ARK Policy Brief

Developing Integrated Sexual & Reproductive Health Services in N. Ireland

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Background / context

The consultation on 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. The consultation seeks to develop "a new framework for access to abortion services in Northern Ireland that is consistent with the recommendations of the 2018 United Nations Committee on the Elimination of Discrimination Against Women Report, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women". But the CEDAW report is not only about abortion; it also makes recommendations in relation to sex education and to contraception services.

It notes that: *Women attested to difficulties in obtaining modern forms of contraception, inter alia, emergency (morning-after pill), oral, long term (intrauterine) and permanent (sterilisation). Testimonies revealed that women were refused sterilisation if deemed too young or unmarried, including pharmacists' reluctance to dispense or provide information about emergency contraception.* (CEDAW 2018, para 46).

We know that enabling women to access a contraceptive method that works for them helps prevent unplanned pregnancies and improve public health outcomes. The Department of Health in England's Framework for Sexual Health Improvement in England estimated that, every £1 invested in contraception saves £11 in averted health outcomes (DoH, 2013).

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

With abortion services being introduced, there is an ideal opportunity to seek greater resources for integrated SRH services across the region. In particular, linking the demand for better contraceptive services in order to reduce the number of unwanted pregnancies is more likely to be heard at this time than at any other. The Executive Formation (NI) Act 2019 does actually warrant such a development since it mandates the government to develop an abortion service "consistent with the recommendations of the 2018 United Nations Committee on the Elimination of Discrimination Against Women Report…".

The CEDAW Inquiry Report recommended that the state party:

> (a) Provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, including on all methods of contraception and access to abortion;
>
> (b) Ensure accessibility and affordability of sexual and reproductive health services and products, including on safe and modern contraception, including oral and emergency, long term or permanent and adopt a protocol to facilitate access at pharmacies, clinics and hospitals;
>
> (c) Provide women with access to high quality abortion and post-abortion care in all public health facilities, and adopt guidance on doctor-patient confidentiality in this area;

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

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

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

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

Contraceptive Use in Northern Ireland

The recent study by Given et al (2019) examined the use of prescribed contraceptives in NI 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 NI 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 GB 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 less than 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.

The study found that the combined oral contraceptive (CoC) pill and progestogen only pill (PoP) were the most frequently dispensed methods of contraception and, in the years examined, there was a decrease in dispensation of the CoC in favour of an increase in the PoP. The CoC is the overwhelmingly preferred choice for younger women while those in the older age groups, who may have contraindications to the CoC, were more likely to use the PoP.

It is important to note that typical failure rates of these methods are 9%, compared with long acting reversible contraceptive (LARC) methods such as the progestogen-only implant 0.05% and levongorgestrel intrauterine contraception 0.2%. (Trussell 2011). Access to LARC is limited, however, and enhanced provision and training for healthcare professionals is required to provide this option, which reduces unintended pregnancies.

The contraceptive methods dispensed varied with the deprivation in the area in which the woman lived. In the least deprived quintile, Emergency Contraception (EC) was dispensed 20% less and the contraceptive injection 12% less compared to the most deprived quintile. Conversely there was 5% greater rate of use of the CoC in the least deprived quintile compared to the most deprived quintile. Dispensation of LARC methods as a whole, was low but use of the contraceptive implant and intrauterine methods have has been increasing. Dispensation of the contraceptive injection has been decreasing which may reflect its side effect profile and shorter duration of action, relative to other LARC methods.

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Table 1: Method of contraception being used when became pregnant

	N	% of all women	% of those using contraception
Condom	84	25	39
Pill	57	17	27
Withdrawal	37	11	17
Emergency contraception	18	5	8
Rhythm	10	3	5
Progestogen -only implant	3	1	1
IUD	2	1	1
Progestogen -only injection	1	<0.5	<0.5
Combined hormonal ring	1	<0.5	<0.5
Combined hormonal patch	1	<0.5	<0.5
Total	214	64	100.0
None	119	36	
Total	333	100	

Source: Horgan (2019)

Practice size and location impacted on choice of the LARC method with smaller practices prescribing more of the contraceptive injection and rural practices prescribing more implants and intrauterine methods than urban practices.

