Event write-up report:

Abortion Reform in Northern Ireland: What Does It Mean for Healthcare Providers (HCP’s)?

A write up of the jointly organised webinar by:

Held on 9 November 2020 virtually.
Acknowledgements

We’d like to thank the delegates who joined us, which made the event was it was. We’d also like to thank the following people:

Speakers

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• Laura McLaughlin Co-chair of Doctors for Choice Northern Ireland
• Ruairi Rowan, ICNI
• Fiona Bloomer, Ulster University
• Ashleigh Topley
• Breedagh Hughes, Former Director RCM NI
• Katie Girling, Area Nursing Manager BPAS
• Jo Fletcher, Consultant nurse/co-chair BSACP
• Jayne Kavanagh, UCL Medical School/ DfC UK
• Trish Horgan, START
• Caitríona Henchion, Medical Director IFPA
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Disclaimer

This paper was written by three researchers who attended the event and is reflective of the content from the evening. This document does not constitute the policy position of the event organisers.
Introduction
On Monday 9th November 2020, key stakeholders including Ulster University, Doctors for Choice Northern Ireland, the Royal College of Midwives, BPAS and various Health Trusts in Northern Ireland gathered together to discuss the impact of The Abortion (Northern Ireland) Regulations 2020 on healthcare provision.

Touching on key issues including: legal framework for abortion, conscientious commitment and objection as well as service provision, over one hundred healthcare providers gathered to discuss these issues and work together to forge new networks and learn new information from international service providers, patient experiences and current abortion and reproductive healthcare being administered in this region currently.

Although abortion has been decriminalised in Northern Ireland, significant barriers to service provision remain. This briefing paper outlines the current laws; barriers to and enablers of service provision, including the impact of conscientious objection; and the current situation and way forward regarding service provision as outlined by a range of speakers on 9th November 2020.

The Legal framework

The NI Executive Formation Act 2019 was called to implement CEDAW recommendations and - with the repeal of sections 58 & 59 of OAPA 1861 - end all prosecutions, and introduce regulations for abortion services in this region.

The Abortion (Northern Ireland) Regulations 2020 allow for abortion on the following grounds (these grounds must be read in conjunction with the explanatory memorandum)

- Regulation 3 allows abortion without a reason to be provided by a registered medical professional up until 12 weeks;
- Regulation 4 contains a broad health ground for abortion up to 24 weeks;
- Regulation 5 allows for terminations with no gestational limits in cases of necessity;
- Regulation 6 allows abortion with no gestational limit in cases of grave or permanent injury/risk to life of the mother; and
- Regulation 7 allows terminations in cases of fatal foetal abnormality and severe foetal impairment, in line with CEDAW recommendations.

Parts 2-4 of the regulations allow abortions to be performed and certified by a ‘registered medical professional’ (i.e. a doctor, nurse or midwife). Terminations must be carried out in hospitals, clinics, GP surgeries and other places as designated. These are broad grounds to ensure services can be commissioned in local areas if needed. Regulation 8 allows early medical abortion (EMA) before 10th week gestation and allows misoprostol, the second medication in EMA, to be used at home.

As McGuinness (2020) outlined there is concern following debates in Stormont to amend the abortion regulations, regarding non-fatal disabilities. Looking to the Republic of Ireland, we can see how similar legislation hinders clinical practice and is quite problematic. In many cases the diagnosis does not reflect the prognosis, and the restrictive legislation prevents pregnant people from accessing an abortion.
Regulation 12 provides for conscientious objection stating 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’ (our emphasis). It is important to note that conscientious objection only applies to direct involvement in the procedure of terminating a pregnancy. It does not apply to providing care and administrative support for example before and after TOP procedures.

The UK Supreme court has defined ‘treatment’ as outlined in the provision for conscientious objection in the 1967 Abortion Act as:

‘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” and includes “the medical and nursing care which is connected with the process of undergoing labour and giving birth” (Greater Glasgow Health Board v Doogan and Another, 2014).

