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Restrictive points of entry into abortion care in Ireland: a qualitative study of expectations and experiences with the service

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Abstract: *This article focuses on access to early medical abortion care under Section 12 of the Health (Regulation of Termination of Pregnancy) Act 2018, in Ireland and identifies existing barriers resulting from gaps in current policy design. The article draws primarily on qualitative interviews with 24 service users, 20 primary healthcare providers in the community and 27 key informants, including from grassroots groups that work with women from different migrant communities, to examine service users' experiences accessing early medical abortions on request up to 12 weeks gestation. The interviews were part of a wider mixed-methods study from 2020-2021 examining the barriers and facilitators to the implementation of abortion policy in Ireland. Our findings highlight care seekers' experiences with the GP-led service provision, including delays, facing non-providers, the mandatory three-day waiting period, and oversubscribed women's health and family planning clinics. Our findings also highlight the compounding challenges for migrants and additional barriers posed by the geographical distribution of the service and the 12-week gestational limit. Finally, it focuses on the remaining challenges for racialised and other marginalised groups. In order to provide a "thick description" of women's lives and the complexity of their experiences with abortion services in Ireland, we also present two narrative vignettes of service users, and their experiences with delays and navigating the healthcare system as migrants. To this effect, this article applies a reproductive justice framework to the results to highlight the compounding effects of these barriers on people located along multiple axes of social inequality.* DOI: 10.1080/26410397.2023.2215567

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Background

The 8th Amendment of the Irish Constitution was introduced through a referendum held in 1983 and granted equal rights to the woman and the "unborn"; this made access to abortions nearly impossible even in life-threatening circumstances.[1] This restriction played out starkly in 2012 in the case of Savita Halappanavar, a 31-year-old Indian-born dentist and resident of Ireland, who died of septic miscarriage after she was denied a termination at Galway University Hospital.[2] Savita Halappanavar's untimely and unnecessary death galvanised an intergenerational crowd of people who gathered for solidarity vigils with banners that said, "Never Again" and demanded the repeal of the 8th Amendment.[3]

The year after her death, the Oireachtas (the Legislature of Ireland) passed the Protection of Life During Pregnancy Act (PLDPA) of 2013, which intended to allow abortions in cases where a pregnancy posed a substantial risk to the life of the pregnant woman.* However, the 2014 case of a suicidal teenage asylum-seeker, Miss Y, who became pregnant because of rape but was denied an abortion, demonstrated the severe limitations of the PLDPA in making abortions available.[2,4] It was the perseverance of grassroots campaigning and coalitions of women's, civil society, and doctors' advocacy organisations[5] which finally culminated in the historic referendum of May 2018, that repealed the 8th Amendment. This paved the way for the adoption of the Health (Regulation of Termination of Pregnancy) Act 2018.

The new law, under Section 12, now allows for abortions without restrictions on requests for pregnancies under 12 weeks' gestation. Over 12 weeks' gestation, terminations can be carried out in cases where the pregnancy poses a risk to the life or a risk of significant harm to the health of the woman (including emergency scenarios) under Sections 9 and 10. Terminations for cases of fatal fetal abnormalities at any gestational age can be provided under Section 11 of the legislation.[6] Under the current clinical guidance, most medical abortions through 9 weeks and 6 days gestation are carried out in the community by General Practitioners (GPs) in their practices or in women's health and family planning clinics.[7] Where the gestational age of the pregnancy is greater than 10 weeks, but still within the legislative limit of 12 weeks, the pregnant person is referred by their GP to a hospital with a maternity unit, which then carries out primarily medical abortions.[8] When abortion is being provided under Section 12 of the legislation, a mandatory three-day wait is required between the patient's first visit contact with a provider and the provision of the medication. The new law under Section 22 (1) also respects the right of a medical practitioner, nurse or midwife to opt out of carrying out or participating in "carrying out a termination of pregnancy in accordance with section 9, 11 or 12 to which he or she has a conscientious objection".[6] The Irish public healthcare system, the Health Service Executive (HSE), requires such conscientiously objecting medical practitioners, nurses and midwives to inform an appropriate manager as soon as practicable. However, such a conscientiously objecting person "must make arrangements for the transfer of care of the pregnant woman concerned as necessary to enable the woman to avail of the termination of pregnancy".[6] The law under Section 22 (2) makes an exception to a medical practitioner's right to conscientious objection when they are required to participate in an emergency situation in accordance with Section 10 of the Health (Regulation of Termination of Pregnancy) Act of 2018.[6] At the start of the abortion services rollout in January 2019, the HSE announced the launch of a 24/7 helpline service - MyOptions - as a system to process requests and facilitate information about abortion services in Ireland.[9] The MyOptions helpline provides information about providers, counselling and clinical nursing support to women and other pregnant people.[8]

In the first year of implementation after the introduction of the service on 1 January 2019, 6666 terminations were carried out in Ireland, of which 6542 were cases of early medical abortion provided under Section 12.[10] In the second year of its implementation in 2020, 6577 terminations were carried out, of which 6455 were early medical abortions.[11] However, some women continue to travel abroad, especially to nearby England and Wales, for care. While abortions were decriminalised in Northern Ireland in 2019, there have been ongoing issues concerning the commissioning of service provision.[12] In 2019, 375 women from the Republic of Ireland travelled to England and Wales for abortion care.[13] While in 2020, this

*See: http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/print.

number had decreased to 194,[14] it increased to 206 in 2021.[15] Since the 2019 introduction of services, non-profit organisations such as Women Help Women (WHW) and Women on Web (WoW) continue to offer some telemedical consultations and pill distribution. Additionally, organisations such as Abortion Support Network (ASN) assist with costs and logistical support for women residing in areas with restricted access and have reported a decline in demand from Irish residents. WoW received 764 requests from Ireland between 2019 and 2020.[16] Between 2 January 2019 and 31 December 2020, around 302 women reached out to ASN for abortion support[17] (p. 29). While 309 women consulted WHW in 2019, the number stood at 64 between January and June 2020[17] (p. 29).

To better understand, analyse and appraise the different aspects of the implementation of Ireland's new abortion services, we undertook a mixed methods study from 2020 through 2021.[9,18–20] The overall study combined primary quantitative and qualitative data, as well as secondary data from existing literature, to examine the barriers and facilitators to the implementation of abortion policy in Ireland. This article draws on qualitative interviews with service users, GPs and key informants to examine users' experiences accessing early medical abortions on request up to 12 weeks' gestation. This article applies the concept of "reproductive justice" as an overarching framework,[21] to examine the barriers resulting from gaps in the policy design. A reproductive justice framework considers the ability to "decide one's own reproductive health" without the negative effects of social, political and economic inequalities as a fundamental right.[22] This approach highlights the impact of such barriers on people located along multiple axes of social inequality. It also considers factors that helped facilitate access to the service.

