accessible contraceptive services will reduce the requirement for abortion.

Emergency contraception is contraception used after coitus has already occurred. It is more effective when used early, which requires knowledge of availability, and easy access to the emergency contraceptive pill or services to fit an intrauterine contraceptive device (IUCD).

One third of births in the UK are estimated to be unplanned. The postpartum period is a particularly high-risk time for unintended pregnancy. The Faculty of Sexual and Reproductive Healthcare (FSRH), the Royal College of Obstetricians and Gynaecologists (RCOG) and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) recommend that maternity services offer all women long acting reversible contraception (LARC) as soon as possible following birth.

Barriers to contraceptive use in Northern Ireland include inadequate and inconsistent sexual health education, a lack of public awareness of different methods and their effectiveness, failure to provide postpartum contraception, a lack of provision within general practice and a lack of provision within community clinics. This is a legacy of the long-standing under investment in sexual and reproductive health and it is now time for change.

## 5 Abortion

On the 22nd October 2019, abortion in Northern Ireland was decriminalised. This meant that criminal charges could no longer be brought against individuals having an abortion or against registered medical professionals providing abortion. After 22nd October 2019 there was a period of consultation on a regulatory framework for abortion, following which, Regulations were drawn up and came into force on 31st March 2020.

During the period 1970 to 2016 a total of 62,038 women travelled from Northern Ireland to Great Britain to access abortion. Abortions during this time period had to be self-funded as they were not available on the NHS to women living in Northern Ireland. In addition to the financial burden, there was also the emotional burden associated with accessing services in an unfamiliar place without the support of friends or family. Some women were unable to travel, including those who were young or from low socio-economic backgrounds or rural communities, those with complex physical or mental health needs, those in situations of domestic violence or coercive relationships, immigrants, asylum seekers, and refugee women. Repatriating the fetal remains in cases of fetal abnormality was extremely distressing, and post-mortems were either not performed or performed at great financial cost.

Since 2017 women from Northern Ireland have been granted access to funded abortion services in Great Britain. However, significant barriers still existed including the financial costs of travel, accommodation, taking time off work and child-care. Research showed that, despite the policy change, women were still accessing abortion medication online. Women who accessed abortion, either through travelling to Great Britain or through abortion medication bought online, often experienced significant barriers in accessing appropriate abortion after-care in Northern Ireland, including referral for psychological support and contraception advice. This was despite Department of Health (Northern Ireland) guidance in 2016 stating that women should be offered post-abortion follow-up, including counselling and aftercare for complications, regardless of where the abortion was carried out.



The passing of the Northern Ireland (Executive Formation) Act 2019 acted as a catalyst to the formation of the Northern Ireland Abortion and Contraception Taskgroup (NIACT), which led to the subsequent rapid implementation of early medical abortion (EMA) services in response to travel restrictions imposed due to the Covid-19 pandemic. Clinic protocols, policies and patient information leaflets were produced in line with RCOG/National Institute for Clinical Effectiveness (NICE) guidelines on Abortion Care. A referral pathway was established in partnership with ICNI, who agreed to provide a Central Access Point, enabling people across Northern Ireland to contact a single telephone number where they could also access information, pregnancy choices counselling, and self-referral into the EMA service within the trusts. Women are referred daily to each trust by ICNI via a secure email, a telephone consultation is offered within a few days, and a time is then agreed to attend for treatment. During 2020, 1599 clients contacted the ICNI Central Access Point; 1395 were referred, and 1299 women had a consultation, the majority of whom proceeded to EMA treatment (1160). Contraception is offered at all clinics and the uptake of LARC is high at over 50%. Feedback from patient surveys has been exceptionally positive.

Surgical abortion is currently not available in Northern Ireland for those who would prefer this method, or need it for medical reasons, and there is no provision for abortion at gestations above 10 weeks except in cases of fetal abnormality. These procedures are generally performed within hospital gynaecology departments, and training updates for gynaecologists and commissioning of such services have not yet been provided. These obstacles have hindered the development of a service in any trust, so many, often vulnerable, women still need to travel to England to access this type of abortion care.

When routine contraception and gynaecology services resume as the effects of the Covid-19 pandemic lessen, there will be reduced capacity to continue the EMA clinics without further funding and support. An

approval order allowing at home use of mifepristone to commence EMA, as has been agreed in Great Britain and the Republic of Ireland, would improve the ongoing feasibility of this interim service. At home use of mifepristone has been recommended in quality statement 4 of the recent NICE Abortion Care Quality Standard (NICE, 2021). To date there has been no official appetite to facilitate this, and there is no sign of the Northern Ireland Executive or the Department of Health Northern Ireland funding or commissioning the comprehensive service that is urgently needed.

Another obstacle to accessing SRH services is the activity of anti-abortion protestors, ranging from the dissemination of misleading information to picketing of clinics. While NIACT believes in upholding the right to assemble and the right to freedom of speech, we assert that this should not interfere with the fundamental right for women, girls and pregnant people to seek scientifically valid information and receive reproductive health care. We believe that the space outside or in close proximity to an abortion service or pregnancy counselling centre is not an appropriate location to oppose abortion provision. Therefore, we would strongly recommend that safe access zones are introduced outside abortion services and pregnancy counselling centres.

First trimester screening and Non Invasive Prenatal Testing (NIPT) are not routinely offered in Northern Ireland and therefore most fetal anomalies are diagnosed following the anomaly scan between 19 and 20 weeks, which in many cases is later compared to the rest of the UK. This results in abortions occurring at a later gestational age, which can carry a greater risk of complications and can be even more distressing for the woman and her family. Many cases of fetal abnormality or suspected fetal abnormality are referred to the Regional Centre for Fetal Medicine. Once referred, there should be timely access to investigations and counselling, and to treatment options in accordance with RCOG Guidance (RCOG, 2010). There should be good access to post-mortem provision with follow-up counselling and involvement of the multidisciplinary team where appropriate.

## 6 Conscientious objection

Recognition of conscientious objection is important in the design and delivery of an abortion service. It is of utmost importance that members of staff are not put in a position where they feel a personal objection to what they are being asked to do. However, it is also important that staff are available to provide the required, legally mandated service.

International human rights bodies do not recognise a right to conscientious objection for healthcare providers, but they recognise that some countries permit healthcare staff to exercise this right. In 2016 the UN Committee on Economic, Social and Cultural Rights stated that “Where healthcare providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone’s access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought and that it does not inhibit the performance of services in urgent or emergency situations”.

In Northern Ireland, a statutory right to conscientious objection is provided by Regulation 12 of the new Abortion (Northern Ireland) Regulations, 2020. However this does not affect “any duty to participate in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health of a pregnant woman or girl”. The Explanatory Memorandum to the Regulations goes on to clarify what constitutes ‘treatment’ using a 2014 Supreme Court ruling which confirmed that statutory protection does not extend to “the ancillary, administrative and managerial tasks that might be associated with that treatment”. The Regulations (and the Explanatory Memorandum) also confirm that, as in the rest of the UK, the burden of proof of conscientious objection in any legal proceeding rests on the person claiming to rely on it.

In order to protect employees and enable employers to plan and deliver an effective abortion service, each professional lead should maintain an up-to-date list of those with a conscientious objection; in doing so the views of employees can be respected when planning service delivery.

## Recommendations

### Relationships and sexuality education (RSE)

1. RSE should be evidence based and delivered in a consistent, high quality, inclusive and sex positive manner across all schools in Northern Ireland, including Special Educational Needs schools, and be included as part of a school's inspection report.
2. Organisations in receipt of public funding should provide a consistent and standardised approach to the delivery of RSE in school and community settings.
3. RSE should start early and be relevant to the individual at each stage of their development and maturity.
4. RSE should be delivered by trainers who are confident in talking about all issues relevant to RSE with an equal emphasis placed on all areas of the programme.
5. RSE programmes should be offered to parents and carers with the view to alleviating their fears and assisting them to support children and young people in making informed choices.
6. Young people should play a key role in formulating RSE programmes in schools and communities.
7. On-line resources should be used in school, community and home settings.
8. All training delivered should be assessed and evaluated to ensure consistency, and that gaps are identified and current trends are incorporated.

### Sexual and Reproductive Health Services (SRH)

9. Investment in a sexual and reproductive training programme for doctors within Northern Ireland with emphasis on recruiting into the field from hospital and GP training programmes.
10. Within every trust there should be a minimum of two SRH consultants. SRH consultants should not work in isolation, and should be supported by other consultant colleagues, as well as a team of specialised healthcare professionals.
11. The role of nurses and midwives should be further developed to include provision of LARC and abortion care.
12. Improved access to contraception services, especially in underprivileged and rural communities, and for particular groups including the homeless, those with disabilities, and people for whom English is not their first language.
13. Improved access to contraception for young people.
14. An ongoing public health campaign, involving the Public Health Agency (PHA) and associated bodies, promoting sexual and reproductive health for all age groups.

## Contraception

15. There should be a more visible and far-reaching Public Health campaign raising awareness of the effectiveness and benefits of LARC, and where and how to access emergency contraception.
16. LARC should be more easily accessible within general practice and EMA services.
17. There should be increased provision of postpartum contraception within maternity services, including access to LARC following the birth.
18. The Progestogen only Pill should be made available as an over-the-counter medication. This would involve the Medicines and Healthcare Products Regulatory Agency (MHRA) reclassifying it from 'prescription-only' to 'pharmacy product'.
19. The most effective form of oral emergency contraception, ulipristal acetate, should be available free of charge and without prescription from every pharmacy within the region and from all SRH clinics within each trust.
20. The MHRA should be asked to reclassify oral emergency contraception to the General Sales List to enable it to be provided without consultation.
21. There needs to be improved awareness, access and referral pathways for emergency IUCD insertion. This should include investment into training more GPs in coil insertion and investment into SRH services within all five trusts in NI.

## Abortion

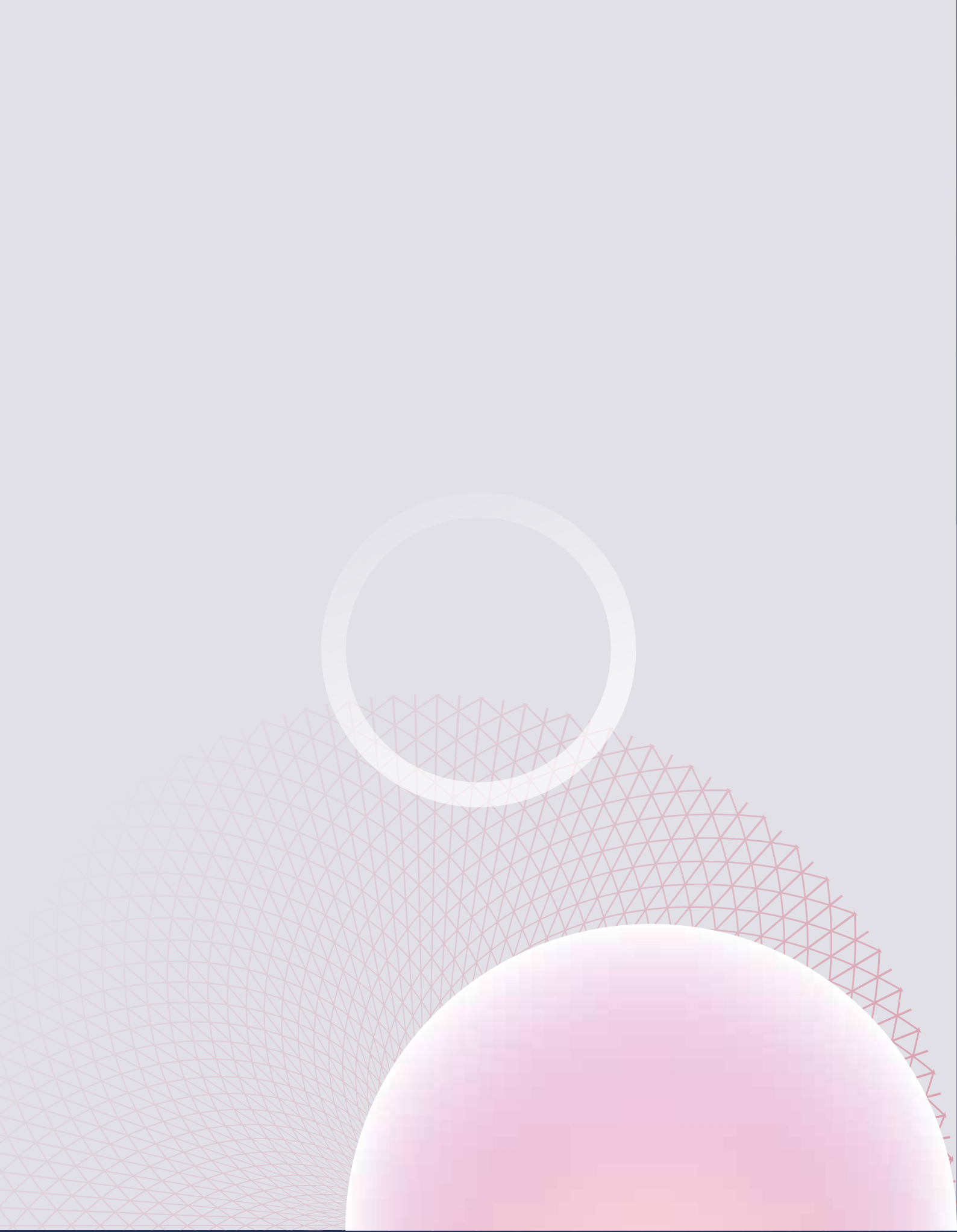
22. There should be a funded regional central access point to which women can self-refer, and to which they are directed by a public health information campaign.
23. There should be an adequately resourced framework to ensure availability of pregnancy choices counselling if requested.
24. Commissioners should ensure that service providers have adequate capacity and resources to ensure waiting times do not exceed one week.
25. The option for telemedicine abortion care should be made available within Northern Ireland, as in the rest of the UK and the Republic of Ireland.
26. Abortion services should be part of an integrated sexual and reproductive health service which provides a seamless pathway from the community/primary care sector to hospital based obstetric and gynaecology services, and also ensures optimal access to contraception.
27. There should be a commissioned surgical abortion service to enable choice of method; this will require some investment in training.
28. The UK National Screening Committee recommendations for first trimester screening should be introduced so that women in Northern Ireland have equity with women in other parts of the UK and, for those who choose abortion, that this can happen at an earlier gestational age.



- 29.** Services should be adequately resourced to ensure that there is the capability to provide abortion within Northern Ireland at all gestations.
- 30.** There should be access to post abortion counselling. Bereavement counselling should be extended to include all pregnancy loss.
- 31.** There should be training for all healthcare professionals, administrative and support staff engaged in abortion services to ensure non-judgmental communication with service users.
- 32.** There should be a public information campaign about abortion to counteract anti-abortion organisations posing as abortion providers.
- 33.** There should be legal provision for exclusion zones to protect women and staff from intimidation and harassment when seeking access to information, support or services.
- 34.** Suitable premises for abortion should be identified and secured for each trust.
- 35.** Interpreter services are required for all stages of service provision.
- 36.** Pathways should be developed for each trust to easily obtain healthcare numbers for those not already registered with the NHS.

### Conscientious objection

- 37.** Training in conscientious objection should be provided for all HSC and primary care staff working in SRH and maternity services, including professionally regulated clinical staff, managers, administrative and other support staff.
- 38.** We recommend that professional leads within the relevant departments should keep a secure record of the position of their staff with regard to conscientious objection to allow for service planning and delivery.





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Full Report

# 1 Introduction

The Northern Ireland Abortion and Contraception Taskgroup (NIACT) is a group of multidisciplinary professionals who have come together in response to the Abortion (Northern Ireland) Regulations 2020, to give guidance on minimising the need for abortion in Northern Ireland and achieving a compassionate and caring abortion service within the framework of the regulations.

The purpose of this document is to outline our vision for a new enlightened approach which will achieve these goals. We review the evidence and make a series of recommendations which will inform those responsible for funding and commissioning in order to develop an integrated sexual and reproductive health service for the women of Northern Ireland which is compliant with the recommendations of the 2018 United Nations *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* (CEDAW) report, and the NICE Abortion Care Quality Standard (NICE, 2021).



We are not seeking to change anyone's moral views or personal beliefs, but we are seeking to engender a greater understanding and acceptance of abortion as an aspect of healthcare. For too long decision makers in Northern Ireland have buried their heads in the sand; wishing abortion away does not take it away. We can no longer export our problems; we are now legally obliged to serve those who need our care. The best way of achieving this is to have an integrated and multi-agency approach which encompasses all aspects of women's reproductive healthcare.

In many situations, abortion arises from systemic problems; a lack of social support, substandard Relationship and Sexuality Education (RSE), inadequate contraceptive provision, and a culture of gender-based oppression. With the right amount of political will and determination, the majority of these underlying problems can be addressed. There are other circumstances, such as fetal abnormality or serious ill health of the woman, which are unavoidable. Regardless of the circumstances, it is women who are best placed to decide what is right for them and their families. As a group of conscientiously committed professionals, our primary aim is to bring about conditions and services to reduce the need for abortion, and to provide it in a safe, compassionate and women-centred way where it is required. Now that the Regulations are in place, we expect those in a position of responsibility to treat abortion for what it is, an important aspect of healthcare, and not to treat it as a political or ideological football.

