



**Beyond Decriminalisation:**  
pregnancy choices and  
abortion care in Northern Ireland



# Contents

## Prologue

**My Story: a woman's experience of accessing local abortion care in Northern Ireland** pages, 4-6

---

## Foreword

**The Walls of Silence Surrounding Abortion: learning from the past and looking to the future**  
by Dr Audrey Simpson OBE pages, 7-9

---

## Executive Summary

pages, 10-13

---

## Chapter 1

**Covid-19 and Access to Abortion: the rapid implementation of an EMA service**  
by Dr Siobhan Kirk pages, 14-16

---

## Chapter 2

**The Central Access Point: standing by women and girls and all pregnancy choices**  
by Ruairi Rowan pages, 17-21

---

## CAP Referrals by Parliamentary Constituency

pages, 22-23

---

## Chapter 3

**The Right to Choose: insights from a counselling service**  
by Carrie Montgomery pages, 24-27

---

## Chapter 4

**Working with No Support: the failure to commission abortion services in Northern Ireland**  
by Dr Sandra McDermott pages, 28-31

---

## Chapter 5

**Safe Access to Healthcare: the negative impact of anti-choice protestors**  
by Dr Caroline Hunter pages, 32-34

---

## Chapter 6

**How to Access Services: the need for a public health information campaign**  
by Dr Sharon Porter pages, 35-36

---

## Chapter 7

**Contraception Provision: additional investment to reduce unintended pregnancies**  
by Dr Eveane Cubitt pages, 37-38

---

## Chapter 8

**The Commissioning of Services: the role and expertise of NIACT**  
by Dr Ralph Roberts and Dr Leanne Morgan pages, 39-41

---

## Epilogue

**Decision Time: where next for local services?**  
by Ruairi Rowan pages, 42-43

---

# Prologue

## My story: a woman's experience of accessing local abortion care in Northern Ireland

*With Health and Social Care (HSC) Trusts in Northern Ireland now providing early medical abortion (EMA) services this article was written by a woman who accessed this healthcare within the South Eastern HSC Trust. It recounts her experience and calls on our government to stop adding additional distress and trauma onto people in crisis and to commission the abortion services which are now legally provided for.*

---

### Initial shock

At the end of June of 2020, I found out I was pregnant. It was a complete shock. When I missed my period, I didn't think much of it, as it was quite normal for me and my body. I only took the test because my partner at the time thought it might be good just to rule it out, and even then, he physically had to buy the test. I took it that evening just to get it over and done with. A few moments later, I looked down, expecting the inevitable negative result, to instead see a clear, dark cross. Before I could even process it, my stomach dropped, I began to feel violently ill and dizzy. I could barely get the words out to get the attention of my partner. Even just writing this, my heart is pounding out of my chest as it was in that moment.

Immediately I felt an overwhelming sense of shame and failure. I've always wanted to be a mum, but I knew that I couldn't put myself and my partner through having a child. We were both nowhere near financially stable, barely at the beginnings of our careers, and I knew I couldn't put our families through being financially and emotionally responsible for a child. Although I knew I was doing the right thing for my family, my partner, and myself, there was no point where it felt an easy decision to make.

### How to access services

After the initial shock, I began looking into getting an abortion. I can't lie, at that point I didn't even know that we had a functioning abortion service in Northern Ireland, and I started calling abortion clinics in Manchester. After a few phone calls, it became clear how difficult it would be making that journey.

Just as I hadn't been aware that a local abortion service existed, I was also unaware that funded travel and treatment was available in England for people living in Northern Ireland. From my conversations directly with the clinics, I was led to believe that it would take all of my savings to make the trip, including the cost of the ferry/inflated covid air travel prices, accommodation, and expenses. Even then, it would not have been enough for both me and my partner to go. The possibility of having to go alone was pretty likely.

Telling our parents, which might have given us access to some money to travel, was not an option either. I can only speak for myself, but I know for me, even in the privileged position of a good relationship with my parents, I felt so much shame, guilt and embarrassment that I couldn't fathom having that conversation. There was also an element where, as twenty-something year olds, it felt like something we needed to emotionally deal with privately, as adults.

Looking back now and being able to remove myself from the situation, I can also see that it is my right to keep my healthcare between me and my healthcare provider. Access to that care should in no way rely on forfeiting that right, or rely on a person having some form of a financial support system already around them in the first place.

For a moment in the first couple of days, I considered ordering pills online, although it never really felt like a real choice. How would I know if they were safe? How would I know if they worked? What would happen if something went wrong? Who was responsible if something went wrong? Who would check up on me? Would there be anyone I could talk to about it?

## Finding local support

As my morning sickness and extreme fatigue set in, I could barely make it past 2pm without needing to sleep or be sitting down. A couple of nights, I woke up with sharp stabbing pains, and in my sleepy panic, I assumed I was having a miscarriage, and began to freak out. They subsided, but it didn't stop me imagining being in pain, more physical and emotional pain than I was already in, as well as nauseous and hormonal, on a plane; on a ferry in the middle of the Irish Sea, with no idea how or if I can get help. After doing a bit of research, I managed to get in contact with Informing Choices NI (ICNI). There is part of me that wants to express how much relief finding them and the services I needed gave me, but I fear that in the process, the pain and distress of a situation like this could be lost. Even in my privileged position, this was easily the worst period of my life, and I can't imagine what it could be like for people less fortunate and with less support than I had.

ICNI arranged for me to have a phone consultation with a doctor. Before the appointment, I drove around to calm my nerves, but also to find a private space where I could take the call, where I could be sure no one could hear or see me. After the phone appointment I was booked in for an appointment at the Ulster Hospital. When I hung up, I sobbed for an hour. In one sense it was relief, but mostly I was just extremely sad about what was happening. In the short weeks I was pregnant, there was rarely a moment it wasn't on my mind, and if I happened to momentarily forget about it, I would quickly be reminded of it with excruciating headaches, nausea and fatigue.

I cannot express to you how lucky I was at every single step of this process. I had time to be sick, I had time to rest when I needed it, I had time to hide from people, so they didn't figure out what was really going on. I had enough time on my own that I could do my crying in private, and I didn't have to hold it together for anyone. I cannot even imagine what it is like for someone to have to continue working, being a parent, looking after family members or dealing with mental or physical health issues. Let alone having to emotionally and physically deal with travelling to a different country, or the uncertainty of ordering medication online.

## Attending for treatment

Soon enough my physical appointment came. I felt relieved to be pulling up to the hospital I had known my entire life. I could, for a brief second, pretend like I was going for any other appointment I had had there. The doctor explained what would happen, and I got the opportunity to ask her a couple of questions about concerns I had. Then I took the first pill. I came out of there knowing that this was a day I would remember for the rest of my life, but feeling like the end of this terrible period of my life could finally be coming to a close. The next morning, I woke up feeling, as usual, weighed down by this big heavy secret, but also feeling grateful to be in the familiarity of my then partners house and family, even if they didn't know what was going on.

I took the second set of pills that evening. My best friend, who I had decided to confide in a few days prior, brought me extra thick sanitary towels, and a special mat to put down on my bed. I lay in bed that evening in more pain than I'd ever experienced before. At one point I was convinced something had gone wrong, but even then, all I could think about was how grateful I was that I knew for certain that the pills I had taken could be trusted, handed to me by a local doctor, and that the hospital was a phone call away. It was only a 15-minute drive, and I had a letter explaining to the A&E doctor/nurse what had happened and who was looking after me. I didn't have to worry about getting in trouble, I didn't have to worry about how I would get from a hotel to a hospital I didn't know, or getting into a taxi, or being alone.

## Post pregnancy counselling

A few hours later, most of the pain subsided. I didn't realise how long my whole body had been tense, shoulders up to my ears. For the first time in two weeks, I felt like I could take a full deep breath. The next few days, a few weeks even, were a bit of a blur. I began to struggle, and luckily at that time my counselling sessions with ICNI began. I can't really remember much of what I said or felt on those calls, but I do know that each time I hung up the phone I felt some of the burden lift off my shoulders,

especially on the days where I knew if it wasn't for my appointments, I wouldn't have spoken to anyone that day at all. A couple of months later, I started to feel better, and like I could start to move on with my life.

## **Failure to implement the law**

I remember having my last call with my ICNI counsellor, and being able to recognise how different I felt from the first time I had spoken to her. I wasn't 100% okay, and it was a few weeks later until I really felt like my body began to move on too, but I knew I really had come to the end of that chapter of my life. A painful chapter, that I had the privilege of experiencing at home, with my own family, my bed, my own surroundings, my local hospital, without having to travel to an unfamiliar city, without fear of getting pills off the internet. All luxuries I would not have been afforded a few months prior, or indeed, several months later, when the service in my local area was suspended due to a staff shortage. Knowing it could have been so much worse, and it has been so much worse for so many people before me, less privileged than I am, and people since me, while our government has failed to put the relevant provisions in place, is something I find very hard to come to terms with.

Travelling to another country or ordering pills online in order to access basic healthcare is not an option, it's a last resort. I hope that my story can be used as example of how difficult this process is for everyone in every circumstance. Even further, how utterly cruel it is to add additional distress and trauma onto people in crisis, due to the failings of our government and its duty to implement the law.

# Foreword

## The Walls of Silence Surrounding Abortion: learning from the past and looking to the future by Dr Audrey Simpson OBE

*This article begins with a reflective journey of the societal, political and medical context surrounding abortion in Northern Ireland over the past thirty years. It provides a synopsis of the motivation for a judicial review to secure guidance for healthcare professionals on the provision of abortion services in Northern Ireland; tracks the legal challenge led by the Family Planning Association in Northern Ireland (FPA NI) and the outcome and impact of this case; the eventual closure of FPA NI, and the formation of Informing Choices NI (ICNI). It ends with the establishment of the central access point (CAP) into early medical abortion (EMA) services in Northern Ireland and the ongoing challenges in securing reproductive rights for all women and girls.*

### The walls of silence

The 1990's was a bleak time for abortion rights for girls and women in Northern Ireland. Unlike many other international countries fighting for reproductive rights, the women's movement and human rights and equality bodies in Northern Ireland were notable by their silence. Apart from Alliance for Choice there was no vociferous grass-roots activism and the overwhelming majority of those who travelled to England to secure an abortion did so in silence.

Furthermore, the main priority for UK Government was the peace process and restoration of a power-sharing legislature in Northern Ireland. In effect abortion was surrounded by what I called 'walls of silence'.

Given the political apathy at Westminster and political vacuum at Stormont for many years FPA NI was a lone voice publicly calling for equal access to a healthcare service in Northern Ireland which was freely available to girls and women in the rest of the UK.

### Taking our funders to court

We recognised that traditional lobbying and campaigning activities were not achieving significant change which left only one further option, to explore the potential of the judicial system to affect real change in securing abortion rights.

From the beginning we recognised that it was highly unlikely that the courts would extend the Abortion Act 1967 to Northern Ireland so our legal team advised that the legal premise with greatest potential was to argue that the Department of Health, Social Services and Public Safety (DHSSPS), as it was then known, was failing in its statutory duty by not issuing official guidance to health professionals on the circumstances in which abortion was lawful in Northern Ireland. It was felt that not only would this clarify the law, but also importantly, mainstream and legitimise abortion services in Northern Ireland.

On 13th June 2001 FPA NI's application for a judicial review was heard in Belfast High Court and leave was granted. The full hearing took place on 21st and 22nd March 2002.

Inside the courtroom FPA NI were opposed by five legal teams representing three anti-choice organisations, the Northern Bishops as well as the government. Outside the court anti-choice protests intensified in their numbers including waving placards showing distorted images of aborted fetuses and false information such as 'abortion causes breast cancer'.

Levels of harassment against FPA NI increased substantially. This included following clients attending our pregnancy counselling service, and staff, to their cars and shouting at them in the streets. Leaflets were thrown through car windows some of which stated that women who had been raped couldn't

become pregnant as the trauma of the rape would prevent conception. On one occasion there was a mock funeral outside our premises with protestors wearing black robes, black tears painted on their faces, carrying a child's white coffin whilst chanting, 'Hey, hey FPA how many kids have you killed today?'

Judgement was finally given in the legal case on July 7th 2003. The presiding judge, Mr Justice Kerr, ruled that the DHSSPS was not failing in its statutory duty to issue guidelines but thought it would be prudent if they did so. (Justice Kerr was latterly appointed to the UK Supreme Court and fifteen years later would rule that Northern Ireland's abortion law constituted a breach of women's human rights).

Following his somewhat ambiguous decision on this occasion papers were lodged by FPA NI on 28th July 2003 appealing the outcome and a hearing was eventually heard by a panel of three judges from the 24th to 26th of May 2004. On October 8th of that year the Court of Appeal ruled in favour of FPA NI and ordered the DHSSPS to consider what steps it should take to fulfil its duties by carrying out an investigation and issuing appropriate guidance.