Research methods

Ethics, samples, and recruitment

From May 7, 2020, to March 2, 2021, we conducted in-depth interviews (IDIs) with service users who sought abortion care in Ireland in 2020. We recruited women via a study flyer shared by 23 GPs across Ireland and posted on Twitter and Facebook. Apart from service users, we also draw on interview data with key informants and primary healthcare providers to provide a comprehensive understanding of service user experiences with abortion care. We recruited providers through an announcement mailout to the Irish College of General Practitioners membership and through a WhatsApp (a text and video messaging platform) provider network and recruited key informants via direct contact with relevant stakeholders engaged in policy implementation. This study received ethical approvals from the World Health Organization Research Ethics Review Committee (protocol ID: A66001; approved 17 March 2020) and the University of Central Florida Institutional Review Board (protocol ID:00000846; approved 11 October 2019). At the time of research design and data collection for this study, there was no federal review of social research required in Ireland. Irish research regulation did not require an ethical review and approval from an Irish research body for this work. Therefore, the approvals by the WHO and UCF were sufficient to meet the obligations in Ireland (for details see Mishtal et al.,[9] p. 3).

Research team, data collection and analysis

Our overall study team comprised of 11 researchers in the fields of social sciences, public health and policy, and medicine. Two researchers (LG and DC) were based in Ireland and conducted remote interviews over the phone with service users. One researcher (JM) was based in Ireland for four months and conducted interviews remotely over Zoom and in person with key informants and providers, depending on the participant's preference and the public health guidelines for the COVID-19 pandemic.

Participants did not receive remuneration. We developed an interview guide following contextual interaction theory (CIT)[23] to conduct interviews. CIT recognises the role that motivation, information and power dynamics play in policy implementation, particularly in relation to the "activities and interactions between several individuals/organisations who already work together, in a variety of contexts, including government, healthcare providers and service providers".[9] With this in mind, the IDI guides were designed to include three sections that explored the theory's themes of motivation, information flow and power dynamics involved either in the development, implementation, and provision of abortion services, or in seeking care in Ireland.

These interviews lasted between 35 and 90 minutes. We deidentified the data collected

from the service user sample; we assigned each service user a participant number, in line with General Data Protection Regulation guidance. The researcher responsible for conducting interviews with GPs retained their names and contact details for two months, only for the purposes of clarifying and reviewing information, after which they were deidentified. Only key informants were given the option of revisiting their position on anonymisation post-interview. Most of the key informants opted for de-identification.

Four members of the study team (JM, KR, DC, LG) coded and analysed the transcripts discussed in this article using Dedoose software. At the outset, three teams of two researchers double-coded approximately 10% of transcripts of each sample. The teams compared codes, discussed and resolved any discrepancies, with no significant disagreements in the interpretation of the data emerging.[24] The study team then finalised the codebooks for each sample. The coding process followed the "dynamic and fluid process" of the grounded theory approach[25] which allows for both predetermined, *a priori codes* to be explored (e.g. "information flow"), as well as the emergence of inductive, not previously considered factors or explanations (e.g. "pathway to hospital care").[26] We refined the codebooks through discussions that emerged in weekly team meetings during the process of coding. This process enabled us to generate a detailed thematic dataset for each sample. The sample sizes permitted saturation of themes.[27]

In the findings section, we present key themes that emerged from these interviews alongside illustrative quotes to demonstrate these themes. In order to produce a "thick description"[28] of women's lives and the complexity of their experiences with abortion services in Ireland, we also present two narrative vignettes of service users, and their experiences with delays and navigating the healthcare system as migrants. For the purposes of this article, we have assigned pseudonyms to these two service users.

Findings

Participant characteristics

We interviewed 30 service users from 12 of Ireland's 26 counties, distributed across rural and urban areas, 24 of whom sought early medical abortions under 12-week gestation. This paper draws on the experiences of these 24 service users. All participants in this sample either received abortion care in the community or received the initial consultation with community GPs en route to hospital care. Table 1 provides the demographic characteristics of these 24 service users.

Apart from service users, we also interviewed 27 key informants including 12 Health Service Executive (HSE) public health officials and national health service administrators, the former Minister of Health, Simon Harris, medical professionals who contributed to the implementation process, and members of different stakeholder organisations including grassroots groups representing migrants and ethnic minorities who could speak to the issues faced by women from these groups when accessing abortion care.

We also interviewed 22 primary healthcare providers in the community comprising 20 GPs who provide abortion care, one midwife, and one administrative coordinator for termination of pregnancy services. Nineteen of 22 providers work in their own general practice, and three work in sexual and reproductive health clinics. The geographical distribution of providers in this study includes representation from 12 of 26 counties, including the following settings: rural, urban, north, west, east, south, and the Irish midlands. All providers started participating in the service in 2019, with most beginning in January of that year.

Care-seekers' experiences with GP-led early medical abortion services

Overall experience with abortion care

Some service users expressed gratitude and relief to be able to access care in the community, as exemplified by the experience of the 34-year-old woman from Dublin, when she said:

"I am happy that I could access care in Ireland. I was extremely aware that if it had happened 2 years ago, I would have to go to England to access services. I did have a choice. I'm really glad that we've come this far." (SU 18)

A 34-year-old woman from Wicklow echoed a similar sentiment when she described her experience of accessing abortion care accordingly: "*Overall, everyone was very helpful, and it was just much better that I could access it here in Ireland.*" (SU11)

Facing non-providing GPs and conscientious objectors

Nine service users reached out to their GPs as the first point of contact and found that these GPs did not provide abortion services. Four of these non-providing GPs referred their patients to the

Table 1. Service users' sample characteristics

#	County	Used MyOptions	Age	Income in Euros/wk	Ethnicity (self-described)
3	Galway	GP; MyOptions	40	None	White Irish
4	Dublin	Yes	42	1200	White Irish
7	Mayo	Yes, Hospital Referral	30	190	White European
8	Kildare	Yes	44	400	White Irish
9	Dublin	Yes; GP Referral	23	None	Malay
10	Kildare	No	43	None	White Irish
11	Wicklow	Yes	34	205	White Irish
12	Dublin	No	26	625	White Irish
13	Carlow	Yes	32	260	White Irish
15	Dublin	Yes	37	900	White
16	Cork	Yes	35	600	White Irish
17	Kildare	Yes	36	550	White Irish
18	Dublin	Yes	34	850	White Irish
19	Meath	No	30	None	European [NZ]
20	Kildare	Yes, referral	33	700	White British
21	Galway	Yes, referral	27	2200	White Irish
22	Kildare	Yes	35	1000	White Irish
23	Kildare	Yes, hospital website	28	450	White Irish
24	Galway	Yes, GP referral	28	250	White European [German]
25	Kildare	Yes	32	900	White Irish
26	Laois	Yes, GP referral	38	350	European Irish
27	Meath	Yes	39	675	White Irish
29	Tipperary	No	37	2000	White Irish
30	Dublin	Yes	24	300	White Irish

