

The impact of Northern Ireland's abortion laws on women's abortion decision-making and experiences

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ABSTRACT

Background In Northern Ireland, abortion is illegal except in very limited circumstances to preserve a woman's life or to prevent permanent or long-term injury to her physical or mental health. Abortions conducted outside the law are a criminal offence punishable by imprisonment. We assessed the impacts of Northern Ireland's abortion laws on women's decision-making and experiences in accessing abortion.

Methods Between April 2017 and February 2018 we interviewed 30 women living in Northern Ireland who had sought abortion by travelling to a clinic in Great Britain or by using online telemedicine to self-manage a medication abortion at home. We interviewed women both before and after a policy change that allowed women from Northern Ireland access to free abortion services in Great Britain. We used a semi-structured in-depth approach and analysed the interviews using grounded theory methodology to identify key themes.

Results Four key findings emerged from our analysis: (1) women experience multiple barriers to travelling for abortion services, even when abortion is provided without charge; (2) self-management is often preferred over travel, but its criminalisation engenders fear and isolation; (3) obstruction of import of abortion medications by Northern Ireland Customs contributes to stress, anxiety, a higher risk of complications, and trial of ineffective or unsafe methods; and (4) lack of clarity surrounding the obligations of healthcare professionals in Northern Ireland causes mistrust of the healthcare system.

Conclusions Northern Ireland's abortion laws negatively affect the quality and safety of women's healthcare and can have serious implications for women's physical and emotional health. Our findings offer new perspectives for the current policy debate over Northern Ireland's abortion laws and suggest a public health rationale for decriminalising abortion.

Key messages

- ▶ Women in Northern Ireland still experience multiple barriers to travelling to access abortion care even though abortions are now provided free in Great Britain.
- ▶ Self-managed medication abortion using online telemedicine may be preferred over travel due its convenience and safety, but the experience is dominated by fear and isolation due to the risk of prosecution.
- ▶ Lack of clarity surrounding Northern Irish abortion laws delays access to care and fuels mistrust of the healthcare system.

INTRODUCTION

Northern Ireland, a part of the United Kingdom (UK), has some of the world's strictest abortion laws. Abortion is permitted only to preserve a pregnant woman's life or to prevent permanent damage to physical or mental health.¹ Abortion following rape or incest, or following the diagnosis of fetal anomaly, is not permitted. In the UK, conducting an abortion outside the law is a criminal offence under the 1861 Offences Against Person Act and carries a maximum penalty of life imprisonment.² The UK's 1967 Abortion Act, which made legal abortion widely available in England, Scotland and Wales, was not adopted in Northern Ireland.²

Despite these laws, women in Northern Ireland do have abortions. For those who do not meet one of the few legal exceptions, there are two main pathways to obtaining care: (1) travelling to countries where abortion is legal, most commonly England, to access services in a clinic; or (2) using online telemedicine to access



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mifepristone and misoprostol, which are mailed to women's homes, allowing them to self-manage a medication abortion at home with instructions and support provided by the telemedicine service.³ Between 2010 and 2016, the number of women who travelled to abortion clinics in England and Wales and who gave Irish and Northern Irish addresses declined from 5503 to 3992.^{4 5} Over the same time period, the number of women living in Ireland and Northern Ireland who requested medication abortion via the online telemedicine service Women on Web (WoW) more than tripled, from 548 to 1748.³

In 2017, however, the number of women giving specifically Northern Ireland addresses at abortion clinics in England and Wales increased for the first time since 2002.⁶ This increase coincided with a policy change by the UK government at the end of July 2017, allowing free abortion care in England and Wales under the National Health Service (NHS) for women from Northern Ireland.⁷ Abortion services were also made free by the Scottish NHS for women travelling from Northern Ireland to Scotland, but no data on the number travelling will be available until 2019.⁸ Prior to this change, Northern Irish women had to pay for abortions in Great Britain, despite being eligible for free NHS care when travelling there for other medical procedures. Yet an increase in travel to England and Wales does not neatly translate into a decrease in the use of online telemedicine. Analysis of the number of women living in Northern Ireland who received abortion medications from WoW in the year prior to the policy change compared with the year after indicates only a 3% decrease.⁹

The recent repeal of the constitutional amendment prohibiting abortion in the Republic of Ireland, along with the passage of a bill to legalise abortion in the Isle of Man, has brought Northern Irish abortion law into the international spotlight. Although possible legal reform is a subject of intense debate among politicians, healthcare professionals, and the general public, no scientific studies have examined Northern Ireland's laws from the perspective of the women who seek abortion services. Our objective was to assess the impacts of Northern Ireland's abortion laws on women's decision-making around how to obtain abortion and on their subsequent experiences accessing care. We used in-depth interviews with women in Northern Ireland who sought abortion either by travelling overseas or by using online telemedicine, both before and after the policy change to offer free NHS abortion care in Great Britain.