## The long wait for guidance

In 2005 DHSSPS set up a working group to take the process forward which included a workshop for healthcare professionals and circulating a questionnaire to the Chief Executives of the Health and Social Care (HSC) Trusts, GPs, gynaecological nurses, midwives and obstetricians. Unbelievably it took twelve years to complete the process, fifteen years from the beginning of the judicial review challenge.

After numerous delays and attempts by anti-choice organisations through the courts to prevent publication, finally on 25th March 2016 the Northern Ireland Executive approved '*Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland*'.

Although it took an interminable length of time to accomplish what we set out to do I am proud of what was achieved throughout those long fifteen years.

The legal challenge attracted considerable media attention which stimulated a public dialogue around reproductive rights in Northern Ireland. The legitimising of the issue '*gave permission*' for health professionals to speak openly for the first time about the impact of the absence of official guidance for their clinical practice. Women's groups and human rights and equality bodies initiated their own campaign activities to support girls and women in Northern Ireland. There was growing support among Northern Ireland politicians but most important of all girls and women felt empowered to join in the public debate by recounting their experiences when faced with a crisis pregnancy. Lastly the guidance document endorsed FPA NI's long standing argument that abortion was indeed legal in Northern Ireland. But more was yet to come!

## Renewed campaigning and new challenges

FPA NI continued to campaign for further reform including the decriminalisation of abortion. A strong effective partnership was formed with Amnesty International UK who like FPA NI had a significant presence at Westminster. We worked with the Northern Ireland Women's European Platform and Alliance for Choice to prepare a submission to the United Nations Committee for the Elimination of Discrimination Against Women (CEDAW) requesting an inquiry into access to abortion in Northern Ireland. Ultimately the findings of this inquiry provided the basis of the legislation to reform abortion law in Northern Ireland in July 2019.

Regretfully FPA NI as an organisation was not around to celebrate this historic change. In May 2019 the London based Trustees of FPA UK placed the organisation into voluntary administration which meant that FPA NI no longer had any legal identity. Now retired I was immensely proud when the staff asked me to work with them to form a new organisation, ICNI, and by the end of May this had been legally constituted and I had the honour of becoming Chair of the Board of Trustees.

The biggest challenge facing ICNI was, and as this report demonstrates, continues to be, ensuring that

the decriminalisation of abortion and the new framework for services is put into practice. Covid-19 created its own challenges but despite this and the lack of political enthusiasm for commissioning abortion services, girls and women, through the commitment of local healthcare professionals are accessing abortion services in Northern Ireland. ICNI has played a significant part in this by establishing the CAP service into local EMA care.

At the time of publication, the Department of Health and the Northern Ireland Executive is refusing to commission full abortion services throughout Northern Ireland. This has resulted in inconsistent provision and ICNI struggling to sustain and develop the CAP service.

As an organisation we are fully committed to ensuring that no woman or girl is forced to leave Northern Ireland to access abortion care that should be available locally. I would like to take this opportunity to thank the staff of ICNI for putting that commitment into practice. Without their willingness to assume additional responsibilities, negotiate the challenges of working in a pandemic, work additional hours and forego annual leave, the CAP service would never have evolved.

This service has now been in operation for 14 months. During this time ICNI have made repeated attempts to engage with the Health Minister about the sustainability and development of the service, including the funding required. Throughout the course of this correspondence, we have repeatedly made clear that an unfunded service of this scale cannot run indefinitely. Despite these repeated warnings we have received no response from the Minister. As a small charity with limited resources and staff the provision of this vital service has placed considerable pressures which we cannot continue to absorb. As a result, the ICNI Board of Trustees have reluctantly taken the very difficult decision that if funding is not made available for the service to continue, we will cease providing it from 1 October 2021.

This report will address the impact that the withdrawal of the CAP service would have alongside the ongoing challenges in securing abortion rights in

Northern Ireland. It is also a celebration of what has been achieved since decriminalisation. Whilst not advocating dwelling on the past I believe at times it is important to reflect on how far we have travelled and the lessons learned. In so doing it will remind us that anything is possible.

Finally, I have to admit that in June 2001 when I began the judicial review process, I never thought I would be writing about inconsistent abortion service provision in Northern Ireland and campaigning for appropriate commissioning of services!

# Executive Summary

---

## Introduction

On 22 October 2019 abortion was decriminalised in Northern Ireland and the Abortion (Northern Ireland) Regulations 2020 came into force from 31 March 2020. The new Regulations coincided with a global health pandemic as a result of the outbreak of Covid-19. Due to the lack of flights, the only option available to women was to undertake an eight-hour ferry journey to England before further onward travel to a clinic. Effectively, women from Northern Ireland accessing abortion services needed to spend three days – including up to 24 hours on public transport – travelling to access care during a pandemic while the general public was being advised to stay at home.

## Rapid implementation of EMA services

As **chapter one** outlines, continuing to expect women to undertake such journeys was neither a safe or reasonable option. As a result, a safe, accessible early medical abortion (EMA) service, with robust clinical governance, was developed within a matter of days and integrated into existing sexual and reproductive health services within Health and Social Care (HSC) Trusts in Northern Ireland.

Many willing staff had previous experience of abortion care from working in other parts of the UK and peer support and training was offered. Clinic protocols and other necessary documentation was rapidly designed. As discussed in **chapter two**, Informing Choices NI (ICNI) agreed to provide an interim central access point (CAP) service into local EMA care. This enables people from across Northern Ireland to contact a single telephone number – 028 9031 6100 – where they can also access non-directive information, pregnancy choices counselling if requested, and referral into an EMA service within their HSC Trust. A medical consultation is offered within a few working days, and a time is then agreed to attend a clinic for treatment.

In the first year of providing the CAP service 2182

women and girls self-referred with an unplanned or crisis pregnancy. The average age of those who sought support was 29. The parliamentary constituency with the highest number of referrals was North Belfast.

## Pregnancy counselling support

As highlighted in **chapter three** ICNI's post pregnancy counselling service offers support on a wide range of pregnancy related issues – pregnancy loss, either through miscarriage, stillbirth or abortion – a traumatic birth or postnatal depression or anxiety. This service has seen an 85% increase in demand since April 2020 compared to the previous six months preceding the launch of the CAP service. One in thirty women who have requested access to abortion care during this past year have referred into ICNI's post pregnancy counselling service for support following treatment.

Women may have conflicted feelings following the loss of a pregnancy by abortion and even when they don't feel conflicted or experience any emotional tension around their decision to end a pregnancy, simply experiencing a stressful situation can trigger feelings of anxiety, panic or depression. For the majority of women who seek support following an abortion, it is more often for the existing stressors in their life which have been exasperated by a crisis/unplanned pregnancy than for grief in relation to the pregnancy loss itself.

It is not uncommon for a stressful situation to trigger previous traumas and for example one third of women who have referred into the service have been impacted by historical sexual abuse/violence and this is first time they have been offered a supportive space where they can discuss these traumas. At the time of reporting twenty-two people are currently on a waiting list for post pregnancy counselling, with the average waiting time of two-three months for new referrals received.

## The precarious provision of local services

Since the introduction of the new Regulations, it has been left to individual HSC Trusts and ICNI to absorb the needs of women, and without additional resources we have seen the services struggle to cope. On Monday 5 October 2020 the Northern HSC Trust ceased providing their EMA service. As a result, people living within this area had their options limited to traveling to England through the UK Government funded central booking system; travelling to the south of Ireland and paying privately to access abortion care at a cost of around €450; or accessing medication outside of NHS/HSE provision through independent online telemedicine providers such as Women Help Women or Women on Web.

The service in the Northern HSC Trust was subsequently reinstated on 4 January 2021. The following day the South Eastern HSC Trust suspended their EMA service. As a result of the suspension women and girls living within this area faced the same limited options as outlined above. The service was subsequently reinstated on 1 February 2021.

On 23 April 2021 the Western HSC Trust suspended their EMA service which had been maintained over the past year by a single doctor working without any support. In **chapter four** the doctor has written a personal account of her experience in which she describes the past year as the most rewarding of her thirty-seven-year career. However, she also states it has been the most stressful and easily the loneliest. At the time of publication, the service remains suspended.

141 people living in the Northern, South Eastern and Western HSC Trust areas self-referred into the CAP service between October 2020 and May 2021 and requested access to abortion whilst the EMA service within their HSC Trust was suspended and there was no local service in which they could receive the care they needed and are legally entitled.

Women were often very distressed when informed that a service was not available due to the area they resided in. Some have been very distressed. The

situation has been described by women as a *'disaster'*. Often, they ask why, if the law has changed, are services not in place. Others asked if they lived in another area, or had called sooner would they have been able to access the service locally. In most cases the answer to both of those questions was yes. This answer has caused those women particular upset.

When informed of the current options available to them when requesting access to abortion, the vast majority of women opt for accessing the medication online. They state that travel, particularly during a global health pandemic, is not *'feasible'* or *'practical'*, with some describing the idea of travel as *'scary'* during the current climate. Some women have stated that accessing pills online is not how they would have preferred to access abortion care, but that they have been left with no other choice.

## Safe access to healthcare

Unfortunately, women accessing abortion services across Northern Ireland have come into contact with anti-choice protest groups who have caused considerable distress. As outlined in **chapter five** there is no evidence that their presence outside healthcare facilities is preventing abortion, which is what they claim to want to achieve, it seems more likely that there may be an increase in morbidity caused by later presentations to the service and reluctance to avail of medical follow up. As lockdown measures ease their activities could increase which will cause additional harm to patients and negatively impact on the legal provision of healthcare services. It is clear that in order to protect patients and staff safe access zones should be introduced around sexual and reproductive health services and pregnancy counselling centres.

## Lack of information

It has become clear over the past year of EMA provision in Northern Ireland, that women and girls are signposted to the CAP service via a number of sources and this is expanded upon in **chapter six**. Due to the absence of a formally commissioned framework, there has been no public health

information campaign to direct women seeking information regarding their pregnancy options and/or abortion care away from rogue agencies and to the CAP service.

Pregnant women and girls seeking healthcare support will generally either search online or contact their GP. Those who first contacted their GP Practice prior to contacting ICNI have reported a range of experiences. The majority indicated that their GP reported either not being aware of how to access the local services or not being aware of the existence of the local service at all. Some reported that their GP took the time to seek out the information for them, some directed to abortion providers based in Great Britain, others reported that they were advised to “Google it” whilst some stated that their GP advised that it was “nothing to do with them”. A sizeable minority who contacted their GP for signposting to the local abortion service reported that this was a negative experience. They stated it was clear that the GP “disapproved” of their decision which left them feeling “judged”. A small number reported that their GP actively tried to convince them to change their mind.

## Access to contraception

Women who access the EMA service in Northern Ireland are either offered a long-acting reversible contraception (LARC) method at the same time as attending for an abortion or they are fast tracked into the service depending on the HSC Trust area they reside in. **Chapter 7** focuses on how added investment and promotion of contraception services, in particular a form of LARC, will reduce the number of unintended pregnancies and improve health outcomes for women and girls.

## Commissioning of services

Chapter 8 discusses the formation of the Northern Ireland Abortion and Contraception Taskgroup (NIACT) and their vision for the future, including their recent report on Sexual and Reproductive Health in Northern Ireland. This report provides a blueprint for the commissioning of services and makes 38

recommendations in total covering the topics of Relationships and Sexuality Education (RSE), sexual and reproductive health services, contraception provision, abortion access and exercising conscientious objection.

## The future of the CAP service

The CAP service has now been in operation for 14 months. During this time ICNI have made repeated attempts to engage with the Health Minister about the sustainability and development of the service, including the funding required. Throughout the course of this correspondence, we have repeatedly made clear that an unfunded service of this scale cannot run indefinitely. Despite these repeated warnings we have received no response from the Minister. As a small charity with limited resources and staff the provision of this vital service has placed considerable pressures which we cannot continue to absorb. As a result, the ICNI Board of Trustees have reluctantly taken the very difficult decision that if funding is not made available for the service to continue, we will cease providing it from 1 October 2021.

Therefore, the report concludes with an **epilogue** which highlights the implications if funding is not secured in the coming weeks to enable the CAP service to continue. Without the service in place, it would be left to each HSC Trust to provide their own pathway into EMA services. This will have financial, staffing and training implications for each HSC Trust.

Three out of the five HSC Trusts have suspended their EMA services to date and this additional strain could facilitate the collapse of, or severe disruption to, other EMA services which heavily rely on ICNI with no means to replace the support.

Centralising the service within ICNI removes service duplication amongst the various HSC Trusts and offers the most cost-effective service. ICNI have a proven track record of delivering these services and are a trusted source of information and support for women and healthcare professionals.

The provision of non-directive information and

pregnancy counselling are neither *'cross-cutting'* or *'controversial'* and do not require agreement from the Northern Ireland Executive. If the Health Minister wanted to provide the additional resources needed to ICNI in order to prevent the collapse of the CAP service he could do so. If he refuses to provide the urgent and essential funding required the Secretary of State should direct him to do so. Such action would aid a regional gold standard information, support and referral service which will benefit women, girls and their families and enable them to experience positive mental health and emotional wellbeing.