HSE MyOptions helpline for further information. However, five service users experienced inadequate or misleading referral pathways to early abortion care. A 28-year-old woman from Kildare shared:

"No, I never heard of MyOptions. I made an appointment with my GP who was not helpful at all. My GP had said go to the Rotunda. I googled their page [Rotunda] and it said they did the service after 12 weeks. I thought I had to wait until 12 weeks. I saw the Rotunda webpage had something about MyOptions at the bottom. I thought MyOptions was counselling only. I'm so so glad that I

rang them … I was so upset after that appointment. And the fear of it thinking I had to carry until 12 weeks when I didn't want it and I probably wouldn't have done it at 12 weeks then because it's further along you know? If she [the locum or substitute in her GP] was any way decent she would have said ring MyOptions. But I wasn't even told that. I rang that helpline out of pure desperation just to see if they could tell me anything and good thing I did." (SU23)

In some cases, non-providing GPs have actively tried to dissuade their patients from accessing abortions. As a 37-year-old woman in Dublin recalls:

"I guess it was with my GP who didn't provide the services but tried to talk me out of it. I was shocked by it. She made me feel like a bad person for wanting an abortion. With the change in legislation, I thought GPs would have to provide the services. I didn't hope that they would refuse." (SU15)

In one instance, a GP described how their patient from India was misled by a local pharmacist to believe that abortions were unavailable in Ireland. As they recall:

"So she was unlucky enough to meet a conscientious obstructer at the local pharmacy who told her she didn't have an option to have a termination and by the time I phoned her back had contacted a family member in India who had mailed her tablets." (Provider 18)

Most pregnant women who accessed abortion care in our study, expected to receive care from their own GPs and experienced disappointment at not being offered the service by them. In some cases, they described these non-providers as barriers to accessing timely care, especially where GP refusal led to delays.

As a 30-year-old woman in Meath described:

"Having to wait for my GP appointment to be told that they don't provide the service was a source of obstacle. My GP was useless. He was googling the HSE website when I asked about the service. I insisted on being referred [or given more information about who to call]. At this point, the GP went to speak to the other doctor in the surgery. He came back and asked me to call the HSE. I was able to find an alternative. But if you are young and not supported at home, this would be extremely disappointing and difficult … The only delay I experienced was because I was waiting for an appointment with my GP. I was delayed by a week." (SU19)

Oversubscribed women's health and family planning clinics

Some women have also reported experiencing delays in their pathway to accessing care, especially when they contacted oversubscribed women's health and family planning clinics. There are five family planning and sexual and reproductive health clinics in Dublin that provide information and access to early medical abortions. These clinics have been longstanding advocates for women's reproductive health and were a popular choice for a number of women in our sample.[29] Many of these clinics were overbooked and not in a position to offer timely appointments. It is also important to note that abortion services in these clinics are limited to Dublin. In such cases they rerouted service users to the MyOptions Helpline for further assistance, as demonstrated by the experience of this 27-year-old service user in Galway:

"I called up the [family planning clinic] first. They told me that they didn't have an appointment for the next week or so … .and then they asked me to call the MyOptions Helpline." (SU21)

Lack of locum physicians covering for doctors who are absent can be a source of potential delay for some service users. Some have also been delayed during bank holidays, where provision is limited. As a 34-year-old woman in Dublin recalled:

"It was the bank-holiday weekend and not Covid which was the problem. I even rang the maternity hospital. They asked me to ring MyOptions. I rang the [women's reproductive health clinic], but they were closing for the bank holiday weekend. Then I rang [the family planning clinic]. I was told that they were really busy and that they had no appointments until the second week of November … It was mainly because of the bank holiday weekend. I'm in Dublin and everything is out here. It was really frustrating that it happened on the Saturday of a bank holiday weekend. In fact, when the MyOptions helpline called me back, my first question to them was about delays. They gave me reassurance. They were good with that." (SU18)

Mandatory three-day wait

Delays linked to the mandatory three-day wait were also raised by service users, and in some cases, the waiting period extended beyond 72 hours where the first consultation took place in

Vignette 1 - Marianne's Story

Marianne is a 43-year-old Irish-Catholic woman who lives in County Kildare. She spoke about her support for the Repeal Campaign in 2018, which paved the way for legalisation of abortion services in Ireland.

During her last pregnancy, she suffered from hyperemesis gravidarum, characterised by extreme nausea. She felt very sick and given that abortions between 9 weeks and 6 days and 12 weeks are carried out in the secondary setting, she went to the hospital. She said, "*I was very dehydrated*". However, she was not admitted at the time. She added: "*The midwife recommended that I be sent home, that I wasn't dehydrated enough to be admitted. She said I could ring the MyOptions helpline from home. The doctor came around and he was very understanding. I was also sent to the social worker and the perinatal health midwife. The doctor was very understanding, and he admitted me because I needed to lie down. Otherwise, I had to sit in a chair and I was so sick*."

Marianne's doctor in the hospital had advised her to contact her GP that day to ensure she received an appointment quickly. As she explained:

"I was also getting more dehydrated, so I made an appointment for Monday. I had a phone call with my GP in the car before I went into the clinic. Then she brought me in. She [Marianne's GP] asked me the reasons why I was having a termination. Did I have a previous pregnancy, all these questions. I felt like I was having to justify my decision. That was really hard. Then she went out of the room, came back and said we don't provide the service here. I was stunned. I'd been with her 15 years. It is advertised as a women's clinic … . It didn't occur to me that they didn't provide. She [the GP] said she was away on maternity leave and didn't know they weren't providing."

She felt aggrieved and frustrated both that the GP did not provide services and that she had to "justify" her decision. Ultimately, with the support of her social worker, she was able to get in touch with a providing GP in a nearby town, but it did require a 40-minute-long drive. She described her abortion provider as "*extremely kind, compassionate [and] very informative*." She was happy with the care she received from this individual, who, unlike her own GP, did not ask her for reasons for seeking an abortion. However, her story also reflects that service users may not be clear about pathways to abortion care, especially above nine weeks gestation. It also raises issues around poor linkages between hospital personnel and community services, except the mediation of a social worker, and also reveals the compounding challenges of facing non-providing GPs alongside an incomplete coverage of abortion services in the country.

the middle of the week. As a 40-year-old woman from County Galway explained:

"I got an appointment for Thursday. After the first appointment I had to wait until Monday. There was a weekend in between. So, it ended up being a four-day waiting period. It was not great. But what can you do? … I do believe that the three-day waiting period is unnecessary." (SU3)

Compounding challenges around access to care for migrants

Mandatory PPSN for state subsidised abortion service

A Personal Public Service Number (PPSN) is a unique number that allows residents in Ireland to access a range of social welfare benefits, public services and information in Ireland. It also allows residents to qualify for a state-subsidised abortion service. However, it poses unique challenges for migrants. Service providers are required to share their patient's PPSN with the HSE in order to avail of their reimbursement schemes. Although it can be difficult to get paid for the service provided in cases where a PPSN is lacking, our data show that GPs and MyOptions have sometimes tried to accommodate patients without a PPSN. According to a Scottish woman in County Mayo:

"With the PPS issue she [MyOptions staff] said if Dr. X won't do it then get back to me and we will find someone who will. It could have been much worse if people hadn't been so nice to me. I had applied for a PPS number and I had an email receipt of that. Dr. X spoke to the HSE and was told he has 3 months to make his claim with them. It takes 8 weeks for the PPS number. Maybe they could work something out with the European Health Insurance Card? If I hadn't had a doctor that was so nice this could have been a huge obstacle. The receptionist in Dr. X's office said you need to come back in eight weeks when you have your PPS number. I was worried about this. Then I got a call from

Dr. X who said I don't need to come back and not to worry about it." (SU7)

There is a diverse population of migrant groups in Ireland. Many migrants, including international students, thus remain unaware of the importance of having a PPSN to access free abortion services in the country. Afsana's story (see Vignette 2) demonstrates how the mandatory PPSN for availing state-subsidised abortion care can pose palpable barriers for migrant women in Ireland.

Additional barriers

Geographical distribution of service

The distribution of abortion services is uneven and incomplete in rural regions and in the west and north of Ireland.[9] Such a patchy geographical distribution of community providers of early medical

Vignette 2 – Afsana's Story:

Afsana is an international student from Malaysia. She moved to Dublin in 2019 to pursue her studies. She was 23 years old at the time of the interview. Since she moved to Ireland after 2018, she was not aware of the campaign to Repeal the 8th Amendment. She receives an allowance from her parents to support her education and subsistence in Ireland.

Afsana had gone back to Malaysia for the summer break. After she reached Dublin at the end of her break, she realised that she was pregnant. She mentioned how difficult it would have been for her had she found out about her pregnancy in Malaysia, as she did not have any information about available abortion services there. She said:

"In the first few minutes after finding out about my pregnancy, I did consider buying pills online but realised it was almost impossible. Firstly, they were expensive and secondly, I read on the internet that it's illegal to get them online."

As she looked for information on abortions online, she came across the link for MyOptions. She called them a few times without being able to get through. As she was panicking, she called up her own GP to see if they offered abortion services. But her GP did not provide abortions and referred her back to MyOptions instead. After she was able to get through to MyOptions, she was relieved at how straightforward the whole process was. Afsana said:

"When I called up the MyOptions Helpline, the kind woman referred me to a GP which was very close to where I live. I could walk to the GP. In fact, the GP gave me the pills right away and explained that I take the first pill that day and the second pill, two days later."

However, Afsana was not able to avail the service free of charge because of her lack of PPSN. In order to access abortion services, she had to pay €100 to the GP provider. The GP assured her this payment was refundable contingent upon her providing him with her PPSN once she received it. She was, however, unaware of the importance of having a PPSN prior to this. She explained:

"… .nobody told me that I had to apply for a PPS number when I arrived in Ireland for my studies. It was the woman on the MyOptions helpline who informed me that I could get the services for free if I had a PPS number. When I told her that I didn't have one, she advised me to apply for one and then speak to the GP about it. It was at the GP that I was told that I had to pay a deposit of 100 euros to avail the services."

She had a positive experience with accessing abortion services despite having to pay €100. But she mentioned the importance of informing non-nationals in Ireland about the necessity of PPSN. She added:

"PPS information should be more widely available. That university students should also have a PPS number. When I attended my university orientation last year, they didn't mention about the PPS number. I was under the impression that it was only for Irish citizens. That international students with an Irish residence permit should apply for a PPS number wasn't known to me. I think that should be more widely known."

Despite the reassurance of her GP provider, she felt isolated and unable to seek support from her ex-roommates or her parents for "cultural and religious differences." She added:

"Even though it was easy for me, it struck me that the instructions that talk about the symptoms one might experience on taking the tablets, mentions that you should be around someone who can support you through it. And I didn't have any support. I simply had to power through it. My partner had no clue what had happened and gets to go about business as usual."

terminations can force service users to travel distances they consider problematic to access care. The following quotes exemplify the range of experiences that women in our study had with regard to travelling for abortion care:

"Travel is a huge obstacle. It is almost four hours of driving per day to get to Galway from Sligo. I have spent so much time in the car. I was still able to stay back in my student accommodation in Galway after the first appointment and go back in for the second one. But if I didn't have that it would have been more travelling. I'm not sure what to think of the three-day-wait. I think one day should be enough … I think more GPs should offer the service. For example, there are no providers in Mayo and no providers in Sligo." (SU24)

"Personally, I didn't have any obstacles but if I didn't have transport, my own car, that would be an obstacle. I went to the third town away which is 25 minutes on the motorway." (SU26)

However, in some cases, these travel burdens were mitigated by telemedicine services. At the onset of the Covid-19 crisis, the Department of Health revised the guidelines around abortion consultations, paving the way for a remote model of care. Under these new guidelines, a service user could have both their consultations remotely and designate a proxy to collect the medication after the three-day-wait.[9] This provision mitigated the logistical burdens and financial costs involved with inter-county travel. This is exemplified by the experience of a 30-year-old woman in County Meath:

"I was able to access care via telemedicine. Like I said, I don't have family here for support. And I have a daughter to take care of. She's just one year old. Being able to do the consultations over the phone made it easier. And the whole process was very transparent. They were brilliant at the [women's sexual and reproductive health clinic]." (SU19)

A 28-year-old woman in Kildare shared her sense of relief with the remote model of care, when she said:

"The phone consultation, that was brilliant. It was the first reassuring conversation I had with someone about it." (SU23)

12-week gestation limit

Service users have pointed to the problems posed by the 12-week gestational limit. A woman who was aware of her pregnancy well before the gestational limit, spoke about how this "*poses a sort of backward shadow on 9 weeks"* (SU4). This "backward shadow" is especially significant in cases where women become aware of their pregnancy closer to 9 weeks and 6 days gestation and are required to have a complete successful abortion within 12 weeks and 0 days. Such a limit poses unique challenges for those who experience failed medical abortions.

Abortions post-12 weeks can be accessed under Sections 9 and 10 of the current legislation on grounds of "Risk to life or health" and "Risk to life or health in emergency" respectively. Women with fatal fetal anomalies can also access abortions under Section 11 of the legislation. The grounds for abortion provision are highly regulated under these sections. While access to abortion care post 12 weeks is beyond the scope of this article, it is worth noting that pathways to completing abortion care remain essentially absent in cases where a failed medical abortion renders a woman pregnant beyond the 12-week gestational limit. This is demonstrated by Mara Clarke's (ASN) experience of helping a woman who had two failed abortions during the 12-week gestational limit. Clarke recalls, "*she was told the baby had a problem"*. The two failed early medical abortions could have potentially caused the fetus to develop an anomaly, but the woman was now was faced with the compounding issue that the anomaly was "*not a bad enough problem to allow her an abortion*" beyond the 12-week time limit.