Investment and recruitment will be needed to adequately meet the needs of the population and to address the recommendations set out in the CEDAW report. The Northern Ireland (Executive Formation etc) Act 2019 requires the government not only to develop an abortion service but to do so in a way consistent with the recommendations of the CEDAW report.

**The CEDAW report recommended that the State party (in this case, the UK) should:**

- (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 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).*



## 2. Relationships and Sexuality Education (RSE)

## 2.1 Research evidence from around the world

In 2009 and again in 2018, the United Nations Educational, Scientific and Cultural Organization (UNESCO) published *International Technical Guidance on Sexuality Education: an evidence-informed approach*, positioning sexuality education within a framework of human rights, the Sustainable Development Goals, and gender equality. The *Guidance* promotes structured learning about sex and relationships in a manner that is “positive, affirming, and centred on the best interest of the young person”. By outlining the essential components of effective sexuality education programmes, the *Guidance* is designed to support countries “to implement effective sexuality education programmes adapted to their contexts”.

The 2018 *Guidance* is based on an evidence review carried out for UNESCO by researchers from the University of Oxford’s Centre for Evidence-Based Intervention. The evidence review is based on results from 22 rigorous systematic reviews and 77 randomised controlled trials in a broad range of countries and contexts, more than half in low or middle income countries. The research reaffirmed the 2008 findings that curriculum-based sexuality education programmes contribute to the following outcomes:

- Delayed initiation of sexual intercourse;
- Decreased frequency of sexual intercourse;
- Decreased number of sexual partners;
- Reduced risk taking;
- Increased use of condoms;
- Increased use of contraception.

The evidence reviews concluded that sexuality education programmes that promote abstinence-only do not work. Such programmes have been found to be ineffective in delaying sexual initiation, reducing the frequency of sex or reducing the number of sexual partners. By contrast, programmes that combine a focus on delaying sexual activity with content about condom or contraceptive use are effective (Kirby, 2007; Underhill et al., 2007; UNESCO, 2009; Fonner et al., 2014).

It found that programmes addressing both pregnancy prevention and STI/HIV prevention are more effective than single focus programmes. For example, such programmes led to more effective contraceptive and condom use, as well as decreased reports of sex without a condom (Lopez et al., 2016).

Sexuality education has greatest impact when school-based programmes are backed up with community elements, including condom distribution, training for health providers to deliver youth-friendly services, and involving parents and teachers (Chandra-Mouli et al., 2015; Fonner et al., 2014; UNESCO, 2015a). Further, linking school-based sexuality education with non-school-based youth-friendly services, is particularly important for reaching marginalised young people, including those who are not in school (UNESCO, 2016).

Overall, the evidence base detailed in the *Guidance* shows that comprehensive sexuality education has positive effects, including increasing knowledge about different aspects of sexuality, behaviours, and risks of pregnancy or HIV and other sexually transmitted infections (STIs). It also reaffirmed the evidence that sexuality education, in or out of schools, does not increase sexual activity, sexual risk-taking behaviour or STI/HIV infection rates (Fonner et al., 2014; Shepherd et al., 2010).

## 2.2 Current provision in Northern Ireland

The current guidance on the provision of RSE for post primary schools in Northern Ireland, published by the Council for Curriculum, Examinations and Assessment (CCEA, 2015:20) states that:

Issues such as abortion, same-sex marriage, sexual orientation, gender identity, sexual abuse and family lifestyle all have the potential to be sensitive, depending on the personal experiences, opinions and values of each individual within the classroom and on the distinctive ethos of the school. Schools may wish to deal with such issues differently, depending on their distinctive ethos.

A study carried out by the Education Inspectorate for Northern Ireland found that Love for Life, a conservative Christian organisation, had provided RSE programmes to 70% of post-primary schools (Education and Training Inspectorate, 2011). The organisation promotes a strong anti-abortion stance, advocates abstinence before marriage, and is extremely wary about contraceptive use. In addition to access to post primary schools, Love for Life offers programmes within churches, youth groups and primary level education. This strong moral conservatism results in young people being provided with only a partial view at a stage in their development when they are forming their attitudes and have not had the opportunity to hear broader perspectives on RSE. Challenging these norms does occur, at family levels and through NGO organisations. The Public Health Agency (PHA) funds RSE programmes within community settings. However, this funding is on a small scale, and has to be proactively sought. Covid-19 has delayed this work going back out to tender as it was initially granted in 2015. Common Youth, Nexus, the Rainbow Project, Relate, ACET and Love for Life are among the organisations previously in receipt of funding. Any future tender should be at least for a period of three years in order to allow for the development of long-term projects.

Much of the RSE that is provided in schools in Northern Ireland is based on an abstinence-only approach which is not informed by the evidence, is often heteronormative i.e., does not discuss different sexual orientations, and is sometimes factually incorrect (IPPF/Coram, 2012). Such an approach does not serve our young people well and does not give them the confidence to delay sexual intercourse.

In November 2013 the former Commissioner for Children and Young People in Scotland, Kathleen Marshall, was appointed to lead an Inquiry into Child Sexual Exploitation in Northern Ireland. The report published in November 2014 stated that lesbian, gay, bisexual and transgender (LGBT) young people reported that RSE in schools rarely addressed same-sex relationship issues (DHSSPS, 2014). A key finding highlighted in the report was that young people stated RSE is poor and called for the delivery of a wider and more consistent curriculum. As a recommendation young people suggested that schools provide more information on sex and relationships and that teachers be better trained to deliver this.

In April 2018, Sir John Gillen was appointed to lead an independent review into how the criminal justice system in Northern Ireland deals with serious sexual offence cases (DOJ, 2019:451). The report published in May 2019 made a series of recommendations including that:

The Department of Education should address the need to include in the school curriculum for disabled children, children with sensory disability and those who are members of marginalised communities, sex education designed in a culturally sensitive manner on matters such as consent, personal space, boundaries, appropriate behaviour, relationships, fears of homophobia and transphobia, gender identity and sexuality.



Research conducted by the Belfast Youth Forum in 2019 found that young people described the RSE they received in school to be ‘basic’, ‘unhelpful’, ‘useless’ and ‘biased’ (Belfast Youth Forum, 2019). 86% felt that school was the best place to receive RSE, yet only 66% said they had actually received RSE. 73% said they had only received RSE ‘once or twice’ or ‘rarely’ and 60% felt that the information they received was either ‘not very useful’ or ‘not useful at all’. 771 young people between the ages of 14-24 participated in this research which recommended that government adopt a rights-based and proactive approach to RSE, that a curriculum programme should be co-produced with relevant interventions from young people, and that specialist staff deliver the subject.

The youth work policy Priorities for Youth, published by the Department of Education in 2013, included helping young people to navigate their sexual development, while the Education Authority in 2019 prioritised “supporting positive outcomes for young people with a range of sexual orientations” as part of its regional strategic outreach funding. Youth Action NI received some of that funding and produced a resource to support youth workers to open up conversations in which young people can discuss and explore attitudes about a range of relationship, sexuality and sexual health themes. The resource, Turn the Light On, was published in July 2020.

Common Youth has provided relationship and sexual health education for 25 years within a variety of community settings and in all areas of Northern Ireland. From 2015, Common Youth has been funded to deliver RSE in the community. The majority of this work has been delivered to vulnerable young people aged under 25 from areas of high social deprivation.

Common Youth provides free RSE programmes for all young people under 25 throughout Northern Ireland. All programmes are age appropriate and can include the following topics:

- Puberty changes, mind, body and relationships;
- Sex, the law and consent;
- Healthy and unhealthy relationships;
- Peer pressure and the influence of alcohol and drugs on sexual behaviour and risk-taking;
- Contraception and condoms;
- STIs;
- Sexuality, sexual orientation and gender;
- Social media and sexting;
- Abortion; and
- Learning disability specific sessions.

Common Youth will develop bespoke sessions to meet the identified needs of groups.

ICNI delivers RSE programmes to parents and individuals with a learning disability/difficulty or autism spectrum disorder (ASD). They also deliver a range of bespoke RSE training programmes for professionals, including teachers and teaching assistants, which are accredited by the Open College Network (OCN).

ICNI's Just Ask project is a unique RSE programme working specifically with people with a learning disability/difficulty or ASD, their families and carers. Their extensive knowledge and experience with the Just Ask project has shown that a holistic approach is vital in the development of self-esteem, confidence, resilience and independence. The focus of this programme is to develop understanding around self/identity, boundaries, personal space, permission, consent and the choices around these topics. It also provides sessions to help parents and carers with these topics while raising awareness and building confidence when dealing with these issues. Programmes run over four to six weeks with sessions lasting about an hour. Parent programmes can be delivered on a one-off information basis or over a longer period allowing for more in-depth work if needed. The Just Ask project has also delivered RSE Awareness Raising training to teachers and classroom assistants in order to develop their skills and knowledge and to ensure a consistent approach throughout the school.

ICNI have produced an easy to read booklet explaining what social distancing is and how it will impact individual's lives, which was distributed to Special Educational Needs schools and learning disability/ASD organisations across Northern Ireland. They have also developed a social distancing and personal space app, 'Bubble Bear', which is now being trialled by several learning disability organisations and will be available for wider use in the near future.

ICNI's Speakeasy project is a community-based parenting programme supporting parents and carers to have conversations with their children about growing up, body changes, boundaries, consent, choice, sex, sexuality and sexual health, and everything to do with relationships. The Speakeasy programme can be delivered in a wide range of settings, including community groups, workplaces, hostels and prisons.

ICNI believes that to ensure the best impact for young people, RSE training must become mandatory for all professionals working with young people, and more funding should be made available to support RSE programmes working with parents and carers. We must strive to achieve a consistent, sex-positive attitude to ensure the eradication of myths, stigma and judgement.

## 2.3 Online provision of RSE

The Covid-19 outbreak significantly impacted the ability to provide RSE sessions both in schools and the community and this focussed attention to online provision. In Northern Ireland, Common Youth moved to delivery online, and completed desk-based research and consulted with their participation group to ensure alignment with ‘best practice’ and the needs of young people.

### 2.3.1 Online learning research

There is a range of research evidence that internet-based sex education programmes can increase students’ reproductive health knowledge effectively and change their attitudes toward sex-related issues. It suggests that the internet offers an important and untapped potential for providing sex education to students and young people (Ellison, Steinfield and Lampe, 2007; Kabilan, Ahmad and Abidin, 2010; Ng and Wong, 2013).

This raises the question as to what works when delivering online education? McCarthy et al., (2012:5) found that young people have a desire for interactivity:

Interactive quizzes designed to prompt active learning and reflection: response options were designed to encourage users to reflect on their views, emotions and experiences, as well as providing information on social norms, and encouraging beliefs and attitudes associated with safer-sex behaviour. Incorporating what was learned from the focus groups, the quizzes were designed and written to be entertaining as well as educational.

Interactive decision-making activities were designed to provoke self-reflection about sexual behaviour, focusing on problematic situations or dilemmas within relationships, and risky or regretted sexual situations.

The participants in the study wanted a website that reflected a mature, trustworthy and true-to-life feel, conveyed through the voice of a knowledgeable youth worker or older sibling. The need for the website to appear trustworthy along with the potential to share and compare “real life” experiences is consistent with previous findings (McCarthy et al., 2012).

McCarthy et al., (2012) also reported that consultation with users is essential in the development of websites targeted at young people, as this group can be particularly influenced by look and feel. This research, and previous research, suggest that listening to and meeting young people’s desires in terms of website design and content is essential in achieving their engagement.

Research suggests that videos are an important tool but should include real people talking about real experiences, that post and comment sections used on social networking sites can be a useful method of delivery, that anonymity is important for young people when discussing sexual health, and that the environment needs to be a ‘safe space’ (Holstrom, 2015). Research has also reported that activities must be short as, if they are too long, young people will lose interest; young people need to be consulted in a systematic way about the information they want and how they want it offered (Bailey et al.,2015).



There is also a role for using social media to educate young people. Research completed using Facebook as an educational tool has suggested that the platform is an ideal host for a blended learning environment, can be utilised to create a more positive and less threatening learning environment, can enhance peer relationships, and can be one of the best ways to enhance communication, inculcate a more positive learning attitude, motivate students to learn, encourage them to take their learning tasks more seriously, and increase their social capital via virtual interactions (Ng and Wong, 2013).

Maher et al., (2014) investigated whether online interventions bring about behaviour change, and found modest evidence that interventions incorporating online social networks may be effective. However, Laranjo et al., (2015) in a systematic review and meta-analysis of five data bases found a statistically significant positive effect of interventions on behaviour change. Further, Bailey et al., (2015) concluded that interactive digital interventions are effective for knowledge acquisition about sexual behaviour, and could usefully contribute

to sexual health education in schools, in clinic settings and online; however, there are obstacles to overcome, such as access to information technology and ensuring the quality and safety of interventions.

Recently, Scotland has produced a new resource for teachers and early years practitioners, which includes information for parents and carers, ideas about communicating between school and home, reading lists for school libraries and reading at home. All the activities and information used as part of the resource, including videos, PowerPoint and other online material, can be viewed by parents - which may be useful to dispel myths. Given the cultural similarities between Scotland and Northern Ireland, the resource: <https://rshp.scot> may be particularly useful for schools here.



## 2.4 Recommendations

The CEDAW Optional Protocol Inquiry Report recommended that the State:

*86 (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.*

Therefore, Department of Education policy needs to be consistent with the CEDAW recommendation. To this end NIACT recommends the following:

- 1.** RSE should be evidence based and delivered in a consistent, high quality, inclusive and sex positive manner across all schools in Northern Ireland, including Special Educational Needs schools, and be included as part of a school's inspection report.
- 2.** Organisations in receipt of public funding should provide a consistent and standardised approach to the delivery of RSE in school and community settings.
- 3.** RSE should start early and be relevant to the individual at each stage of their development and maturity.
- 4.** RSE should be delivered by trainers who are confident in talking about all issues relevant to RSE with an equal emphasis placed on all areas of the programme.
- 5.** RSE programmes should be offered to parents and carers with the view to alleviating their fears and assisting them to support children and young people in making informed choices.
- 6.** Young people should play a key role in formulating RSE programmes in schools and communities.
- 7.** On-line resources should be used in school, community and home settings.
- 8.** All training delivered should be assessed and evaluated to ensure consistency, and that gaps are identified and current trends are incorporated.



### 3. Sexual and Reproductive Health (SRH) Services

## 3 Sexual and Reproductive Health (SRH) Services

The introduction of a new legal framework for abortion services in Northern Ireland provides a unique opportunity to develop an integrated sexual and reproductive health (SRH) service for the region. While there has been considerable debate about developing an abortion service that is consistent with the recommendations of the 2018 United Nations CEDAW report, it should be noted that the report also makes recommendations in relation to RSE and contraception services.

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 and Social Care's (DHSC) *Framework for Sexual Health Improvement in England* estimated that every £1 invested in contraception saves £11 in averted health outcomes (DHSC, 2013), while Public Health England (PHE) estimates that every £1 invested in the provision of contraception achieves a £9 saving across the public sector (PHE, 2018). Whichever figure we accept, it is clear that investment in contraception is good for both public health and the public purse.

### 3.1 Current provision

In spite of the evidence supporting better access to SRH services, 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 SRH 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.

Contraception service provision and accessibility varies significantly between trusts, but all trusts have staffing shortages due to staff retirement and lack of workforce planning. Sessional doctors are remunerated significantly better for GP work than SRH, reducing availability of appropriately trained doctors. The Southern Trust does not have any SRH doctors, but has a limited nurse led service. There is no consultant in SRH in the whole of Northern Ireland and this was highlighted as an issue in the Regulation and Quality Improvement Authority's (RQIA) Review of

Specialist Sexual Health Services in Northern Ireland (RQIA, 2013). Given previous restrictions on abortion provision, it had not been possible to develop a comprehensive SRH training programme in Northern Ireland, so currently any doctor wishing to become a consultant in SRH needs to access a six year training programme in other parts of the UK. Another consequence of the lack of consultant leadership is a deficiency in training of specialist nurses.

Services are provided by registered nurses with health care assistants fulfilling supporting roles (Agenda for change pay bands 3-6). There needs to be a lead nurse (Band 8a) for each service who will oversee the development of the nurse's role in line with the rest of the UK, where the SRH service is mainly nurse led with most nurses fitting LARC, leaving doctors to see patients with complex needs, medical problems and difficult coil or implant procedures.