Much positive change has occurred over the past year. Now is the time to keep moving forward, not take a step back. We must move beyond decriminalisation and not only remove the walls of silence surrounding abortion, but also the walls of access.

# Chapter 1

## **Covid-19 and Access to Abortion: the rapid implementation of an EMA service by Dr Siobhan Kirk**

*On the 31st March 2020 the Abortion (Northern Ireland) Regulations 2020 took effect and on 10th April 2020 the first early medical abortion (EMA) treatments under the new Regulations took place. Five days later Informing Choices NI (ICNI) launched a regional central access point (CAP) service into which women across Northern Ireland could self-refer. The rapid implementation of this service occurred outside of a commissioned framework and was only made possible by a small team of dedicated professionals committed to ensuring that women could access high quality abortion care during a global pandemic. This article outlines how such provision was made possible.*

### Planning for services

Following the decriminalisation of abortion in October 2019, Doctors for Choice NI, a recently formed pro-choice group of clinicians, started a process of engagement with healthcare professionals around the provision of abortion services in Northern Ireland. In January 2020 they held a conference in collaboration with Ulster University entitled, “*Shaping the future of women’s sexual and reproductive health in NI*”. This provided valuable networking for interested health professionals and other agencies, such as ICNI, and resulted in the development of the Northern Ireland Abortion Contraception Taskgroup (NIACT).

When the first UK lockdown and travel restrictions were introduced on the 23rd March 2020, and with the new Regulations coming into effect eight days later, NIACT quickly held their first virtual meeting to discuss the possibility of implementing a temporary local EMA service (up to 9 weeks and 6 days gestation).

Continuing to expect women to travel to England in the midst of a pandemic was not a safe or reasonable option and the plan was for EMA treatment to be offered within existing sexual and reproductive health services where possible. This was only feasible due to the downturn in normal work schedules due to Covid-19 and initially only in the Belfast, Northern and Western Health and Social Care (HSC) Trust areas.

### Rapid implementation

Setting up an abortion service in Northern Ireland was always going to be challenging but we had to develop a safe, accessible service with robust clinical governance within a matter of days. Approval was sought at Chief Executive level within the HSC Trusts and after some initial confusion the Chief Medical Officer, Michael McBride, confirmed on the 9th April 2020 that healthcare professionals could legally provide abortion care in line with the new Regulations.

Many willing staff had previous experience of abortion care from working in other parts of the UK and peer support and training was offered. The British Society of Abortion Care Providers (BSACP) enabled access to training webinars, and the British Pregnancy Advisory Service (BPAS) shared their patient information and consent forms.

Clinic protocols and other necessary documentation was rapidly designed and shared between HSC Trusts and to fulfil legal requirements a standardised notification and certification form was utilised.

Sexual and reproductive health services in Northern Ireland use Lilie – an online IT system – and templates for EMA telephone consultations, treatments, and reviews were designed and added by the system administrator in each HSC Trust.

A referral pathway was developed in partnership with ICNI who kindly agreed to provide the CAP service.

Pharmacy links were established to order the new medication -mifepristone, misoprostol, analgesia and anti-emetics. This was not straightforward as most of the medication required over-labelling (repackaging and labelling with dosage instructions, batch number and expiry date by the hospital pharmacy department). A secure controlled drug cupboard was also required for storage along with a record book.

Low sensitivity pregnancy tests were sourced and ordered. These are provided to patients to take between two and three weeks after their treatment to confirm that the medication has been effective. Links were also made with Early Pregnancy Clinics in each HSC Trust to facilitate referral if necessary, as not all services were able to offer in-clinic scanning if clinically required to confirm gestation, exclude ectopic pregnancy or access follow up care.

In the Belfast HSC Trust a mobile phone was requested to offer patient support during clinic hours as a back up to the contact details provided in the patient information leaflet. This enables patients to contact us if their pregnancy test remained positive or they had any other concerns. All HSC Trusts offer similar telephone support.

One obstacle in the beginning was obtaining a Health and Care Number for women not registered with a GP in Northern Ireland - a requirement on the notification forms. This has since been streamlined and now easily obtained in most cases.

## Services commence

Belfast staff initially agreed to treat women from the South Eastern and Southern HSC Trusts until services within those areas could be established. The first EMA treatments under the new Regulations took place on the 10th April 2020, Good Friday, in the College Street clinic in Belfast and ICNI launched the regional CAP service on the 15th April 2020.

Training to staff in other HSC Trusts was offered within the Belfast clinic which was initially running five days a week due to the level of demand and necessity to cover three HSC Trust areas. 77 people self-referred into the CAP service in the opening week - this

heightened activity was as a result of people being redirected from the central booking system, then operated by BPAS, as well as from online telemedicine providers, due to the fact that services were now being delivered on the ground in Northern Ireland.

There is no doctor working in the sexual and reproductive health service in the Southern HSC Trust and most nurses had been redeployed as a result of Covid-19. However, following communication from NIACT, ICNI and other HSC Trust Chief Executives their service commenced in May 2020.

The Belfast HSC Trust was responsible for contraception provision for people living in the South Eastern HSC Trust until October 2020, however due to the dedication of a Consultant in Obstetrics and Gynaecology and a few committed colleagues a service within this HSC Trust commenced mid-June 2020. This meant all five HSC Trusts now had their own EMA service.

One of the advantages of EMA provision being located within sexual and reproductive health services is immediate access to contraception. In the Belfast HSC Trust 71% of women referred in 2020 had not been using any method of contraception and 15% conceived on oral contraception. At some clinics all methods of contraception, including immediate implant insertion, or a fast-track coil appointment are available. As a result, uptake of long-acting reversible contraception (LARC) is high, 55% in the Belfast HSC Trust in 2020, with 28% opting for a subdermal implant, the most effective form of LARC.

## Positive feedback

Patient feedback has been excellent with women delighted to have safe local access to abortion.

*"Everything you did for me was perfect and I would like to thank you for your help."*

*"I thought the whole process was so smooth. All staff on the phone and face to face were so professional and friendly. Thank you so much."*

*“Thank you for your help during this difficult time. A very valuable, excellent service.”*

*“All people really lovely, especially my doctor, she really put my mind at peace.”*

*“Very nice and helpful and helped me to choose the right contraception.”*

*“Everyone has been very helpful and easy to talk to about my situation. It makes all the difference at a difficult time.”*

*“Excellent service! I was really happy with the doctor, facilities and treatment.”*

*“Very friendly and professional. I was very pleased with the nurse who looked after me.”*

*“The doctor was excellent in her professionalism and explanation of everything. So glad this service is now available in Northern Ireland. Thank-you.”*

## Failure to commission services

However, due to the ongoing lack of commissioning or funding the services are extremely fragile – three of the five HSC Trusts have temporarily suspended services to date - we have no surgical treatment for those who would prefer this option and there is no pathway to care for women over 10 weeks gestation.

Unfortunately, at home mifepristone has not yet been allowed in Northern Ireland necessitating a clinic visit for all women, unlike in the rest of the UK and Ireland where full telemedicine is available temporarily due to Covid-19. Despite lockdown restrictions, clinics are also experiencing increasing protests from anti-choice organisations.

## Overcoming obstacles

Notwithstanding the challenges, we have demonstrated that safe local abortion care can be delivered within sexual and reproductive health services with the support of ICNI providing the CAP service.

Waiting times are low, allowing safer treatment at earlier gestations. Due to the small number of dedicated people involved, from ICNI and the HSC Trusts, we have a very effective team with excellent communication, and this has optimised patient care.

We have monthly Clinical Lead meetings with the ICNI team for support and service updates and a regional clinical WhatsApp group for medical queries.

EMA staff have found this new role challenging but also immensely rewarding. Hopefully commissioning will happen soon and both ICNI and the HSC Trusts will get the funding and support they urgently need and deserve.

# Chapter 2

## The Central Access Point: standing by women and girls and all pregnancy choices by Ruairi Rowan

*“Should a woman want to access abortion services, she can contact her GP in the first instance or she can contact Informing Choices NI.” – Robin Swann MLA, Health Minister*

*The words above were spoken by the Health Minister, Robin Swann MLA, in the Northern Ireland Assembly in March 2021. In doing so he was signposting women to a service which thus far his Department has refused to commission. How did such a scenario come into being? This article builds on the foreword written by Dr Audrey Simpson and focuses on the closure of the Family Planning Association (FPA), the emergence of Informing Choices NI (ICNI) and the launch of a ground breaking non-commissioned service that has supported over 2000 women and girls with an unplanned or crisis pregnancy during the past year.*

---

### The end of an era

On 30 April 2019 I sat in the former FPA office in Belfast alongside all my colleagues from Northern Ireland. Three non-staff members were in the room. One was the former FPA NI Director, Dr Audrey Simpson, the other two belonged to an organisation called RSM, an audit, tax and consulting firm, who had been instructed by the London based FPA Board of Trustees to place the charity into what is known as a Creditors’ Voluntary Liquidation.

The Trustees, concerned by a long-standing final salary pension repayment commitment, had taken the shocking decision to close the charity. All staff were being made redundant and 90 years of history was coming to an end in two weeks. As a result, the organisation which had led the charge on securing abortion rights in Northern Ireland wasn’t there to witness the change.

### New beginnings

The next few months were tough and often it felt like we were taking one step forward and two steps back. Forming a new organisation may sound glamorous, but try opening a bank account and you’ll quickly discover how difficult things can be. ICNI eventually managed to maintain all contracts previously held by FPA NI. However, what we had hoped would take a

matter of weeks to agree, ended up with protracted conversations with funders and the liquidators spanning six months and where my resilience as a campaigner proved beneficial.

One thing that did proceed with pace was the recruitment of a new Board of Trustees with Dr Audrey Simpson as chair-elect. This was one of the reasons why she was in attendance during the meeting with the representatives from RSM.

Following that meeting I called my colleague and friend Grainne Teggart. Grainne is the Campaigns Manager for Amnesty International in Northern Ireland and together we had formed a strong partnership and had a significant presence at Westminster in the lead up to Northern Ireland’s abortion law finally being changed. I updated her on the situation with FPA, which was initially met with shock, and our plans to reform as a new organisation. She immediately agreed to become a Trustee.

My next call was to the leader of the Green Party in Northern Ireland, Clare Bailey MLA. I asked if she was free and made the short walk from the FPA office in Shaftesbury Square to her constituency office on University Street. I relayed a similar account of the situation with FPA and discussed our future intentions. Clare too agreed to become a Trustee and assist in any way she could.

An hour after the meeting with RSM and we now had three new Trustees. Within 24 hours four more had been recruited. Professor Bill Rolston, a founding member of the Northern Ireland Abortion Law Reform Association; Dawn Purvis, a former MLA and Programme Director of Marie Stopes International in Northern Ireland; Mary Crawford, the former Director of Brook in Northern Ireland; and Georgie McCormick, who established FPA NI's pregnancy counselling service.

This group of individuals, alongside the remaining staff team, held much of the history associated with FPA NI and the role it played in contributing to the improvement and change in societal attitudes towards sexual and reproductive health and their support was crucial in continuing this work and supporting it to evolve.

We held our inaugural meeting of the new Board of Trustees the following week and had some good news to report regarding donations received, including a sizable contribution from the British Pregnancy Advisory Service (BPAS). This enabled us to retain our premises and a small staff team during the transition period and I'll always be grateful to them, and their then Chief Executive Ann Furedi, for the support provided to get ICNI off the ground.

ICNI were registered with Companies House on 20 May 2019 and work continued over the next few months to retain our sexual health helpline, pregnancy counselling service, Relationships and Sexuality Education (RSE) programmes, RSE training courses and wider advocacy work in relation to sexual and reproductive rights and education services.

## Launch of ICNI

With all funding in place and services retained by the end of 2019 we officially launched the organisation in January 2020. At this point abortion had been decriminalised in Northern Ireland and a consultation on a new legal framework had been conducted. The first case of coronavirus had also been reported and it was to be this emerging global health pandemic that led to the rapid implementation of early medical abortion (EMA) services in Northern Ireland.

In the lead up to the Abortion (Northern Ireland) Regulations 2020 coming into force on 31 March 2020 ICNI experienced a growing number of calls to our sexual health helpline with people struggling to access abortion care in England due to Covid-19 travel restrictions, flight cancellations and hotel closures.

Due to the lack of flights, the only option available to women was to undertake an eight-hour ferry journey to England before further onward travel to a clinic. Effectively, women from Northern Ireland accessing abortion services needed to spend three days - including up to 24 hours on public transport - travelling to access care during a pandemic while the general public was being advised to stay at home.

As a result, ICNI worked alongside healthcare professionals and members of the Northern Ireland Abortion and Contraception Taskgroup (NIACT) to establish an interim EMA service which was integrated into existing sexual and reproductive health services in Health and Social Care (HSC) Trusts in Northern Ireland.

