More than Committed Providers: Health Care Providers, Practice Learning, and Building Abortion Services in Ireland

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Abstract

Under the Health [Regulation of Termination of Pregnancy] Act 2018, a range of abortion care pathways have been introduced in the Republic of Ireland since 2019. The new abortion services were intended to transform the Republic of Ireland from a hyperrestrictive to a liberal abortion regime. Health care providers, committed to making abortion care a reality in Ireland, were central to establishing and implementing abortion services. Literature on the role of health providers during this implementation period has underscored this 'committed provider' subjectivity. Here we wish to draw attention to another role they played. Applying Ahmed's writing on phenomenological diversity work, the paper positions health care providers as 'workers and knowledge creators' who have generated new knowledge about walls in practice. Drawing on qualitative findings from 40 semi-structured interviews undertaken as part of a Realist Evaluation, commissioned by the Department of Health, in 2022, this paper outlines what understandings of impediments to abortion in a post-liberalisation moment have been generated by the experience of implementation and provision. Through this discussion, the paper shows how providers are not just instrumental in implementation but also, through their reflections and accounts, in generating insights to ensure the on-going improvement of abortion services.

Keywords

Abortion provision; health care providers; Ireland; liberalisation; barriers to abortion; evaluation

Introduction

The 2018 referendum to repeal Article 40.3.3 of the Irish constitution, which had underpinned a legal and political framework restrictive abortion except in extreme circumstances, where the women's life was at risk resulted in a fundamental transformation in abortion care in Ireland (AUTHORS; Taylor et al, 2020). Under the Health (Regulation of the Termination of Pregnancy) Act on 1 January 2019, a termination can be sought under four legal grounds: If the pregnancy has not exceeded 12 weeks; If there is a risk to the life of the pregnant person; Where there is a risk to the health of the pregnant person; If there is a fetal abnormality where the baby will die within 28 days of life. Initially four care pathways, mapped onto each of the legal grounds, were drafted by the Institute of Obstetricians and Gynaecologists (IOG). A fifth telemedical pathway was added in 2020 in response to the COVID-19 restrictions on physical access to health centres (Greene et al, 2022).

The 'abortion care workforce' that emerged in the period immediately before the introduction of services and has, since 2019, led the implementation and expansion of services (Bergen, 2022). Health care professionals (HCPs) occupy an important position within the broader discourse of abortion in Ireland prior to and following liberalisation. Their position is not solely a functionary one. HCPs in the abortion care workforce act as committed providers (AUTHORS; Donnelly and Murray, 2020), pro-choice advocates (Bergen, 2022) and leaders in abortion service integration (van Keizerswaard et al, 2024). Before service implementation in 2019, HCPs, particularly those involved in pro-choice activism, played a central role in progressing the legislative changes as well as drafting

care guidelines and operational practice frameworks (Higgins et al, 2021). In the post-liberalisation period, they have spear-headed professional training (Eogan et al, 2023) and pushed forwards the project of embedding the new range of abortion services within the existing health service (Dempsey et al, 2023) which had, until the 2018 legal reforms, been prohibited from supporting abortion care except under extremely limited circumstances (AUTHORS).

Despite their demonstrable role in teaching the Irish health workforce how to provide excellent, women-centred abortion care (AUTHORS; Higgins et al, 2021), the pedagogical contribution of HCPs has not been the dominant theme of literature on HCPs, post-2019 abortion implementation and Ireland. Published research on the position of HCPs within the abortion care workforce has emphasised their role as leading the introduction, implementation, and development of abortion services in Ireland (Dempsey et al, 2023; Hayes-Ryan et al, 2021). The HCP experience within a reformed legal context and the change in HCP perspectives has received significant attention. The literature focuses on HCPs role as committed and conscientious abortion care providers (Donnelly and Murray, 2020) who, despite professional isolation and stigma (Dempsey et al, 2021), have facilitated the introduction of a functioning, women-centred abortion service. This framing resonates with broader literature on the role of HCPs in abortion care as committed providers (Merner et al, 2024) invested in, depending on the legal status of abortion, health care activism or the development and continued provision of abortion services (Bergen, 2022). Often this work involves challenging anti-abortion discourses within health, acting as a "medical voice" in the pro-choice discourse (Bergen, 2022) or self-censorship regarding the professional challenges of abortion care out of concern of undermining the continued availability of abortion (Martin et al, 2017).