**TABLE 1**  
Whole time equivalent (WTE) staffing levels within SRH services in each trust  
(currently reduced in some areas due to Covid/sick leave)

Trust	Belfast	Northern	Southern	South Eastern	Western	Total
Number of SRH doctors	8	5	0	3	2	18
Full time equivalent doctors	2.7	1.65	0	0.3	0.95	5.6
Number of doctor led contraception sessions per week	18	13	0	3	7	41
Number of EMA doctor sessions per week	8	4	2	2	3	19
Number of SRH nurses	7	12	3	1	6	29
Full time equivalent nurses	3	3	0.5	1	3.7	11.2
Number of nurses fitting LARC	1	4	3	0	6	14
Number of nurse led LARC sessions per week	2	12	8	0	22	44
Number of EMA nurse/ midwife sessions per week	3	0	2	2	0	7



## 3.2 Issues of access

The dearth of allocated resources and inadequate staffing levels has led to a suboptimal and vulnerable service. The figures above for some trusts e.g., Southern, were reduced further due to redeployment during the Covid-19 pandemic, against the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Health (FSRH) that contraception is an essential element of health care, and services should be maintained during the pandemic.

The Northern Trust SRH staff also operate six sessions a week (four nurse led and two doctor sessions) funded by the PHA, offering contraception and sexual health screening to the campuses of the Ulster University and the Northern Regional College.

The GP Federation clinics that have now been rolled out throughout Northern Ireland offer LARC. These sessions were working well but, unfortunately, LARC provision in general practice has reduced dramatically due to the pandemic, leading to unprecedented demand for LARC in the already overstretched SRH services. As noted above, remuneration for these GP Federation contraception sessions is significantly more than a specialist SRH doctor session, making it difficult to recruit doctors into SRH services.

Outside of the NHS, Common Youth offers sexual health clinics in Northern Ireland for young people under 25, and contraception for under 19s, seven days a week.

The CEDAW Report noted 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). The recent study by Given et al., (2019) examined the use of prescribed contraceptives in Northern Ireland and how this varies according to a woman’s age and the deprivation in the area in which she lives.

This is the first population-based study to explore contraceptive use in Northern Ireland and includes 560,074 females, aged 12-49 registered with a GP (2010-2016), contributing 3,255,500 woman-years of follow-up. In keeping with figures for Great Britain and Ireland, just over a quarter of women of reproductive age were using prescribed contraceptives in any one year. The greatest users were aged 20-24 with those aged under 16 least likely to have a contraceptive dispensed. There was no evidence that the level of deprivation in the area in which the woman lived was related to her use of prescribed contraceptives. However, after adjustment for patient and other practice characteristics, practices operating in the least deprived quintile prescribed 6% more contraception.

Over the years Northern Ireland has seen a lack of commitment to sexual health. There is an out-of-date strategy, the Sexual Health Promotion Strategy and Action Plan 2008-2013, and we are waiting for an updated action plan “to improve, protect and promote the sexual health and welling of the population in Northern Ireland” (DOH, 2014). This has left current provision struggling without direction, but with ever-increasing demands. Feedback from young people has shown that they find it hard to access mainstream clinic services because of their concerns about confidentiality and fears of staff being unfriendly and judgemental.

Although the previous Strategy and Action Plan referred to the importance of access to sexual health services, it did not consider the development of services in detail. Even with RQIA’s review of sexual health services in 2013, most recommendations have still not been met. RQIA states “there is a need for a clear strategic direction to be set for specialist sexual health services and that a set of standards for service delivery should be agreed”. Clearly, this has not yet happened.

### 3.2.1 Safe access to healthcare

Under International Human Rights Law, states have an obligation to take effective measures to protect and guarantee women, girls and pregnant people’s right to health, physical integrity, non-discrimination and privacy as they seek healthcare information and services, free of harassment and intimidation amounting to obstruction of their access to that healthcare (CEDAW; Article 8 EU Convention on Human Rights). One measure to facilitate such protection could be to put in place exclusion or safe access zones to ensure the right to healthcare can be exercised (BPAS, 2019).

ICNI has direct experience of the negative impact anti-abortion protestors have on client’s experiences of accessing their pregnancy counselling services as well as their impact on staff and other individuals

who share or work near their office. Pre Covid-19, ICNI experienced daily protestors outside their offices (and previously those of the Family Planning Association [FPA]), for over twenty years. Individuals assembled around the entrance to their building each day and attempted to start unsolicited conversations with women on their reasons for entering. This included forcing misleading and potentially distressing leaflets on to them which contained inaccurate information and potentially distressing language such as, “Abortion does not unrape the mother - it makes her the mother of a dead baby”.

They displayed graphic images, followed clients and their families as they left the building, and used emotive and coercive language to dissuade visitors from medical treatment, under the assumption that any woman entering or leaving the building was pregnant and considering an abortion.

Experiencing these behaviours impacts negatively on clients and their families and influences their decision to access, or not access, ICNI’s counselling services. ICNI are aware of clients who have been attending counselling and the sessions were proving beneficial, but the activities of individuals outside the building adversely affected them and, as a result, they decided not to continue with counselling. Below is an extract from a client evaluation of ICNI’s pregnancy choices counselling service:

I think it’s a real shame there are protestors outside the building. It is very intimidating and I feel it could put a lot of vulnerable girls off going to discuss their options, or to have a counselling session. I was told if I wanted, I could return for a further session, but I definitely wouldn’t feel comfortable to do so. I think it is difficult enough without having to face questioning and judgements along with accusations from people who have absolutely no idea what each person is going into the building for.

As FPA and subsequently ICNI, share a building with other organisations the negative impact of these protests extends beyond the organisation and its clients. Below is a testimony from one woman who worked for a different organisation within the same building:

I worked in an office in the same building as FPA for four years. During that time, I would have to walk past anti-abortion protesters at the front door of the building to get to work. It was such a daunting ordeal to walk past them, brandishing graphic depictions of what I presume must have been late term miscarriages and abortions. Sometimes the protesters would talk to me, telling me not to abort my baby. I wasn't pregnant, and I wasn't going to FPA, but I was a young woman in my 20s, unaccompanied by anyone else, so I suppose I was their target demographic. As I only worked part-time and on different days each week, the protesters would be there some days and not there other days. On the days that they weren't there, I'd feel this wave of relief going into the building that I didn't have to walk past them and possibly be confronted by them. I think that's what made me realise just how much of a negative impact their presence had. I can't even imagine what it must have been like to have to walk past such hostility if I was a young, vulnerable woman trying to deal with a crisis pregnancy. I can only speak for myself, but I don't think I'd have felt able to walk past them to get to the advice I needed, even if I wanted to continue with a pregnancy or just wanted information on safe, healthy relationships. I would have felt too intimidated to walk through the door.

On one occasion protestors turned up outside dressed in black robes with their faces painted white with black tears, carrying a baby's coffin. The CEO of an organisation in the building next door approached and politely asked them to take the coffin away explaining that one of his employees had just returned to work after her baby had died at six months. He added that the woman was extremely upset at the sight of the coffin; however, they refused to remove it.

In 2015 a protestor was convicted for assaulting an FPA employee in the belief she was a pregnant woman leaving a counselling session. The protestor followed the staff member down the street after she left the FPA/ICNI office, attempted to put leaflets into her handbag and eventually hit her with the clipboard she was carrying. Despite this conviction the individual continued to stand outside their office without sanction.

Another staff member was followed from the building on a number of occasions during her pregnancy. This employee was subjected to unsolicited conversations while these individuals attempted to force leaflets on to her on separate occasions as she attempted to leave work in her mothers' car and in a taxi. Male and female staff members entering work together were subjected to emotive and coercive language.

Staff members also have experience of these individuals outside of work. One employee was followed around a supermarket in an attempt to intimidate her while another was confronted while she was shopping.

While NIACT believes in upholding the right to assemble, this should not interfere with the fundamental right for women, girls and pregnant people to seek information and counselling or to make individual reproductive choices. We support the freedom of speech but believe that the space outside or in close proximity to an abortion service or pregnancy counselling centre is not an appropriate location to oppose abortion provision. Therefore, we would recommend that safe access zones are introduced around SRH clinics and pregnancy counselling centres.

## 3.3 Young people's services

Provision of young peoples' services should be in line with quality assurance standards, for example, the National Institute for Health and Care Excellence (NICE) guidance on one-to-one interventions to reduce STIs and under 18 conceptions recommends that clinicians assess risk when the opportunity arises, for example when someone attends for contraception or registers as a new patient.

The DHSC's *You're welcome* (2011) quality standards for young people-friendly services makes recommendations including: involving young people in care and design of services; explaining confidentiality and consent; making young people welcome; providing high quality services; improving staff skills and training; linking with other services; and supporting young people's changing needs.

The Faculty for Sexual and Reproductive Healthcare Position Statement on Young People (2017) includes the following: "every young person has the right to access high-quality, confidential, contraceptive care and receive age appropriate sex and relationships (SRE) education, including objective information about their fertility...young people are able to confidently access contraceptive care in a setting in which they are comfortable and reassured about their right to confidentiality" (FSRH, 2017a).

Common Youth offers free confidential sexual health advice, contraception services and sexually transmitted infections testing and treatment for young people under 25 years of age. On average 8,000 young people from across Northern Ireland access their Belfast and Coleraine sites every year. Staff consist of doctors, nurses, counsellors, information workers and receptionists, who all have relevant, professional qualifications and experience in their field and in working with young people.

Common Youth's experience in Northern Ireland has informed its practice in the region. It aims to provide the best service possible for young people; services should work on a needs led approach, within the legal framework, using safeguarding policies and procedures to ensure best practice. For Common Youth, participation of young people should be sought at every stage of development and delivery of the service. Young people repeatedly voice their concerns regarding confidentiality when accessing sexual health services. The organisation understands that finding a balance between offering a confidential service and keeping young people safe involves trust. Securing the trust of young people is vital; it takes time, sensitivity, patience and sound professional judgment. Young people should be at the centre of what happens, and each young person should be viewed individually, and a course of action agreed to meet the needs of that particular person. Accessibility is also of prime importance. Young people need services which are available at times to suit. This means staff will need to be prepared to work outside normal hours, including after school and weekends. In summary, the ideal will be a seven day a week integrated contraceptive and sexual health service with open access and highly trained, non-judgmental staff operating throughout Northern Ireland.



## 3.4 Recommendations

The CEDAW Optional Protocol Inquiry Report recommended that the State:

*86(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;*

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

The FSRH also published a report in September 2016, The FSRH Service Standards for Sexual and Reproductive HealthCare. This report was developed to support providers and commissioners in providing safe, high-quality sexual and reproductive health services. Their recommendations, with regard to service quality, can be used to maintain levels of excellence and to inform commissioners and all other providers as they plan SRH services for the future.

**Notably, within the report, the FSRH recommend:**

- All sexual and reproductive health services should be led by appropriately trained clinical and managerial personnel to ensure quality of service provision, service development, training and clinical governance;
- Service provision should include a range of sexual and reproductive health services;
- Services need to be patient-focussed ensuring good communication, clear patient information and working to FSRH standards on consent and confidentiality;
- Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation;
- There should be easy and quick non-discriminatory access to sexual and reproductive health services for all;
- All staff working in sexual and reproductive health services should receive appropriate training and must maintain their skills;

- Sexual and reproductive health service provision should be evidence-based, which will include the use of national and local guidelines and policies;
- All users seeking sexual and reproductive health services should be made aware that their right to confidentiality will be respected and maintained in line with GMC, NMC and other professional bodies' recommendations;
- The role of nurses in sexual and reproductive health service provision should be enhanced.

The Department of Health policy needs to be consistent with the CEDAW recommendations and would be advised to use the influence and direction of the FSRH Service Standards for Sexual and Reproductive Healthcare.

**To this end NIACT recommends the following:**

9. Investment in a sexual and reproductive training programme for doctors within Northern Ireland with emphasis on recruiting into the field from hospital and GP training programmes.
10. Within every trust there should be a minimum of two SRH consultants. SRH consultants should not work in isolation, and should be supported by other consultant colleagues, as well as a team of specialised healthcare professionals.
11. The role of nurses and midwives should be further developed to include provision of LARC and abortion care.
12. Improved access to contraception services, especially in underprivileged and rural communities, and for particular groups including the homeless, those with disabilities, and people for whom English is not their first language.
13. Improved access to contraception for young people.
14. An ongoing public health campaign, involving the Public Health Agency (PHA) and associated bodies, promoting sexual and reproductive health for all age groups.



## 4 Contraception

Sexual and reproductive health matters to us all at different points in our lives. When considering all modern healthcare interventions, effective contraception has had the most profound positive effect on the health of women. Improved access to abortion and contraception has revolutionised women's lives by supporting them to take control of their reproductive health and the future of their family (FSRH 2015).

## 4.1 Available methods

**TABLE 2**  
 Methods of contraception and their failure rates

Type	Failure rate
Condoms	Up to 13 in 100 women per year.
Fertility apps/natural family planning.	2-23 in 100 women per year.
Combined hormonal contraception (pills, patch, ring) and progestogen pills.	1 in 100 women per year with perfect use, higher with typical use.
Injectable medroxyprogesterone acetate.	1 in 200 women per year. Need for clinic attendance every 3 months.
Intrauterine methods - intrauterine system (Mirena, Kyleena) and copper IUCD.	Fewer than 1 in 100 women per year. Lasts 5-10 years.
Nexplanon subdermal implant.	1 in 1000 women per year. Lasts 3 years.
Female sterilisation involves general anaesthetic and keyhole surgery with risk of bladder and bowel damage.	Lifetime failure rate of 1 in 200. Should be considered irreversible. Long waiting times for surgery in Northern Ireland.
Male sterilisation (vasectomy) - simple outpatient procedure under local anaesthetic.	Failure rate low 1 in 1000. Should be considered irreversible.

Of these methods LARC is the most effective; this includes, subdermal implant, intrauterine methods and injectables.

There needs to be an increase in the provision of easily accessible contraception if we are to reduce the numbers of unintended pregnancies. Effective use of contraception is extremely cost effective. 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 adverse health impacts (DHSC, 2013). The cost effectiveness of each method of contraception is set out here:

- The contraceptive implant (a LARC method) lasts for 3 years, and at a cost of £78 results in a yearly contraceptive cost of £26.
- The IUCD /copper coil (a LARC method) will last 5-10 years, and at a cost of between £10 and £15 (depending on type) results in a yearly cost of between £1.50 and £2.
- The IUS / hormonal coils (a LARC method) differ in hormone dose and last 5 years, and at a cost of £78-£88 results in a yearly cost of between £15 and £23.
- The contraceptive injection (a LARC method) is given every 13 weeks, and at a cost of £6.90 results in a yearly cost of £28
- The contraceptive pills vary in price between £1 and £6 for 3 month's supply and result in a yearly cost of between £4 and £24.



## 4.2 Emergency contraception

The most common form of emergency contraception used in Northern Ireland is the emergency contraceptive pill; this is available free of charge from GPs, SRH clinics and some pharmacies. It is available as an over-the-counter medicine from most pharmacies, priced around £15 per dose. Ulipristal acetate is more effective than levonorgestrel, but more expensive.

Unfortunately, many women are still prescribed or sold the less effective option. It is important to note that oral emergency contraception is ineffective after ovulation and therefore an IUCD is indicated. This should be offered to all women seeking emergency contraception. Levonorgestrel has to be taken within 72 hours of unprotected sex, Ulipristal acetate within 120 hours, while an IUCD can be inserted up to 5 days following unprotected intercourse. Unfortunately, due to lack of service provision, accessing an emergency IUCD is not easy and sometimes simply unavailable in some trusts (and most GPs do not provide this service).



## 4.3 Postpartum contraception

One third of births in the UK are estimated to be unplanned at the time of conception (Lakha et al., 2006). This rate is likely to be higher in Northern Ireland, where community sexual health services are less well established than in the rest of the UK and where, until recently, there has been longstanding legislation restricting access to abortion (UN CEDAW, 2018). The postpartum period, in particular, is a high-risk time for unintended pregnancy.

Fertility can return as early as three weeks in non-breastfeeding women and as many as 50% of women are estimated to resume sexual activity by six weeks (Jackson et al., 2011; McDonald et al., 2013). Attending an SRH clinic or GP for contraceptive advice prior to resumption of sexual activity can be challenging for women in the postnatal period, and this presents a significant barrier to contraceptive uptake. Whilst exclusive breastfeeding can be used as a method of contraception up to six months postpartum, exclusive breastfeeding rates are low in Northern Ireland (14.1% at six months) and only marginally better in the rest of the UK (PHA, 2018).

A further pregnancy within 12 months of birth is associated with an increased risk of maternal and neonatal adverse outcomes including preterm birth, intrauterine growth restriction, and maternal and neonatal morbidity (Smith et al., 2003). If a pregnancy occurs in the 12 months following a caesarean section there is an increased risk of uterine rupture and associated morbidity. For the health service, the cost implications of unintended pregnancy are estimated to be in the region of one billion pounds per year (Hall et al., 2017). From a societal perspective, a short inter-pregnancy interval can be the cause of significant psychological stress and financial burden for families, particularly for women with pre-existing health needs or from low socio-economic background. Inadequate inter-pregnancy spacing can prevent women from fulfilling their potential both in their education and in the workplace, further compounding socio-economic issues.