METHODS

Between April 2017 and February 2018, we conducted anonymous in-depth interviews with 30 women living in Northern Ireland. Women were eligible to participate if they: (1) were over 18 years old; (2) had had an abortion within the last 8 years (ie, since both WoW

and travel have been available options); (3) lived in Northern Ireland at the time of their abortion; and (4) sought abortion either by travelling or by online telemedicine. Participants were invited through three organisations that have frequent contact with women in Northern Ireland who are seeking abortion: (1) the Abortion Support Network (ASN), which provides information and financial assistance to women who travel from Northern Ireland to access abortion and which sent invitations to their mailing list; (2) WoW, which sent invitations to women who had used their online telemedicine service; and (3) Alliance For Choice, a Northern Irish organisation that provides information and support to those seeking abortion, and which shared the invitation via social media. Eligible women contacted the research team to set up an interview. The study was reviewed and approved by the Institutional Review Board of the University of Texas at Austin.

Trained research team members conducted the interviews by phone. All participants gave their informed consent to participate and for the interview to be audio recorded. Audio recordings were stored on an SSL-protected server and no records of personal information were included in the recordings or retained by the research team. Participants were not asked to share their real names and were provided with pseudonyms. Interviews lasted between 35 and 75 min and were conducted in English. Participants were offered £80/€90 in appreciation for their time.

The interviews followed a guide developed using insights from existing literature on Northern Irish abortion laws,^{10–12} the options available to women,^{3 13} and the theoretical context of the AAAQ (Availability, Accessibility, Acceptability, Quality) framework, which is used by the WHO to ensure the highest standard of healthcare services.¹⁴ We asked women about their circumstances at the time of their pregnancy, their decision-making when choosing a pathway to abortion, and their experiences with that pathway. The change in UK policy to offer free abortion services in Great Britain for women travelling from Northern Ireland took place during our data collection phase, so we were able to interview women who sought abortion both before and after NHS coverage was available. Because the interviews were semi-structured, participants were also able to explore whatever they considered important about their experience. We obtained very limited demographic information in the interests of protecting anonymity. Four pilot interviews were conducted to test the interview guide.

Our analysis followed the principles of grounded theory.¹⁵ Interviewers made field notes immediately after completing each interview and engaged in constant comparison between data and notes to develop both the interview guide and coding schema, updating them iteratively for emerging theory. The final sample size was determined by the point at which

Table 1 Characteristics of study participants who sought abortion either by travelling or by using online telemedicine (n=30)

Characteristic	Frequency (%)
Age (years)	
<20	3 (10.0)
20–24	8 (26.7)
25–29	7 (23.3)
30–34	5 (16.7)
35–39	6 (20.0)
40–44	1 (3.0)
Employment status	
Working	16 (53.3)
Student	5 (16.7)
Both student and working	4 (13.3)
Neither student nor working	5 (16.7)
Children	
0	19 (63.3)
1+	11 (36.7)
Pathway to abortion	
Self-managed using online telemedicine	18 (60.0)
Travelled for abortion	11 (36.7)
Qualified for exception to NI law	1 (3.3)
NHS policy change	
Sought abortion before change	16 (53.3)
Sought abortion after change	14 (46.7)

NI, Northern Ireland; NHS, National Health Service.

the research team judged that thematic saturation had been reached. Each interview was transcribed and coded by two research team members, who met to discuss and refine coding and to conduct thematic analysis, organising and analysing coding patterns to identify key themes. We used Dedoose version 7.6.21 (2017; Los Angeles, CA: SocioCultural Research Consultants, LLC) qualitative analysis software to assist with data organisation and analysis.