Healthcare professionals must have the relevant qualifications and training to fit and remove implants and intrauterine contraception (FSRH Letters of Competency Intrauterine Techniques and Sub-Dermal Implants). This requires recertification every 5 years. Training has to be delivered by FSRH registered trainers, who can also deliver Diploma level training in SRH.

The National Institute of Health and Care Excellence LARC guideline (2005) recommends that intrauterine methods are only inserted by trained healthcare professionals who insert at least one a month, impacting on the ability of smaller practices to provide this service.

Horgan (2019) analysed data from of a sample of 333 women living in NI who had obtained abortion pills from the feminist website Women Help Women in 2016. The women ranged in age from 14 to 47; the mean age was 27.5 years, with precisely half (50%) aged between 20 and 29 years. The majority (64%) were using contraception when they became pregnant. The most common contraceptive that failed was a condom (39%), followed by the contraceptive pill (27%). It is worth noting that the sample included a small number of women who were using LARC, see Table 1.

An Integrated Sexual and Reproductive Health Service?

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

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

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

In the USA, there are now 15 states that allow EMA to be provided via telemedicine and others where telemedicine is used to meet some of the regulatory barriers that have been imposed in recent years (Ekland et al, 2010; Grossman et al, 2011; Grindley et al, 2013; Grindley et al 2017).

One of the findings of the qualitative research with

Table 2: Roles of health professionals in managing first trimester abortion

Source: World Health Organisation (2015)

Management of abortion and post-abortion care in the first trimester

	Lay health workers	Pharmacy workers	Pharma-cists	Doctors of comple-mentary systems of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Vacuum aspiration for induced abortion	✗**	✗**	✗**	✓	✓	✓	✓	✓	✓*	✓*
Vacuum aspiration for management of uncomplicated incomplete abortion/ miscarriage	✗**	✗**	✗**	✓	✓	✓	✓	✓	✓*	✓*
Medical abortion in the first trimester	Recom-mendation for subtasks (see below)	✗	Recom-mendation for subtasks (see below)	✓	✓	✓	✓	✓	✓*	✓*
Management of uncomplicated incomplete abortion/ miscarriage with misoprostol	✓ℝ	✗	✗	✓	✓	✓	✓	✓	✓*	✓*

* considered within typical scope of practice; evidence not assessed.
** considered outside of typical scope of practice; evidence not assessed.

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

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

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

Issues for discussion

The report of the CEDAW Committee identifies deficiencies regarding the provision of women's access to contraception advice and services. The consultation document published by the government does not specifically ask about sexual health services although it does note a commitment to implementing the recommendations of the Inquiry. Should we be encouraging health professionals and women's organisations to raise the question of contraception in their responses to the consultation – and how might we do this?

What are the current challenges in relation to sexual health services? We know from the research quoted above from Given et al (2019) that most LARCs are provided at SRH / CASH clinics, not GPs. Yet it is virtually impossible to obtain data about such provision.

Resources are clearly an issue for any new service and we need to push for more funding but what are the other challenges? There have already been moves towards developing more integrated sexual and reproductive health services – the Northern Trust's nurse-led Contraceptive and Sexual Health Hub at Braid Valley Hospital, Ballymena was featured in the RCOG's recent report on reducing health inequalities among women and girls Better for Women (RCOG, 2019).

The NIO consultation certainly provides opportunities to promote SRH services. An integrated service that includes EMA is likely to be more effective, and efficient. But is it a real possibility and what would a people-centred integrated service look like in terms of services across Northern Ireland's Health and Social Care Trusts?