It is important to note that there are patient groups who have a significantly greater need for improved access to LARC. These include women with high-risk medical conditions for whom pregnancy presents an unacceptable risk to their health, women with a significant mental health history, and those who are considered ‘vulnerable’ due to social issues which may include poverty, domestic abuse and addiction. The FSRH recommends that maternity services offer all eligible women LARC, not limited to those with health needs or vulnerability, and that this should be initiated as soon as possible following birth (FSRH, 2017b). This can either be in the form of an implant which can be inserted any time after birth, or an IUCD fitted immediately after expulsion of the placenta at caesarean section or within 48 hours of delivery (RCOG, 2015). The need for postpartum contraception to be a key part of maternity pathways was strongly reiterated in the RCOG 2019 Better for Women Strategy, which states that “Health and Social Care Northern Ireland must embed immediate post-pregnancy contraception maternity pathways and support for all women”.

There is a large body of evidence for safety and efficacy of postpartum contraception. Previously the evidence for effective service design and implementation was lacking. However, a significant amount of research into this has now been undertaken, particularly in NHS Lothian, where a comprehensive framework for implementation of a postpartum contraception service has been developed (Cameron et al., 2017). Evidence has shown that implementation of a postpartum contraception service is not only effective but is also cost-effective. The research from NHS Lothian has shown that the traditional model of provision of postpartum contraception in general practice leads to unnecessary delay and significant barriers to access. Providing contraception shortly after the birth allows for timely provision and has been demonstrated to be acceptable, and even preferable, to women. This is a model of contraception provision, that is patient-centred and better able to meet the needs of new mothers and which can be provided by obstetricians and midwives postpartum.



## 4.4 Barriers to contraceptive use

The 2018 CEDAW report 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).” (CEDAW 2018, para 46).

Barriers to contraceptive use in Northern Ireland comprise inadequate and inconsistent RSE, lack of public awareness of different methods and their effectiveness, lack of provision within general practice, and lack of provision within community clinics. This is a result of minimal investment in SRH, particularly the failure to address chronic workforce issues, which include pay disparity and poor workforce planning.

## 4.5 Recommendations

The CEDAW Optional Protocol Inquiry Report recommended that the State:

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

In December 2019 the RCOG published the **Better for Women** strategy. As part of this report it was recommended that:

- *Accessing the full range of contraception methods should be as easy as possible for all women.*
- *Post-pregnancy contraception should be a key part of the maternity pathway.*
- *Make access to progestogen-only (POP) contraceptives and emergency hormonal contraception (EHC) as easy as possible for all women.*

In April 2020, in response to the Covid-19 pandemic, a joint statement was released by the FSRH, the RCOG and the RCM stating that:

- *Evidence suggests sexual activity and fertility may return quickly after childbirth, and pregnancies soon after giving birth may increase the risk of complications.*
- *Women should be able to access effective contraception as soon as possible after childbirth.*
- *Most contraceptive methods (except the combined pill, patch and vaginal ring) can be started safely immediately after giving birth, including women who are fully breastfeeding.*
- *A six month-supply of the progestogen-only pill (POP) can be offered to women after childbirth, unless they have a medical reason not to.*

The Department of Health policy needs to be consistent with the CEDAW recommendations, and should use the direction of the RCOG Better for Women Strategy and recommendations coming from the three main healthcare organisations, representing thousands of doctors, nurses and midwives working in women's health.

**To this end NIACT recommends the following:**

- 15.** There should be a more visible and far-reaching Public Health campaign raising awareness of the effectiveness and benefits of LARC, and where and how to access emergency contraception.
- 16.** LARC should be more easily accessible within general practice and EMA services.
- 17.** There should be increased provision of postpartum contraception within maternity services, including access to LARC following the birth.
- 18.** The Progestogen only Pill should be made available as an over-the-counter medication. This would involve the Medicines and Healthcare Products Regulatory Agency (MHRA) reclassifying it from 'prescription-only' to 'pharmacy product'.
- 19.** The most effective form of oral emergency contraception, ulipristal acetate, should be available free of charge and without prescription from every pharmacy within the region and from all SRH clinics within each trust.
- 20.** The MHRA should be asked to reclassify oral emergency contraception to the General Sales List to enable it to be provided without consultation.
- 21.** There needs to be improved awareness, access and referral pathways for emergency IUCD insertion. This should include investment into training more GPs in coil insertion and investment into SRH services within all five trusts in NI.





# 5. Abortion



## 5.1 A brief history of abortion in Northern Ireland

### 5.1.1 Background/Context

On 18th July 2019, the Northern Ireland (Executive Formation etc) Bill passed in Westminster. A cross-party amendment to this Bill required that, unless there was a functioning Northern Ireland Assembly on the 21st October 2019, the Secretary of State for Northern Ireland would comply with international human rights obligations and implement the recommendations of the UN CEDAW Committee report that abortion should be decriminalised in Northern Ireland. On 24th July 2019, the Northern Ireland (Executive Formation etc) Bill received Royal Assent making it an Act of Parliament (law). Therefore, on the 22nd October 2019, in the absence of a functioning Northern Ireland Executive and through repeal of sections 58 and 59 of the Offences Against the Person Act 1861, criminal sanctions for abortion in Northern Ireland were removed. This meant that criminal charges could no longer be brought against individuals having an abortion or against registered medical professionals providing abortion (Aiken and Bloomer, 2019).

After 22nd October 2019, there was a period of consultation on a regulatory framework for abortion, following which, Regulations were drawn up and came into force on 31st March 2020.

### 5.1.2 The law in Northern Ireland prior to decriminalisation

Abortion in Northern Ireland was permitted in very limited circumstances where a woman's life was at risk or where there was a risk of serious long-term damage to her physical or mental health. As such, abortion law in Northern Ireland was one of the most restrictive globally, and carried with it the harshest criminal penalties in Europe. It was governed by the Offences Against the Person Act 1861. Section 58 made it a crime for a woman to cause her own abortion through medication or instruments; this was punishable by up to life in prison. Section 59 made it a crime to assist a woman in causing her abortion; this applied to medical professionals providing abortion as a healthcare treatment in a clinical setting (Bloomer et al., 2018). The Bourne case in

1939 provided a defence against prosecution where a doctor performs an abortion acting in good faith for the purpose only of preserving the life of the woman or girl, (Bloomer and Fegan, 2014).

Section 5 of the Criminal Law Act (Northern Ireland) 1967, stipulated that it was a crime to have knowledge of and not report to the police any offence which carries a sentence of five years or more. This applied to medical, midwifery and nursing professionals who gained knowledge of a woman procuring an abortion in Northern Ireland either through use of abortion medication or other methods.

### 5.1.3 The situation regarding severe fetal abnormality

Prior to 2013, doctors in Northern Ireland provided abortion in cases of severe fetal abnormality where the woman felt that she could not carry the pregnancy to term, and there were concerns about the adverse effect on her mental health.

In early 2013, the Attorney General wrote to obstetricians and gynaecologists to ensure they were working within the law, and to remind them that failure to do so would put them at risk of prosecution and imprisonment. 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 of abortion and hence the need for abortion services in Northern Ireland, and for unnecessarily cautioning against 'counselling' patients on where to access abortion elsewhere in the UK (DOH, 2013). The latter had no legal basis as the provision of information to women concerning abortion services abroad is protected under article 10 of the European Convention of Human Rights (Open Door and Dublin Well Woman v Ireland).

Later that year, there was a high-profile case of a woman, Sarah Ewart, who had to travel to England to seek abortion for a fatal fetal abnormality (FFA). Having sought legal advice, her medical team were told they could not legally provide abortion for FFA in Northern Ireland.

The 2013 guideline was subsequently withdrawn and new guidance published in 2016 (DOH, 2016). The UN CEDAW Committee was of the view that the 2016 guidelines failed to clarify the circumstances in which abortions were lawful in Northern Ireland. It placed responsibility on health professionals to assess on a case-by-case basis whether an individual's circumstances met the legal criteria for abortion. The guidance recommended that two doctors with appropriate skills and expertise undertook the assessment, but did not provide a framework to guide the assessment. It was indicated in the guidance 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 did not clarify whether abortion was an option.

After 2013 there had been a “chilling effect”, with doctors left unsure of where the balance of risk lay and thus reluctant to perform abortions for fear they would end up facing prosecution (McNeilly et al., 2016). As such, the number of abortions performed in Northern Ireland fell to 8 in 2018-2019, having previously been at 51 in 2012 (DOH, 2020).

Women with a FFA diagnosis had to 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 opted for post-mortem examinations sometimes needed to spend longer away from home and faced difficulties in repatriating the fetal remains, further compounding an already very distressing situation (McNeilly et al., 2016; Bloomer et al., 2017a).

#### **5.1.4** The practicalities of abortion for women in Northern Ireland prior to decriminalisation

During the period from 1970 (when data was first recorded) to 2016, a total of 62,038 women travelled from Northern Ireland to Great Britain to access abortion (Bloomer et al., 2017b).

These abortions had to be self-funded as they were not available to women from Northern Ireland on the NHS, except for a small minority referred for second opinion on management.

Since 2017, women from Northern Ireland have been granted access to funded abortion services in Great Britain. This funding was, and continues to be, provided by the UK Department for Women and Equalities. It is estimated that over 1000 women travelled from Northern Ireland to access abortion in 2018. However, significant barriers still existed:

1. There remained the financial costs of travel, accommodation, taking time off work and child-care. There was a grant available for travel and accommodation if income fell below a certain threshold. However, not all were aware that a grant was available.
2. There was an additional emotional burden associated with accessing services in an unfamiliar place without the support of friends or family.
3. Young women and girls, and those from low socio-economic backgrounds or rural communities may not have been familiar with the documentation required for travelling; some did not even have a passport.
4. Women with complex physical or mental health needs may not have been fit to travel.
5. Women in violent or coercive relationships may have been unable to travel.
6. Immigrants, asylum seekers, and refugee women were unable to travel.
7. Homeless women, women in refuges, women in prison, women on daily prescriptions, and children also may not have been able to travel.

Research showed that, despite the policy change, women were still accessing abortion medication online, but the number was difficult to determine due to the existence of multiple online sources. Whilst there are reputable sites such as Women on Web and

Women Help Women, there are also unscrupulous traders who may sell counterfeit or unsafe abortion pills. Regardless of the online source, under the law prior to the Northern Ireland (Executive Formation etc) Act 2019, women risked prosecution and there was a risk of them delaying seeking medical help for abortion-related complications. While mifepristone and misoprostol have an excellent safety record, this is based on the pregnant woman being able to access medical assistance if required. Research from Ulster University suggests that, after prosecutions of those using the pills began, younger women were unlikely to seek medical help for fear of arrest (Horgan, 2019).

Women who accessed abortion, either through travelling to Great Britain or through abortion medication bought online, often experienced significant barriers in accessing appropriate abortion after-care in Northern Ireland, including referral for psychological support and contraception. This was despite 2016 Department of Health (Northern Ireland) 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.

### 5.1.5 Public support for legislative change

Studies suggested that the majority of the public in Northern Ireland supported legislative change on abortion. In the NI Life and Times Survey 2016, support for abortion reform was found to be consistently high across the political spectrum. 80% of DUP voters stated abortion should be permitted in the context of fatal fetal abnormality. While in 2016, 71% of respondents agreed that 'Abortion should be a matter for medical regulation and not criminal law' (Gray, 2017), in the 2018 Life and Times Survey, this had risen to 82%. In the Trade Union Survey of Abortion as a Workplace Issue, 84% stated that women should not be prosecuted for having an abortion (Bloomer et al., 2017c), and in the Amnesty International Survey 2018, 65% stated abortion should not be a crime (Amnesty International, 2018).

### 5.1.6 Support for legislative change from the medical community

A 2009 study of attitudes and practice of obstetricians and gynaecologists towards abortion in Northern Ireland found that 57% were in favour of liberalisation of abortion law (Francome and Savage, 2011). A recent post-decriminalisation study by Ulster University has shown that support amongst obstetricians and gynaecologists has grown significantly with 67% reporting to be in favour of decriminalisation up until 24 weeks gestation (Bloomer et al., 2021).

Decriminalisation of abortion is supported by many professional bodies including the British Medical Association, the Faculty of Sexual and Reproductive Health, the Royal College of GPs, the Royal College of Midwives, the Royal College of Nursing, and the Royal College of Obstetricians and Gynaecologists.

### 5.1.7 International evidence supporting decriminalisation of abortion

The lowest abortion rates are observed in countries where abortion laws are permissive and abortion services are accessible. Countries where abortion is highly restricted have three to five-fold higher abortion rates (Bloomer et al., 2018).

Countries where abortion has been decriminalised and which have regulations in place, such as Canada and parts of Australia, have not experienced a subsequent rise in abortion rates, particularly for third trimester abortions (Bloomer et al., 2018).

## 5.2 The need for abortion

In a synthesis of studies from 14 countries, Chae et al., (2017:233) observed that women have abortions for a variety of reasons, and often for multiple reasons. The authors noted that the most frequently cited reasons for having an abortion were socioeconomic concerns or limiting childbearing. Little variation existed in the reasons given by women's sociodemographic characteristics.

### 5.2.1 Reproductive Injustice as a driver of abortion

Reproductive justice is a concept that includes, not only a woman's right not to have a child, but also the right to have children and to raise them with dignity in safe, healthy, and supportive environments (Ross and Solinger, 2017). However, the extent of child poverty in Northern Ireland suggests that the recent legalisation on abortion here promises to deliver only half this equation.

In early December 2020, the British Pregnancy Advisory Service (BPAS) revealed that the two-child limit, restricting the amount that larger families can receive in social security benefits, was a key factor in many women's decisions to terminate their pregnancy during the pandemic in England. The abortion provider revealed that those seeking abortions told them "the combination of economic and job insecurity triggered by the pandemic and the two-child limit effectively removed their choice over the pregnancy, persuading them to end a pregnancy they would in a less fraught financial situation have wanted to keep." (Butler, 2020)

This is not surprising. In studies across a range of countries, financial reasons are the most often cited for seeking an abortion (Kirkman et al, 2009; Chae et al, 2017; Horgan, 2019). The constrained choices faced by so many women who find themselves with an unintended pregnancy demand a response from government. This is particularly so if that government seeks to keep the number of abortions in its jurisdiction as low as possible. Figures for the number of families

in Northern Ireland impacted by the two-child policy are not available but it is estimated to be 3,000 at a minimum, with over 10,000 children affected.

Austerity measures imposed by the UK coalition government 2010-15 and the Conservative government since 2015 have seen the abolition of the Health in Pregnancy Grant, and the SureStart Maternity Grant has been restricted to the first baby born to a family. These cuts have hugely impacted on families living in poverty since, for all families, the first year of a child's life is when they are most likely to be in poverty. For those already in poverty, the birth of a child can see a move into more severe poverty where food insecurity becomes a real issue.

If Northern Ireland is to have a lower rate of abortion than Britain, then the devolved government must move to ensure there is reproductive justice. It must ensure that parents are able to bring a child into the world secure in the knowledge that they will be able to bring that child up in dignity, to feed, clothe, shelter and educate them in line with the norms of the society in which we live. NIACT would recommend an immediate removal of the two-child limit, resumption of the Health in Pregnancy Grant, and restoration of the SureStart Maternity Grant on the birth of every child.

### 5.2.2 Case studies

**Case studies from testimonies provided to the Women and Equalities Committee Inquiry (2018), by Alliance for Choice, illustrate a range of the reasons provided:**

I knew straight away when I saw two lines I would not be continuing the pregnancy as I knew what was right for me and my life. At that time in NI it was still illegal to have an abortion. I contacted FPA as I had barely any money and knew it would be an expensive trip to England. I told my friend and her mum booked me a flight and accommodation in Birmingham. The first day I took the mifepristone, the second day misoprostol then I was immediately returning home to NI. I was at the train station when the side effects of the tablets occurred. I was vomiting, dizzy and had



severe cramps and just wanted to get home. As the plane was taking off the pregnancy started to come away. I couldn't get up from my seat, I could just feel the blood expelling everywhere and down my legs. No woman should ever be subjected to the loss of dignity or feeling like they are doing something wrong and humiliation added to an already stressful situation. I am delighted that this service is now available in NI as nobody should have to experience what I went through.

I have two sisters who needed abortions, one was in an abusive relationship and the other was 15. They could not go through with pregnancy for the sake of their mental health.

I'm 39 and a mother of two daughters. It took four rounds of IVF and thousands of pounds for us to make our family. You cannot believe how lucky we feel to have our children. We feel complete. Five months ago I fell pregnant. After spending 20 years completely infertile, I was suddenly pregnant. Five years ago, I would have been ecstatic. This time I was devastated. My husband and I hadn't planned for another child. We couldn't afford to bring up another child. We couldn't imagine how another child would fit into our world. We didn't have the energy or capacity to have another baby. We just couldn't go ahead with it. The guilt I felt about booking in an abortion was immense. But I was confident about my decision and I didn't feel shame.