Additionally, as noted by women in our sample, diagnosis of fetal anomalies is often only possible after the gestational limit. A 40-year-old woman in County Cork summarises the dilemma around this gestational limit as follows:

"The 12-week cut-off is a major problem. You can only get a fetal diagnosis after 12 weeks and if there's a problem there, which is not fatal, you still have to travel. I have a friend who had four miscarriages in the last year. But we are somehow forgotten." (SU6)

Where an anomaly is not deemed to be clearly fatal within 28 days of birth, and women concerned are over the gestational limit of 12 weeks, they are unable to access abortion services in Ireland due to the specific wording of the existing legislation.

Remaining challenges for racialised and other marginalised groups

While we were unable to reach several other vulnerable groups including homeless people, Irish Travellers, undocumented migrants and asylum-seekers, our interview data with GPs and key informants from grassroots organisations that work with these groups have identified challenges with respect to their access to abortion care in the country.

Language and translation

One of the biggest challenges that remain is around language and lack of formalised translation services available at GPs' offices. Migrants and asylum-seekers with limited or no knowledge of English are faced with unique barriers in terms of their access to information and care, in general registered medical care. They may be able to avail assistance with translation services provided by MyOptions when they call for initial information. However, translation services are often unavailable during the appointment at the doctor's office. In such cases, individuals seek recourse to translation support from members of family or other members of their social network. Such practices can lead to difficulties such as the one explained by this GP:

"I've never met that lady before. She arrived on Tuesday with her husband. She doesn't speak any English. He was interpreting for her. She had left it all till the last minute and so clearly there's ambivalence there and there's problems and I don't have the capacity really to go into that and you know, if there is social problems for her, I hope that the hospital will help her with that. She's going to have to have the abortion in hospital anyway because she's nearly 12 weeks." (Provider 20)

Apart from affecting the overall quality of care for non-English speaking patients, lack of formalised translation services may make their pathway of abortion care more precarious, especially if they encounter a non-providing obstructive GP.

Pathways to care

A second significant challenge is in terms of the lack of proper pathways to care for asylum-seekers living in Direct Provision centres[30] consisting of "a hodge-podge of accommodations" (Conlon 2010, cited in O'Reilly[31]) including hotels, caravan parks and former army barracks.[31] Many asylum-seekers end up sharing accommodation which are unsuitable for the self-management of early medical abortions (IFPA 2017, 2019 cited in Side[30]). A key informant from a grassroots activist group with experience working with ethnic minorities and asylum-seekers highlights:

"….to be honest, because you're living in such tight quarters and people gossip, I mean institutional living is horrific, right? People … when they do have issues with … abortion, they don't necessarily want their neighbours to know, and some healthcare is provided. Like you literally go into the room … on the day that the GP is there or whatever, like everyone kind of goes in together. You know, you're seen kind of … all together, so you don't necessarily want to have all your personal business." (KI19)

The current geographical distribution of abortion services in the country relies on the potential of service users to travel for services. Such an arrangement overlooks the specific barriers that asylum-seekers living in Direct Provision (DP) centres face. DP centres are located in very rural parts of country with scant public transport.[30] This exacerbates problems around access to abortion care for asylum-seekers, who are usually living on a below-minimum rate of subsistence. As a grassroots activist (KI19) explained, the cost of taxis and buses between these remotely located DP centres, such as Knockalisheen (County Clare), and nearby cities, such as Limerick in this case, are very high. The financial burden of such travel is borne by the asylum-seekers themselves.

GPs in our study have also raised concerns about the added burden of travel for asylum-seekers living in DP centres in remote areas:

"I have seen a woman who was living in direct provision who had to get a bus to Cork and a bus back to [town] to see me, and she had a very clear and definite decision and I saw her long before the Covid thing, so the remote provision wasn't an option for her, and I felt very sorry for her, she had … you know, it was a huge imposition on her". (Provider 44)

Racism

In addition to the travel concerns discussed, there are compounding issues such as racism in public health that contribute to unequal health

outcomes for racialised people in the country. Racism and Afrophobia in particular, as identified by a key informant working with migrants and asylum-seekers in Ireland, are expressed in different ways within the public health system in Ireland. There are still remnants of racial anxieties around non-Irish women as "ethnic subjects" circumventing asylum laws in Ireland,[4,32–35] and other transnational racial assumptions about women of colour. In fact, Eithne Luibheid has argued that in the period after the 1990s which witnessed an increase in "in-migration" to Ireland, practices created to control the entry of asylum-seekers had come to affect all categories of migrants, as well as some citizens.[32] It is not surprising that asylum-seeking women, migrants and women of colour often have disproportionate adverse reproductive health outcomes. The key informant with experience of working with women from migrant and ethnic minority backgrounds, further points out:

"Like racism is rife in the public health services and specifically the maternity services because there's this notion that … especially African women … come to like give birth … as if Ireland is such a great place to … give birth, you know what I mean. Like it's not actually. And … Irish women even will tell you it's not. But then they are kind of treated like oh, you're a monster anyway. We're not going to … You know, they have a lot more difficulty sort of being listened to, being heard." (KI19)

Another key informant who works with African migrant communities pointed to the high percentage of maternal mortality amongst migrant women. She commented on the need to expand the contours of reproductive rights and articulated a demand for more comprehensive reproductive healthcare by saying, "*when you look at the rights of women, it's not just the right to have an abortion"* (KI15).

Discussion

While we have interviewed women who accessed abortions beyond 12-week gestation, this article centres on the experiences of service users' access to early medical abortions up to 12 weeks gestational limit. This helps us analyse and appraise the different aspects of the Health (Regulation of Termination of Pregnancy) Act of 2018. It does so by drawing on interviews with service users, service providers and key informants as a way to triangulate data on the experiences of abortion care. To shed light on the compounding effects of gaps in the existing policy, and especially on groups located along different axes of inequality, it examines the results through a framework of reproductive justice which helps us consider the "links between reproductive rights and social justice".[22] The current law grants the right to abortions within a tight framework without the guarantee for equitable access to service provision for all potential service users, as reflected in the results of our study. With its adoption of intersectionality,[36,37] reproductive justice focuses on inequities that "are mediated through discrimination based on race, culture, socioeconomic status, gender identity, sexual orientation, immigration status, religion [and] age" amongst many considerations. Such an approach allows us to see how these intersectional identities "contribute to poor reproductive health outcomes" and threaten a woman's bodily autonomy.[21,36]