The regulators (Nursing and Midwifery Council, UK; General Medical Council, UK) and professional bodies (RCOG, RCM, RCN, and RCGP) all provide guidance for their members on conscientious objection and their responsibilities as healthcare workers. This guidance stresses the need to:

- Inform your manager if you conscientiously object to a procedure and arrange for another colleague(s) to cover your duties. Staff need to alert their manager of their intention to avail of the conscientious objection clause before they go to work (e.g. in a labour ward)
- Inform your patients if you conscientiously object to a procedure and arrange for them to have enough information and to receive care from another doctor or colleague(s)
- Do not allow your beliefs to negatively impact on the therapeutic relationship
- Understand that CO only applies to direct involvement in the procedure of terminating pregnancy.
- Understand that you cannot refuse to provide emergency care to patients.

Ideally in Northern Ireland GPs, practice managers and the PHA should provide information on who has availed of the conscientious objection provision with regard to abortion care. Pharmacists also need to understand that if they cannot provide a service they have a professional responsibility to take reasonable steps to refer the patient or service user to an appropriate alternative service provider for the service they require (Note - the Pharmaceutical Society of NI in December 2019 suspended consultation on their response to the introduction of the Act).

Some healthcare providers have explicitly stated their conscientious commitment to providing abortion care. For example, START (Southern Task Group on Abortion and Reproductive Topics) is made up of a core group of healthcare providers who hold the belief that abortion and reproductive care should be implemented in general practice. START propose that GPs are well placed to provide the full range of reproductive care services. They know their patients well and they can provide a non-judgemental and thorough exploration of treatment options, which is the foundation for successful patient care (Horgan, 2020). Nurse and midwife led
abortion services also create a greater capacity for service provision and so it is important to build capacity and commitment among nurses and midwives too (Fletcher, 2020).

Providing a full range of reproductive care services thus involves building skills, knowledge of, and commitment to abortion service provision among healthcare workers; whilst recognising the need for, and right to, a conscientious objection provision for healthcare workers.

Healthcare providers may opt out of providing hands on care for a wide range of reasons. They may have had an abortion themselves; they 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); they may have never been able to have any children of their own; they may be undergoing fertility treatment; they may have had a previous miscarriage, stillbirth or neonatal death – or indeed lost a child at any age; and/or they may have a religious or moral objection to abortion. Hughes (2020) stressed the importance of including the professional organisations and trade unions in discussions on service provision so that a balance is struck between the right of an individual to access healthcare, and the right of their members to ‘opt out’ of providing that care. It should also be clear that HCP conscientious objection is to the procedure and ought not to be to individual patients.

A 2019 survey of health professionals working in Obstetrics and Gynaecology in Northern Ireland found that 75.5% of respondents were content with the current definition of conscientious objection. However a significant percentage - 18.8% - were not content with the definition, with some stating that they would find it difficult to provide care before and after an abortion procedure (Bloomer, 2020).

**Barriers to service provision in Northern Ireland**

*Failure to commission services*

The Department of Health has refused to engage healthcare providers, arguing that abortion provision is a matter for the Northern Ireland Executive and not for the Department of Health. It should be noted that responsibility for commissioning services rests with the Health Minister. By April 2nd 2020, as a result of the work of the NI abortion and contraception task group (NIACT) an Early Medical Abortion (EMA) service was in place, however HCPs were initially advised that they could not carry out abortion on premises. It took over 2 weeks to clarify this and obtain permission during which time two women attempted suicide (McLaughlin, 2020). Currently there are no surgical options, treatment over 10 weeks or telemedicine available. Many women still travel to England for services, particularly those over 10 weeks gestation. Early Medical Abortion services eventually commenced on the 16th April. There were originally 5 EMA services but the Northern Trust service has since closed due to the Health Minister’s failure to commission services.

*Northern Trust Closure of EMA services*

This closure has affected 1/3 of the people living in Northern Ireland. Women/pregnant people in the Northern Trust cannot access services within another Trust and so their options are to travel to another jurisdiction or access telemedicine via the internet.
Demand for services

As a result of the failure to commission services, abortion service provision is currently run within parallel services. At present HCPs are coping with demand but this will change once the current restrictions are lifted and regular healthcare services resume in full - e.g. cancer/STI screening etc (McLaughlin, 2020).