Patient and public involvement

Patients or members of the public were not involved in the design or conduct of the study. However, the pilot interviews we conducted with women to iteratively develop the in-depth interview guide had the aim of making sure that the interview questions could accurately and fully capture the experiences of women in Northern Ireland who seek abortion.

RESULTS

Participants were diverse in terms of age, employment status, and number of children (table 1). Among the 30 women interviewed, 18 self-managed their abortions at home using medications obtained from online telemedicine organisations, 11 travelled to England to

obtain an abortion at a clinic, and one qualified for a legal abortion in Northern Ireland. Sixteen had their abortions before the NHS policy change and 14 after the change (table 1). While we did not formally collect information about place of residence or income, the information provided by participants during their interviews indicated that they came from both rural and urban locations and from a range of socioeconomic groups.

Four major themes emerged from our analysis.

Barriers to clinic travel despite free abortion care

Many participants experienced barriers to travelling to England to obtain legal abortion services at a clinic. Among those seeking abortion before they were provided free by the NHS, covering the cost of the procedure was a major challenge. However, those seeking care after abortions became free still described significant barriers. One major barrier is covering travel costs, which are exacerbated by the need to book flights at very short notice and to complete return travel on the same day to avoid accommodation costs. While the policy change does provide travel costs for women below a certain income threshold,⁷ none of the women in our study were aware of this allowance. Lucy, who is 34 years old, spoke about the experience of a friend whom she helped to travel. Worried that her friend would self-harm to end her pregnancy, they turned to informal and potentially dangerous funding sources: *"We had to book flights, which were horrendously expensive given the timeframe. I think they were around £150 return each for the day, and that was another huge cost to my friend, who didn't have much money. She borrowed the money from [a proscribed organisation]. She couldn't access funds any other way because she was in debt already, and so she couldn't get a credit card or bank loan."*

For others, the barriers were insurmountable. Travelling for an abortion can become a very public process, and Sonya, a 40-year-old mother of two, self-managed her medication abortion because she could not travel and keep her abortion confidential: *"Even though the procedure is covered now for Northern Irish women in England, there's other factors as well. It would have been a whole host of lies: 'Why are you getting up so early? Where are you going? Why will you not be back until late? Where have you been?' I speak to lots of people in my family two or three times a day, and to have no contact with them would have made them suspicious."*

Pamela, a 33-year-old mother of three who also used online telemedicine, explained the compounding barriers of being unable to leave children at home and the stigma surrounding abortion: *"Being a single mum of quite a few children I'd have to somehow find childcare. And on top of that I'd have to try to hide it, because there's a massive stigma attached to it in this country. You feel like a criminal no matter what pathway you take."*

Some participants were not accustomed to travel and were suddenly faced with the need to obtain the documents required by the few airlines that fly from Northern Ireland to England, at least one of which requires passengers to carry a passport. They also experienced fear and anxiety travelling on their own to seek care in what they regarded as a foreign place. Cassidy, a 23-year-old mother of two young children, who used online telemedicine, explained: "I knew I could get it free in England, but I don't really travel, so the idea of it was very scary. I don't even have a passport. There was so much distress I was going through on top of the trauma of the pregnancy itself."

Self-management as a preference

While some participants resorted to self-management because of barriers to travel, others viewed online telemedicine as a first choice. Factors underlying this preference included the perceived advantages of comfort, privacy and autonomy. Some participants had a strong preference for medication over surgical abortion and chose self-management despite the legal risks because they perceived it to be the only feasible way to obtain a medication abortion. For these women, self-management was perceived as safer and more acceptable than the possibility of having to manage the pain and bleeding associated with a medication abortion on a plane or boat journey home. Despite these perceived advantages, however, almost all women who chose this option experienced fear due to the criminalisation of abortion in Northern Ireland, preventing them from seeking support from friends and family.

Pearl, a 36-year-old mother of five, strongly preferred the option of self-management, but fear quickly set in as she waited for the medications to arrive: "There would be such a traumatic side to having to travel instead of being in the comfort of your own home. But I was absolutely frightened. I never slept for weeks tracing that parcel. Oh my god, it was a scary time, and I probably never settled for even a week after receiving it, because I was so scared that the police were going to land on my door ... I just thought, my god, is this really what it could actually come to? Where you can get an hour's flight, and not get into any trouble. But you get it sent to your home and you could be arrested...."