I discovered I was 4 weeks pregnant. I already have children and was only a few months into a new relationship. I have a chronic illness which means contraception makes symptoms worse. Condoms failed. I was very ill after my children and the stress on my body made my chronic illness permanently worse. Aside from this I didn't want another child. Even if I did I was already living in unsuitable housing and although I work I rely on tax credits to get by. A new child wouldn't have been eligible for tax credits. So I was a few months into a new dream job and a new relationship. I knew I couldn't go ahead with this pregnancy.

At my 21 week scan, it revealed that my much longed-for baby boy had bilateral ventriculomegaly and a severely underdeveloped heart. After further tests it was discovered that he had a chromosomal disorder. My husband and I made the heart-breaking decision to end my pregnancy and on the 21st May under the care and guidance of midwives at Hillingdon Hospital in London I gave birth to my stillborn son. He was 23 weeks old.

I got pregnant at 21. I told my parents and they said that it was entirely up to me and they would support me with whatever choice I made. I went for counselling to try and help me decide but left the counselling session in tears and distraught by the anti-abortion views that were thrown at me in that session. I thought it was going to be an impartial counsellor but it most certainly wasn't. I decided to have an abortion as it wasn't the right time in my life to have a baby.

I had to travel to England to access abortion due to current abortion laws in NI. This was extremely expensive, stressful, and required a lot of secrecy and lies to family and friends in order to conceal what I was going there for. I am a non-binary, trans-masculine person, and I became pregnant as a result of coercion (I was beaten if I tried to take or use contraception) and rape while in a physically abusive relationship with a cisgender man. In addition to the trauma of being raped and beaten, I had to deal with the trauma of becoming pregnant by this man who nearly killed me.

I have had both of my children in NI and always the worry about what might happen if something went wrong was present in my mind. I have had friends and a sister who lost much wanted babies to FFAs and the worry never ends. Before my two children I had an abortion using pills. I was not in a fit state to have a baby, I had no family support, my relationship was not steady, I had no money and only temporary work. It was an easy decision to make and the right thing to do.

## 5.3 Survey of attitudes to abortion amongst healthcare professionals in Northern Ireland

Prior to the decriminalisation of abortion, a small number of studies explored the views of medical staff in Northern Ireland as to their opinion on legal reform, identifying that most were in favour of some legal change (Francome and Savage, 2011; Theodosiou and Mitchell, 2015). In late 2019 / early 2020, a survey of health professionals working in obstetric and gynaecology units in Northern Ireland, conducted by Ulster University and University College London (UCL), sought to address this dearth of evidence. The purpose of the study was to identify the levels of support for decriminalisation, and willingness to deliver services, and to assess training needs.

Of the 312 respondents, 113 (36%) were obstetricians / gynaecologists, 112 (36%) were midwives, and the remainder comprised anaesthetists, gynae ward nurses, theatre nurses, sexual and reproductive health nurses, sexual and reproductive health doctors, and early pregnancy assessment service nurses. The vast majority of respondents were women (256; 82%).

In relation to respondents' views on decriminalisation of abortion up to 24 weeks gestation, 54% were in favour, 35% were not in favour, and 11% were unsure. Analysis indicates that there is evidence of a strong relationship between views on decriminalisation and health trust area, with 61% of respondents in Belfast Health and Social Care Trust (BHST) and the Western Health and Social Care Trust (WHST) stating they favoured it, compared to 53% in South Eastern Health and Social Care Trust (SEHST), 46% in Southern Health and Social Care Trust (SHST) and 43% in Northern Health and Social Care Trust (NHST).

The majority of respondents, 60%, stated that they would be willing to actively participate in medical abortion of pregnancy in certain circumstances; 34% were not willing, and 6% were unsure. Half of respondents were willing to actively participate in surgical abortion of pregnancy in certain circumstances, 41% were not, and 9% were unsure. Analysis indicates that there was no evidence of a strong relationship between views on medical abortion, surgical abortion and health trust area.

## 5.4 Best practice in abortion services

This section identifies factors important for women when accessing abortion services.

### 5.4.1 Introduction

**To optimise access to safe abortion services health systems need to:**

- Establish national standards and guidelines facilitating access to and provision of safe abortion care to the full extent of the law;
- Ensure healthcare providers' skills and performance through training, supportive and facilitative supervision, monitoring, evaluation and other quality-improvement processes;
- Include the costs of staff, training programmes, equipment, medications, supplies and capital costs in health service budgets;
- Adopt a systematic approach to policy and programme development that promotes women's health and their human rights (WHO, 2012).

Best practice indicates that abortion services should be accessible to all who need them; they should be provided in a timely manner, there should be an appropriate choice of method, empathetic and non-judgmental care should be provided, and the unique situation of each woman should be recognised. Evidence indicates that, even in high resource settings with liberal laws, women still encounter barriers to accessing care.

### 5.4.2 Accessibility

#### **Information provision**

It is important that information on abortion services is widely available and accessible to people with diverse abilities – e.g., on fully accessible websites, in pharmacies, GP practices and in publicly funded facilities, such as libraries and community centres. A recent example of this is that which the Republic of Ireland has introduced for its abortion services.

#### **Care close to home**

Being able to access abortion services at home or close to home is very important. The need to travel contributes to a 'sense of discrimination and stigmatisation' (Purcell et al., 2014). Travelling long distances and a requirement for multiple appointments has several effects including, less privacy due to the need to disclose to more people what is happening, childcare for longer periods of time, and experiencing pain whilst travelling (Heller et al., 2016).

#### **Cost**

Although fully funded abortion services for women in Northern Ireland are now available through the NHS, consideration is needed for people who may not be entitled to NHS services, such as those not ordinarily resident in Northern Ireland. A calculation of associated costs is needed (e.g., travel, accommodation, subsistence), particularly for people who need to travel long distances to multiple appointments. It should also be noted that if women cannot access abortion services, they may attempt to self-induce abortion or go to unsafe providers, possibly resulting in hospitalisation for serious complications which generates much higher costs for the health system (Rowlands et al., 2016).



### **Socio-economic conditions**

In Great Britain, where abortion has been readily available within the NHS for many years, barriers to accessing services and appropriate care remain. Aiken et al., (2018) conducted a non-generalisable study on the reasons women from Great Britain contact WoW for help accessing at home medication abortion. A total of 519 British women contacted WoW during the time period of the study. Of those, 180 provided the reasons for seeking home medication abortion, the most prevalent was experiencing delays in accessing services, including waiting times of several weeks; further reasons included privacy concerns, threat of violence or controlling circumstances.

Aiken et al., noted that difficulties in accessing in-clinic abortions are not unique to women living in remote areas. Women can have difficulty accessing services for combined and interconnected reasons, including domestic abuse, poverty, immigration status, and multiple appointments. Improved information dissemination on patient pathways, evidence-based women-centred clinical care, and integrated services which can address multiple needs simultaneously are required. They also stated that their results 'reflect previous studies of stigma, finding that internalised negative attitudes from partners, family, and friends may cause women to conceal or delaying seeking abortion' (Aiken et al., 2018: 183).

Regarding later abortions, pregnant people present for later abortions for a range of reasons. These could include delayed recognition of pregnancy, changed life circumstances (e.g., a partner losing interest, the prospect of social services being involved, the prospect of being tied to an ex-partner, considerations of wellbeing of their family), and not identifying as a parent (Purcell et al., 2014).

In the UK, undocumented people, refugees and asylum seekers suffer disproportionately with regard to access to abortion and reproductive health care services. As Aiken et al., (2018) noted, 13.4% of their respondents cited lack of eligibility for NHS services as a reason for contacting WoW and it was a significant barrier to accessing in-clinic care.

### **Residency status**

Phillimore (2016) found a lack of cultural insight by health providers which was exacerbated by language barriers, and argued that more understanding of the constraints and barriers experienced by migrant women is required. This study suggested that migrant status rather than, or in tandem with, ethnicity 'may be a key factor in increasing the vulnerability of migrants and is associated with legal and structural barriers to attending antenatal care or receiving efficacious care' (Phillimore, 2016: 158).

Asylum seeking women can be required to move at short notice (dispersal), they can be detained, and they are least likely to have knowledge about their entitlements. They are also less likely to be able to source information on services. With regard to formal NHS services, these factors result in asylum seeking women having difficulty registering with healthcare services, difficulty in learning about local services after dispersal, having little or no money to travel to appointments, being less likely to attend follow-up appointments, and suffering from significant discontinuity in care (Phillimore, 2013; 2016). Failed asylum seekers and irregular migrants with no access to public funds are not allowed to work and so may be entirely dependent on friends for food and travel costs. Although maternity services including antenatal treatment are deemed immediately necessary and therefore provided free of charge (NRPF, 2017), irregular migrants may not have money to pay travel costs and there may be no interpreters available to assist. Some women stopped attending antenatal appointments because the interpreter was inappropriate, for example they were male, known to the patient, or a family member who excluded patients from discussions about their care (Phillimore 2016: 156).

In Northern Ireland, difficulties in acquiring a Health and Care number out of hours, and availability of interpreters, have created delays to advice and treatment within the interim EMA service.



### **Telemedicine**

There is recent evidence that the use of telemedicine, which was approved during the Covid pandemic, has improved some issues of access (Porter et al., 2020; Meurice et al., 2020). Telemedicine for abortion services involves telephone or video consultations, after which a treatment package is sent to enable self-administration of medication. This has been made available by the issuing of approval orders to allow home use by the governments in England, Scotland, Wales and the Republic of Ireland. Unfortunately, no approval order has been issued in Northern Ireland. Before the pandemic, research had shown abortions provided via telemedicine were highly acceptable to women and were as effective as in person care (Endler et al., 2019).

Furthermore, recent evidence during the pandemic from a cohort study confirms the safety, ease of access and user acceptability of telemedicine facilitated abortion (Aiken et al., 2020a, 2020b; Porter et al., 2020; Assis and Larrea, 2020). To assist clinical practice, the RCOG have produced guidelines on telemedicine abortion during the Covid-19 pandemic (RCOG, 2020). It is hoped that telemedicine abortion will remain available in the rest of the UK after the pandemic. There is an urgent need for it to become available in Northern Ireland. The option of at home mifepristone is recommended in quality statement 4 of the recent NICE Abortion Care Quality Standard (NICE, 2021).

### **5.4.3 Engagement with health professionals**

#### **Referral systems**

Self-referral to a central booking system avoids delays and can be effective in facilitating access. A requirement for GP referrals can cause delays if doctors have negative attitudes or object to abortion service provision (Rowlands, 2006). The benefits of self-referral are particularly pertinent to women in rural areas. A study in rural areas of Scotland highlighted barriers to accessing services which translated to a higher proportion of abortion at later gestations, a greater risk to women, and higher cost to the health system (Heller et al., 2016: 1689).

Reports from the interim service in Northern Ireland indicate some negative experiences during GP consultations:

**My GP services were shocking. I felt judged. They just gave me a phone number for a booking line in England. It really upset me and I found it to be quite shocking in 2020.**

**My GP spent 10 minutes trying to convince me not to go down this route.**

**My GP was no help at all. He said it was against the law. I am 18 and have a 7 month old baby.**

#### **Health professional attitudes to abortion seekers**

Most women decide to terminate the pregnancy before they seek an abortion. Whilst access in the UK is relatively good, some women experience difficult interactions with health professionals (Beynon-Jones, 2012: 510). Beynon-Jones (2012) argued that health professionals prejudge women requesting abortion on the basis of age, whether or not they have existing children and socioeconomic circumstances. Maxwell et al., (2020) identified that health professionals have a key role to play in normalising abortion and challenging stigmatising terminology.

#### **5.4.4 Termination of Pregnancy for Fetal Abnormality (TOPFA)**

A study examining the experiences of people's care when undergoing termination of pregnancy for fetal abnormality found five themes underpinned that which was considered 'good care' (Fisher and Lafarge, 2015).

##### ***Being cared for in a timeframe and environment that feels right***

The speed of diagnosis and a short wait for the procedure were positive factors. Gestational age impacted on care. Women who received a diagnosis of fetal abnormality in the first trimester reported increased pressure to make a decision at 13-14 weeks gestation. Pressure to make a decision was also commented upon around the 24-week legal limit. Most women had 'vivid memories' of the procedure and the environment they were in (gynaecology ward/labour ward). There was no consensus on the most suitable environment, although individual rooms were greatly valued and a gynaecology ward was favoured by some of those at earlier stages of pregnancy. Being in the 'wrong' ward was a cause of distress (Fisher and Lafarge, 2015).

##### ***Receiving the appropriate level of care***

Being cared for by experienced members of staff was greatly valued. Short staffing and being cared for by junior or inexperienced members of staff (who admitted their inexperience) was a cause of distress. Access to analgesia, particularly the correct dose of morphine, was important to women undergoing medical terminations. Continuity of care, ideally by the same midwife, was also very important. Healthcare professionals who were new to the case, had not read the notes, and who made inappropriate comments were a cause of distress. The consequences of poor communication, a lack of continuity of care, and unsuitable aftercare, included some women being referred to antenatal care, being contacted by children's services, not being visited by community healthcare professionals after the procedure, and having to cancel antenatal appointments themselves and 'feeling abandoned' (Fisher and Lafarge, 2015:77).

##### ***The role of healthcare professionals and support organisations***

Women valued information about the procedure which helped them prepare for the physical experience, the time it would take, psychological effects, and what would happen to the remains. Inconsistent information was a cause of distress, and the timing of information provision was not always appropriate (e.g., being asked about post-mortem consent while in labour). Empathetic care was very important and was not always given. A lack of understanding about women's circumstances and dismissals of the physical and emotional pain were causes of distress. Providing empathetic care is demanding on staff, and staff would benefit from receiving formal support themselves. Consistent signposting to support organisations is important, with women commenting that they would have liked to have been referred to support organisations earlier in the process. Support organisations alleviate a sense of isolation, and for some the information provided by support organisations was their only source of information (Fisher and Lafarge, 2015).

### ***Acknowledging women's particular circumstances***

Participants were keen for professionals to recognise the unique nature of TOPFA. This could include recognising that the pregnancy was wanted, that it was different to a miscarriage, and taking care with terminology – (e.g., being in tune with the woman as to whether to refer to a fetus or baby). Participants feared judgement and a high value was accorded to non-judgemental care from all professionals. In some cases where the decision for termination for fetal abnormality is made after the stage of viability, women may wish to have the option of fetal intracardiac potassium chloride so that the baby does not show signs of life at delivery (Fisher and Lafarge, 2015).

### ***Enabling women to make choices***

Women who had limited choices reported more negative experiences. Most women 'greatly valued being given choices, including whether to have the termination or not, the method of termination, the types and levels of analgesia, whether to spend time with the baby or not, and what to do with the baby's remains. For many women, these choices appear to give them a level of control over a situation most felt they had no control over' (Fisher and Lafarge, 2015: 80). The lack of choice over the termination method was a particular issue with some women unaware that they could have had a choice.

Although 75% of all second trimester abortions for indications not related to fetal abnormality are done surgically in the UK, only 16% of those for indications related to fetal abnormality are done surgically, the majority being performed medically (Lysus et al., 2013). Reasons for this include the facts that on average these terminations are performed at a later gestation, the pregnancies were generally wanted, and importance is attributed to the delivery of an intact fetus for post-mortem examination in TOPFA. In addition, vaginal birth offers reduced risk for the woman wishing to retain her fertility.

### **5.4.5 Timely provision of care**

Research shows most women have made the decision before they approach health professionals (Bloomer et al., 2018) and they experience delays as distressing. This can be of particular significance for women in rural areas where a clinic may only be weekly, may be far away, and accessing services presents financial and logistical challenges.

A study on provision for women from remote areas in Scotland found that the time between referral and assessment varied between 10 days and 3 weeks. Once women had made the decision, they wanted to complete the termination as soon as possible. Participants were aware that gestational age could alter the care received. The wait period was identified as a key problem and it was a cause of distress due to factors such as 'pregnancy-associated nausea, a wish to conceal the pregnancy, growing fear that the pregnancy would become evident to others in the woman's changing body shape, and concerns that they would begin to 'bond' with the pregnancy, despite certainty in their decision to terminate.' (Heller et al., 2016: 1687).

Timely provision of care should also be a factor when designing the model of service delivery. There is clear evidence that abortion services should be part of an integrated SRH service (Bloomer et al, 2018; Horgan et al, 2019; RCOG, 2019). The current situation where SRH services also dispense medication is ideal, but this will obviously not be the case in a GP led service where women must be provided with a prescription for medication which is then dispensed by a pharmacist.

## 5.5 Summary of new regulations

**Currently in Northern Ireland the legal framework provides for:**

- Registered medical professionals (doctors, nurses and midwives) to legally perform a termination. Abortions can be carried out in GP premises, and in HSC clinics and hospitals;
- Unconditional abortion services until the 12th week of pregnancy;
- Terminations before 12 weeks to be certified by a single registered medical professional, stating that they are of the opinion, formed ‘in good faith’ that the pregnancy has not exceeded its 12th week;
- Terminations after 12 weeks to be certified by two medical professionals who state that ‘in good faith’ one of the grounds has been met;
- Abortion services up to 24 weeks if the continuation of the pregnancy would involve a risk to the women’s physical or mental health greater than that of termination;
- Abortion services with no time limit in cases of severe fetal impairment or fatal fetal abnormality;
- Abortion services with no time limit if there is a risk of death or grave permanent injury to the pregnant person;
- Healthcare professionals with a conscientious objection are not required to participate in abortion treatment unless it is necessary to save the woman’s life or prevent grave permanent injury to her physical or mental health;
- A failure to comply with the requirements of the Regulations is a criminal offence punishable with a level five fine (up to £5000 in Northern Ireland). An intentional failure to comply with certification and notification requirements will be a level four fine (up to £2500 in Northern Ireland);
- Safe access (exclusion) zones have not been established as part of the Regulations.