Medical and Surgical Abortions

A 2019 survey of health professionals working in Obstetrics and Gynaecology in Northern Ireland found that more respondents were willing to actively participate in medical abortion than in surgical abortion. 48.8% of midwives and 77.5% of Obstetrics and Gynaecology respondents were willing to participate in medical abortion but only 37.5% of midwives and 63% of Obstetrics and Gynaecology respondents were willing to actively participate in surgical abortion.

Lack of services and pathway for people with a diagnosis of fatal foetal abnormality

The political resistance to commissioning abortion services will continue to negatively impact on patients with a diagnosis of fatal foetal abnormality in particular. Ashley Topley presented her experiences of seeking abortion care in Northern Ireland in 2014. Ashley’s daughter was initially diagnosed with a fatal foetal abnormality at the 20-week scan in February 2014. Ashley’s experiences highlight need for both full abortion services and for a dedicated pathway for people with a diagnosis of fatal foetal abnormality who decide to continue with their pregnancy

- Toll of continuing the pregnancy – Ashley did not receive full and correct information about her options by healthcare staff and external helplines she contacted. With decriminalisation one would hope that the chilling effect the previous law had on healthcare staff will be removed and someone in her situation will be able to have a full and honest conversation with their doctors and consultants. Given the information she received however, Ashley understood that she had no choice but to continue with her pregnancy. She was pregnant for 15 additional weeks after receiving the initial diagnosis. During this time, she was in constant pain and endured physical, mental and emotional suffering. She found going out difficult as members of the public would congratulate her etc. Nine times out of ten she went along with this and pretended that everything was ok. On the few occasions she told people the truth it caused confusion and shock. She could not work and was on sick leave from the end of February to October 2014. She was lucky insofar as she was on full sick pay but many people in similar circumstances might not qualify for this. Ashley had an extremely difficult time after the initial diagnosis. She felt angry, abandoned, isolated, ignored and hopeless. She started grieving once they received the initial diagnosis at 20 wks and when her waters broke at 35 wks and the midwife said there was no heartbeat she felt relieved that the end was in sight, and then guilty for feeling relieved. When Katie was born her skin was blue and splitting and she looked very sick. Ashley was encouraged to hold her and they took photos which was good, but they cannot show those photos to their other children as they would get a fright. Ashley noted that the diagnosis was punishment enough but having to continue the pregnancy was an additional
punishment. In not being able to choose when to end the pregnancy she felt they were robbed of a potentially positive experience in a controlled environment.

- Need for dedicated pathway - After receiving the initial diagnosis Ashley found herself in waiting rooms with other happy pregnant people and their families; saw several new consultants in succession after the initial diagnosis to whom she had to explain her situation; saw new staff as part of routine antenatal appointments who did not know her diagnosis and so asked inappropriate questions; had to explain her diagnosis to pharmacists so that they would understand why she was being prescribed slow release morphine; and gave birth to Katie on a regular maternity ward albeit in a private room (there is no specific room for stillbirths in Craigavon hospital).

- Ashley noted that the ongoing under-resourcing of health services was also a barrier to compassionate care. After the initial diagnosis Ashley and her husband had three subsequent appointments to confirm the diagnosis. There was a wait of 10 days in between the 1st and 2nd and 2nd and 3rd appointments respectively. This draws out the suffering of patients and their families

Healthcare provider attitudes

The level of misinformation among some healthcare workers with regard to why people need and have abortions was highlighted as a key concern across several presentations. As Girling (2020) outlined common misconceptions about abortion include that the person will be young, single and irresponsible; that everyone who has an abortion will need counselling after the procedure; and that abortion is a dangerous procedure. There is a need for training on the reasons people have abortions as some existing strong views don’t reflect the reasoning for abortion (Bloomer, 2020). Also greater training is needed with regard to the unacceptability of lecturing patients about their choices and/or discussing the HCPs own personal beliefs with patients (Hughes, 2020).

Enablers of Service Provision in Northern Ireland

Committed healthcare provider groups

Groups such as DFCNI and START are committed to establishing and providing abortion care services in line with best practice and international standards.