The availability of abortion services in Ireland since its legalisation has reduced many obstacles associated with the "need for border crossings and associated costs" that existed prior to 2019[30] (p. 123). However, results from our study suggest that the access to abortions remains precarious for women and other pregnant people, especially those located along intersecting axes of socio-economic inequalities, such as migrants, including international students and asylum-seekers, rural users and other racialised groups including Travellers. KI19's reflections as discussed in the previous section resonate with Ruth Fletcher's[38] argument around the culture of disrespecting the voices of - especially - migrant and ethnic minority women in maternity care. The experience of Jane Xavier,[39] an Irish activist of Afro-Brazilian heritage, of not being listened to during her high-risk pregnancy is supported in existing literature around Black women's experiences with reproductive healthcare.[40,41] The National Women's Council of Ireland's (NWCI) report on *Accessing Abortion in Ireland: Meeting the Needs of Every Woman*[42] quotes research conducted by the National Traveller Women's Forum to shed light on how high rates of unemployment and risk of poverty contribute to unequal reproductive health outcomes for Traveller women. According to the report, 66.7% of service providers agree that Traveller women sometimes experience

discrimination in their use of health services.[42] Such factors exacerbate their mistrust in health services and affect their ability to access timely reproductive healthcare.[42]

It is important to remember that abortion services in Ireland exist as long as medical practitioners are willing to "opt in" for service provision, with contact details provided to the HSE's central information centre MyOptions.[9,30] The opt-in system in turn preserves doctors' right to conscientiously object.[30,43] With waning promotional campaigns to popularise MyOptions, women in our sample tended to contact their GPs, often non-providers, as their first point of contact, expecting to be cared for by them. Some women could experience delays and protracted journeys especially when their non-providing GPs refused to provide more information or tried actively to dissuade them from accessing abortion care. Our data also show that migrant women have been misled by pharmacists and/or physicians citing conscientious objection, thus forcing them into importing abortion pills through their social networks. Migge and Gilmartin's scholarship on patient mobility amongst migrants in Ireland notes that many of them are "confused about the Irish health system, including their entitlements, procedures for obtaining it and the services available".[44] Additionally, their research shows that migrants often felt that their lack of information and palpable difficulties in navigating healthcare were the result of the system's desire to remain opaque to newcomers. Our research shows that migrants with limited prior legal knowledge or requisite skills in English are particularly vulnerable to facing objection when encountering non-providing GPs or misleading pharmacists.

Conscientious objection is a complex issue in Ireland. Elsewhere, we show that "unreliable or unclear referral pathways from primary to secondary care" discourage some GPs, especially in rural regions where there are fewer hospitals providing abortion services, from providing abortions.[9] We believe that there is a role for the HSE and its national lead for abortion services to facilitate and standardise the development of these protocols.[9]

The literature on conscientious objection also poses important questions on the ethical obligations of medical service providers towards their patients.[45] The consensus around a "moderate view" states that healthcare providers can reserve the right to refuse to perform a certain activity, but they are required to refer their patients to a willing service provider.[45] In fact, the Irish Medical Council's *Guide to Professional Conduct and Ethics* mentions that non-providing doctors have an obligation to either signpost their patients to the MyOptions helpline or refer them to a providing GP.[7] However, as Minerva argues, such an approach fails to offer an effective solution in areas with a high percentage of conscientious objectors[45] and does not provide a viable solution in rural areas with low service coverage.

Conscientious objection, along with a mandatory waiting period, delays women's access to abortion care.[46] The mandatory three-day wait after the first in-person consultation posed more barriers for the women in our study. Our data are thus consistent with existing research in other contexts that speaks to several logistical issues including personal and financial costs associated with travel that a mandatory waiting period poses for women,[47] particularly for women who are closer to the 12-week limit.[42] Furthermore, as per the National Women's Council Report on access to abortion services in Ireland, those women who remain pregnant after a failed medical abortion under 12 weeks are required to re-start the whole process, including the waiting period, if they wish to undergo the procedure again.[42] For those that exceed 12 weeks even by one day, access to termination under Section 12 can be denied. The low number of abortions provided under Sections 9 and 10 of the abortion legislation in Ireland,[11] and the national abortion statistics from England and Wales, suggest that women from Ireland continue to travel when they are unable to access services in Ireland.[14,15] The lower number of people travelling to jurisdictions outside Ireland for abortion care reflects the existence of a pathway to some abortion care, nonetheless. However, this pathway continues to remain poorly defined. This data fails to account for the lack of reproductive options for poorer women and those with visa restrictions who might find themselves in a situation where they cannot access abortion care in Ireland. With these complications in mind, we believe in the removal of the three-day wait from policy. We also believe that there is room for clarifying that the 12-week gestational limit refers to the beginning of the procedure, which should be completed even after 12 weeks.

Uneven and incomplete geographical distribution of service provision in rural regions, especially in the west and north of the country remains a barrier for service users. At the time of our data collection, around 385 GPs in 25 counties have signed contracts with the HSE to provide medical abortions.[9] A recent report by the National Women's Council[42] highlights that there are 3496 GPs actively practising in Ireland, which means that one in every ten GPs provide abortions (NWCI 2021). These services are concentrated in urban centres with scant coverage in rural areas (NWCI 2021). Such an uneven coverage can sometimes pose significant challenges for service users who do not drive or asylum-seekers living in Direct Provision centres located in isolated, rural areas with poor public transport.[48,49] A potential solution to address this barrier would be incentives offered by the HSE to encourage doctors to practise in more rural areas. Continuation of telemedicine may help address the burden of domestic travel for potential service users in rural areas.[9]

The sharing of service users' PPSN data between providers and the HSE in order to enable the former to avail of the HSE's reimbursement scheme, raises unique challenges for undocumented migrants. Their lack of a valid legal status in the country might otherwise go unnoticed,[50] thereby protecting them from the threat of potential deportation. The HSE can address this issue by ensuring and standardising reimbursements for GPs who provide abortion care to those without a PPSN.[9]

The policy recommendations suggested above, alongside a consideration of social and economic circumstances that "hinder … patients' sexual and reproductive rights"[21] will help us envision strategies that promote and advance the equitable access to reproductive healthcare for all. However, it is necessary for researchers to work closely with advocacy organisations to help develop shared policy messages and push for change that enables women and other people a greater bodily autonomy.

Limitations and strengths

As with qualitative studies in general, this research is not meant to be generalisable. There are some limitations to the use of purposive sampling in this research study. One major limitation was the use of gendered language in the research design. This could have limited our ability to recruit service user participants from gender non-binary and transgender populations. Despite continued efforts, we were also unable to reach other marginalised communities such as asylum-seekers currently living in Direct Provision Centres and members of the Irish Travelling Community. However, the triangulation of data from three samples, and the wide geographical distribution of research participants including members of grassroots groups and service providers, enabled us to explore the question of access to early medical abortion care for service users from hard-to-reach demographics. Thus, as an early study on the implementation of the Health (Regulation of Termination of Pregnancy) Act 2018, this research sheds light on the question of access to early medical abortions in Ireland.