## CAP service

A vital part of this process is the ease of the referral pathway through the central access point (CAP) service provided by ICNI. This enables people from across Northern Ireland to contact a single telephone number - 028 9031 6100 - where they can also access non-directive information, pregnancy choices counselling if requested, and referral into an EMA service within their HSC Trust. Access to follow up support is also available via our post pregnancy counselling service.

In addition, ICNI undertakes all safeguarding with girls aged between 13-15 years-old and assess their ability to consent to medical treatment using the Fraser guidelines. We refer daily to the HSC Trusts, a medical consultation is offered within a few working days, and a time is then agreed to attend a clinic for treatment. Clients value the service provided by ICNI as is highlighted by the feedback from patient evaluation surveys:

*“Informing Choices were the only people to help me get the proper services and help.”*

*“Fantastic service, put me at ease from the very first phone call.”*

*“I was very nervous making the call but the people I spoke to were very reassuring and I never once felt judged.”*

*“Very helpful and comforting. They ensured I understood what was being said and made the situation easier.”*

*“Really informative and explained the process thoroughly.”*

*“So professional and instantly made me feel at ease and reassured.”*

In the first year of providing the CAP service 2182 women and girls self-referred with an unplanned or crisis pregnancy. The average age of those who sought support was 29. The parliamentary constituency with the highest number of referrals was North Belfast. (A full breakdown by constituency follows this chapter).

As expected, the provision of the CAP service has impacted upon the demand for ICNI’s pregnancy counselling service with requests for post pregnancy counselling increasing by 85% since April 2020 compared to the previous six months before the service launched. ICNI applied for a community grant to enable the organisation to increase our counselling support in order to deliver twenty post pregnancy counselling sessions per week. Additional pregnancy choices counselling sessions are provided when requested. However, this is only a short-term solution which will not sustain the current level of counselling requests going forward. At the time of reporting twenty-two people are currently on a waiting list for post pregnancy counselling, with the average waiting time of two-three months for new referrals received. No one is waiting for pregnancy choices counselling.

## Hokey-Cokey healthcare

Since the introduction of the abortion Regulations, it has been left to individual HSC Trusts and ICNI to absorb the needs of women, and without additional resources we have seen the services struggle to cope.

On Monday 5 October 2020 the Northern HSC Trust ceased providing their EMA service. They stated that they were unable to continue to deliver the unfunded service and as other HSC Trusts did not have the capacity to accommodate women who fell within this area a pathway to care was no longer available to all women in Northern Ireland.

As a result, people living within this area once again had their options limited to traveling to England through the UK Government funded central booking system; travelling to the south of Ireland and paying privately to access abortion care at a cost of around €450; or accessing medication outside of NHS/HSE provision through independent online telemedicine providers such as Women Help Women.

The fact that women were being denied access to local healthcare based on their location was grossly unfair and it was left to ICNI to inform them of this and the options available to them.

The service in the Northern HSC Trust was subsequently reinstated on 4 January 2021. The following day the South Eastern HSC Trust suspended their EMA service stating unforeseen circumstances resulting in no senior medical cover. As a result of the suspension women and girls living within this area faced the same limited options as outlined above. The service was subsequently reinstated on 1 February 2021.

113 people living in the Northern and South Eastern HSC Trust areas self-referred into the CAP service between October 2020 and January 2021 and requested access to abortion and there was no local EMA service in which they could receive the care they needed and are legally entitled.

Women were often very distressed when informed that a service was not available due to the area they resided in. The situation has been described by

women as a *'disaster'*. The majority of women had not been aware that the service was suspended before calling ICNI and many were extremely upset and angry when informed of this and said it was *'unfair'*.

Some often ask why, if the law has changed, are services not in place and expressed concern for other women and girls faced with a similar situation. Others asked if they lived in another area, or had called sooner would they have been able to access the service locally. In most cases the answer to both of those questions was yes. This answer has caused those women particular upset.

When informed of the current options available to them when requesting access to abortion, the vast majority of women opt for accessing the medication online. They state that travel, particularly during a global health pandemic, is not *'feasible'* or *'practical'*, with some describing the idea of travel as *'scary'* during the current climate.

Women have mentioned that accessing abortion pills online would save an already stretched health service money, whilst other women have raised concerns that they would not be able to afford the donation to access the pills online despite this being their preference. I am worried that such women will be so desperate and may turn to more dangerous methods.

Women ask a number of questions regarding online medication, with the main questions being are they safe to take, is it legal to access the medication in this way, as public prosecutions of others who have done so are still fresh in many people's minds, and are they able to access medical support afterwards if necessary. Some women have stated that accessing pills online is not how they would have preferred to access abortion care, but that they have been left with no other choice.

On 23 April 2021 the Western HSC Trust suspended their EMA service and ceased accepting referrals. The service had been maintained over the past year by a single doctor working without any support. In the correspondence I received from the doctor regarding this she highlighted that this had taken both a mental

and physical toll on her which could no longer be sustained. At the time of publication, the service remains suspended. During the first six weeks that the service was suspended, 26 April – 30 May, 28 people were impacted.

Therefore, three out of the five HSC Trusts have suspended their EMA services in Northern Ireland during a six-month period, and without additional funding in place the CAP service could be the next to face withdrawal.

## Service development or withdrawal?

ICNI stepped in to provide an interim referral pathway and additional counselling support as an emergency response to Covid-19 and by doing so ensured that there was no delay in EMA services being established in Northern Ireland.

We have highlighted how a service can operate, the willingness of healthcare professionals in Northern Ireland to provide the service and the numbers availing of it. Most importantly we assisted with the provision of a vital local service to women and girls during a global health pandemic. Such a ground-breaking service would not have been possible without our involvement.

However, an essential service of this scale cannot continue to function without additional resources and the current CAP service has only been maintained as staff have worked additional hours and foregone the majority of their annual leave. Without additional funding in place the service will be forced to cease on 1 October 2021.

In their recently published, *'Monitoring Report on Reproductive Healthcare Provision in NI'* the Northern Ireland Human Rights Commission (NIHRC) recommends, *'sufficient, long-term, ring-fenced funding for a Central Access Point'* to *'ensure the continuation and effective delivery of a referral pathway for termination services that upholds the privacy and confidentiality of women and girls.'*

However, ICNI's requests for funding from the

Department of Health remain unacknowledged and our requests of support from local commissioning groups have received similar treatment.

If the CAP service was removed it would be left to individual HSC Trusts to pick up, and provide a pathway to this service. During this pandemic and period of high pressure this will have financial, staffing and training implications for each HSC Trust which continues to operate an EMA service.

ICNI already receive funding from the Department of Health and the Public Health Agency to provide a pregnancy counselling service and the provision of a sexual health helpline. The additional resources we require relate to the extension and staffing of these services.

Failure to secure resources will leave ICNI with no option but to withdraw the CAP service from 1 October 2021. This could also facilitate the collapse of, or severe disruption to, local EMA services which heavily rely on our support with no means to replace it.

As an organisation with a proud history of supporting women and girls with an unplanned or crisis pregnancy this is not a decision we have taken lightly and such an outcome would have devastating consequences for many people and be a backward step for the provision of healthcare services in Northern Ireland.

Over the past year I have spoken with over 1000 women. While I have dedicated the last six years to advocating for the advancement of reproductive rights in Northern Ireland, supporting women directly over the past year has been the greatest privilege of my career. Being forced to withdraw that support, after all the effort that has been put into establishing and maintaining the service, would be completely demoralising.

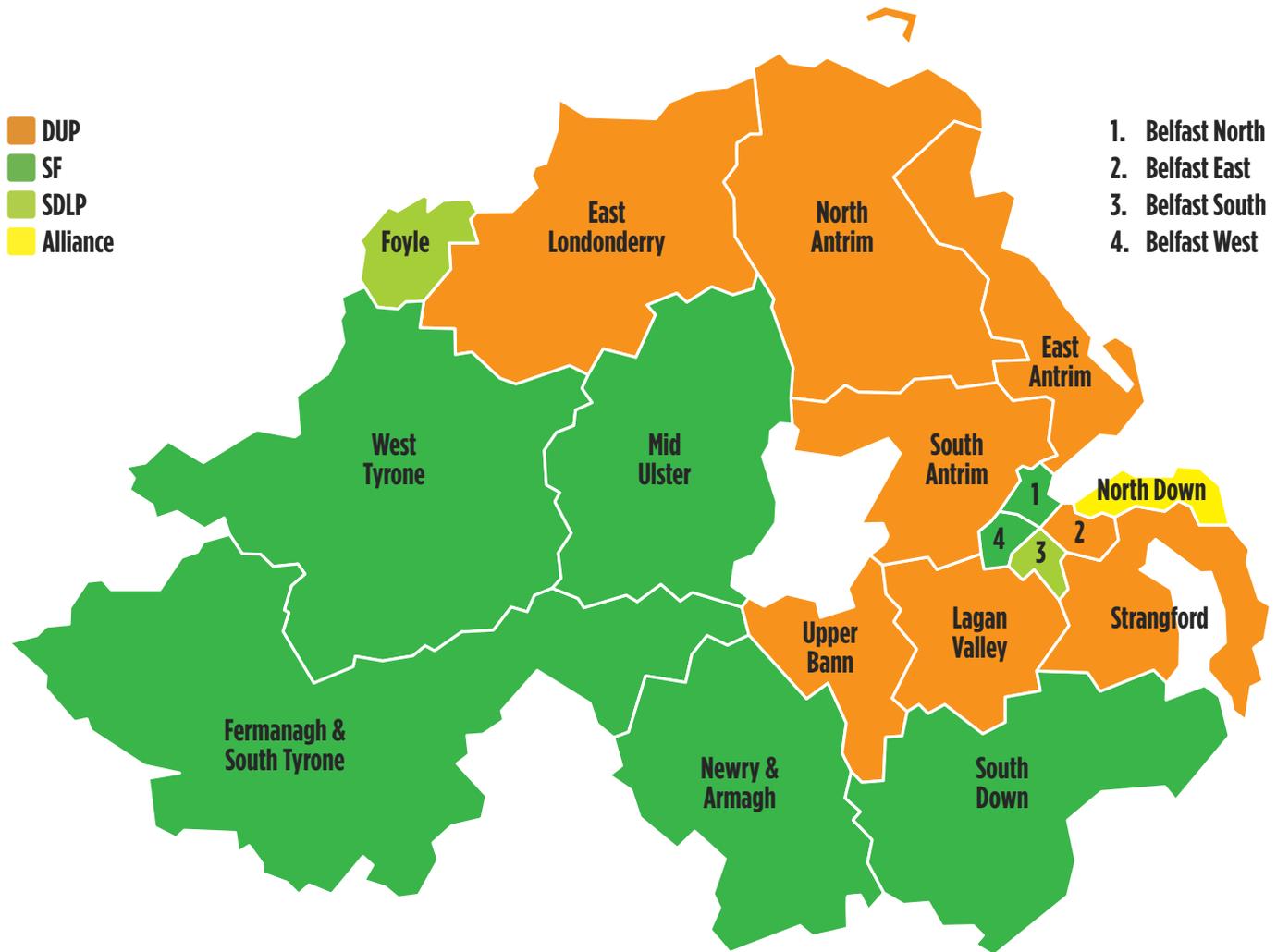
However, when things look at their bleakest, and it appears that services may come to an end I can look back to the closure of FPA and the establishment of ICNI for inspiration. Our sheer existence proves that solutions can be found even in the most difficult of circumstances.

The NIHRC has taken legal action against the Secretary of State for Northern Ireland, the Department of Health and the Northern Ireland Executive challenging their failure to commission abortion services. ICNI alongside Amnesty International UK jointly intervened in this case to highlight that abortion services in Northern Ireland are not only limited, they are also highly precarious.

The Secretary of State has also taken powers to direct local bodies and office-holders to commission abortion services and has stated that concrete steps towards doing so must take place before the summer. At the time of writing, he is yet to exercise these powers. Given the failure of politicians in Northern Ireland to commission abortion services we would support urgent intervention from the Secretary of State to ensure that all services provided for under the Regulations are enacted, and the rights of women and girls are realised.

ICNI has done all it can to maintain the interim CAP and EMA services that are in place. It is now up to our political leaders to provide the necessary funding to sustain and develop our service. Let's hope they act before it's too late. Their time is running out.