## 5.6 Methods of procuring abortion

### 5.6.1 Medical abortion

Home self-management of medical abortion is effective and satisfactory for patients. A UK study with 44 women who had undergone medical abortion, at or under 63 days gestation, found that home self-management was the preferred option for most participants. Their first appointment at the clinic entailed vaginal self-administration of misoprostol, though some preferred a nurse to do this. Information from health professionals was crucial in ensuring participants’ comfort with home self-management. After the appointment, participants reported a clear sense of what was ‘normal’, though some participants were still unsure about ‘what expulsion would feel like, and what the pregnancy tissue would look like’ (Purcell et al., 2017: 2004).

Participants discussed being in pain whilst travelling home, passing the bulk of the pregnancy tissue and looking/not looking at it, the attitude of their partners/friends, and male partners’ feelings of helplessness or male partner preference for hospital care, even where this was not the woman’s preference. Some women preferred to be alone with telephone support on hand. For those who sought support, the reassurance provided by nurses was generally felt to be invaluable, particularly where experiences differed from what had been expected (Purcell et al., 2017: 2005). Participants were provided with a low-sensitivity urine pregnancy test to confirm termination 2 weeks after abortion.

The authors concluded that, although home self-management is the preferred option for most women, it does need to be conveyed as optional, and the availability of hospital care should also be clear. It is also important that health professionals communicate the potential for variation in experiences of medical abortion, striking ‘a delicate balance between the specific detail that (some) women want and the range of experiences that they may face (Purcell et al., 2017: 2006). Experiences of passing larger clots of pregnancy tissue was a significant and often surprising component of first trimester medical abortion for participants. This may be because health professionals have difficulty verbalising it, or it has not been highlighted to professionals as information women undertaking home self-management may want.



A 2011 US study comparing women who obtained a medical abortion by telemedicine or face to face physician visits concluded that service provision via telemedicine is effective and has high levels of acceptability for patients. Data was obtained for 223 telemedicine patients and 226 face-to-face patients. 99% of telemedicine patients and 97% of face-to-face patients had a successful abortion. 91% of all patients were very satisfied with their abortion, but telemedicine patients had higher odds of saying they would recommend the service to a friend. 25% of telemedicine patients said they would have preferred face-to-face communication. Less education, younger age and not having completed a pregnancy beyond 20 weeks were significantly associated with a preference for face-to-face communication (Grossman et al., 2011: 296).

A 2013 study of abortion provision using telemedicine in Iowa found that, after the introduction of telemedicine, women were less likely to have a second-trimester abortion in the clinic system. Further research is needed to determine if telemedicine reduces barriers to early abortion. Telemedicine enabled more clinics to provide abortion services, there was an increase in the use of medical abortion among women living in remote areas (suggesting improved accessibility), and satisfaction with clinic wait time was significantly higher among telemedicine patients. Telemedicine also possibly reduces associated costs such as childcare, time off work and travel costs (Grossman et al., 2013). Emerging data in the UK of over 50,000 cases indicates a shorter waiting time for telemedicine services of approximately 4.2 days (Aiken et al., 2020b).

Women in Northern Ireland have used telemedicine to self-manage early medical abortions outside the law, and outside the health care system, for over a decade prior to decriminalisation. The pills were obtained from feminist websites that provide detailed information on how to use the medication and what to expect. A number of studies found that much of their experience was similar to those who self-managed via the NHS but, particularly in the aftermath of prosecutions, criminalisation caused fear and the potential that medical assistance would not be sought if required (Horgan, 2019).

### 5.6.2 Second trimester abortions

Clinical studies have determined the importance to the woman of choice in the second trimester between surgical and medical methods; both are equally safe and effective (Grimes, et al., 2004; Kelly, et al., 2010; Say, et al., Westhoff, et al., 2003). This is supported by NICE who state that, “given the evidence that women preferred a choice of procedure, and the lack of evidence that either procedure is superior, the committee recommended offering women up to and including 23+6 weeks a choice (as long as it is clinically appropriate)” (NICE, 2019:43).

## 5.7 Interim provision of abortion in Northern Ireland

### 5.7.1 Early Medical Abortion

Following the passing of the Northern Ireland (Executive Formation etc) Act 2019, Doctors for Choice NI (DFCNI) began a process of clinical engagement to stimulate discussion around what legislative change would mean for women, clinicians and healthcare services in Northern Ireland. The first meeting, well-attended by obstetricians and gynaecologists from across the region, coincided with the timely publication of NICE guidelines on Abortion Care which provided clinical standards and a service framework to aspire to.

In September 2019, a roundtable discussion, jointly hosted by Access Research Knowledge (ARK) and DFCNI, was attended by obstetricians, gynaecologists and midwives, and facilitated conversations around how these services may be provided within Health and Social Care in Northern Ireland (HSCNI). This explored both the benefits and barriers to NHS provision, but concluded that provision within HSCNI was a viable and preferable option. This was further supported by Ulster University research on the views of healthcare professionals working in obstetric and gynaecology units which found that the majority were in favour of decriminalisation of abortion up until 24 weeks, with a significant proportion willing to provide care (Bloomer et al, 2021).

In December 2019, a second roundtable discussion was attended by SRH and Genito-Urinary Medicine (GUM) doctors, nurses and service managers from across Northern Ireland. It aimed to explore the possibility of an integrated SRH model of care in

Northern Ireland. Subsequently published as an ARK Policy Brief, it was instrumental in allowing clinicians to consider how EMA may be provided within existing SRH services, and led to a DFCNI visit to the Sandyford service in Glasgow. DFCNI, in collaboration with Ulster University, held a conference 'Shaping the future of women's sexual and reproductive health in NI' on the 17th January 2020. This focussed on the commissioning, development and implementation of a Northern Ireland abortion service and brought together healthcare professionals, political representatives, academics and experts in the field of abortion care from the UK and Ireland. It acted as a catalyst in the formation of NIACT which would lead the subsequent rapid implementation of EMA services in response to travel restrictions imposed due to the Covid-19 pandemic.

Whilst EMA services were ready to commence on the 2nd of April, HSC trusts were informed that this would need a formal direction from the DOH. The Chief Medical Officer wrote to the NIRCOG chair, and the five HSC trusts on the 9th April 2020 stating that clinicians could legally provide the full range of abortion care. Within a couple of weeks, three of the five HSC trusts had started treatments and by mid-June there were clinics in each trust. Belfast staff provided treatment for women from Southern and South Eastern Trusts until their own service was established. Most of the willing staff had previous experience in abortion care from training elsewhere in the UK, and online training resources were utilised.

Clinic protocols, policies and patient information leaflets were produced in line with RCOG/NICE guidelines on Abortion Care. Templates for telephone consultations and treatment were designed for the online consultation system Lillie Blythe.

A referral pathway was established in partnership with ICNI who agreed to provide the Central Access Point, enabling people across Northern Ireland to contact a single telephone number where they can also access non-directive information, pregnancy choices counselling if requested, and referral into the EMA service within our trusts. Seamless access to follow up support is also available via ICNI's post pregnancy counselling service.

In addition, ICNI undertakes all safeguarding with girls aged between 13 and 15 years-old and assesses their ability to consent to medical treatment using the Fraser guidelines. They also conduct safeguarding assessments with clients who disclose domestic or sexual abuse.

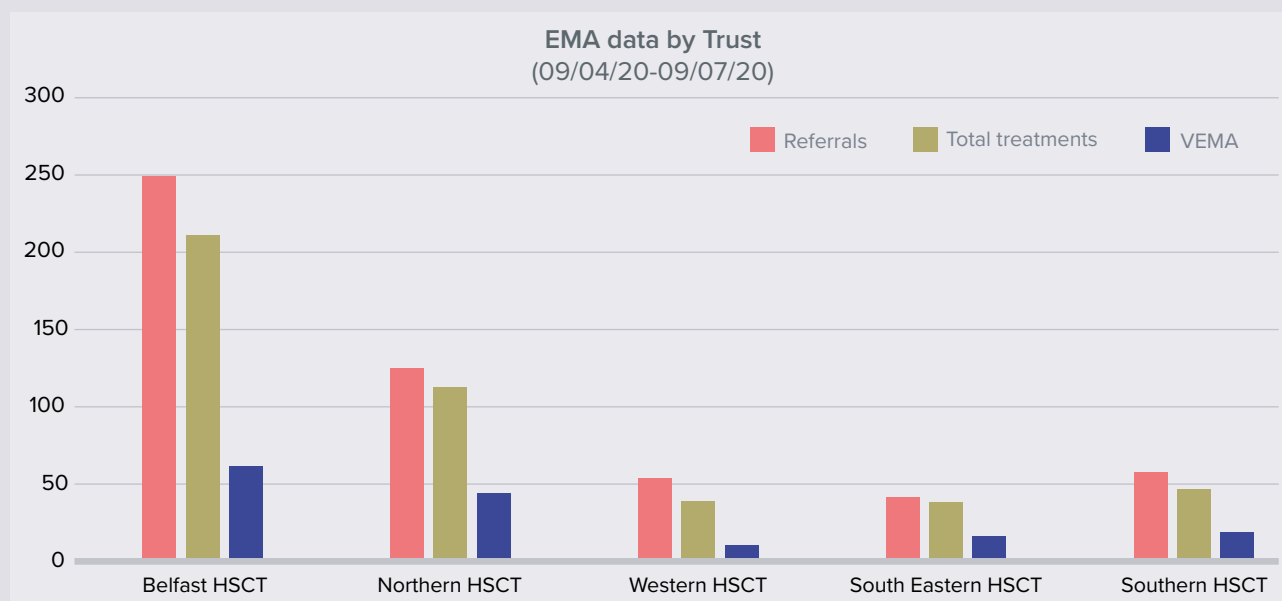
ICNI refers daily to each trust via secure email, and a telephone consultation is offered within a few days and, where appropriate, a time is then agreed to attend for treatment. Clients value the services provided by ICNI as feedback from service users highlight:

So professional and instantly made me feel at ease and reassured.

Made me feel relaxed and gave all the information I needed.

Really informative and explained the whole process thoroughly.

**TABLE 3**  
**Experience of the first three months**



(Source Kirk et al., 2021), VEMA refers to very early medical abortion, under 6 weeks.

Kirk et al., (2021) reported on the establishment of the first 3 months of the interim service. During this time a total of 572 clients contacted the ICNI Central Access Point; 524 women had a consultation, the majority receiving EMA treatment.

The Belfast Trust receives the largest number of referrals. In the first three months this equated to 252 women (48%). Of these, 212 (84%) received EMA treatment. The average waiting time was 1.58 days and the average time between consultation and treatment was 0.81 days (Kirk et al., 2021).

The average age of women undergoing treatment in Belfast was 28.9 years. 126 (59.4%) women already had children (Kirk et al., 2021). Of these, 1 in 4 women had given birth in the previous 18 months; 1 in 6 in the previous 12 months. Inadequate birth spacing accounts for approximately ten abortions per month in the Belfast Trust, highlighting further the significant unmet need for postpartum contraception.

During the first nine months of the interim service, 1346 referrals were made, 1299 consultations occurred, and 1160 women received treatment.

Regionally, over 30% of treatments occur at less than six weeks gestation, which is a significant advantage of not having to arrange travel and treatment in England. Known as very early medical abortion (VEMA), this is safer, associated with less pain and bleeding and lower complication and failure rates. A fairly recent concept in the UK, it allows for treatment without evidence of an intrauterine pregnancy on ultrasound.

If clinically indicated, ultrasound scans are available in some of the clinics or referral is made to an early pregnancy service.

Contraception is offered at all clinics, and some offer immediate subdermal implant insertion and fast track appointments for intrauterine device insertion once successful treatment is confirmed by a negative pregnancy test. The uptake of LARC is high at over 50%.

Feedback from a patient survey has been exceptionally positive. Patients are delighted to access the service locally and be offered effective contraception:

What you are doing in lockdown is perfect. Discreet, essential service. Needs to continue.

Great to have in NI. Should be available in NI in long term.

Great, well supported, friendly, non-judgemental.

The staff made it so much easier. I felt very comfortable and safe.

Really thankful – really impressed with service. Thank you.

An advantage of the pandemic has been the absence of anti-abortion protests outside the clinics, but when lockdown was eased clinics began to be targeted. This is likely to become a significant issue without the establishment of safe access zones.

There is no surgical option available for those who prefer or need it for medical reasons, which is contrary to quality statement 2 of NICE Quality Standard (2021), and no formal service at gestations above 10 weeks. Many, often vulnerable, women still need to travel to England to access abortion care.

A downturn in contraception services due to the Covid pandemic, freed time for SRH professionals to develop the EMA service. However, the lack of designated staff and funding has made the service fragile. As the impact of Covid diminished in the autumn of 2020 and routine contraceptive services resumed, a lack of staff led the Northern Trust to withdraw their EMA service at the beginning of October. During the thirteen-week suspension there were 96 people who self-referred into the central access point provided by ICNI from the Northern Trust, 89 of whom requested an abortion and there was no local EMA service to which they could be referred. Other Trusts were unable to accommodate these women who then became reliant upon on-line resources and BPAS services in England until the service was restored on 4th January 2021. On 5th January 2021, the South Eastern Trust suspended its EMA service due to a failure to secure maternity leave cover for the lead clinician. The service was subsequently reinstated on 1st February 2021. During the suspension 26 people living within this Trust area self-referred into the central access point, 24 of whom requested access to abortion. An approval order allowing at home use of mifepristone, ideally up to 12 weeks gestation, would improve the ongoing feasibility of this interim service by reducing pressure on the existing resources.

To date neither the Northern Ireland Executive, the Department of Health Northern Ireland, or the HSCB have established a clear commissioning plan to establish and fund a permanent and comprehensive service. Urgent action is required to break the deadlock.



### 5.7.2 Anti-abortion organisations

The lack of adequate signposting to the central access point for abortion services in Northern Ireland has resulted in some women inadvertently seeking support from organisations claiming to offer services to women in need of abortion, but who have a distinctly anti-abortion agenda. A number of these women have had their care complicated by delaying tactics or by being given inaccurate information by a sonographer concerning the gestation of their pregnancy.

The Advertising Standards Authority can impose sanctions where advertising falls short of the Advertising Code. This, however, does not go far enough to safeguard those who find themselves unwittingly using an anti-abortion service. The Department of Health should raise public awareness regarding local legal abortion services and ICNI as the regional central access point to mitigate the risk of women inadvertently attending an anti-abortion clinic.

There is no legal requirement to hold a recognised ultrasound qualification in order to practice as a sonographer in the UK. Indeed, as sonography is not recognised as a profession by the Health and Care Professions Council (HCPC), there is no possibility of individuals practicing as sonographers to be statutorily registered or regulated. Under the current legislation, independent clinics are only required to register with the RQIA if they employ a doctor who works solely in the independent sector. This absence of regulatory oversight by the RQIA represents a significant deficit in the legislation to ensure the safety and wellbeing of women.

### 5.7.3 Abortion after 10 weeks for non-fetal medicine reasons

No trust has a formal referral pathway or service post 9 weeks and 6 days gestation. There are logistical reasons for this, as the regulations suggest that for medical termination, misoprostol should be taken in an appropriate medical facility with access to surgical or medical procedures. A few ad hoc medical terminations have been performed on a case-by-case basis in most trusts, after discussion with senior management.

Surgical options are more likely to be required or requested after 10 weeks gestation, but should also be available as a choice for women at lower gestations, as per NICE guidance. These procedures are generally performed within hospital Gynaecology departments. Lack of commissioning and ongoing pressures within existing gynaecology services have hindered the development of such a service within any Trust. Additional training may be required for some gynaecologists.

Clients contacting ICNI who are over 10 weeks gestation are given information regarding services in Ireland and Great Britain, including details of the central booking system provided by BPAS which is currently funded by the Government Equalities Office in England and Wales. Others who cannot access the current EMA service, due to gestational age, turn to Alliance for Choice (especially if referred to ICNI from AfC), for assistance via WoW or WHW if under 12 weeks.

## 5.8 Counselling services

### 5.7.4 Termination of Pregnancy for Fetal Abnormality (TOPFA)

Abortion for reasons of fetal abnormality differs from that of abortion performed for other reasons. In the vast majority of cases, there has been a much wanted pregnancy with all the associated hopes, dreams and expectations of parenthood. As such, abortion in these circumstances tends to represent a particularly devastating loss for both the woman and her family.