Conclusion

Overall, this study shows that the new abortion policy has improved women's access to abortion care in Ireland. There has been a steady decline in the number of women travelling to the UK for abortion care. This could mean a positive change in reproductive rights in the country. However, we do not have complete data on women still seeking abortion support from groups such as Women Help Women or Women on Web. Service users in our data expressed an overall satisfaction with the availability of abortion care in Ireland. However, gaps in the existing policy in terms of the gestational limit and mandatory three-day wait, alongside the uneven geographical distribution of service provision, disproportionately affect women from marginalised backgrounds. While most women present themselves at an early gestational age, the pathway to care remains unclear for those who exceed 12 weeks' gestation.

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References

1. Field L. The abortion referendum of 2018 and a timeline of abortion politics in Ireland to date. Irish Polit Stud. 2018;33(4):608–628.
2. Lentin R. After Savita: migrant m/others and the politics of birth in Ireland. In: A Quilty, S Kennedy, C Conlon, editors. The abortion papers Ireland: volume 2. Cork: Attic Press; 2015 [cited 2020 Jun 28]. Available from: https://www.amazon.co.uk/Abortion-Papers-Ireland-2-ebook/dp/B019WQR5IM
3. Chakravarty D, Feldman A, Penney E. Analysing contemporary women's movements for bodily autonomy, pluriversalizing the feminist scholarship on the politics of respectability. J Int Womens Stud. 2020;21(7):170–188.
4. Side K. The geopolitics of abortion, migration and mobility: the Republic of Ireland. Gender Place Cult: J Feminist Geogr. 2016;23(12):1788–1799.
5. Enright M, Conway V, de Londras F, et al. Abortion law reform in Ireland: a model for change. Feminists@Law. 2015;5(1):1–17.
6. Oireachtas. Health (Regulation of Termination of Pregnancy) Act 2018; 2018. Available from: https://www.oireachtas.ie/en/bills/bill/2018/105/?tab=bill-text
7. Irish College of General Practitioners Quick Reference Guide (version 2) (ICGP QRG). Clinical support for termination of pregnancy in general practice. Dublin: ICGP; 2021 [cited 2021 Jul]. Available from: www.icgp.ie
8. Health Service Executive. Unplanned pregnancy support services: MyOptions freephone line. Ireland [six screens]; 2018 [cited 2022 Feb 22]. Available from: https://www2.hse.ie/services/unplanned-pregnancy-support-services/my-options-freephone-line.html
9. Mishtal J, Reeves K, Chakravarty D, et al. Abortion policy implementation in Ireland: lessons from the community model of care. PLoS One. 2022 (in press).
10. Department of Health. Health (Regulation of Termination of Pregnancy) Act 2018: annual report on notifications: 2020; 2021 [cited 2022 Feb 22]. Available from: https://www.gov.ie/en/publication/ef674-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2020/
11. Department of Health. Health (Regulation of Termination of Pregnancy) Act 2018: annual report on notifications: 2019; 2020 [cited 2022 Feb 22]. Available from: https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/#
12. Rough E. Abortion in Northern Ireland: recent changes to the legal framework. Commons Library Research Briefing; 2023 Feb 6 [cited 2023 May 5]. Available from: https://researchbriefings.files.parliament.uk/documents/CBP-8909/CBP-8909.pdf
13. Abortion Statistics, England and Wales: 2019 summary of information from the abortion notification forms returned to the Chief Medical Officers of England and Wales. January to December 2019 [cited 2022 Feb 22]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf
14. Abortion Statistics, England and Wales: 2020; [cited 2022 Feb 22]. Available from: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020
15. Abortion Statistics, England and Wales: 2021; [cited 2023 May 5]. Available from: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021
16. Greene J, Butler E, Conlon C, et al. Seeking online telemedicine abortion outside the jurisdiction from Ireland following implementation of telemedicine provision locally. BMJ Sex Reprod Health. 2021. DOI:10.1136/bmjsrh-2021-201205
17. Mishtal J, Duffy D, Chavkin W, et al. Policy implementation – access to safe abortion services in Ireland research dissemination report. Geneva: UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization; 2021 Apr 23. p. 1–37.
18. Stifani BM, Mishtal J, Chavkin W, et al. Abortion policy implementation in Ireland: successes and challenges in the establishment of hospital-based services. SSM – Qual Res Health. 2022;2: Article 100090, 1–12.
19. Duffy D, Mishtal J, Grimes L, et al. Information flow as reproductive governance. Patient journey analysis of