Healthcare provider attitudes

A 2019 survey of health professionals working in Obstetrics and Gynaecology in Northern Ireland found that 54% were in favour of decriminalisation of abortion; 35.3% opposed it; and 10.8% did not know their position. 35.3% is admittedly a significant % opposition to decriminalisation. However, just over half of the respondents supported decriminalisation and of those who were unsure, some said they were personally opposed to abortion but they supported women’s choices (Bloomer, 2020). The survey also showed that there was a willingness to learn more about the changes to the law and its requirements. For example, 83% of respondents wanted training on the new regulations; 69.8% on counselling about new abortion services; and 66.9% overall (and 79.3% of Obstetrics and Gynaecology respondents) wanted training on the differing types of abortion.
Some respondents highlighted their existing skills stating that updated training on TOP and relevant counselling would be welcome.

**Service Provision in Northern Ireland**

Women and pregnant people who need an abortion or more information on abortion services in Northern Ireland currently contact a Central Access Point which is run by Informing Choices Northern Ireland (ICNI). Service users can contact 028 9031 6100 for information, to request pregnancy choices counselling and referral into early medical abortion (EMA) in NI.

When someone contacts the Central Access Point their contact details are taken, and they are phoned back by a trained advisor. The structure of these calls is the same as detailed below:

1. The conversation begins with 3 options: continuing with pregnancy, adoption and abortion.
2. The service user can be referred to counselling if unsure.
3. Most people opt for abortion and the ICNI representative will advise the of next steps for access. Referrals to EMA can take place when the person is pregnant, up to 9 weeks and 6 days.
4. The ICNI representative will ask questions such as who else is aware of the pregnancy as this can be important for safeguarding
5. The ICNI representative will answer any questions the service user may have. Common questions include - Is there a cost? What has changed with the law? Service users may also ask about myths such as those re abortion and infertility for example and the ICNI provides evidence based information to the service user.
6. The service user will also be offered access to a post-pregnancy counselling service. This counselling service has been developed by Lifeline NI. It now takes place over the phone to adapt to COVID-19 and this has actually made it much more accessible to a wider range of service users.

The service user will attend their local service for mifepristone and contraception will also be provided at this time. Misoprostol is taken at home by the service user and a low sensitivity pregnancy test is taken afterward. Thus far the feedback on EMA service provision has been very positive (McLaughlin, 2020). Comments from service users include - “Really thankful - really impressed with service. Thank you”; “Great, well supported, friendly, non-judgemental”; “The staff made it so much easier. I felt very comfortable and safe”; “What you are doing in lockdown is perfect. Discreet, essential service. Needs to continue.”

Data collected for the first 3 months of services in two Trusts list referral and treatment rates as below:

<table>
<thead>
<tr>
<th>Belfast Trust</th>
<th>South Eastern Trust</th>
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<tbody>
<tr>
<td>April - July 2020</td>
<td>June - Sept 2020</td>
</tr>
<tr>
<td>251 referrals</td>
<td>103 referrals</td>
</tr>
<tr>
<td>212 treatments</td>
<td>84 treatments</td>
</tr>
<tr>
<td>Average age 28.9 years</td>
<td>Average age 25.75 years</td>
</tr>
<tr>
<td>40.6% had a scan</td>
<td>37% had a scan</td>
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60-63% of service users already had children and that there were no failed EMAs in the Belfast or South Eastern Trusts during this data collection period. This data is very much in line with findings in Great Britain.

Follow up and counselling have provided an excellent service but there is still huge stigma surrounding abortion in Northern Ireland. This is illustrated by the considerable political resistance to full service provision (McLaughlin, 2020).

**Immediate Problems**

Dr McLaughlin reported that many women have very short interpregnancy intervals and there is a real need for postpartum contraception. In Belfast 30% of service users were using a form of contraception and 42% were using a form of contraception in the South Eastern Trust prior to attending the service, but there is a need for LARC and postnatal contraception.

**Comparable Services**

To note the model of care developed in the Republic of Ireland provides for the majority of women in early pregnancy to be cared for in the community. In this model service users are seen by a community provider who certifies the gestation does not exceed 12 weeks and the abortion can then proceed a minimum of 3 days after this certification is made. Gestation can be certified based on LMP data and examination and does not require ultrasound. Ultrasound service is available free of charge but it is out-sourced to a private company (so getting one can cause delays) and availability is not equal nationwide.