# CAP Referrals by Parliamentary Constituency



Constituency	Number of referrals
East Antrim	99
East Belfast	135
East Londonderry	93
Fermanagh and South Tyrone	96
Foyle	113
Lagan Valley	118
Mid Ulster	100
Newry and Armagh	146
North Antrim	91
North Belfast	178
North Down	108
South Antrim	124
South Belfast	174
South Down	88
Strangford	104
Upper Bann	165
West Belfast	169
West Tyrone	81

N.B. This table highlights the number of women and girls who self-referred into the CAP service between 15 April 2020 to 14 April 2021. It does not correspond with the number of abortions which have occurred in Northern Ireland during this period. There are a number of reasons for this e.g., not all women who self-refer into the CAP service will decide to end the pregnancy after discussing their options, some may ask to be referred and then decide not to access the service, others may miscarry before attending the clinic, while some may scan over 10 weeks and be unable to access a local service in Northern Ireland. A significant number of women who self-referred into the CAP service were also affected by the suspension of local EMA services.

Constituency	% CAP Service Referrals	% Reproductive Age Population	% Differential (demand/population)
North Belfast	8.2%	5.8%	+41%
West Belfast	7.7%	5.5%	+41%
East Belfast	6.2%	5.3%	+17%
North Down	4.9%	4.3%	+14%
Upper Bann	7.6%	6.9%	+10%
Strangford	4.8%	4.4%	+8%
Newry and Armagh	6.7%	6.3%	+6%
South Antrim	5.7%	5.5%	+4%
South Belfast	8.0%	7.7%	+4%
East Antrim	4.5%	4.5%	+1%
Lagan Valley	5.4%	5.6%	-3%
Foyle	5.2%	5.7%	-10%
East Londonderry	4.3%	5.1%	-17%
Mid Ulster	4.6%	5.6%	-18%
Fermanagh and South Tyrone	4.4%	5.5%	-21%
West Tyrone	3.7%	4.8%	-22%
North Antrim	4.2%	5.6%	-26%
South Down	4.0%	5.8%	-30%

This table highlights the percentage of referrals received by the CAP service in each parliamentary constituency compared with the percentage of women of reproductive age (15-45 years-old) who live in the area. While there is a clear need across all areas in Northern Ireland the data shows that there is greater demand than would be projected in North Belfast, West Belfast, East Belfast, North Down and Upper Bann. Whereas referrals from South Down, North Antrim, West Tyrone, Fermanagh and South Tyrone, Mid Ulster, East Londonderry and Foyle have been fewer than anticipated with respect to their population densities. The other constituencies are within the margins of appreciation.

[Source: NISRA – 2019 Mid-Year Population Estimates for Northern Ireland]

Age Range	Number of referrals
Under 16	14
16-17	58
18-19	127
20-24	513
25-29	471
30-34	492
35-39	338
40+	168
Unknown	1

**2182 people with an unplanned or crisis pregnancy self-referred into the CAP service provided by ICNI within the past year. They came from all parts of Northern Ireland. They are your neighbours, your colleagues, your family and your friends. ICNI has had the privilege to support them and will continue to campaign to ensure that sexual and reproductive health services, including abortion care, is readily accessible and meets the needs of all citizens in Northern Ireland.**

# Chapter 3

## The Right to Choose: insights from a counselling service by Carrie Montgomery

*This article focuses on the pregnancy counselling service provided by Informing Choices NI (ICNI). It discusses pregnancy choices counselling support and the dilemmas and stigma women experience when faced with an unplanned or crisis pregnancy. It also highlights the increase in requests for post pregnancy counselling and the reasons for this including the isolation women experience following a pregnancy loss. It ends by outlining the future aspirations of the service, including outreach to men.*

### The first generation with choices

One hundred years ago, the first UK birth control clinic was founded in 1921. However, it wasn't until 1967 the National Health Service (Family Planning) Act enabled local health authorities to provide birth control advice regardless of marital status, followed in 1974 by advice and contraceptive prescriptions provided free of charge on the NHS. 1967 was also the year the Abortion Act was passed allowing women in England, Scotland and Wales legal access to terminate a pregnancy. In effect, this is the first generation of reproductive aged women who are in a position to enjoy sex with legal rights and healthcare access to make individual choices over when or if sexual activity results in parenthood. It was not until 2019 that abortion treatment was decriminalised for women in Northern Ireland and new Regulations governing lawful access to services came into effect in March 2020.

In 2019, I joined ICNI as Counselling Services Coordinator following over fifteen years professional experience of providing support services focused on suicide prevention and trauma recovery. This included developing the pilot of Northern Ireland's 24/7 suicide prevention service, Lifeline, which I co-lead for over a decade. While no stranger to supporting people in crisis who have had the additional challenge of stigma and discrimination, I stand on the shoulders of giants – my colleagues who have a thirty years history, under FPA NI, of advocating for reproductive healthcare rights alongside providing support to women in an era when abortion treatment in Northern Ireland was highly restrictive and

attending their workplace each day involved being confronted by groups of anti-choice protestors.

### Navigating choices

ICNI's pregnancy choices counselling service has been providing support to women for over thirty years. Given the context within Northern Ireland during this era, the most pressing need women had was seeking confidential information and support on what options they had to access abortion treatment safely. As ICNI's central access point (CAP) service, established in April 2020, now provides information to women on all of their options when faced with an unplanned/crisis pregnancy, including referral into local abortion services, the counselling service has evolved.

It's not hard for most sexually active women to picture the scenario, as most at some point will have had 'a scare'. Maybe waiting for reassurance that an emergency contraceptive pill was effective after a condom split or if on the pill, realising your period is a day or two late, trying not to worry, and casting your mind back over the month and remembering the days you forgot to take it. For most a period will arrive, but for some, considering almost half of pregnancies are unplanned, two lines appear on a pregnancy test. For these women the options are to either continue with the pregnancy, consider adoption or abortion.

The majority of women who contact us in relation to an unplanned/crisis pregnancy will already have

made the decision to end their pregnancy and are seeking information on their options for accessing abortion care. While I've yet to speak to a woman who does not feel the weight of ending a pregnancy on their shoulders, most women seeking an abortion will view this option as best for their individual circumstances, often having done everything they could to prevent becoming pregnant in the first place and are grateful to be able to receive treatment locally. There are also one in fifty women contacting our services who want to discuss their thoughts and feelings with an impartial person before reaching a final decision and will therefore refer into the pregnancy choices counselling service.

## Choice or choicelessness?

For the women who refer into the pregnancy choices counselling service, without over-generalising, there are common themes – often women are feeling isolated with their decision-making process, perceiving they may face stigma/discrimination and have fears that their decision will have a negative impact on their mental health.

As women's reproductive health is not usually something we openly discuss over the breakfast table with family or friends, women will often think of common voices they have heard most loudly in society – the polar opposite viewpoints. On one side they hear the opinions of people who are against women having a choice in relation to their reproductive rights and who often use derogatory/discriminatory terms to describe women who are contemplating the option of not continuing with a pregnancy. In response to this strong opinion, they hear those who are robust vocal advocates of women having a choice, and perceive that this demographic has an expectation that *'you're either with us or against us'* and visible in relation to women's rights campaigns. Campaigns for change by their very nature provoke and encourage society to consider which side of the debate they are on, but can mean most women don't see or hear their more nuanced experience reflected. The vast majority of women (and indeed men) sit somewhere in the middle – in support of women having choice but unsure how they would feel if they were faced with an

unplanned/crisis pregnancy themselves. As this ambivalent voice is not one they hear represented publicly, they feel isolated in their views with an underlying fear they could be judged for even considering their options and rarely turn to family or friends to talk out their dilemma.

Most women referring into the pregnancy choices counselling service are in a real dilemma, not sure what to do, which can feel like choicelessness rather than a choice – often wishing the decision will be made for them. On one hand they fear the risk of a negative impact on their mental health if they decide not to continue with the pregnancy, with the perceived judgement that comes with this decision – their own, their families and society. On the other, their reasons for not feeling they can continue with the pregnancy are usually complex with their current life circumstances generally already stressful e.g., relationship breakdown or the risk of a relationship breakdown with the added strain of an unplanned pregnancy, family health issues/their own health concerns, contemplating what it would mean to add to their family/become a mother before feeling ready, or not yet knowing if they want to be a mother. Similarly, their concern is that continuing with the pregnancy could have a negative impact on their mental health or place additional strain on their family, both adults and children.

They can also often feel pressured to make a timely decision – either due to the limit of ten weeks for women to currently access abortion care locally or their own personal view on what stage ending a pregnancy is acceptable to them. Most women appreciate more than one counselling session, using the support to slow things down and come to a decision that is right for them – of which a third will decide to continue and two thirds will decide ending the pregnancy is best for their circumstances. While most abortions occur during the first eight weeks of pregnancy, for the women who need a bit more time to be confident about their decision it is critical that local services are resourced to provide this option in line with the Regulations – up to 12 weeks on request, currently limited to 10 weeks due to an absence of commissioned services, and on health grounds thereafter.

Not all pregnancies ending in childbirth are planned, and not all those that end in abortion are unwanted at the time of conception. The other group of women for whom pregnancy choices counselling service benefits are those who have had the distressing news in the second or third trimester that there is a problem with fetal development. The prognosis that their much-wanted baby will either not survive or live with severe disabilities is devastating. Where data is available (England and Wales) terminations under these circumstances represents 1% of abortions. While there is no time limit for treatment, these women again often feel time pressure to decide on whether to continue with the pregnancy until full term or end the pregnancy. They often do not access counselling support until after termination/stillbirth, when struggling with feelings of complex grief. Feedback from this group of women is that pregnancy choices counselling would have been a critical support while considering their options and should be a resource offered as standard.

## Do women regret their choice?

ICNI's post pregnancy counselling service offers support on a wide range of pregnancy related issues. The service has seen an 85% increase in demand since April 2020 compared to the previous six months.

One in five women experience a mental health issue during pregnancy. Yet it can often feel for many women that society does little to acknowledge the impact that difficult pregnancy experiences, such as a traumatic birth and/or post-natal depression or anxiety, can have on them and their families. Currently this is even more problematic as women have experienced additional isolation from family support and relevant health services during the global pandemic.

Pregnancy loss, be it through miscarriage, stillbirth or abortion, can be shrouded in secrecy, creating a sense of isolation for those who have experienced a loss. Stigma related to abortion experiences remains pervasive despite lawful access to services from 31 March 2020.

One in thirty women who have requested access to abortion care during this past year have referred into ICNI's post pregnancy counselling service for support following treatment. A concern on hearing this has been whether this means women have regretted their decision given the common myth that while women may initially feel relief following an abortion, they will at some point regret their decision.

Women may have conflicted feelings following the loss of a pregnancy by abortion and even when they don't feel conflicted or experience any emotional tension around their decision to end a pregnancy, simply experiencing a stressful situation can trigger feelings of anxiety, panic or depression. For the majority of women who seek support following an abortion, it is more often for the existing stressors in their life which have been exasperated by a crisis/unplanned pregnancy than for grief in relation to the pregnancy loss itself. It is not uncommon for a stressful situation to trigger previous traumas and for example one third of women who have referred into service have been impacted by historical sexual abuse/violence and this is the first time they have been offered a supportive space where they can discuss these traumas. It is also not unusual for the birth of a child or the pregnancy to raise issues in relation to motherhood/parenthood and memories of their own early years with unresolved/unspoken adverse childhood events.

Since March 2020, the service has been provided via telephone counselling. Given the majority of women in receipt of counselling is for post pregnancy support rather than to discuss their choices in relation to an unplanned or crisis pregnancy, they have also raised their concerns, both prior to and since the change in Regulations, to seeking support when there is the risk of being challenged entering the building by anti-choice protestors.

Due to current circumstances, Covid-19, telephone counselling provides a solution to the fact that face to face counselling rooms have not been designed with the need for social distancing in mind. It also ensures the service remains accessible for those who have dependents or cannot travel. However, a key consideration when the pandemic is no longer a risk, is the barrier for women seeking the support they

need without the introduction of a safe access zone, from those who oppose abortion provision, outside ICNI offices.

My hope is that in this next year the counselling service is sufficiently resourced to reach all those who require it, regardless of gender.

## What about men?

Despite the service being available to all genders, during the past year all referrals into the counselling service, pregnancy choices and post pregnancy, have been received from females.

While the difficult decision about how to proceed with an unplanned or crisis pregnancy should rightly lie with the pregnant person, many women will seek the opinion of their partner or close family members/friends. The majority of women report their loved ones have aptly replied *'the decision is yours and I will support you either way'*. However, some women express that while supportive they are also worried about the impact on their relationship if they decide on a different course of action from what their partner actually wanted and recognise their partner may also be feeling isolated, excluded or conflicted.

For women who experience grief or other complicated emotions following a pregnancy loss, whether by abortion, miscarriage or stillbirth, they often worry that their partners have also been impacted but are not receiving support or are feeling helpless in how best to support the woman as they are confused by the intensity of emotions they are experiencing. In these instances, women will often enquire about the availability of counselling support for the men in their life.

In my previous experience for over a decade of providing support services targeted towards men, a common encouragement I often heard, due to low uptake of health and care services, is for men to *'reach out for support'*. While well meaning, the inference is that men are in some way to blame for an absence of timely help seeking behaviour. The reality is that services need to improve on how to reach out to men – a particular challenge for a service that is perceived as solely supporting women and women's rights. Effectively promoting the service during the past year while resources have been stretched and the CAP service has remained unfunded has been a critical gap.