This framing, while important, is instrumental and centres HCPs contribution to leading the implementation and delivery of abortion. It overlooks the contribution of HCPs to on-going service learning and improvement after implementation. Here we discuss abortion providing HCPs role in generating a deeper understanding of the impediments to abortion care in practice in the post-liberalisation phase. We outline how HCPs involved in providing abortion care, in primary and secondary care settings, offer insights regarding the complex barriers within abortion care in post-liberalisation contexts. We argue that this insider perspective is vital in the meaningful improvement of abortion care. In making this argument, we relocate appraisal of the role of abortion providers in moments of liberalisation from instrumental, committed providers of abortion care and training for care to a more sociologically-inspired position as generators of new understandings about impediments to abortion care in healthcare systems. Centrally we contend that HCPs not only lead the training of the Irish health workforce towards an abortion-providing workforce; they also reveal and amplify complex problematics in abortion care. In making these arguments we draw together provider accounts with sociological perspectives on critical pedagogy.

HCPs and learning about abortion after liberalisation

Training and education were of critical importance to the successful implementation of the post-liberalisation abortion services. As Higgins et al (2021) note, this was a new area for most clinicians. Although there was significant knowledge, and pre-existing training programmes for primary and secondary care clinicians on miscarriage support, abortion in cases of emergency and post-abortion care, there were pronounced gaps among the HCP workforce. Knowledge of second-trimester surgical abortion, a preference for many pregnant people, was "minimal" (Higgins et al, 2021: 247) and there was a "competency gap [in] the provision of feticide and second-trimester dilation and evacuation (D&E)" (ibid: 349). It is unclear how much these educational needs extended to nurses and midwives, who would also have been involved, pre-implementation, in miscarriage and post-

abortion care. O'Shaughnessy et al (2021) highlight gaps in clinical knowledge and understanding identified through a survey of staff knowledge at a large maternity hospital in 2019. However, the authors' of this piece note that while their data indicates knowledge issues among midwifery and nursing respondents, the data collected from these HCPs is limited in size.

HCPs developed and led the nascent abortion training programme from summer 2018, prior to the official implementation of the new care pathways, onwards. Initially this was co-ordinated by HCPs working collectively but independently of the Irish health service, Department of Health, or national professional organisations (AUTHORS). A group of primary and secondary care providers based mainly in the south west of Ireland – the Southern Taskforce for Abortion and Reproductive Topics (START) - were instrumental in developing and co-ordinating this training and on establishing a peer support group, offering mentorship. START adopted a 'train the trainer' approach to expand the reach of education and training sessions (AUTHORS). These training programmes have, since 2019, been integrated into the programme of professional education for newly qualified clinicians in primary and secondary care. A training programme has also been made available to midwives and nurses. Evaluations of the latter programme indicates its positive influence on knowledge and understanding of abortion care and the current services among training participants (Fletcher et al, 2023).

The design and roll-out of training for abortion care, and abortion care's integration in established teaching and professional development frameworks, has been and is undoubtedly a crucial contribution by HCPs in the transition from a restrictive to a liberalised abortion context. However, an arguably more substantive contribution made by HCPs, particularly from a sociological perspective, is the development of a critical consciousness of the on-going impediments to implementing and practicing abortion care following transition from a hyperrestrictive and liberalised abortion care regime (see Coast et al, 2018 and AUTHORS on barriers outside law). In other words, while developing training is an important contribution by committed providers, abortion-providing HCPs more substantive influence is as what we label *knowledge generators*. It is this contribution that, we argue, is underrecognised within current writing on abortion-providing HCPs which predominantly engages and amplifies HCPs as committed, conscientious providers.

Proposing HCPs as knowledge generators rearticulates the abortion-providing HCPs subjectivity and subject position within the discourse of abortion services in Ireland. It aligns to sociological writing, specifically that of Sara Ahmed (2012), on workers within institutions where certain barriers or exclusions have or are being removed. Ahmed's focus is diversity workers within institutions where anti-racist, equality, diversity and inclusion (EDI) measures have been introduced. Writing on the role of diversity workers in higher education institutions (HEIs), Sara Ahmed (2012) argues that these actors follow conflicting trajectories with regard to the work of equality, diversity and inclusion. On the one hand, they adhere to institutionally-influenced labour of non-performative diversity and inclusion. Ahmed conceptualises non-performativity not as diversity and inclusion work that does not perform its intend role, i.e. to establish an equitable and inclusive institutional infrastructure, but as institutional practices and technologies of working that are constituted to not perform.

Non-performativity is discussed by Ahmed through the problem of racialised inequality and exclusion. Institutional practices and technologies of working, such as equality, diversity and inclusion (EDI) policies or fora, are established and directed towards either obfuscating the persistence of racialised exclusion and inequity or to deny the existence of EDI issues through claiming that they have been addressed. The role of diversity workers is to actively or implicitly silence and invisibilise racism through a subjecthood – as the embodiment of an active resolution to EDI issues – and subjectivity – as consistently and meaningfully addressing EDI problems. This

subjecthood/subjectivity is performatively non-performative. Within the broader institutional discourse Ahmed addresses the diversity worker is constituted as exemplifying the inherently inclusive, non-racist and diversity-sensitive nature of HEIs (i.e. we have a diversity worker and therefore have addressed racism). This performative subjectivity is, however, intentionally non-performative. Their existence allows institutions to avoid addressing, recognising or openly accepting their racist qualities by historicising racism as an issue that only existed prior to the existence of a diversity worker.