For a long time, the experiences of women undergoing abortion for reasons of fetal abnormality in Northern Ireland has lagged behind the experiences of women in the rest of the UK. First trimester screening and Non Invasive Prenatal Testing (NIPT) are not routinely offered in Northern Ireland and therefore most fetal anomalies are diagnosed following the anomaly scan between 19 and 20 weeks, which in many cases is later compared to the rest of the UK. This results in time pressures in undertaking diagnostic and confirmatory tests and hence in decision making. It also results in abortions occurring at a later gestational age, which can carry a greater risk of complications and can be even more distressing for the woman and her family.

The service should be adequately resourced to ensure that cases referred to the Regional Centre for Fetal Medicine are seen in a timely manner, facilitating timely investigations, counselling and treatment options in accordance with RCOG Guidance (RCOG, 2010). There should be good access to post-mortem examinations, follow-up counselling and involvement of the multidisciplinary team where appropriate. All trusts should have adequate bereavement counselling to support women and their partners at this difficult time.

The UK National Screening Committee recommendations (PHE, 2019) for first trimester screening should be introduced so that women in Northern Ireland have equitable care and, for those who decide to terminate the pregnancy, to allow this to happen at an earlier gestational age.

The RCOG recommends that women should have access to objective information and, if required, counselling and decision making support about their pregnancy options. However, women who are certain about their decision to have an abortion should not be subjected to delay or compelled to have counselling (RCOG, FSRH, and BSACP, 2019).

NICE also recommends availability of post-abortion counselling if requested (NICE, 2019). ICNI provides both pregnancy choices and post pregnancy counselling. They have 30 years' experience of supporting those who have experienced complex emotions as part of being pregnant, and recommend that all counsellors have a recognised counselling qualification to at least diploma level, a minimum of 250 hours of supervised counselling practice, and are accredited by a professional counselling and psychotherapy body or are working towards accreditation and receive monthly clinical supervision.

Pregnancy loss, through miscarriage, stillbirth or abortion, is shrouded in secrecy, exacerbating a sense of isolation for those who have experienced such loss. Stigma related to abortion remains pervasive despite lawful access to services from 31 March 2020. This highlights the need for easily accessible specialised counselling for those who request support.

The coronavirus pandemic has led to an increase in the use of virtual consultations within healthcare. Telephone counselling has ensured that support remains accessible for those who are shielding, have dependents or cannot travel. It has also been shown to be effective and to significantly improve attendance rates.

## 5.9 Recommendations

The CEDAW Optional Protocol Inquiry Report recommended that the State:

*86 (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;*

In September 2019, NICE published comprehensive abortion care guidelines with the aim of improving the organisation of services and making them easier for women to access. Detailed recommendations on conducting abortions at different gestational stages are also included to ensure that women get the safest and most effective care possible. These are supplemented by the Coronavirus infection and abortion care guidelines published by RCOG (2020). Both documents should be adhered to regarding policy development and clinical practice, and should be supplemented with recommendations particular to Northern Ireland.

**NIACT therefore recommends the following:**

- 22.** There should be a funded regional central access point to which women can self-refer, and to which they are directed by a public health information campaign.
- 23.** There should be an adequately resourced framework to ensure availability of pregnancy choices counselling if requested.
- 24.** Commissioners should ensure that service providers have adequate capacity and resources to ensure waiting times do not exceed one week.
- 25.** The option for telemedicine abortion care should be made available within Northern Ireland, as in the rest of the UK and the Republic of Ireland.
- 26.** Abortion services should be part of an integrated sexual and reproductive health service which provides a seamless pathway from the community/primary care sector to hospital based obstetric and gynaecology services, and also ensures optimal access to contraception.
- 27.** There should be a commissioned surgical abortion service to enable choice of method; this will require some investment in training.
- 28.** The UK National Screening Committee recommendations for first trimester screening should be introduced so that women in Northern Ireland have equity with women in other parts of the UK and, for those who choose abortion, that this can happen at an earlier gestational age.
- 29.** Services should be adequately resourced to ensure that there is the capability to provide abortion within Northern Ireland at all gestations.
- 30.** There should be access to post abortion counselling. Bereavement counselling should be extended to include all pregnancy loss.
- 31.** There should be training for all healthcare professionals, administrative and support staff engaged in abortion services to ensure non-judgmental communication with service users.
- 32.** There should be a public information campaign about abortion to counteract anti-abortion organisations posing as abortion providers.
- 33.** There should be legal provision for exclusion zones to protect women and staff from intimidation and harassment when seeking access to information, support or services.
- 34.** Suitable premises for abortion should be identified and secured for each trust.
- 35.** Interpreter services are required for all stages of service provision.
- 36.** Pathways should be developed for each trust to easily obtain healthcare numbers for those not already registered with the NHS.



## 6. Conscientious Objection in Abortion



## 6 Conscientious objection in abortion

International human rights bodies do not recognise a right to conscientious objection for healthcare providers. However, they do recognise that some countries permit healthcare staff to exercise this right. In such cases, human rights treaty monitoring bodies have called for limitations on their use in order to ensure that healthcare providers' personal beliefs do not hinder access to services. In 2016 the UN Committee on Economic, Social and Cultural Rights stated:

Where healthcare providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought and that it does not inhibit the performance of services in urgent or emergency situations.

## 6.1 Statutory right to conscientious objection

The statutory right to conscientious objection in the provision of abortion services in Great Britain is contained within Section 4 of the Abortion Act 1967, which states that:

No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: provided that in any legal proceedings the burden of the proof of conscientious objection shall rest on the person claiming to rely on it.

The definition of ‘treatment’ was clarified in the UK Supreme Court in 2014 in the case of *Greater Glasgow Health Board v Doogan and Another* when the Court found (unanimously) that it:

...would agree with the appellants (*Greater Glasgow Health Board*) that the course of treatment to which the petitioners may object is the whole course of medical treatment bringing about the termination of the pregnancy. It begins with the administration of the drugs designed to induce labour and normally ends with the ending of the pregnancy by delivery of the foetus, placenta and membrane. It would also, in my view, include the medical and nursing care which is connected with the process of undergoing labour and giving birth, - the monitoring of the progress of labour, the administration of pain relief, the giving of advice and support to the patient who is going through it all, the delivery of the foetus, which may require the assistance of forceps or an episiotomy, or in some cases an emergency Caesarian [sic] section, and the disposal of the foetus, placenta and membrane. In some cases, there may be specific aftercare which is required as a result of the process of giving birth, such as the repair of an episiotomy.

“Treatment” therefore begins with the administration of drugs and ends with the “expulsion of the products of conception” so the conscience clause does not cover making bookings or providing aftercare for patients who have undergone a termination, nor does it cover eg. ordering or fetching a drug before it is administered. “Participating” is limited to direct participation in the treatment involved. It does not cover administrative and managerial tasks, such as allocating ward resources and assigning staff. Nor does it cover supervisory duties which are concerned with ensuring that general nursing care of an appropriate standard is provided to women undergoing a termination.

The Supreme Court also found that in an emergency the woman’s right to life and health (physical or mental) takes precedence over the right to conscientious objection:

These conclusions are supported by the exception in section 4(2), (*of the 1967 Abortion Act*) which provides that “the right of conscientious objection does not affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman. One would expect this duty to cover any medical, midwifery or nursing care during the process of termination and delivery which was necessary for those purposes.

## 6.2 The impact of the Northern Ireland (Executive Formation etc) Act 2019

The Northern Ireland (Executive Formation etc) Act 2019 aimed to implement some of the recommendations of the CEDAW report, decriminalising abortion and making it more easily available to women in Northern Ireland. Interestingly, the Act does not confer (or require the Secretary of State to confer) any statutory right to conscientious objection. The right is, however, provided by Regulation 12 of the new Abortion (Northern Ireland) Regulations, 2020 which states that:

**A person is not under a duty to participate in any treatment authorised by these Regulations to which the person has a conscientious objection.**

This applies “whether the duty arises under contract or under any statutory or other legal requirement” and does not affect “any duty to participate in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health of a pregnant woman or girl.”

The Explanatory Memorandum to the Regulations goes on to clarify what constitutes ‘treatment’ using the Supreme Court ruling and confirms that the statutory protection does not extend to “the ancillary, administrative and managerial tasks that might be associated with that treatment”. The Regulations (and the explanatory Memorandum) also confirm that, as in Great Britain, the burden of proof of conscientious objection in any legal proceeding rests on the person claiming to rely on it.

## 6.3 Contractual right to conscientious objection

In addition to the statutory right to conscientious objection contained within the 1967 Abortion Act and the 2020 Abortion (NI) Regulations, some doctors also have a contractual right that enables them to refuse to provide abortion services. This is especially true in the case of GPs, including GPs in Northern Ireland. As independent contractors, their contract is negotiated with the DOH and this currently contains a provision to opt out of providing abortion services. Following the introduction of the UK wide new GP contract in 2003, the Standard General Medical Services Contract (NI) - March 2004 included a contractual right for GPs to opt out of providing sexual health services, including contraceptive and abortion services.

## 6.4 Professional regulatory responsibilities

### 6.4.1 The General Medical Council (GMC)

**The GMC's *Good Medical Practice* (2013) states that:**

You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right... If it is not practical for a patient to arrange to see another doctor you must make sure that arrangements are made for another suitably qualified colleague to take over your role.

### 6.4.2 The Nursing and Midwifery Council (NMC)

**Para 4.4, of the *NMC Code* (2015) which applies to midwives and nurses states:**

You must tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care.



## 6.5 The professional bodies

### 6.5.1 The Royal College of Obstetricians and Gynaecologists (RCOG)

**The RCOG document ‘The Care of Women Requesting Induced Abortion’, Nov 2011, says:**

- Doctors who have a conscientious objection to abortion must tell women of their right to see another doctor;
- NHS GPs who have contracted to provide contraceptive services and who have a conscientious objection to abortion must, where appropriate, refer women promptly to another doctor;
- Doctors should not share their private moral views with patients unless explicitly invited to do so; and
- Doctors should ensure that any manifestation of their religious or cultural beliefs (such as clothing or other religious icons) do not impact negatively upon the therapeutic relationship.

### 6.5.2 The Royal College of General Practitioners (RCGP)

**The RCGP in its *Position Statement on Abortion*, 2012, recognises that:**

GPs will have many views on abortion, including some who will have a personal belief against abortion, which could potentially influence their attitude to, and management of, patients requesting an abortion. It is important that GPs recognise their duties and obligations in this area, which can raise personal ethical issues for a practitioner” and goes on to clarify that “The Abortion Act 1967 provides a right of conscientious objection which allows doctors and nurses to decline to participate in arranging or performing an abortion. This right is limited only to the active participation in an abortion where there is no emergency with regard to the physical or mental health of the pregnant woman. Doctors cannot refuse to provide emergency and other medical care for these women.

### 6.5.3 The Royal College of Midwives (RCM)

**The RCM in its position statement on abortion (2014) says that:**

- All midwives should be prepared to care for women before and after a termination in a maternity unit under obstetric care;
- The rights of midwives or maternity support workers to hold a position of conscientious objection, as described in the Abortion Act (1967), should be recognised but should only apply to direct involvement in the procedure of terminating pregnancy; and
- Access to safe abortion services is a fundamental healthcare issue for women wherever they live.

### 6.5.4 The Royal College of Nursing (RCN)

**The RCN states in *Guidance Conscientious Objection (Termination of Pregnancy)*, 2019:**

If you have a conscientious objection to termination of pregnancy (TOP) you should discuss the issue with your manager and confirm your objection in writing. The issue should be dealt with sensitively, so that nurses, midwives and patients/clients can establish a successful therapeutic relationship.

### 6.5.5 The Faculty of Sexual and Reproductive Healthcare (FSRH)

**The FSRH states in its *Principles of Care* (2017c:5) that practitioners are required:**

To take personal responsibility for ensuring that the patient is provided with appropriate care and treatment, including a prescription, without delay and

To be open with colleagues and employers about any personal beliefs which could compromise care or outcomes in order that service provision and planning can accommodate this.

## 6.6 The trade unions

There are 700,000 trade union members in Ireland (North and South), over 50% of whom are women. In 2008 the Trade Union Congress (TUC) in the UK unanimously passed a motion supporting a woman's right to choose. This was re-affirmed in 2014 at the TUC Women's Conference, and in July 2017 The Irish Congress of Trade Unions (ICTU) supported a motion calling for repeal of the 8th Amendment to the Irish Constitution, demanded that reproductive rights in Ireland should meet international human rights standards, and called for the decriminalisation of abortion. The 8th Amendment was repealed in 2018, and abortion has now also been decriminalised in Northern Ireland.

In 2017 several ICTU affiliated healthcare trade unions commissioned a report, "*Abortion as a Workplace Issue*" to obtain some insight into how trade union members in Ireland viewed abortion in the workplace (Bloomer et al., 2017).

The report found that abortion is a workplace health and social care issue that affects both women and their colleagues in the workplace. It was clear that less than 10% of respondents believed that abortion should not be available in any circumstance while almost 90% felt that abortion should be decriminalised.

The report also examined the role of those working in abortion care, and found that those working in this area are mainly women who will have many and varied life experiences which might influence their wish to opt out of providing abortion care. These include women who may have had an abortion, women who may not have had an abortion but wished they had been able to have one, including women who were forced to have their baby adopted, women who have never been able to have any children of their own, women who are undergoing fertility treatment, women who have had a previous miscarriage, stillbirth or neonatal death - or indeed lost a child at any age and, of course, those with a religious or moral objection.

## 6.7 Providing notification of conscientious objection

The right to conscientious objection is balanced by the requirement to preserve the woman's life and physical/mental health, so it is not an absolute right. The right to conscientious objection is also limited to participation in the act of abortion and will not apply to the care that women receive before or after the procedure. Staff cannot, for example, refuse to serve a woman a meal, refuse to process related paperwork, or refuse to provide nursing or other care to her either before or after the procedure.

In Great Britain, abortion services are mainly provided by charities that are funded by the Government, and those who choose to work in this area waive their right to conscientious objection. Some services (especially in Scotland) are, however, provided in hospitals where staff are required to notify their manager of their intention to avail of the conscientious objection clause before they go to work in e.g., a labour ward or operating theatre. This prevents an element of judgement from creeping in such as, "I approve of this woman's reason for having an abortion so I'm happy to care for her; however, I don't approve of that woman's so I won't care for her" and ensures that the objection is to the procedure and not the individual woman's reasons for deciding to terminate a pregnancy.

In order to ensure that a full range of services is available for women, it is essential that they are planned and managed in a way that accommodates an employee's right to opt out of providing hands on treatment whilst at the same time ensuring a safe and sustainable service for women.

Given the easy access to pregnancy testing kits, many women now know at an early stage that they are pregnant, and some will contact their GP in relation to accessing abortion. This service could be easily and widely available within the Primary Care sector. Ideally this would require GP practices to make known their willingness to provide abortion services before a woman goes to see them, perhaps by stating this on the practice website and advising ICNI of their position.

Within SRH and hospital services, there are medical, nursing and midwifery staff who may wish to opt out of providing abortion care. Each trust should maintain an up-to-date list of those with a conscientious objection so the views of employees are respected when planning service delivery. This information would be kept by professional leads, and not the Human Resources department. Staff members' views may alter over time and, in this case, the onus should be on the individual staff member to notify their manager so that the list can be amended.

All notifications should be in writing as this protects both the employee and the employer. If the employee was ever called upon to justify their position in any professional or legal process, (including Industrial Tribunals), they would have a record of having notified their employer of their views. It also helps the employer to have a written record of all staff who wish to exercise their right to conscientious objection.

## 6.8 Recommendations

It is necessary for the Department of Health to ensure provision for conscientious objection which follows the recommendations of the regulators, and the relevant professional organisations.

**NIACT therefore recommends:**

- 37** Training in conscientious objection should be provided for all HSC and primary care staff working in SRH and maternity services, including professionally regulated clinical staff, managers, administrative and other support staff.
- 38** We recommend that professional leads within the relevant departments should keep a secure record of the position of their staff with regard to conscientious objection to allow for service planning and delivery.