## Chapter 4

### Working with No Support: the failure to commission abortion services in Northern Ireland by Dr Sandra McDermott

*Due to the current failure to commission abortion services interim early medical abortion (EMA) services have been operating across Northern Ireland with a threadbare staff, working with little or no support. This article outlines how the service in the Western Health and Social Care (HSC) Trust was being sustained by a single doctor, the consequences of this for both women accessing the service and the doctor providing it, and its ultimate withdrawal due to the strains this caused.*

#### Changes across the island of Ireland

I remember, very clearly, in 2018, the excitement surrounding the #hometovote campaign in Ireland that urged people abroad to return home to vote to repeal the country's abortion ban. Pictures of droves of people arriving in Dublin airport from countries all over the world was not just heart-warming, but humbling to see so many making that effort to express their views and support women.

The result was an overwhelming majority for repeal. I recall the positive atmosphere at work, seemingly from everyone. I honestly thought we would never be seeing similar progress in Northern Ireland, certainly not in my working lifetime. Happily, I was wrong.

A year later, whilst the Northern Ireland Executive was in a three-year hiatus, abortion was decriminalised. I attended a conference in January 2020 organised by Doctors for Choice NI and was excited to be amongst people from different backgrounds and careers but with the same pro-choice aspirations.

On 31 March 2020 a new legal framework for abortion services in Northern Ireland took effect. By that time, we were in lockdown due to a worldwide pandemic. Significant travel restrictions were in place. Flights cancelled. Hotels closed. It was unthinkable for women and girls to have to travel to England for abortions at this time. And so, without funding, a group of conscientious providers, including myself, commenced EMA services in April 2020.

#### Lack of support

With my devotion, or perhaps naivety, I assumed that other staff members in our small sexual and reproductive health team in the Western HSC Trust would be equally as committed. To my utter shock, and disbelief, that was not the case.

Initially, two or three staff members said that although not wanting to be part of the 'treatment giving' they would be happy to do the consultations. This very quickly changed when staff were enabled to go beyond the extent of conscientious objection, a vital right in healthcare, and be excused from playing any part in the service. This included administrative staff who have no right to conscientious objection.

Research on the views of health professionals working in obstetrics and gynaecology units in Northern Ireland regarding the provision of abortion published in March 2021 found that there are sufficient numbers of clinicians in each HSC trust to provide abortion care (Bloomer F, Kavanagh J, Morgan L, et al., 2021). In fact, the findings showed that the Western HSC Trust had the highest levels of support in percentage terms of healthcare professionals willing to participate in medical abortion, 65% (n=17) as well as surgical abortion 54% (n=14) in certain circumstances.

However, the lack of a commissioning and funding for the service, coupled with the outbreak of Covid-19, meant the scope of staffing the service was limited to within our small sexual and reproductive health team.

As a result, I was *'Billy No Mates'*. Providing an essential, legal healthcare service on my own with no medical, nursing or administrative support.

Furthermore, I somehow had to do that within my weekly 26-hour contract whilst also keeping the sexual and reproductive health service in the Western HSC Trust afloat during these difficult times.

I have a stubborn side and I guess this just made me more determined. I was already seeing women for EMA and that very quickly reinforced, for me, how vital this service was. I may not have had support from my own team but I certainly did from my colleagues in the Northern Ireland Abortion and Contraception Taskgroup (NIACT) with frequent Zoom meetings, WhatsApp chats and telephone calls. That support was immense. Looking back, a year later, I know I may never have got this far without those people.

Working in a small service like sexual and reproductive health, I always encouraged and embraced the concept of *'team'* with no hierarchical structure and encouraged others to do the same. We have always been a team. However, when you know that discussions are happening behind your back, when you can feel the hostility, and even worse, when your patients feel that hostility, you have come to a very sad place in an otherwise happy career.

## The easing of restrictions

Only a couple of months into the service I informed management that I needed help. The summer was looming and how was I to take annual leave never mind anything else? However, no additional support was put in place. So, although usually taking a three-week break, I took a week off at the start of August. I went on holidays with my daughter and my work phone. I may not have seen patients, but those I had seen recently were still keeping in touch. The patients who were being referred by Informing Choices NI (ICNI) were still needing to be seen the following week, doubling the EMA work. At this stage I was receiving about four-five referrals per week.

From September, the sexual and reproductive health

services began to open up with lockdown restrictions easing. We had over 400 women whose long-acting reversible contraception (LARC) insertions had been cancelled. It concerned me that the majority of women and girls who were accessing EMA were not using any method of contraception, many of these due to an inability, or perceived inability to access contraception during lockdown but also due to the poor contraceptive services, our own included, particularly in rural parts of the HSC Trust. It was imperative, in my eyes, to clear this backlog, and facilitate any new patients who were currently not using contraception. Huge and heroic efforts were made by an already dwindling staff and the LARC waiting list was cleared by December 2020.

## Christmas and New Year

By this stage, we unfortunately had two nursing staff, of five, off, which turned out to be long term absence. This, coupled with the EMA referrals having increased to six-seven per week, was piling on pressure which I was, initially, either immune to or more likely, was very good at fooling myself that this was sustainable. Christmas and the New Year were looming. I was longing for a break, completely disassociated from work. This did not happen. Although I saw no patients, I still had to do the administration associated with receiving referrals and responding to patients with post EMA queries.

Nine women had their treatment delayed during this break, some by almost three weeks, simply because there was no one else to cover my annual leave. I felt much guilt around the difference this would make to these women going through a termination at a later gestation, and of course, their emotional turmoil over that waiting period.

January 2021 hit with a vengeance. The backlog of nine delayed referrals to be seen in the first week and an additional 31 referrals throughout the month. Nineteen patients per week for *'Billy No Mates'* is 18-20 hours (not including any follow up texts, calls or appointments). My contract is 26 hours of sexual and reproductive health, eight of which should be time for non-patient related activity; continuing professional development, appraisal work, audit, reviewing patient

group directions and reassessing the sexual and reproductive health provision with fewer staff and a further lockdown. All but the last, have not been done for many months.

## Service withdrawal

By February, I knew this service was not sustainable as a one person show. Certainly not if my own physical and mental health were to survive. We'd also lost another fulltime nurse to long term absence. I discussed, with fellow providers in other HSC Trusts, the possibility of approaching management within the Western HSC Trust and stating that unless I was provided with help, I would withdraw the service. They encouraged me to do this.

My own passion, as a doctor, to always put the patient first, knowing what withdrawal of the service would mean to so many women in the Western HSC Trust, coupled with my greatest talent, procrastination, saw me gritting my teeth, and carrying on. I know for sure, the feedback I had from women in the clinic (included at the end of this article), by text, or in cards, the genuine gratitude they felt, that knowledge that you have made a difference to someone's life, all put my absolute fatigue into the shade.

Then came mid-March. Another nurse on long term leave, leaving only one part-time nurse based in Omagh, and the start of protests from anti-choice individuals outside the clinic. My heart ached for the pain and distress this would cause the women attending the service.

In April the effects of continuing to provide the service with no support had finally taken its toll on me mentally and physically and I made my resolve. I would stop providing EMA on the first anniversary of my starting.

I wrote an email to our Chief Executive on the evening of Thursday 15 April explaining, fully, the situation. This was probably the hardest decision I ever had to make in my medical career. I did not send it. That evening I took home all the previously unopened feedback forms from the EMA patients. I

started opening them on Friday morning. I cried. So positive, so appreciative, so full of gratitude, so personal. I cried some more; I attached a couple of those feedbacks to the email and I pressed 'send'.

Urgent meetings were then convened and I relayed the same information that I had previously discussed with management about what was needed to maintain the service. I explained the stress I was under and was encouraged to take time off. I was then asked to continue the service for another while but I declined. I had provided the service single-handedly for a year and was exhausted. I had also expressed my opinions to management on several previous occasions about the impact that the lack of support was having both on me, and the patients accessing the service. Therefore, I saw my last EMA patients, for the time being, on 28th April.

## Future aspirations

It has been a surreal year for everyone. Covid-19 has changed the way we work and the way we deliver services. There have been steps back and steps forward but the most positive change for my co-conscientious providers and I, is that we are now able to provide an EMA service to women living in our own HSC Trust areas. Fewer women having to make the arduous, emotional journey to England, often alone.

I have said to many people, patients, colleagues, management, family and friends that this past year has been the most rewarding of my 37-year career. Sadly, it has also been the most stressful and easily the loneliest.

I have been privy to women's most personal and private thoughts, often saddened by the hugely difficult circumstances some find themselves in. I have also been uplifted and encouraged by women realising that their family and friends are not anti-abortion as they had thought, but completely supportive of their decision, and in some cases disclosing previous abortions of their own which they never felt able to talk about. To be able to help these women has been an absolute privilege. I am confident that I shall return to work as part of an EMA

team. My wish, that this service is properly commissioned and funded and that the women and girls accessing it do not have to run the gauntlet of people lacking compassion while either arriving or leaving the clinic.

*"I struggle to find words to say how grateful I am for the care I received from Dr Sandra. I felt so looked after, safe and understood in her presence. She made a daunting experience feel normal. I can honestly say had I not received the care I did from Dr Sandra my decision-making process and my overall mental health would have been severely affected. I was so terribly afraid of the pain and Dr Sandra was able to calm me and help me rationalise with just her words. Because of Dr Sandra's outstanding care, myself and my mum will be making a large donation towards the abortion services. She is truly the kindest doctor either of us have ever encountered. A very special lady with not only immense knowledge of her field but the kindest heart. Thank you so much."*

*"Amazing. Just wanted to say a massive thank you to Sandra who helped me through a stressful situation. Was very helpful and went above and beyond. So thankful."*

*"Dr McDermott was very friendly, informative and very non-judgemental - a lovely lady."*

*"The doctor was very helpful with all my questions and her care was excellent even after my appointment to ensure that I was okay."*

*"The doctor is so lovely, I was amazed she made everything even easier, and gave me so much reassurance, best personality for her hard job."*

*"Dr McDermott was excellent. She was professional and empathetic. She took the time to talk me through the process in detail so I was fully informed. She was contactable and followed up as promised. I am very grateful for her help."*

# Chapter 5

## Safe Access to Healthcare: the negative impact of anti-choice protestors by Dr Caroline Hunter

*Over the past year while the general public were being told to stay at home and protect the NHS groups of anti-choice protestors have been travelling the breadth of Northern Ireland and intimidating women accessing lawful services and causing additional work on an already overstretched health service. This article focuses on the actions of these individuals, their impact on women and healthcare professionals and the urgent need for the introduction of safe access zones to ensure unimpeded access to sexual and reproductive health services as lockdown measures ease.*

### Emergence of protestors

In June 2020 protestors first appeared outside the early medical abortion (EMA) service located in the Portadown Health Centre. A young woman who was attending for treatment arrived holding a bag of anti-abortion literature. She informed us that her boyfriend's family had contacted a service purporting to offer help and advice about abortion. The family had given this organisation details about her appointment and someone addressed her by name on her way into the building and handed her the bag.

Over the next few months groups of anti-choice protestors made occasional appearances outside sexual and reproductive health services and then in January 2021 two protestors entered the Portadown Health Centre at night during clinic hours and filmed what they believed was where the EMA service was operating. In fact, the EMA service was located in a different part of the building, and the patients were relatively untroubled by these intruders. They posted the film on Facebook the same evening, with close up shots of notices about the contraception and sexual health (CASH) and Genito-Urinary medicine (GUM) services. This caused considerable distress particularly to staff working in these two services. One member of staff received a number of messages during the night asking if they were involved in the EMA service, while another reported unpleasant messages sent to a young family member.

The Southern Health and Social Care (HSC) Trust released a statement regarding the incident in which

they said that, "Staff and anyone using our services should feel safe to attend our facilities without threat or fear. It is vital at this time, with cases of Covid-19 so widespread in our community that everyone follows Executive guidance to stay at home. We appeal in the interest of everyone's safety – please do not come to our facilities unless absolutely necessary."

Despite this appeal protestors continued to show disdain for the health service, their staff and women accessing services by continuing to stand at the entrance to the car park holding anti-abortion literature, including placards containing graphic images. Sometimes children under the age of ten were seen holding these up.

Women attending the EMA service expressed some concern at having to drive past them on their way in however, things became worse when the protestors claimed to have discovered a loophole, in that the path, which passed the front door of the building, was a right of way and moved their protest to the door and began harassing everyone, both staff and patients, using the building for any purpose.

### Regular pickets and services relocated

They also started to regularly picket the clinic in John Mitchel Place in Newry which was held on a Monday morning. The door of the clinic is much closer to the road, and they became very vocal, shouting and chanting, upsetting staff and patients, and making

the work of some services, particularly speech therapy, almost impossible.