If the gestation does not exceed 9 weeks, the procedure is usually a medical abortion. If the gestation exceeds 9 weeks, a referral is made to a termination of pregnancy clinic in a maternity unit and the abortion takes place there. Currently 9 of the 18 maternity units in ROI are providing the full range of abortion services.

During COVID-19 restrictions this model of care was altered with no change to the law. Women’s health clinics saw increased demand for their services as many GPs were overwhelmed with COVID related cases. Remote provision of care includes a:

- Phone call from a counsellor before the remote doctor consultations to prepare client for what was involved
- An information pack is emailed by the counsellor and particularly difficult circumstances or medical conditions could be identified at that point too. A series of video clips assist women to understand the Early Medical Abortion process, how to take misoprostol and how to use the low sensitivity pregnancy test. A step by Step guide is provided and a translation feature has been added to this on IFPA website.
- During COVID restrictions both doctor consultations were remote and patients came to the clinic to collect their home care pack; they could nominate some to come collect it; or it could be delivered by courier. They would only see the doctor in exceptional cases. There is no reason why the first consultation cannot remain remote after the restrictions lift as it is much more convenient for patients.
The model of care is set out by the HSE and it was initially developed by representatives of
GP, Women’s Health Clinics and Ob/Gyn participating in a Collaborative Group convened by
the HSE.

In the ROI they note that some disadvantages of the women’s health clinic setting (IFPA) are
that patients are less likely to be known to the staff; there is high demand for the service;
several staff work part-time thus impacting on continuity of care; and capacity for other
services needs to be maintained. They have strong protocols in place and careful scheduling
to ensure links are made and patients receive high quality care. Advantages of a women’s
health clinic setting (as opposed to a GP setting) is that there is an experienced community of
providers and nurse practitioners in place; staff have more experience due to the high demand
for services; there are ancillary supports in place such as specialist pregnancy counselling;
and women’s health clinics are linked to advocacy and research. In the IFPA they can offer
counselling to all clients and they have insight into the experiences of women who are not
eligible for care under the current law. The IFPA are currently building an evidence base for
the 2021 review of the law in ROI.

Results of the IFPA analysis of 6 months of 2019 data on their service provision (prior to
COVID amendments) demonstrate that overall the Irish model of community based abortion
care compares well with services in countries where women are routinely scanned. 92% of
their clients self-managed medical abortion at home. Caitriona Henchion stressed the
importance of providing a comprehensive service. The uptake of post-abortion contraception
was high and there was also substantial demand for specialist pregnancy counselling and STI
screening. The complication rate was in line with international evidence. In the data 0.6% of
clients suffered EMA failure, 3.2% had an incomplete abortion and 0.6% got an infection
(Henchion, 2020).

**Best Practice - Midwives and Nurses**

Fletcher (2020) outlined key skills required for abortion service provision by midwives and
nurses including risk management knowledge; research and audit skills; and knowledge of
support services e.g. one needs to know who to contact with problems - if someone have a
thrombo-medical disorder that means they may not be suited to a certain type of abortion
care?

Best practice involves advocating for the client, putting all your own biases aside; remaining
professional at all times; listening and empathising with your patient; offering support; and
centring your client’s needs, remembering that this is about them and their decision

Normally, abortion consultations are conducted with only the person accessing the abortion.

- This is to help with safe-guarding and identifying reproductive coercion, sexual
  violence and domestic abuse.
- At times it may be appropriate to include a partner, but this should be considered on
  an individual, case-by-case basis.

Midwives also need to be aware of anti-choice clinics which claim to offer “counselling” for
pregnant people. These clinics can deter, delay and greatly upset vulnerable pregnant women
& people from accessing abortions. Midwives should give direct referrals, phone numbers and
links to websites to patients and be aware of anti-choice clinics in their area, e.g. Belfast has Stanton Healthcare Clinic.

Best Practice - GPs

Kavanagh (2020) outlined that for GP’s, abortion consultations can be straightforward – but may become challenging when there are issues around support, coercion or safeguarding issues. It is important not to use stigmatising or ‘value laden’ language in consultations and instead use neutral expressions without presumption of gender, relationships or sexuality.