Some women actually cancelled their travel plans on finding out about online telemedicine. Tracey, a 37-year-old woman with one child explained: "I think there's a lot to be said for being in the comfort of your own surroundings. When I found out about Women on Web I just didn't use the flights and lost whatever money I spent." However, she faced intense fear and anxiety waiting for the pills to arrive. One evening, she came home from work to find a police car parked near her house: "I was going, oh my god are they here for me? I thought I was getting arrested. I actually went and drove my car two streets away and walked at half past 12 at night. It was horrendous ... The thought of

being arrested and put in jail for something that is quite legal anywhere else in the UK is just mind-blowing."

Others who travelled did not know about online telemedicine at the time of their abortion but would have preferred this pathway had they known it existed. Sally, aged 21, explained: "Taking the pills at home would be so much easier than travelling. I wouldn't have had to think: 'What if I don't get this abortion, because by the time I get the money, the flights and everything together, I'm going to be too far along?' I was drinking castor oil, I was going through quite a lot of vodka...I asked (my partner) a few times to punch me in the stomach. I was already thinking of overdosing." Sally did eventually manage to book travel, but her experience of uncertainty about how to access to care, including the methods she resorted to and the severe anxiety she experienced, were shared by many others.

Northern Irish Customs obstruct and delay care

Almost every participant who used online telemedicine reported feeling intense worry that Northern Irish Customs would confiscate or delay their packages. For many, those fears were realised: some packages were intercepted and confiscated while others were significantly delayed, sometimes by several weeks. These delays meant that some women ended up using the medications at later gestations than they had anticipated or desired.

Ruth, aged 18, was about to start university when she discovered she was pregnant. She chose to use online telemedicine and not only had her abortion delayed, but was also interrogated: "My first packet got seized and I went into a state of panic ... I rung up Customs and asked them did they know where my package was because it was taking weeks. The person on the phone asked me if I knew that [misoprostol] was a Class A drug...he compared it to heroin. He actually said to me 'It's in the same class as heroin'." Misoprostol is not classed as a Drug of Misuse and is on the WHO List of Essential Medicines.¹⁶

Tracey, a 37-year-old mother of one, had to request a second set of pills after the first package was seized by Customs. The additional time she spent waiting concerned her greatly as her pregnancy progressed: "I ended up only 4 or 5 days off the 9 weeks cut-off — the first set of tablets were meant to arrive before 7 weeks — I was very afraid of that time difference." During the 2 weeks that Tracey waited for the second package, she ended up turning to alternative methods to end her pregnancy. Like others who experienced delays, she had read online about botanicals, alcohol, household cleaning substances, or causing physical trauma to the abdomen. Tracey described the other methods she considered while waiting for the pills: "One of them was Vitamin C. I swear to god, the amount of Vitamin C I took in 1 day, I was like 'This is outrageous, why are you doing this to yourself? The tablets are coming!' And

then they were seized by the bloody Customs. But you would do anything to get yourself out of the situation. So I did; I took large doses of Vitamin C." Although vitamin C was ineffective, Tracey's situation reveals the emotional burden and potential risks caused by delays in receiving abortion care.

Lack of legal clarity and the role of the healthcare system

While all respondents were aware that abortion is highly restricted in Northern Ireland, many were uncertain about the exceptions under which abortion can be legally granted and were confused about the information and support that healthcare professionals can lawfully provide. As a consequence, women's interactions with the healthcare system in Northern Ireland were highly variable and many were reluctant to attend for follow-up care after their abortions. While some women received phone numbers for clinics in England, Elaine, aged 35, was surprised and upset that her doctor did not offer any information: "*The doctor just gave me unplanned pregnancy counselling but said that there was nothing that could be done. ... It's very frightening and very demeaning not to be able to control your own health, especially with something that's life changing. For him not even to say 'Here's information on the clinic', it's very backward for this day and age.*"

The assumption of doctors having a duty to report self-management to the police was also common. Samantha, aged 20, who self-managed her abortion, explained: "*I knew that I wanted to have an abortion, but I didn't know how to go about it... But you can't go to your doctor because if you say that you're going to order pills, they have to report it and you can't go and see them afterwards either if you need help.*"