Roundtable discussion

The roundtable heard about the integrated Sexual and Reproductive Health (SRH) services available in Scotland. For example, Sandyford Sexual Health Service in NHS Greater Glasgow and Clyde provides everything from LARC to a sexual assault and rape centre, complex SRH management including specialist menopause service, counselling, GUM, and gender identity clinics – as well as hosting the

abortion assessment service and managing early medical abortions at home. This is within the one building, with peripheral connect clinics across the city.

Their abortion services are primarily self-referral, which addresses the issues of delayed or obstructed referrals to the service. This means women do not need to see their GP to obtain an appointment; this self-referral system is now being rolled out across the rest of Scotland for all abortion services.

The importance to those having an EMA of being able to obtain LARC methods such as implants or progestogen-only injections at the same appointment where they are receiving their abortion medication was emphasised. This emerged clearly from the comparative study of women in Northern Ireland and those in Scotland who were self-managing abortions (Horgan, 2019). A fast track appointment is made for those women who choose an intrauterine method.

While the 1967 Abortion Act applies in Scotland, with the requirement of two doctors having to sign Certificate A , most of the service is provided by nurses. Doctors, after familiarising themselves with the persons case, complete the necessary paperwork and prescribe the medication. In Scotland, medication for EMA is kept at the clinic in a locked drug cupboard. Surgical terminations are available only in hospital and only up to 12-13 weeks. Each health board will have their own SRH provision, with and sexual health has its own separate budget in Scotland.

There are just over 40 doctors (excluding Gender team Psychiatrists) working in Sandyford and its connects across NHS GGC; this compares with just 8 doctors serving the SRH needs of half a million people in the Belfast and South East Trusts.

In 2013, RQIA recommended an SRH consultant to cover the whole of NI, although our population profile would suggest we need an SRH consultant in every Trust if the gross inequalities in the health of women and girls is to be reduced (RCOG, 2019).

However, there has been no movement on the RQIA recommendation, and the clinicians present noted that one of the main reasons adduced for not having a consultant was that Northern Ireland did not have an abortion service.

The Northern Trust has started to develop some integrated SRH services, as highlighted in the RCOG's Better for Women report. However, there are real problems recruiting doctors to work in SRH services because the sessional rate for a GP session is almost double that of a SRH one and doctors, understandably, are less likely to choose the lower rate. This pay differential was seen as one of the obstacles to a fully integrated service in NI, since it meant that doctors were less likely to train in the specialism.

The point was made that conceptions as a result of rape could now have DNA analysis to aid the PSNI but this does require the abortion to take place in hospital or clinic as opposed to at home as the products of conception need to be admitted into the evidential chain

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

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

Without the constraints of the 1967 Abortion Act, there is now scope to develop a fully nurse-led early medical abortion service within SRH services in NI. There is a proposal in the consultation for flexible model of service delivery, whereby trained and competent health professionals could provide abortion treatment and, if approved as part of

the regulatory framework, this would be hugely advantageous in improving access and providing a cost-effective service. Nurses can also be trained to independently provide LARC, an important aspect of abortion care.

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

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

There was a discussion about the need for strong medical leadership on abortion in NI; this could ideally be provided by the Faculty of Sexual and Reproductive Health (FSRH). There was consensus that FSRH engagement in discussions about abortion would be welcomed by NI members, as would additional support and guidance. It was noted that those living in GB may not fully understand the political context in NI or the 'chilling' effect of having parties in government that take a very biblical approach to matters of sex and sexuality and, as a result, strong advocacy on behalf of clinicians and patients in NI is essential. In order to address workforce issues and effect a cultural shift towards destigmatisation, it was felt that the provision of training, support and guidance from FSRH would not only be welcomed but would be hugely beneficial.

As with the earlier roundtable (Horgan et al, 2019) with Obstetricians and Gynaecologists, the main message coming from this roundtable was that the opportunity ought to be grasped, when introducing an EMA service, to ensure that any such service would be community-based and provided in expanded and properly resourced CASH/SRH clinics where LARCs could be provided at the same time as the EMA.

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