As a counterpoint to this performatively non-performative function, Ahmed argues that some diversity workers can and do act as critical pedagogues or, to use Ahmed's phrasing, phenomenological diversity workers. This subjectivity is characterised not by performative non-performativity – a mode of being that in itself (re)produces racists institutional discourses as post-racist – but as generators of knowledge about the contours of exclusionary and racist discourses. More importantly, these contours are not flat or homogeneous. They have points of malleability and fragility which, through ongoing learning and phenomenological practice, diversity workers come to know about and know how to work through.

In terms of abortion care providers in the post-liberalisation space, Ahmed's intervention offers important insight into the differing role these HCPs can play. On the one hand, abortion providing HCPs can be part of a performatively non-performative strategy where their appointment is used as evidence of the implementation of abortion services. Effectively abortion providing HCPs can operate as an emblematic proxy for abortion services having been successfully established, undermining critiques of whether the achievements of liberalisation have been realised. To draw again on Ahmed's depiction of performatively non-performative EDI policy, through appointing EDI workers institutions are able to present themselves as equal, diverse and inclusive even where this is not the case. Abortion-providing HCPs in post-liberalisation contexts can play a similar role.

Alternatively, based on Ahmed's work, it is possible to frame abortion-providing HCPs in this context as generating nuanced insights into the impediments to putting the aspirations and principles of the new abortion service into practice. Ahmed presents this as phenomenology work or learning about the contours and textures of a wall to progress – whether progress towards inclusion and equity or, in the case of abortion in Ireland, progress towards implementing a liberalised portfolio of abortion services – through the experience of encountering the wall. Crucially, this phenomenological pedagogical contribution is not solely restricted to generating knowledge of walls but to generating knowledge of how to work through impediments in meaningful ways.

This article outlines the impediments to abortion access that became visible due to the work of HCPs during this implementation period. It also draws attention to the mechanisms for working through these barriers that HCPs were able to map out through their phenomenological work. Importantly, we foreground the fact that many of the barriers are not solely due to problems related to abortion legislation. Rather they are connected with cross-cutting issues within Irish health services. Furthermore, we highlight the key role of individual HCPs and informal practices, or practices outside and beyond a proscribed HCPs role, in addressing these barriers. These findings, we argue, have important messages for health policy leaders in the Republic of Ireland as well as those pursuing both the liberalisation and enhancement of abortion access elsewhere.

Methodology

The study used a realist evaluation design (Pawson and Tilley, 2001). Realist evaluation explores, and aims to improve, social programmes and policy interventions through a 'what works, for whom,

under what circumstances?' framework. Data, including primary and secondary data, is used to connect the conditions and context of a programme (Context or C), approaches used by those working on the programme (Mechanisms/Methods or M) and the observed or documented outcomes (Outcomes or O). These C-M-O chains operate a mid-range or programme theories to explain variations in outcomes reported (demi-regularity).

The study primarily used qualitative data from semi-structured, in-depth interviews with health professionals working in primary and secondary care, staff at Women's Health Centres (WHC), members of professional representative groups, and members of the Health Service Executive's National Women and Infants Health Programme (NWIHP) who were involved in the co-ordination of services nationally. Interviews were undertaken using two web platforms (Zoom and Microsoft Teams). In total we conducted 40 interviews with 43 participants. We followed a convenience sampling approach, guided by the requirements of the Department of Health, who commissioned the evaluation, as well as a rapid evidence assessment of empirical data of provider perspectives of the new termination of pregnancy services published since 2020. Ethics approval was given by AUTHORS INSTITUTIONS REMOVED FOR REVIEW.

The specific professional roles of interviewees ranged from hospital-based social worker to consultant obstetrician, these have been tabulated below. To ensure individual respondents remain anonymous we have not named participants' geographic locations or place of work in reporting. Demographic details have been removed for similar reasons. The limitations of our research approach are outlined later in this paper.

Initial programme theories were developed iteratively by two researchers (AUTHOR 1 and AUTHOR 2) using verbatim interview transcripts. IPTs were further refined using feedback from an advisor in primary and an advisor in secondary care. We also used comparison with secondary literature on abortion services in Ireland, published since 2020, gathered from the PubMed and Medline databases. Through these stages we reduced the IPTs to mid-range/programme theories focused on demi-regularity, from the perspective of HCPs, in the successful implementation of accessible abortion services.