Tina, aged 28, experienced health issues and met the criteria for an abortion in Northern Ireland. Nevertheless, she had to endure 2 months of travelling and waiting and sought abortion pills online in the meantime: "*I had to go back and forth three or four times over 3 weeks to get scans. It was a long way to go and after that I had to wait another 3 weeks to see if I would meet the criteria. In the end, 2 weeks later, it finally all happened. But in the meantime, I'd already been on Women on Web to order the pills. I didn't think for one second I would qualify for anything over here.*"

DISCUSSION

Our findings add to the growing body of literature from settings worldwide showing that the home use of abortion medications is acceptable to women, but that the criminalisation of abortion is harmful to both physical and mental health.^{17–21}

The main limitation is that our sample was necessarily self-selected, which limits our ability to generalise our findings to all women in Northern Ireland who have had abortions. Additionally, women may obtain abortions by other routes not represented in

our sample, including travelling to clinics in mainland Europe or purchasing medications from online pharmacy sites. The main strength of our analysis is that it fills a significant gap in the scientific literature by providing a novel and detailed analysis of a highly stigmatised and legally risky experience.

In 2015, the Belfast High Court ruled that Northern Irish abortion laws are incompatible with Article 8 of the European Convention on Human Rights, the right to private and family life, because they ban abortion in cases of rape, incest, and fatal or serious fetal abnormality.²² In June 2018, the UK Supreme Court confirmed and extended this ruling, stating that banning abortion in these circumstances is incompatible with not only Article 8, but also with Article 3 of the European Convention on Human Rights; the right to be free from torture, inhuman or degrading treatment.²³ In the light of these rulings, our results provide an important new perspective: in addition to women who have survived rape or incest, or who have suffered the distress of a fetal anomaly diagnosis, we find that women in a wide range of circumstances are significantly adversely affected, both physically and mentally, by the current abortion laws. In particular, it is clear that the stigma engendered by the illegal status of abortion in Northern Ireland shapes every aspect of women's experiences of unwanted pregnancy and engenders isolation at a time when many need support. Moreover, the barriers to accessing abortion clinics experienced by women in our study reflect the challenges experienced by women in the Republic of Ireland and the United States, who also frequently travel long distances for services.^{24 25}

In 2016, the Northern Ireland Department of Health, Social Services, and Public Safety issued a clarification to the country's abortion laws, explicitly stating that medical personnel treating women who present with miscarriage symptoms do not have an obligation to inquire about or report on attempted abortion.²⁶ It is clear from our findings, however, that this clarification has not become widespread knowledge and that the relationship between women and healthcare professionals in Northern Ireland remains adversely affected. To date, two Northern Irish women have been prosecuted for alleged self-management; one of these cases is awaiting judicial review.^{27 28} One of the women was reported by housemates and the other by healthcare professionals. A further woman avoided prosecution but was given a formal caution, while others have had their homes raided by police. This climate of fear and intimidation is reflected in our findings regarding the terror women who self-manage their abortions experience at the prospect of prosecution. However, the small amount of literature that exists on healthcare professionals' perspectives on abortion suggests that a majority of obstetricians, gynaecologists and general practitioners surveyed in Northern Ireland support legal reform.^{29 30} Moreover, while it is not explicitly

illegal to import medications with a prescription for personal use under UK law,³¹ seizure of abortion medications by Northern Irish Customs leads some to try ineffective or unsafe methods, while others end up using the medications at later gestational ages and thus at increased risk of complications.

Public health and policy implications

Following the repeal of the Eighth Constitutional Amendment in the Republic of Ireland and the pending legalisation of abortion in the Isle of Man, there is growing pressure on politicians in the UK Parliament and Stormont (the devolved Northern Irish Legislative Assembly) to address the Northern Irish abortion laws. However, Stormont has been suspended indefinitely since January 2017. While the content and adoption of any revised abortion legislation would require action by Stormont, the UK Parliament has the authority to amend the 1861 Offences Against the Person Act to remove the sections criminalising those who procure abortion and those who assist others in such procurement. If that Act were amended, self-management would no longer be criminalised before 24 weeks' gestation, and it would be up to Stormont, when reconvened, to legislate on whatever law would replace it. A 2017 nationally-representative survey of public opinion shows that there is widespread support among people in Northern Ireland for a change to the current law.³² As both policymakers and the public consider reform, our findings provide important evidence of the negative impact of the current law on the quality and safety of women's healthcare in Northern Ireland and offer a public health rationale for ending the criminalisation of abortion.

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