Newry is a small community, and word soon got around about the protestors. As such women requesting the EMA service began expressing concern about attending the service and required additional reassurance. Staff in John Mitchel Place were professional – never complaining about the service, at least not to us, and were kind and welcoming to the women attending it. However, with the continuing protests it became clear that the two venues were not suitable to continue providing the EMA service, and efforts were made to find alternatives.

After a few weeks we were re-located to the two hospitals within the Southern HSC Trust, the Craigavon Area Hospital and the Daisy Hill Hospital in Newry and this caused a lot of extra work for the nurse working in the EMA service. I am the only doctor who regularly provides the service within the Southern HSC Trust and I am supported by one nurse who has recently been seconded to two additional administration sessions a week. This is barely enough to manage the day to day running of the service, and the additional work in arranging the move caused much stress and exhaustion to the nurse, who worked tirelessly to keep the clinic open while we moved premises.

The protestors soon realised we had moved, and set about trying to find out where the new locations were based. This entailed people posing as women seeking abortion and trying every way possible to get us to disclose the time and place of the new clinics. One protestor boasted to a doctor working in the Portadown Health Centre in a different service, about making such bogus appointments.

This practice is detrimental to our service in many ways. Not only do we waste time with pointless medical assessments, which can take up to half an hour, but it has also made us suspicious of any woman requesting to use the service. We have started insisting on a Health and Care Number before we will book them in, and being vague with details about the time and place of the clinic. This is not ideal, as it is our wish to be open and welcoming to

women who are already often quite stressed about accessing our service.

Despite our best efforts, the protestors managed to track us down to the Daisy Hill Hospital and staged a protest in the street outside, stopping traffic and again standing with large images of macerated fetuses with the accompanying statement that, *“Unborn babies are killed inside this building.”*

Another claim they are fond of making is about so called *“abortion pill reversal”*, encouraging women to think they can change their minds after the first treatment, which we take time to explain is not the case.

## Regional impact

Several EMA services have been similarly targeted in other HSC Trusts. The service in Belfast is located in the city centre and accessed directly from a pedestrianised street. Protestors stand blocking access to the entrance and verbally harass all women accessing the building. Often handbags/shopping bags are opened and anti-abortion leaflets are put inside. Many clients have been too frightened to attempt clinic entry and ring the healthcare professionals for assistance. Staff have been subject to verbal abuse and called murderers. Women attending for other contraceptive reasons are also finding the graphic images and harassment very distressing and all clients accessing the clinic are now being forewarned that there may be protests outside and this may negatively affect women trying to access effective contraception. Due to the ongoing impact of the protestors the Belfast HSC Trust has now employed a security guard to staff the front door.

The service in the Northern HSC Trust is located within a multipurpose, community clinic which people enter to access various services such as midwifery, physiotherapy or podiatry. Protestors stand opposite the single-entry point holding placards with emotive text and graphic images. Inflammatory language has been used which has been broadcast through loudspeakers. Patients accessing the building, whatever their reason report

being distressed by the protestors. Some have been approached with anti-abortion leaflets and others had family members approached whilst they waited in their car.

Weekly protestors have also taken place outside the clinic in the Western HSC Trust. Despite the service now being suspended protestors have continued to picket the multipurpose healthcare centre in Derry/Londonderry.

I am also hearing stories of women not getting the medical attention they require. For example, in one HSC Trust a doctor reported that a woman failed to attend for a follow up despite prolonged heavy bleeding reporting that she, *“could not face seeing the protestors again.”*

Informing Choices NI (ICNI) also has direct experience of the negative impact anti-choice protestors have on client’s experiences of accessing their pregnancy counselling services as well as the impact on staff and other individuals who share or work near their offices. In 2015 a protestor was convicted for assaulting an employee of FPA NI 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.

As lockdown measures begin to ease their activities could increase outside EMA services which will cause additional distress to patients and negatively impact on the legal provision of healthcare services. Reports have been made to the police on numerous occasions over the past year regarding the activities of the protestors but no action has been taken. It is clear that in order to protect patients and staff safe access zones should be introduced around sexual and reproductive health services and pregnancy counselling centres. A private members bill is currently being prepared by Clare Bailey MLA to create legal provision for these. For the women accessing our services, and the healthcare professional providing them, this legislation cannot come soon enough.

## Safe access to healthcare

In summary, the anti-abortion protest groups are causing considerable distress both to women using the EMA service, staff working within them, and patients accessing other services. There has also been additional work for staff having to find and relocate to new premises.

There is no evidence that this approach by the protestors is actually *“saving lives”*, i.e., preventing abortion, which is what they claim to want to achieve. It seems more likely that there may be an increase in morbidity caused by later presentations to the service and reluctance to avail of medical follow up, rather than an actual reduction in women using the service.

## Chapter 6

### How to Access Services: the need for a public health information campaign by Dr Sharon Porter

*The organic nature of the development of early medical abortion (EMA) services and the establishment of the central access point (CAP) service provided by Informing Choices NI (ICNI) has meant that no public health information campaign directing women to the services has been conducted. This article focuses on how women have been signposted to local services, the interactions they have experienced with their general practitioner (GP), what they should expect if they choose to discuss their pregnancy options with a GP, and the training required on non-judgmental communication and the availability of, and limits to, conscientious objection.*

#### Signposting to services

It has become clear over the past year of EMA provision in Northern Ireland, that women and girls are signposted to the CAP service via a number of sources. Some report being signposted by abortion providers in Great Britain such as the British Pregnancy Advisory Service (BPAS) or MSI Reproductive Choices, others by their GP, with the majority reporting contacting ICNI following an internet search for local services.

The internet is recognised, generally to be a commonly used, useful source of information on multiple aspects of modern life including healthcare. ICNI, a number of the Health and Social Care (HSC) Trusts, abortion providers based in Great Britain and reproductive rights groups all highlight the CAP telephone number on their websites. However, there are of course organisations who provide misinformation on the availability of local abortion services and what is involved in treatment, and refuse to direct those who come into contact with them to the CAP service. If women or girls in error contact these organisations it can lead to them receiving biased or false information and also cause delay in accessing services in a timely manner which may impact on their treatment.

#### Interactions with GPs

Due to the absence of a formally commissioned framework, there has sadly been no public health

information campaign to direct women seeking information regarding their pregnancy options and/or abortion care away from rogue agencies and to the CAP service. ICNI have endeavoured to highlight the service by sending information leaflets and posters to all GP practices and through social media advertising. However, the lack of a formal campaign has led to reduced awareness of the availability of the EMA service and how to access it, not only amongst those who may personally need the service but also amongst medical professionals such as GPs.

Women and girls who first contacted their GP practice prior to contacting ICNI have reported a range of experiences. The majority indicated that their GP reported either not being aware of how to access the local services or not being aware of the existence of the local service at all. This is likely due to a number of factors including no public health information campaign and no correspondence from the Department of Health or HSC Trusts to advise of the available service. With the introduction of a fully commissioned service and promotion of the same this will hopefully in time improve.

Of those who contacted their GPs, some reported that their GP took the time to seek out the information for them, some directed to abortion providers based in Great Britain, others reported that they were advised to “Google it” whilst some stated that their GP advised that it was “nothing to do with them”. A sizeable minority who contacted their GP for signposting to the local abortion service reported

that this was a negative experience. They stated it was clear that the GP “disapproved” of their decision which left them feeling “judged”. A small number reported that their GP actively tried to convince them to change their mind.

## Conscientious objection

Women should never be placed in the position where they feel judged for exercising their reproductive rights and if they choose to end a pregnancy, they should be cared for by medical professionals who understand and support their choice. The Abortion (Northern Ireland) Regulations 2020 confirm the right to conscientious objection whereby, “a person is not under a duty to participate in any treatment authorised by these regulations”.

The definition of ‘treatment’ was clarified by the UK Supreme Court as beginning with the administration of the drugs designed to induce labour and ending with the expulsion of the pregnancy. People carrying out the host of ancillary, administrative and managerial tasks that might be associated with those acts do not have the same right to conscientious objection.

The explanatory memorandum which accompanies the Regulations states, “The (UK) Government considered that broadening the scope beyond ‘participation in treatment’ would have consequences on a practical level and would therefore undermine the effective provision of abortion services in Northern Ireland.”

Therefore, while the right to conscientious objection extends to GPs, it does not remove their professional duty recognised by both the General Medical Council (GMC) and the Royal College of General Practitioners (RCGP) to provide the patient with sufficient information to seek out another professional willing to provide the service. This may take the form of directing them to another GP in the practice who will provide non-directive information regarding their pregnancy choices and signpost them to the CAP service.

## Information and training needs

Hopefully with commissioning of full abortion services in line with the new Regulations, a formal public health campaign will follow together with information being clearly highlighted on all HSC Trust websites and social media platforms. This will enable many women and girls to access the service directly without requiring a discussion with their GP to seek signposting. For those who do wish to discuss a pregnancy with their GP they should expect as a minimum clear, unbiased signposting to where they can seek information on the local service.

With commissioning it is also hoped that the Department of Health and HSC Trusts will ensure that formal correspondence is sent to all GP practices so that GPs can be fully informed of what is available for their patients. Training should also be accessible to GPs to ensure non-judgmental communication with service users and to inform of the availability of, and limits to, conscientious objection. This would not only benefit GPs but also patients who rely on them to provide accurate, impartial information regarding the availability of healthcare services.

# Chapter 7

## Contraception Provision: additional investment to reduce unintended pregnancies by Dr Eveane Cubitt

*One year on from the provision of early medical abortion (EMA) care in Northern Ireland this article focuses on what we can learn regarding the reasons why some women have accessed this healthcare and how added investment and promotion of contraception services, in particular a form of long-acting reversible contraception (LARC), will reduce the number of unintended pregnancies and improve health outcomes for women and girls.*

---

### Reducing unintended pregnancies

As we began to provide EMA care in April 2020, we were all, as clinicians, aware of the experiences of service providers across the UK and in Ireland and the statistics surrounding the broad age groups of clients accessing this healthcare and their reasons for presenting with crisis pregnancies.

Although we felt it likely that the clients' we would see would broadly follow the same patterns it has been interesting and enlightening to look back over the last year and to see that there are many preventable unplanned pregnancies amongst the women presenting for EMA in Northern Ireland.

This should inform the future planning of services as the long-term goal will be reducing the number of people who need to access an EMA and we can do this through better education regarding fertility and contraceptive options, including better access to LARC generally among all age groups.

This aspiration has been presented by a multidisciplinary group in their recent report on Sexual and Reproductive Health in Northern Ireland published by the Northern Ireland Abortion and Contraception Taskgroup (NIACT) in March 2021.

### Client profiles

Interestingly most of the women we see accessing the EMA service are their mid-20s to early 40s, many of whom already have children, are often in long term, stable relationships and regularly where there

has been a failure in contraceptive use or lack of contraception altogether.

Most women we see are either not using a method of contraception, relying on condoms alone or using the combined oral contraception pill (COCP) or the progestogen-only pill (POP). We know that failure rates are significantly higher with typical use of oral contraception than with a LARC method.

The problem with running out of pill supply resulting in a break in contraceptive use has been exacerbated due to the Covid-19 pandemic by real and perceived lack of access to the usual contraceptive services many women normally use, such as their GP or Health and Social Care (HSC) Trust based sexual and reproductive health services.

Indeed, other services in England and Wales reported an increase in numbers accessing EMA services of up to 30% during the first lockdown which was felt to be at least in part due to disruption in access to contraception provision due to the pandemic.

Hopefully moving forward into 2021/22 with the reopening of services as the Covid-19 surge abates and vaccination rates rise this number will fall again to pre-pandemic levels and perhaps lessons learnt regarding efficient use of services during the pandemic, such as SH:24, a free online sexual and reproductive health service delivered in partnership with local HSC Trusts, will improve access to contraception for more women.

## Long-acting reversible contraception

The importance of easy access to LARC for women of all ages cannot be over-emphasised if the numbers of those having to make the difficult choice to end an unplanned pregnancy are to be reduced.

Within the Northern HSC Trust in the last 12 months the number of women who have presented for EMA due to true method failure of LARC is extremely small. Two clients became pregnant with an intrauterine device (IUD) – copper coil – in place, while one client presented with subdermal implant in situ. However, this was not a true method failure as the client was at high risk of unplanned pregnancy resulting in the implant being “*quick-started*” with follow up pregnancy test after 21 days which was unfortunately positive and the client requested referral for EMA.

Therefore, it is safe to conclude that the more women who know about and have access to LARC the lower the unplanned pregnancy rate and EMA numbers will be.

A significant number of clients seen via the EMA service also reported using oral hormonal post coital emergency contraception. We know that again there is a significant failure rate with oral emergency contraception but not so with post coital contraception (PCC) using an IUD.

When suitable and accessible for emergency contraception the insertion of a copper IUD is 99% effective in preventing an unplanned pregnancy so improved education about this option and better provision due to increased funding of sexual and reproductive health services and primary care access for IUD insertion would improve success rates with PCC.