Applying Ahmed's writing on diversity workers as knowledge generators about walls, the remainder of this paper focuses on the demi-regularity identified by HCPs who participated in this study. Using interview data, we foreground the issues that HCPs drew attention to as impediments to implementing abortion care successfully. Based on the data collected, we underscore four 'walls' within abortion services HCPs reported they encountered through implementation – *workforce issues*, *resource issues*, *acceptance of the service*, and *peer and managerial support*. In the remainder of this paper, we argue that these experiences offer a more nuanced insight into the walls within Irish abortion services post-liberalisation. We conclude by suggesting that a major contribution of abortion providers during the implementation period has not just been the introduction of services but the generation of knowledge about the multiple walls within a post-liberalisation abortion service, knowledge which can be used to further improve abortion services in the Republic of Ireland.

Walls within abortion services post-liberalisation

Workforce issues

Workforce issues were identified as a key feature of the wall encountered by HCPs during implementation. HCP interviews indicated that workforce was a wall in both primary (general

practice, in the community) and secondary (acute settings, hospital-based) care. Here the data raises two interconnected issues - workforce size and staff workload. For example, HCPs in primary care drew attention to the limited number of GPs involved in provision. Providing abortion care, under the new legislation, is optional. While the size of the primary care abortion workforce has increased since 2019, fewer than 10% of General Practitioners (GPs) were involved in providing abortion at time of research (AUTHORS). GP research participants involved in the research argued that the limited size of the workforce meant that GPs who are providing have had to add an additional service onto their already busy schedules.

> I think the GP workload crisis and workforce crisis, probably a lot of GPs have said that and capacity within general practice is a massive problem at the moment. We are out the door. I think many of the GP providers, they've created time in their schedule to look after termination of pregnancy patients but it just becomes challenging when you might have someone goes on annual leave and even things like if you're locum comes in, maybe not provide training. (R201)

> There's definitely a certain amount of GPs for whom it's just like, "I can't take on anything else now. I'd love to be able to do it but the thought of sitting down and organising it and figuring it all out and all the rest of it, I just can't actually go there," and these consultations are long and they have to be scheduled quickly, they can't be put off. (R101)

GPs also outlined how their understanding of the workforce aspect of the wall had expanded during implementation as they became more familiar with the burden of work providing abortion entailed. The quotes below illustrate how these more nuanced insights emerged from the experience of encountering the workforce wall during implementation:

> It's quite complex administratively and this might be a small practice with one GP, one nurse, one secretary, it's not a thing in terms of financial, there might be a huge volume that you wouldn't be doing. So even if you're looking at it purely from that point of view, of course that can affect the number of providers that would sign up. (R121)

> I think sometimes, if there's only one of us there, sometimes you see the MyOptions call and you say 'oh God', just from a time factor. Because they're so unpredictable, you know, when you can't book in the appointment as such, for people waiting, you don't know how many will ring. And I mean, I would find that even more that we would do more with the follow-on. Very rarely, I think, some visits are done. That's a good 45 minutes usually, I would find, maybe not 45 minutes, actually, for that, it'd be a good 20 to 30 minutes. Which is a fair bit out of your day when you don't have that schedule, and generally when a call comes in, maybe in the morning, or often late afternoon, and it's not scheduled into your day. So that's the biggest difficulty, I think, with us. And especially if we need lots of numbers, it's whoa, it became too much. (R213)

The fact that only 10 per cent of GPs are providing abortion leaves those who are providers with a larger geographical area and a bigger population to cover. One GP who opted into the service decided to stop providing because of the time-sensitive nature of the service and their workload capacity.

> I know of one provider who no longer is providing because they too were covering in a huge area and it just wasn't possible to keep up and keep going. Because they are very involved consultations and they take time and they take a lot of consideration, and they're not easy in the point of view that you have to tick a lot of boxes and make sure you're doing the right thing all the time. So it's not reflex, they walk in, you give them their pills and they're out the door. There's a lot to be considered and thought about before they even get to that point. So yeah, they do take quite a lot of our time, effort and concentration.(R109)

GPs noted the administrative burden of the service. All medical practitioners who sign off on a termination must complete paperwork after each case to notify the Department of Health of the particulars surrounding the case and under which grounds the termination was granted. This adds additional work which is not necessary in any other medical service offered. One GP queried

> Why do we have to notify this particular part of healthcare? For some GPs they might feel, "Look, I just don't have time for this. This is nonsense." … I do think it's further stigma of women and our history of keeping tabs and controlling women.... Rather than manually sending in an individual return for each termination... If it was deemed that this was information that was necessary, perhaps it could be collected in a better way. (R121)