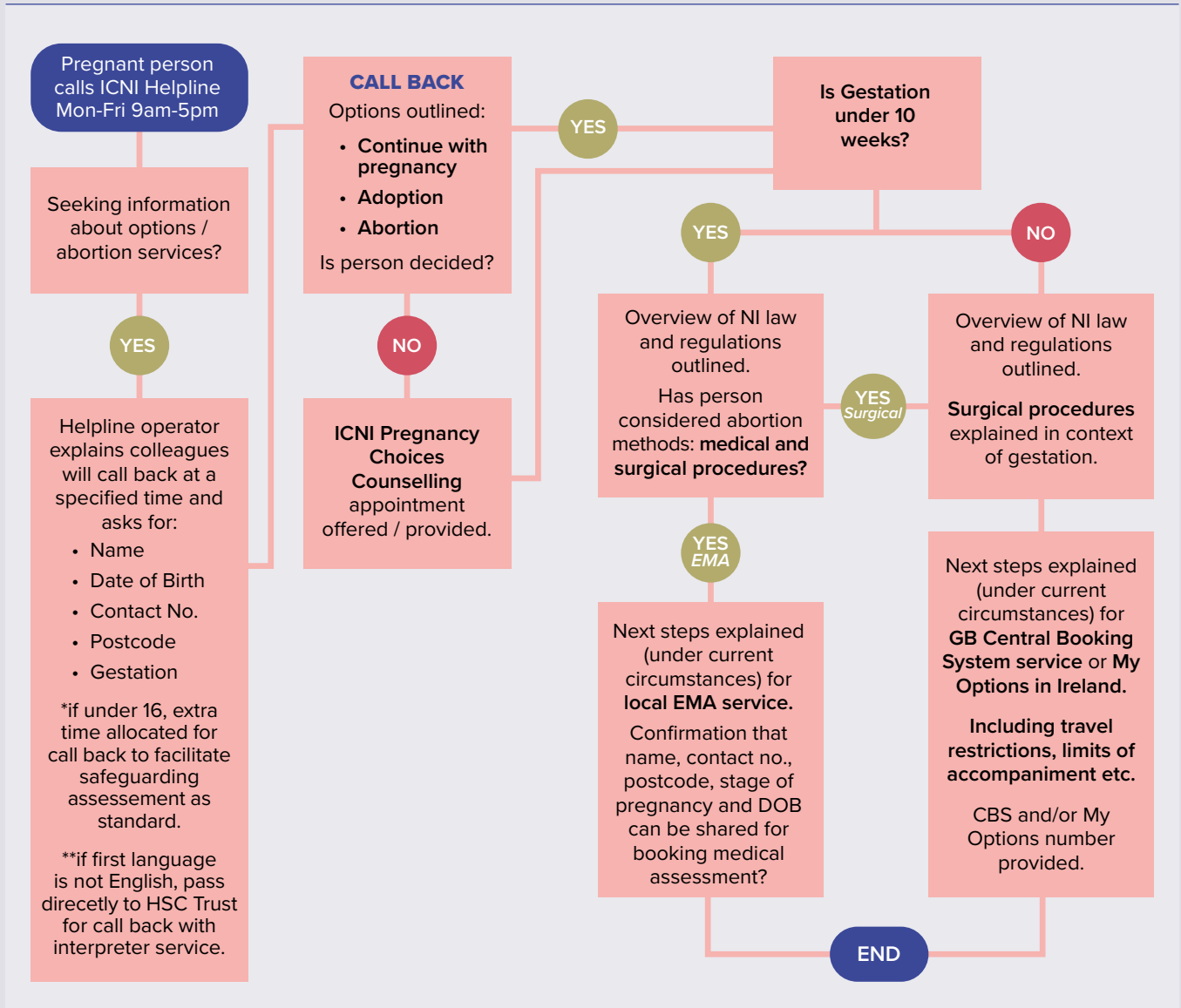




# 7. Appendices

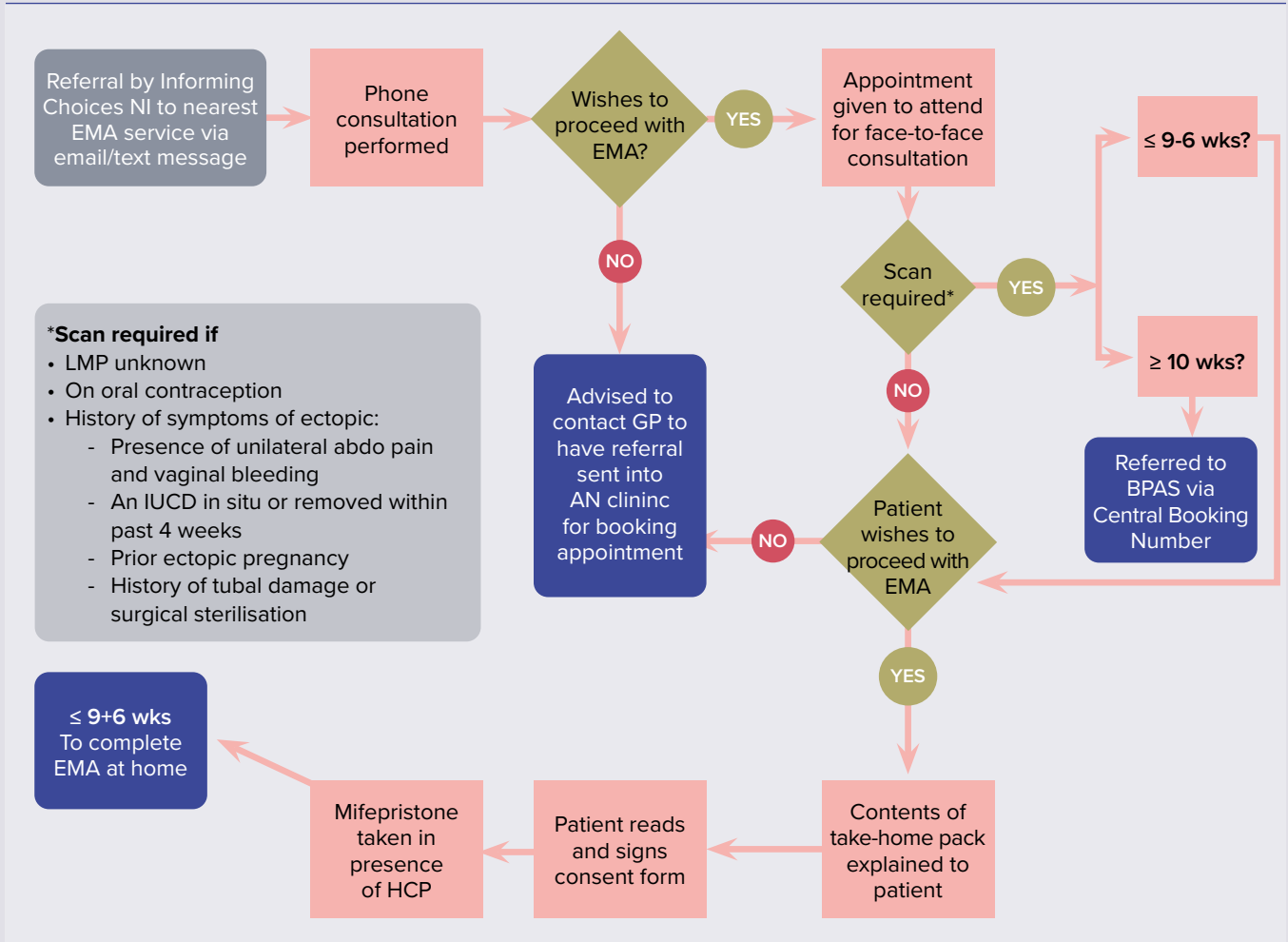
# Appendix 7.1 Referral Pathway

Central Access Point



## Appendix 7.2 Clinical Pathway

Clinical Pathway/Process Map for those women referred by Informing Choices (ICNI)



## Appendix 7.3 Forms

### (1) Certificate of Opinion

IN CONFIDENCE  
CERTIFICATE OF OPINION

**ABORTION (NORTHERN IRELAND) REGULATIONS 2020**

Not to be destroyed within three years of the date of the termination

To be retained by the medical professional who terminated the pregnancy

#### 1. CERTIFYING MEDICAL PROFESSIONAL/S

##### A. FIRST CERTIFYING MEDICAL PROFESSIONAL (TO BE COMPLETED IN ALL CASES)

Name: I,

---

(Name and qualifications of professional in block capitals) of

---

(Permanent\* address of professional)

Have/have not seen/and examined (delete as appropriate) the pregnant woman to whom this certificate relates.

##### B. SECOND CERTIFYING MEDICAL PROFESSIONAL –

NOT required for terminations under ground A (reg 3) or G (reg 5)

Name: I,

---

(Name and qualifications of professional in block capitals) of

---

(Permanent\* address of professional)

Have/have not seen/and examined (delete as appropriate) the pregnant woman to whom this certificate relates. I/ We (delete as appropriate) hereby certify that I am/we are (delete as appropriate) of the opinion, formed in good faith, that in the case of

---

(Health and Care number (NOT NAME) of pregnant woman)

\*: *to be interpreted as permanent work-related address of practitioner*



(tick as appropriate)

- A** (regulation 3) the pregnancy has not exceeded 11 weeks + 6 days
- B** (regulation 4) that the pregnancy has not exceeded 23 weeks + 6 days and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman
- C** (regulation 6(a)) that termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman
- D** (regulation 6(b)) that the continuance of the pregnancy would involve risk to the life of the pregnant woman which is greater than if the pregnancy were terminated
- E** (regulation 7(1)(b)) that the condition of the fetus is such that if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled
- F** (regulation 7(1)(a)) that there is a substantial risk that the condition of the fetus is such that the death of the fetus is likely before, during or shortly after birth

**EMERGENCY ONLY**

- G** (regulation 5) that the termination is immediately necessary to save the life of the pregnant woman or prevent grave permanent injury to the physical or mental health of the pregnant woman

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case unless in the case of an emergency only (ground G (regulation 5)) this is not reasonably practicable, in which case this certificate must be given not later than 24 hours after the termination.

Signed

\_\_\_\_\_

Date

\_\_\_\_\_

Signed

\_\_\_\_\_

Date

**(2) Notification of Abortion**

**ABORTION NOTIFICATION  
THE ABORTION (NORTHERN IRELAND) REGULATIONS 2020  
FORM FOR NOTIFICATION (NORTHERN IRELAND)**

This form is to be **COMPLETED BY THE PRACTITIONER TERMINATING THE PREGNANCY** and sent within 14 days of the abortion, marked 'OFFICIAL-SENSITIVE'

by email to: [cmooffice@health-ni.gov.uk](mailto:cmooffice@health-ni.gov.uk)

or in a sealed envelope to:

**Chief Medical Officer**

Department of Health

Castle Buildings

Stormont Estate

Belfast

Antrim

BT4 3SL

USE BLOCK CAPITALS AND NUMERALS FOR DATES THROUGHOUT

**1. MEDICAL PROFESSIONAL TERMINATING THE PREGNANCY**

NAME: I,

---

GENERAL MEDICAL COUNCIL (GMC) REGISTRATION NUMBER OR NURSING AND MIDWIFERY COUNCIL (NMC) REGISTRATION NUMBER:

---

PERMANENT\* ADDRESS of

---

Hereby give notice that I terminated the pregnancy referenced in this form and to the best of my knowledge the information on this form is correct.

## 2. CERTIFICATE OF OPINION GIVEN UNDER REGULATION 9

1. NAME OF CERTIFYING PROFESSIONAL  
(to be completed in all cases)

---

PERMANENT\* ADDRESS OF CERTIFYING  
PROFESSIONAL

---



---

GMC / NMC REGISTRATION NUMBER  
OF CERTIFYING PROFESSIONAL

---

Did the professional named at 1 certify that they saw  
the patient before giving the certificate?  
(tick appropriate box)

Yes

No

2. NAME OF SECOND CERTIFYING PROFESSIONAL  
(to be completed for terminations under grounds B,  
C, D, E, F - regulations 4, 6, or 7)

---

PERMANENT\* ADDRESS OF CERTIFYING  
PROFESSIONAL

---



---

GMC / NMC REGISTRATION NUMBER  
OF CERTIFYING PROFESSIONAL

---

Did the professional named at 2 certify that they saw  
the patient before giving the certificate?  
(tick appropriate box)

Yes

No

*\*: to be interpreted as permanent work-related address of practitioner*

## 3. INFORMATION ABOUT THE PATIENT WHOSE PREGNANCY WAS TERMINATED

a) Health and care number

---

b) age of patient

---

c) postal district or place of residence in UK

---

d) place of residence outside of UK

---

e) gestation estimated at  weeks

f) method of estimation (tick as appropriate)

LMP       Ultrasound       Other

g) ethnicity (if disclosed)

---

h) marital status (if disclosed)

---

i) Number of previous:

livebirths       stillbirths

miscarriages       terminations

#### 4. NON-SURGICAL TERMINATION

a) Date of treatment with Mifepristone (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

b) Place of treatment with Mifepristone

---

c) Date of treatment with Misoprostol (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

d) Place of treatment with Misoprostol

---

e) Date termination is confirmed (if known) (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

f) Details of other agents used and date of administration (if appropriate)

---

g) The date of discharge if overnight stay required (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

#### 5. SURGICAL TERMINATION

a) Name and address of place where termination is carried out

---

b) Date of surgical termination (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

c) Method of surgical termination

---

d) Was feticide used? (tick if applicable)

Yes

No

e) Date of admission / date of discharge if different to (b) \_\_\_/\_\_\_/\_\_\_



## 6. GROUNDS

The certified ground(s) for terminating the pregnancy stated on the A(NI)1 certification of termination were (tick as appropriate):

- A** (regulation 3) the pregnancy has not exceeded 11 weeks + 6 days
- B** (regulation 4) that the pregnancy has not exceeded 23 weeks + 6 days and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnancy woman.

Is the termination on grounds of mental health?      Yes       No  (tick if applicable)

If on ground other than mental health state the main medical condition(s)

---

- C** (regulation 6(a)) that termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Is the termination on grounds of mental health?      Yes       No  (tick if applicable)

If on grounds other than mental health state the main medical condition(s)

---

- D** (regulation 6(b)) that the continuance of the pregnancy would involve risk to the life of the pregnant woman which is greater than if the pregnancy were terminated.

State the main medical condition(s)

---

- E** (regulation 7(1)(b)) that the condition of the fetus is such that if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled.

State the primary fetal abnormality and any other fetal abnormalities diagnosed

---

State the method/methods of diagnosis used

Amniocentesis       Ultrasound       Chorionic Villus Sampling       Other (specify)

- F** (regulation 7(1)(a)) that there is a substantial risk that the condition of the fetus is such that the death of the fetus is likely before, during or shortly after birth.

State the primary fetal abnormality and any other fetal abnormalities diagnosed

---

State the method / methods of diagnosis used

Amniocentesis       Ultrasound       Chorionic Villus Sampling       Other (specify)

**7. EMERGENCY ONLY** (regulation 5)

**G** that the termination is immediately necessary to save the life of the pregnant woman or prevent grave permanent injury to the physical or mental health of the pregnant woman.

State the main medical condition(s)

---

**8. SELECTIVE TERMINATION**

Was this a selective termination?      Yes       No  (tick if applicable)

The original number of fetuses

---

The number of fetuses remaining

---

**9. CHLAMYDIA SCREENING**

Was the patient offered chlamydia screening?      Yes       No  (tick if applicable)

**10. COMPLICATIONS**

None       Haemorrhage       Uterine Perforation       Sepsis

Other (specify)

---

*\*Do not enter an evacuation of retained products of conception as a complication*

**11. DEATH OF WOMAN**

In the case of the death of the patient, specify

(i) Date (DD/MM/YYYY) \_\_\_/\_\_\_/\_\_\_

(ii) Cause of death

---

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## Appendix 7.5 NIACT Membership List

- 1** Dr Ralph Roberts (*Chair*), Consultant Obstetrician and Gynaecologist, SEHSCT
- 2** Dr Carolyn Baillie, Chair NI RCOG Committee
- 3** Nicola Bailey, Nurse Lead Sexual and Reproductive Healthcare Services, BHSC
- 4** Dr Fiona Bloomer, Senior Lecturer in Social Policy, Ulster University
- 5** Chair Regional FSRH Committee NI, Specialty Dr SRH, NHSCT
- 6** Dr Tara Farrington, SRH and Genitourinary Medicine, NHSCT
- 7** Claire Galloway, Head of Service, The Rowan Sexual Assault Centre and Contraceptive/ Sexual Health services, NHSCT
- 8** Goretti Horgan, Policy Director ARK, Ulster University
- 9** Breedagh Hughes, former RCM Director NI
- 10** Dr Alyson Hunter, Consultant in Obstetrics and Fetal and Maternal Medicine, BHSC, Honorary Senior Lecturer QUB.
- 11** Dr Caroline Hunter, Senior Doctor Common Youth
- 12** Dr Siobhan Kirk, Specialty Improvement Lead Sexual and Reproductive Healthcare, BHSC
- 13** Dr Sandra McDermott, Lead Associate Specialist, Sexual and Reproductive Healthcare, WHSC
- 14** Lead Nurse Contraceptive and Sexual Health Services, NHSCT
- 15** Dr Laura McLaughlin, Consultant Obstetrician and Gynaecologist, Clinical Lead for Abortion Services, SEHSCT
- 16** Dr Leanne Morgan, Locum Consultant Obstetrician, BHSC
- 17** Karen Murray, RCM Director, NI
- 18** Ruairi Rowan, Director of Advocacy and Policy, ICNI
- 19** Dr Sharon Porter, GP with special interest in SRH, NHSCT.

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## About

The Northern Ireland Abortion and Contraception Taskgroup (NIACT) is a group of multidisciplinary professionals formed in response to the Abortion (Northern Ireland) Regulations 2020 to give professional guidance on bringing about the conditions and services required to minimise the need for abortion in Northern Ireland and, when it is required, to provide a compassionate and caring abortion service within the framework of the Regulations.

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