We have also seen a significant number of women in the early postnatal period and again it is well documented that this is a group at high risk of unplanned pregnancy and that the obstetric risks increase for women with very short interval pregnancy spacing. Indeed, a significant number of these women may present for EMA services.

## Future planning and contraception provision

Funding for and service planning where all women could be provided with a contraceptive method of their choice before leaving the maternity unit would be very cost effective in preventing negative health outcomes in this group and is supported by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Health (FSRH).

We have also provided EMA care for a group of women who had decided their family was complete, who may have had difficulty finding a method of contraception acceptable to them due to unacceptable side-effects and who were on a waiting list for a sterilisation procedure or whose partner was on the waiting list for vasectomy.

It was particularly distressing for these women who had made every effort to avoid an unplanned pregnancy, that due to unacceptably long waiting times for an elective procedure found themselves in the difficult position of continuing with a pregnancy having decided their family was complete or ending that pregnancy. Again, this is something post pandemic with extra resource and innovative service planning could be improved upon.

Women who access the EMA service in Northern Ireland are either offered a LARC method of contraception at the same time as attending for an abortion or they are fast tracked into the service depending on the HSC Trust area they reside in. All other contraceptive options are also available including COCP and POP before the client leaves the clinic. The contraceptive implant, Nexplanon, if chosen is inserted and is immediately effective at the time of EMA. Insertion of an intrauterine system (IUS) or IUD is offered as a priority approximately three weeks post EMA. We have seen good uptake rates of LARC, higher than the percentages of women generally using it.

As we look forward to the future with a fully resourced, commissioned abortion service and additional contraception investment in Northern Ireland we would hope that the uptake rates of LARC would only continue to improve.

## Chapter 8

### The Commissioning of Services: the role and expertise of NIACT by Dr Ralph Roberts and Dr Leanne Morgan

*Following the publication of the Abortion (Northern Ireland) Regulations 2020 a multidisciplinary group of professionals came together to give professional guidance on bringing about the conditions and services required to minimise the need for abortion, and when it is required, to provide a compassionate and caring abortion service within the new legal framework. This article outlines the conditions which led to the formation of the Northern Ireland Abortion and Contraception Taskgroup (NIACT), the work they undertook to establish early medical abortion (EMA) services and their vision for the future including their recommendations for the commissioning of high-quality abortion, contraception and education services.*

#### The formation of NIACT

On 17th January 2020 Doctors for Choice NI held a conference in collaboration with Ulster University called, 'Shaping the future of women's sexual and reproductive health in Northern Ireland'. Well attended by local clinicians, academics, advocacy groups and politicians, it featured an array of expert speakers from across UK and Ireland and acted as catalyst for the formation of NIACT and the multidisciplinary collaborative working required to effect change.

The taskgroup was assembled by Dr Leanne Morgan, co-chair for Doctors for Choice NI, who had previously led clinical engagement and collaborative work across disciplines to develop a shared vision and mutual understanding of what was required for the development of services that would meet the needs of the Northern Ireland population post-decriminalisation. Following recruitment of expert members and the development of agreed terms of reference, the first official meeting was held on 30th March 2020.

The group is chaired by Dr Ralph Roberts, a Consultant Obstetrician and Gynaecologist in the South Eastern Health and Social Care (HSC) Trust. Dr Roberts was chosen to chair the group due to his extensive experience in the delivery of women's healthcare and his inspirational vision for how sexual and reproductive healthcare could be transformed in Northern Ireland. As he is not involved in the delivery of abortion services and has a broader perspective

including an understanding of the views of those with conscientious objection, he was felt to be a strong yet neutral chair which would be invaluable in developing a strategy with the potential to get buy-in from across the political spectrum.

#### Establishing and developing services

The membership includes healthcare professionals from each HSC Trust, professional medical bodies, academics with a research and policy interest in abortion, and relevant charities including Informing Choices NI (ICNI).

Terms of Reference for the group were drafted which took into account the political landscape in Northern Ireland and have specifically guided the group on working to reduce the need for abortion by improving Relationships and Sexuality Education (RSE) and provision of contraception, in addition to providing an accessible and high-quality abortion service within Northern Ireland.

NIACT has met at least monthly since March 2020, with more frequent meetings when the agenda required. In the early stages, the work of the group focused largely on the logistics of setting up EMA services. This was in response to travel restrictions imposed due to the Covid-19 pandemic. For the first time since the introduction of the Abortion Act 1967, travel to Great Britain to access abortion care was

severely restricted. The only option for travel at the height of the first wave of the pandemic was an eight-hour freight ferry with no accommodation at the other side, and the very clear risk of Covid-19 transmission. The very grave human rights and patient safety implications soon became apparent when two women attempted to take their own lives.

## NIACT report – a blueprint for a commissioned service

NIACT set to work to urgently establish EMA services in line with the new legal framework. A regional CAP service was established through ICNI providing a means for self-referral and counselling. Non-funded EMA services were implemented within existing sexual and reproductive health services across all five HSC Trusts. Since April 2020, data has been collected on the number of women self-referring to ICNI, accessibility to HSC Trust services, waiting times, patient outcomes, contraceptive uptake, and service user feedback. This was important background information for the report NIACT published on Sexual and Reproductive Health in Northern Ireland.

Writing the report became the focus of the group's work once EMA services were well established. This report was published on 31st March 2021. It provides an evidence base and sets out a forward-thinking strategy to inform the funding and commissioning of RSE provision, and integrated sexual and reproductive healthcare for the population of Northern Ireland. It is based on a six-point vision which is outlined below and encompasses the themes of reproductive justice, RSE, awareness and provision of contraception, and providing non-stigmatised, safe and compassionate abortion care:

- 1) 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.
- 2) 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 to start a family.
- 3) We believe that all young people and adults should be educated about the benefits and effectiveness of different methods of contraception.
- 4) Women and girls should be empowered to take control of their fertility, and contraception should be easily accessible and freely available.
- 5) 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.
- 6) Where abortion is needed, services should be accessible, high-quality and designed to deliver safe and compassionate care.

## Recommendations

The report sets out a new enlightened approach to achieve these goals. There are 38 recommendations covering the topics of RSE, sexual and reproductive health services, contraception, abortion and conscientious objection. A number of these relate to issues outlined in this report, including that:

- 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;
- There should be an adequately resourced framework to ensure availability of pregnancy choices counselling if requested;
- There should be access to post abortion counselling. Bereavement counselling should be extended to include all pregnancy loss;
- 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;
- 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;

- 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;
- The role of nurses and midwives should be further developed to include provision of LARC and abortion care; and
- There should be training for all healthcare professionals, administrative and support staff engaged in abortion services to ensure non-judgmental communication with service users.

## An integrated and multi-agency approach

Looking forward, the work of NIACT will focus on influencing politicians, policy-makers and commissioners to use our report as a blue-print for the development of services. For too long decisionmakers in Northern Ireland have buried their heads in the sand, but NIACT wants there to be a widespread understanding that wishing abortion away does not take it away. We must no longer export abortion either to the internet or to providers in Great Britain; 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.

We are committed to supporting HSC organisations and clinicians to deliver effective services, whilst ensuring that the systems for delivery permit the management of conscientious objection in a way which respects the rights of clinicians but also facilitates the provision of safe compassionate care to patients.

You can read the full NIACT report and its recommendations for Sexual and Reproductive Health in Northern Ireland by visiting <https://www.fsrh.org/documents/niact-full-report-31st-march-2021/>

# Epilogue

## Decision Time: where next for local services? by Ruairi Rowan

### Key decisions

This report highlights how far we have travelled in relation to reproductive rights and the provision of healthcare and support services in Northern Ireland. It also outlines how that journey is far from complete. We now stand at the crossroads, with key decisions to be made in the weeks ahead.

Will the Health Minister and the Northern Ireland Executive reach a consensus on the commissioning of abortion services? Given the failure to progress the matter over the past year, what hope of agreement in the coming weeks?

If the matter remains unresolved will the Secretary of State act to advance the matter? If so, what form will this direction take, and how quickly can it be acted upon?

Will the courts have their say? The judicial review taken by the Northern Ireland Human Rights Commission (NIHRC) has now been heard and the outcome of this case is pending. When will this judgment be given and could its decision influence the next steps in the commissioning process?

### The precarious nature of service provision

While these questions surround the expansion of services there remains questions around the current provision that is in place, with the most pressing matters being the resumption of the early medical abortion (EMA) service in the Western Health and Social Care (HSC) Trust, and the sustainability of the central access point (CAP) service provided by Informing Choices NI (ICNI).

In relation to the CAP service as has been noted this

cannot be sustained without additional funding. As a result, the ICNI Board of Trustees have reluctantly taken the very difficult decision that if funding is not made available for the service to continue, we will cease providing it from 1 October 2021.

If the service was to be withdrawn it would be left up to each HSC Trust that continues to provide an EMA service to pick up, and provide their own pathway to the service. During this pandemic and period of high pressure and financial squeeze this will have financial, staffing and training implications for each HSC Trust.

Three of the five HSC Trusts have suspended services to date and this additional strain may facilitate the collapse of, or severe disruption to, EMA services which heavily rely on ICNI's support with no means to replace it.

The removal of local services will result in women accessing abortion outside of HSC services. By accessing medication from independent online telemedicine providers, they will not be provided with a form of contraception, including a long-acting reversible method, which will prevent future unintended pregnancies.

It will also leave some women without counselling support before or after an abortion as ICNI will not be able to continue to sustain the current levels of counselling provision and have already needed to gain private funding in order to cope with the demands on the service. This funding too will end on 1 October 2021.

### The need for a centralised pathway

Without a centralised information, support and referral service where will women turn? Their GP? As

highlighted in this report the majority of women who discussed a pregnancy with their GP indicated that they were either not aware of how to access local EMA services or not aware of their existence at all. Some highlighted a negative experience and were left feeling *'judged'* for the decision they had made and a small number reported that their GP actively tried to convince them to change their mind.

If not their GP, then who? Rogue agencies who purport to assist and guide women in these situations? This involves stalling women by arranging scans that are medically unnecessary and can be provided by the health service if required, subject them to judgment for the choice they have made and ultimately delay them accessing local healthcare services.

Without access to high quality, non-directive information and support more women will come into contact with rogue agencies and have their care jeopardised. For these reasons it is vital that the CAP service is maintained and is provided with the necessary resources to enable it to develop. Centralising the service within ICNI removes service duplication amongst the various HSC Trusts and offers the most cost-effective service. Also, a high-quality, regional pathway within Northern Ireland is the most convenient avenue of support for women and girls accessing the service, many of whom may not be aware of which HSC Trust area they live within, and has been recommended by the NIHRC and the Northern Ireland Abortion and Contraception Taskgroup (NIACT).

## **Urgent and essential funding required**

ICNI have a proven track record of delivering these services and are a trusted source of information and support for women and healthcare professionals. We already receive some funding from the Department of Health and the Public Health Agency to provide a pregnancy counselling service and the provision of a sexual health helpline. The additional funding required relates to the extension of these services.

As we already receive funding to provide similar support the additional resources required could be made available outside of the formal process undertaken to secure a fully commissioned abortion service.

The provision of non-directive information and pregnancy counselling are neither *'cross-cutting'* or *'controversial'* and do not require agreement from the Northern Ireland Executive. Put simply, if the Health Minister wanted to provide the additional resources needed to ICNI in order to prevent the collapse of the service he could do so. Such action would aid a regional gold standard information, support and referral service which will benefit women, girls and their families and enable them to experience positive mental health and emotional wellbeing.

If the Health Minister refuses to provide the urgent and essential funding needed the Secretary of State should direct him to do so. Otherwise, they will be complicit in the collapse of the CAP service, cause severe disruption to, or the suspension of, local EMA services, and embolden the activities of rogue agencies who continue to prey on vulnerable women and girls.

Much positive change has occurred over the past year. Now is the time to keep moving forward, not take a step back. We must move beyond decriminalisation and not only remove the walls of silence surrounding abortion, but also the walls of access.

# About

---

Informing Choices NI is a sexual and reproductive health charity. We champion informed choices around sex, sexuality and reproductive health and emotional wellbeing through advocacy, counselling, education, information and training. Our vision is a society where individuals have the right and freedom to make informed choices about their sexual and reproductive health.

## Contact us

Informing Choices NI  
3rd Floor, Ascot House  
24-31 Shaftesbury Square  
Belfast, BT2 7DB

Tel: **028 9031 6100**

Email: **[info@informingchoicesni.org](mailto:info@informingchoicesni.org)**

Twitter: **@ICNI2019**

Facebook: **[/InformingChoicesNI](#)**

Website: **[www.informingchoicesni.org](http://www.informingchoicesni.org)**

Informing Choices NI (trading as ICNI) Ltd is a charity registered with The Charity Commission for Northern Ireland (NIC107581).

Companies House registration number NI661550.