> If you were a single handed GP or somebody who had limited secretarial support, having to send in notifications to the Department of Health every 30 days is quite onerous to keep a handle on all of that. (R123)

The workforce component of the wall abortion providers became aware of during the implementation period was not just about the size and capacity of the existing abortion workforce. It also related to the potential growth of that workforce. This is outlined in the illustrative quotes below from GPs:

> I think it's just the thought of trying to add in another service to what you're already doing when you're barely keeping your head above water with the amount of work that's coming in. I think that's probably a big thing. (R201)

> So, I had a colleague who isn't involved in the service, not because [they were not] interested. Just like, [they] don't want to do all that extra work, [they] have enough work to be doing. (R108)

This shortage of GP staff has an impact on the patient and being able to access abortion in a time-appropriate manner. As one GP explains, this becomes a problem when one practitioner becomes ill or goes on leave.

> Often times the first and the second appointment will be much more than three days apart, whether it's because of staff availability, whether it's because of somebody testing positive for COVID, that's less often now but can definitely still happen. (R106)

When asked if there was coordination of GP annual leave or maternity leave to ensure abortion services were covered in their absence, one GP replied

> No, and I suppose part of that is because we are all separate business entities. Each practice is a private business with public contracts and therefore, we work independently of each other. (R109)

> Every consultation is it's time heavy. They're not 15-minute consultations. If one of us who's a provider in the practice goes on holiday for a week, we can't provide the same number of terminations in that week, we just physically can't do it. (R109)

Due to the nature of the business, it is difficult to ensure cover for services when on leave. The service is an opt-in service, therefore, many locums may not have signed a contract to provide.

Workforce size and capacity was also underscored as a potential wall by staff working in hospitals. Again, the data highlighted the size of the abortion-providing workforce as presenting a challenge. During implementation, research participants outlined how the wall was not just about how many staff were available but, in a context where the workforce was limited, the additional work abortion created for abortion-providing staff. This is illustrated in the quote below from an obstetrician:

> But again, it takes a lot of coordination for me at the minute, if I have somebody who needs surgical, I need to try to see the patient, then I have to find a day in theatre that I am free. As I like to do it, that there's an anaesthetic person, find out who's available that day. Are they comfortable with termination? Find out from the Theatre Sister, what theatre nurses are on that day? Are they comfortable with it and all that, so there's a lot of co-ordination. It takes me two or three hours work just to book someone in for a surgical termination (R108)

What is interesting about this interviewee's comments is that they do not reflect encounters with workforce walls among the clinicians directly involved in providing abortion care but workforce walls in relation to integrated care co-ordinators. As an integrated service, requiring patient referrals from primary to secondary care, medical or surgical abortion and gestational scans, depending on the circumstances of the abortion seeker. Depending on which pathway or area of the legislation the application for abortion falls under, providing abortion requires the involvement of a range of HCPs from different disciplines. The delivery of abortion care requires the co-ordination of staff across these categories and as such the size and capacity of a dedicated, co-ordinating workforce is important. As the interview quotes below indicate, HCPs in primary and secondary care suggested that have a dedicated co-ordinating workforce available minimised the wall.

> Oh no, we're very lucky here, we are very lucky. We have our midwife, who it's solely her main, she has a couple of roles but basically her primary role is to the termination services. She is a very experienced midwife who's a sonographer, who's had many years in early pregnancy and gynae, so she scans them all. And if she's away then early pregnancy are very happy to have the termination services under their wing as well. But we have a primary midwife who does the dating herself, and coordinates all of it. And then I will come and do concerns and any complication stuff, and any queries. But no, we're very lucky, we have really good access for scanning. We think so. (R105)

> Certainly in the bigger units it works extremely well. Because you have quite a senior admin person, you have someone who is the initial point of contact for GPs. (R125)

> When you connect with the lead person there, the Clinical Nurse Specialist. Everything works really smoothly. Fantastic. If they're on holiday or they're not there that afternoon and then I'm off the next day, and it gets lost. Not lost but just, that streamlining isn't there, you know. So, for me, that's probably the biggest issue with the hospitals. (R213)

In terms of phenomenological learning, the data above demonstrates how HCPs implementing abortion services gained a greater, more nuanced understanding of how workforce considerations – i.e. size of workforce and capacity – can act as a wall within the implementation and delivery of abortion services. Their practice experiences illustrate how the workforce wall includes different categories of staff, or HCPs in different roles, including co-ordinating roles, depending on the patient needs and pathway their abortion request falls within. Furthermore, their accounts illuminate different textures of the workforce wall, specifically how capacity barriers do not solely relate to the availability of staff but the additional workload that implementing, delivering and co-ordinating abortion care creates.