Statements to use

- Listen and encourage questions.
- Give clear and accurate information.
- Smile and make eye contact.
- Emphasise that abortion care is a routine part of healthcare.
- Statements like: “How did you feel when you first realised you were pregnant?” and “Have your feelings changed?”
- Encourage talking to a counsellor.
- Try to discuss contraception at the end of consultation.

Statements to avoid

- Terminology of ‘mummy’ and ‘baby’.
- Repeatedly questioning the decision.
- Talking about morality and abortion.
- Delaying referral.
- Giving false information.
- Persuading patients abortion is wrong.
- Showing disapproval.
- Being unkind, judgemental or dismissive.

Developing second trimester abortion services

Dr Donnelly outlined the ROI experience of developing and implementing second trimester abortion service. Only 1.8% of abortions in 2019 were after 12 weeks. Of these, 21 were carried out under section 9 – risk to life or health; 3 were carried out under section 10 – risk to life or health in an emergency; and 100 were carried out under section 11 – condition likely to lead to death of foetus. Each of these sections (9, 10 and 11) are open to interpretation and are tricky to negotiate. Section 11 in particular requires medical practitioners to be of the ‘reasonable opinion formed in good faith that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before or within 28 days of birth’. This is extremely difficult to define, is very restrictive and is the source of a lot of difficulty.

In ROI much of the resources were dedicated to putting the model of community care in place for Early Medical Abortion.

However, work on developing guidelines for second trimester abortions did start before the 2018 referendum. A fetal medicine working group was set up to develop guidance on
‘Pathway for management of fatal fetal anomalies and/or life-limiting conditions diagnosed during pregnancy’. In developing this guidance more than 50 individuals and representatives were consulted from relevant specialities, patient groups and legal advisors and the draft document was available in Jan 2019. The guidance outlines the relevant pathways and algorithms. Dr Donnelly stressed the importance of consulting with all relevant groups in development of this guidance.

Guidance was also developed on managing the ‘Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy’. This work began late 2018 and the guidance was published in May 2019. They also engaged in wide consultation on this guidance including with representatives from women’s groups and with legal advisors. It does not specify what constitutes serious harm or risk to life as it is impossible to arrive at an exhaustive list, although it does specify chorioamnionitis.

In preparing for service provision it is important to have all the correct documentation in place. Existing leaflets and patient documents (e.g. bereavement leaflets, consent forms) can reviewed and modified in line with requirements. Dr. Donnelly also noted that the IOG had sought clarity from the DOH regarding feticide. It is important to have local written guidance with fully documented procedures in place.

After service provision commenced they found that institutional support varied between hospitals. Although they were providing a new service they did not get assigned additional resources and there was an increased workload.

The question of training is also important. The Royal College of Obstetricians & Gynaecologists (RCOG, UK) only recommends D&E when undertaken by specialist practitioners with access to the necessary instruments and who have a sufficiently large caseload to maintain their skill. Currently no one is fully trained in Ireland. Dr. Donnelly stressed that all trainees ought to be trained in TOP because otherwise they may see it as optional rather than as essential training for a common healthcare procedure.

To finish Dr. Donnelly stressed the importance of teamwork within multi-disciplinary teams. Developing and maintaining good working relationships; having respect for each other’s knowledge and expertise; recognising the difficulty that people have in providing and being part of abortion healthcare; and supporting each other via formal and informal networks is all essential to the provision of care to patients.

**Conclusion**

What is clear from these sessions is the conscientious commitment to providing abortion and reproductive healthcare in Northern Ireland. Key needs from HCP’s include enhanced training on the new legislation, direction from the Department of Health as well as financial and institutional support by way of commissioning services. Additionally, the need for a cohesive community of medics who are dedicated to providing care was flagged, with both local and national peer assistance and communication deemed extremely valuable.

The recognition that abortion is a nuanced issue for HCP’s was acknowledged, with detailed conversations about the nature of objection to provision of service illustrating a spectrum of positions that must be accommodated by healthcare professions. The stigma surrounding
abortion and reproductive healthcare is still evident as illustrated by responses to a questionnaire on this issue and highlights the need for more conversations on this issue to take place.
Reference List