information barriers and facilitators to abortion care in the Republic of Ireland. SSM – Popul Health. 2022;19:Article 101132, 1–8.
20. Grimes L, Mishtal J, Reeves K, et al. 'Still travelling': access to abortion post-12 weeks gestation in Ireland. Women's Stud Int Forum. 2023;98:Article 102709, 1–8.
21. Gilliam ML, Neustadt A, Gordon R. A call to incorporate a reproductive justice agenda into reproductive health clinical practice and policy. Contraception. 2009;79(4):243–246.
22. Idriss-Wheeler D, El-Mowafi IM, Coen-Sanchez K, et al. Looking through the lens of reproductive justice: the need for a paradigm shift in sexual and reproductive health and rights research in Canada. Reprod Health. 2021;18(129):1–7.
23. Bressers H. Implementing sustainable development: how to know what works, where, when and how. In: Lafferty WM, editor. Governance for sustainable development: the challenge of adapting form to function. Cheltenham: Edward Elgar; 2004. p. 284–318.
24. Carey JW, Morgan M, Oxtoby MJ. Intercoder agreement in analysis of responses to open-ended interview questions: examples from tuberculosis research. Cult Anthropol Methods. 1996;8(1):1–5.
25. Strauss A, Corbin J. Basics in qualitative research: techniques and procedures for developing grounded theory. 2nd ed. London: Sage; 1998.
26. Coffey A, Atkinson P. Making sense of qualitative data. Thousand Oaks (CA): Sage; 1996.
27. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52:1893–1907.
28. Geertz C. The interpretation of cultures: selected essays. New York: Basic; 1973.
29. Bakhru TS. Reproductive health and human rights: lessons from Ireland. J Int Women's Stud. 2017;18 (2):27–44.
30. Side K. Abortion im/mobility: spatial consequences in the Republic of Ireland. Fem Rev. 2020;124:15–31.
31. O'Reilly Z. 'Living liminality': everyday experiences of asylum-seekers in the 'Direct Provision' system in Ireland. Gender Place Cult. 2018;25(6):821–842.
32. Luibheid E. Pregnant on arrival: making the 'illegal' immigrant. Minneapolis: University of Minnesota Press; 2013.
33. Lentin R. 'Pregnant silence: (en)gendering Ireland's asylum space'. Patterns Prejudice. 2003;37(3):301–322.
34. Lentin R. From racial state to racist state? Racism and immigration in twenty first century Ireland. In: Lentin A, Lentin R, editors. Race and state. Newcastle: Cambridge Scholars Press; 2006. p. 187–208.
35. Lentin R. A woman died: abortion and the politics of birth in Ireland. Fem Rev. 2013;105(1):130–136.
36. Mukherjee TI, Khan AG, Dasgupta A, et al. Reproductive justice in the time of COVID-19: a systematic review of the indirect impacts of COVID-19 on sexual and reproductive health. Reprod Health. 2021;18(252):1–25.
37. Ross L. What is reproductive justice? Retrieved from A primer on reproductive justice and social change; 2007.
38. Fletcher R. #Repealedthe8th: translating travesty, global conversation, and the Irish abortion referendum. Feminist Legal Stud. 2018;26:233–259.
39. Xavier J. My activism and my experience in a maternity hospital in Ireland; 2019 [cited 2022 Sep 7]. Available from: https://merjireland.org/index.php/2019/04/09/my-activism-my-experience-in-a-maternity-hospital-in-ireland/
40. Campbell C. Medical violence, obstetric racism, and the limits of informed consent for black women. Mich J Race Law. 2021;26(4):48–74.
41. Davis DA. Obstetric racism: the racial politics of pregnancy, labor, and birthing. Med Anthropol. 2018;38 (7):560–573.
42. Kennedy S. Accessing abortion care in Ireland: meeting the needs of every woman. National Women's Council of Ireland Report; 2021. Available from: https://www.nwci.ie/images/uploads/15572_NWC_Abortion_Paper_WEB.pdf.
43. Grimes L. The fight continues: new access to abortion services in Ireland. E-International Relations; 2019 Mar 8 [cited 2021 Oct 19]. Available from: https://www.e-ir.info/2019/03/08/the-fight-continues-new-access-to-abortion-services-in-ireland/
44. Migge B, Gilmartin M. Migrants and healthcare: investigating patient mobility among migrants in Ireland. Health Place. 2011;17(5):1144–1149.
45. Minerva F. Conscientious objection in Italy. J Med Ethics. 2015;41:170–173.
46. Autorino T, Mattioli F, Mencarini L. The impact of gynaecologists' conscientious objection on abortion access. Soc Sci Res. 2020;87:1–16.
47. Joyce TJ, Henshaw SK, Dennis A, et al. The impact of state mandatory counseling and waiting period laws on abortion: a literature review. New York: Guttmacher Institute; 2009.
48. Lentin R, Nedeljkovic V. Disavowing asylum: documenting Ireland's asylum industrial complex. Lanham (MD): Rowman & Littlefield; 2021.
49. Murphy F. Direct provision, rights and everyday life for asylum-seekers in Ireland during COVID-19. Soc Sci. 2021;10(4):140, pp. 1–12.
50. Cairde. Assessing the health and related needs of minority ethnic groups in Dublin's north inner city: a case study of a community development approach to health needs assessment. Dublin: Cairde; 2006. Available from: http://www.cairde.ie/research-policy/reports/

Résumé

Cet article porte sur l'accès à l'avortement médicamenteux précoce en vertu de la section 12 de la loi de santé (réglementation de l'interruption de grossesse) de 2018 en Irlande et identifie les obstacles résultant de lacunes dans la conception actuelle de la politique. L'article se fonde principalement sur des entretiens qualitatifs avec 24 utilisatrices des services, 20 prestataires de soins de santé primaires dans la communauté et 27 informateurs clés, notamment issus de groupes locaux qui travaillent avec des femmes appartenant à différentes communautés migrantes, pour examiner l'expérience vécue par les utilisatrices pour avoir accès à l'avortement médicamenteux précoce à la demande jusqu'à 12 semaines de gestation. Les entretiens faisaient partie d'une étude plus large à méthodologie mixte réalisée en 2020-2021 qui examinait les facteurs entravant ou facilitant la mise en oeuvre de la politique d'avortement en Irlande. Nos résultats mettent en lumière l'expérience que les femmes ayant demandé des soins ont vécu avec la prestation de services sous l'égide des médecins généralistes, y compris les retards, le contact avec des non-prestataires, le délai d'attente obligatoire de trois jours et les centres de santé des femmes et de planification familiale surchargés. Nos résultats soulignent aussi les difficultés additionnelles des migrantes et les barrières supplémentaires posées par la répartition géographique du service et la limite gestationnelle des 12 semaines. Enfin, l'étude se centre sur les problèmes restants pour les groupes racialisés et autres communautés marginalisées. Afin de fournir une « description rapide » de la vie des femmes et de la complexité de leur expérience avec les services d'avortement en Irlande, nous présentons également deux anecdotes d'utilisatrices de services, qui racontent aussi leur expérience des retards et de la navigation dans le système de santé en tant que migrantes. À cette fin, l'article applique un cadre de justice reproductive aux résultats pour dégager les circonstances aggravantes de ces obstacles sur les personnes qui se trouvent sur de multiples axes d'inégalité sociale.

Resumen

Este artículo se enfoca en el acceso a servicios de aborto con medicamentos en las etapas iniciales del embarazo, bajo la Sección 12 de la Ley sobre Salud (Regulación de la Interrupción del Embarazo) de 2018 en Irlanda e identifica las barreras existentes causadas por las brechas en la formulación de políticas vigentes. El artículo se basa principalmente en entrevistas cualitativas con 24 usuarias de servicios, 20 prestadores de servicios de atención primaria en la comunidad y 27 Informantes Clave, entre ellos personas de grupos de base que trabajan con mujeres de diferentes comunidades de migrantes, para examinar las experiencias de las usuarias de servicios accediendo al aborto con medicamentos temprano a petición hasta las primeras 12 semanas de gestación. *Las entrevistas* fueron parte de un estudio más extenso con métodos mixtos, realizado entre 2020 y 2021, que examinó barreras y facilitadores para la aplicación de la política de aborto en Irlanda. Nuestros hallazgos destacan las experiencias de las personas que buscaban servicios con la prestación de servicios dirigida por GP, tales como retrasos, tener que enfrentar a personas que no son prestadores de servicios, el período de espera obligatorio de tres días y sobrecarga de los centros de salud de la mujer y de planificación familiar. Además, nuestros hallazgos ponen de relieve los retos agravantes para migrantes, y otras barreras atribuibles a la distribución geográfica del servicio y el límite gestacional de 12 semanas. Por último, se enfoca en los retos restantes para grupos racializados y otros grupos marginados. A fin de ofrecer una "descripción detallada" de la vida de las mujeres y la complejidad de sus experiencias con los servicios de aborto en Irlanda, también presentamos dos viñetas narrativas de las usuarias de servicios y sus experiencias con retrasos y navegando el sistema de salud como migrantes. Para ello, este artículo aplica el marco de justicia reproductive a los resultados para destacar los efectos agravantes de estas barreras en personas situadas a lo largo de múltiples ejes de desigualdad social.