Resource issues

The second 'wall' within abortion services HCPs implementing services from January 2019 onwards quickly became aware of was resources. Abortion services under the Health Act 2018 are embedded in the public health care infrastructure co-ordinated by the Irish public health system, the Health Service Executive (HSE). Abortions under section 12, before 10-weeks' gestational age (dated from the first day of the last menstrual period) are provided in the community through GPs and women's health centres (WHCs). Abortions under sections 9, 10 and 11 that are under 10-weeks' GA, where there are no additional healthcare needs, who can use medication abortion are also provided outside hospitals. After 10-weeks' abortions should be overseen by clinicians in one of Ireland's 19 maternity hospitals, if that hospital is providing abortion services. At time of research, only 11 hospitals were providing abortion services; at time of publication, based on the instruction of the Minister of Health based on the findings of the Review, abortion services are available at 17 of the 22 maternity hospitals around the country.

Hospital-based abortion care providers participating in the research highlighted resource limitations within hospital settings as an impediment to implementing a full range of abortion services. This is outlined in the comments of one respondent on whether access to all abortion methods had been achieved:

> It's a postcode lottery. It depends on where you go. Some units have very good access to surgical termination. They tend to be maternity hospitals and that's just because the focus in maternity hospitals is women's health, that's all they do. If you go to a general hospital that has a maternity unit on site, their operating theatres are part of the general operating theatres, so they have broken bones, appendixes, burns, whatever going through them as well. Their focus is not on looking after women's health. (R125)

Other respondents noted the absence of surgical abortion:

> So women who are in second trimester and undergoing a termination for whatever reason, aren't offered a surgical option. It's medical, or nothing in Ireland. (R108)

> there aren't other centres, like, I can't say, "We can't do that here in HOSPITAL, but I can arrange for you to go to HOSPITAL", we haven't got that option either, so it's like, no surgical pathway (R212)

Some respondents expressed that the resource wall was more nuanced than an absence of resources or dearth of resources; the barrier was the fact that, in a context of limited resources, HCPs had strong views about what forms of care were permissible uses of those resources. This is illustrated in the quote below, where the respondent notes the problem with convincing theatre staff to accept the use of theatres for surgical abortions.

> Originally, before I even realised that theatre access was very difficult, I suppose, broadly, in the whole obstetrics and gynaecological service here, it did feel like there was a lot of resistance from the theatre staff. We have a labour ward theatre and a general theatre, and there was a lot of, "I do not feel it is appropriate to perform terminations in a labour ward theatre," and it was very strong about that. The general theatre [staff] were very resistant originally to have these cases in theatre. (R105)

Through the experience of implementing services, HCPs became familiar with both the limitations of resources needed for some forms of abortion care as well as the reservations colleagues' had about already-limited resources being used for a service that was seen as non-essential. Again, this is an important area of phenomenological learning through the experience of implementing new abortion services.

Acceptance of the service

A further wall foregrounded by HCPs was acceptance of the service. Here respondents did not necessarily refer to issues of conscientious objection or opposition to abortion, but the existence of abortion care within the portfolio of health care in Ireland. Some participants felt that a lack of acceptance of the service resulted in a lack of respect for their work as abortion providers by non-providing colleagues. As the following respondent comments:

> They're not exactly grateful that you're doing it instead of them. I think it's probably seen as being quite niche and maybe a little bit indulgent. Yes. Maybe a little bit of a luxury and we can probably do without it. If it disappeared tomorrow, nothing bad would happen. Whereas they wouldn't say the same for a labour ward or operating theatre or fetal medicine scanning. It's not that integrated or that normalised to the extent that people would realise that we couldn't do without it (R125)

The reflections of this participant offer a more textured picture of the 'acceptance wall'. Rather than a straightforward rejection of the service or opposition to abortion care, the challenge during implementation they encountered was a reticence in accepting abortion as a normal part of the work of HCPs. Despite the strong messaging during and after the referendum campaign and in advance of the introduction of abortion care pathways in January 2019, abortion care was still not, for them, accepted as a normal, essential form of reproductive healthcare.

For this participant, the issue was most pronounced in the case of staff who worked in fetal medicine. Fetal medicine specialists – including neonatologists and paediatricians – play a key role in abortion care within the care models introduced by the Health Act 2018. Section 11 (termination in fetal anomaly) makes specific reference to the likelihood of survival longer than 28-days post-partum. Guidance for the delivery of care under this section recommends the use of multidisciplinary teams to confirm diagnosis and support applicants for abortion. These MDTs should, according the guidance, include relevant specialisms such as neonatology. For this respondent, and others, this cohort of HCP staff did not necessarily accept abortion as part of their work. This lack of acceptance acted as a barrier to care.

> This is a group of people, fetal medicine specialists in general and paediatricians are a group of people whose job it is to save babies' lives, to get these pregnancies as far along as possible and to ensure a good outcome for parents who want to continue with the pregnancy. So it takes a huge shift in thinking really for them to do it and that's their own responsibility is to actually change the way they think with the woman at the centre of it. But some of them aren't very good at that. (R125)

These comments resonate with reflections from the interviewees working in the field of neonatology quoted below who describe their contribution to abortion care as limited to an advisory capacity:

> The neonatologists spend…[time] trying to make a decision about what would be the best information for the parents. Just getting as many opinions, and that would be the extent of the neonatal. They wouldn't necessarily be involved in the case then after that. (R114)

> My role and involvement generally comes when asked for our expert opinion when it comes to cases relating to section 11 and babies with fatal foetal anomalies or conditions that are likely to lead to death of the foetus within 28 days. So we'll be asked with the obstetric team or those practitioners that are likely to perform the termination about our opinion as to whether a case would meet the criteria or not…. […] It [the legislation] says two medical practitioners who've examined the pregnant woman. No neonatologist is ever going to examine a pregnant woman. (R216)

> We're there [in the MDT] for advocating if we feel that there's something that's not a lethal malformation, or something along those lines. But again, we're not actually having to provide the therapy, it's not a routine fit. […]From a neonatologist's perspective, we're very much in this, we're not secondary in the process but we're very much as part of the MDT, as opposed to the actual providers. (R211)

HCPs participating in the research described how they had taken steps to address the 'acceptance wall'. One area where interviewees indicated there had been progress was acceptance of the necessity of a surgical abortion where a medication abortion had failed, where the abortion was incomplete, and a surgical procedure was needed to remove retained products. While, as the interview quotes below suggest, abortion was not yet fully accepted as a normal part of healthcare, they had been able to progress the acceptance of one form of abortion with some staff.

> I do a lot to try and make it more acceptable, but despite all that, our surgical pathway is very limited. I then went on the attack saying, "Maybe in at least three circumstances if we could

> secure a surgical pathway, and those instances would be if we had a medical indication, and it would have to be a failed medical termination" We're trying. (R212)

> So, I do think there's been a lot of work done where we've now identified, I have found a number of key staff who are very comfortable and willing to be involved, both from a theatre nursing point of view and anaesthetics. (R105)

The qualitative data indicates that acceptance of abortion services as an ordinary part of healthcare was encountered by HCPs as a wall during implementation. Importantly this was not simply a matter of opposition to abortion. Again, abortion implementing HCPs described encounters with a more nuanced wall – characterised by a feeling among some HCPs that abortion was non-essential to their work. This is an important area of phenomenological learning.

> People might think our role isn't busy, you know? They might think, like someone who is not in my role might think, 'Oh that's a lovely role, that's a really cushy number,' you know…they might think it's very little work because we mightn't see loads and loads of patients, but I don't think they realise how much time one patient could take. (R117)

The data from HCPs shows they had made some progress on addressing this acceptance wall through identifying circumstances where colleagues agreed abortion care was necessary as well as connecting with staff in their workplaces who are more open to being involved in supporting abortion care.

Peer and managerial support

A key wall encountered by HCPs implementing abortion services was peer and managerial support. Again, the reflections of research participants are educative and offer insight into the nuances of this wall. An important aspect interviewee accounts draw attention to is the fact that the wall was not solely a matter of institutional refusal to provide by a particular setting. Part of the wall they encountered was that they were permitted to introduce service but not provided with meaningful support in either introducing or delivering a full range of services. The quote below exemplifies this experience as the respondent describes having to absorb additional work due to the absence of staff support:

> I'm on my own. I should have a nurse with me. I did have a nurse with me. She's gone now. She's on maternity leave and she's not coming back to the service... Another nurse came into the service...but she really doesn't want a huge amount to do with the [termination of pregnancy] service... So I'm at a disadvantage with that... Even writing in diaries. I can't even get the time to do that. (R201)

The experience of being permitted to provide abortion by hospital or practice setting management but not supported in doing so was echoed by other participants, such as the interviewee quoted below, who outlined how implementation of abortion services was led by small groups of providers:

> But again, [training sessions] were run by a very small number of… I would say, committed doctors on sites who, you know, drove this rather than necessarily the management or anything within the sites, yeah, so. (R204)

> I'm new in the role and motivated and have time at the minute, able to commit. All the extra work it takes to develop these protocols and SOPs and to have the meetings with the different people involved from management and pharmacy to everything and trying to push this…I've done a lot of work since then, I suppose with the education sessions with theatre staff to try and get them to understand what situations are arising. (R108)

The absence or presence of support, according to some research participants, made a meaningful difference to the normalisation of abortion services. The quotes below are demonstrative of this argument. In the first quote, the respondent describes the challenges of introducing services, connecting these to a lack of support from other staff; in the second, the participant outlines how the existence of peer support networks such as the Southern Taskforce for Abortion and Reproductive Topics (START) helped normalise and embed abortion care:

> But it's a kind of an uphill battle at the minute because obviously introducing a full service involves not just me being on board, it involves other colleagues, as well as anaesthetics, as well as theatre staff. And then because you're introducing a new surgical service, you're taking away from the hours in theatre from other gynae procedures for example and bed days and beds. (R108)

> In general, there is good collegial support but with regard to termination of pregnancy, certainly at the beginning, we wouldn't have… things have changed...My colleagues in START who we have a very good network within START, that has normalised it very much and has normalised the conversation. So now I'm much more comfortable talking about it just like any other type of healthcare with my colleagues. (R121)

What is needed is an expansion of the workforce to meet the expansion of the service and ensure leadership support the service. One consultant explained:

> You would have to expand the number of consultants as well because we've gone from a one in three rota for fourteen years, to one in four, just about now. So, you'll have to have at least two providers available at any point in time…That's hard to keep going…Ideally, you would need at least two people to be able to support each other for the service. (R113)

Data from HCPs draws attention to how the absence of peer or managerial support can be experienced as a wall within the implementation and delivery of services. Importantly the reflections from research participants indicate that this wall is not a straightforward refusal to permit abortion care provision in a setting. Permitting abortion provision without offering meaningful support to staff delivering abortion care also acts an impediment to care as it required providing staff to implement, deliver and sustain abortion services. By comparison, the data indicates that more peer and managerial support can help normalise abortion services, relieving the burden of championing and ensure the existence of abortion services from individual or very small groups of HCPs.

Discussion

Writing on the accounts of HCPs in primary and secondary care in the Republic of Ireland following liberalisation, Dempsey et al (2023) highlight the feeling among their research participants that the experience of establishing and implementing services following the 2018 legislative changes had expanded their understanding of their own professional identity and of the barriers to abortion care.

Dempsey et al's work draws attention to HCPs understanding of themselves as committed, women-centred providers; their appreciation of the importance of peer support; and their knowledge of the effect of limited or poor service integration on abortion care provision. Data from the Independent Review's provider perspectives study offers further insight into the experiences of HCPs and the expansion of abortion services since their introduction in January 2019. Broadly, the findings resonate with existing research on HCP in abortion services – foregrounding the experiences of stigma, workforce and workload challenges, issues with integration and acceptance of the service, and importance of peer support. Our findings also point to the critical role of HCPs as committed, conscientious providers, particularly in contexts where the move from a restrictive to a supportive environment for abortion access is recent.

However, what this paper has attempted to show is that HCPs contribution to abortion care in the post-liberalisation context following the 2018 referendum was more than an instrumental one. Drawing together qualitative data with theoretical frameworks from Ahmed on the generation of knowledge, the paper presents HCPs as important producers of more nuanced understandings of the barriers within abortion care post-liberalisation. While research such as Dempsey et al's points to this contribution, literature to date does not engage extensively with the insights offered by HCP accounts. In the previous section we identified five issues impeding abortion service implementation and provision using data from HCPs.

Combining these insights with literature on abortion care and HCPs indicates that many of the challenges encountered by the abortion care workforce in the Republic of Ireland not only resonated with challenges in abortion care provision in other jurisdictions but also with broader challenges within health care. For example, much of the discussion within interviews focused on more general impediments to delivering health care, i.e. workforce capacity and competition over physical resources. There are, certainly, aspects of the 'wall' in abortion service provision that are abortion-specific. The acceptance of the service by colleagues in disciplines such as neonatology, for example, is arguably coloured by the fact that these are abortion services.

To address these walls, like the diversity workers in Ahmed's study of EDI workings at universities, HCPs have undertaken what Ahmed positions as a phenomenological approach. By living and learning the contours of the walls faced by those seeking equality and inclusion, according to Ahmed, EDI workers learn the cracks in the walls and come to know the most effective strategies for working through those cracks. HCPs in the post-liberalisation context in the Republic of Ireland speak to a similar contribution. By encountering the challenges of workforce, acceptance, resource limitations and an absence of peer support, and having to provide abortion care within and around these challenges, HCPs in the Republic of Ireland have expanded their understanding of how to mobilise to achieve abortion implementation. Through our data, and published research elsewhere, communication, dialogue and education appear as key strategies (Eogan et al, 2023).

At the same time, these tasks require HCPs to absorb additional work and responsibilities. There is a need, as indicated in the research findings regarding the impact of meaningful support, for health care institutions to actively enable the integration of abortion services. The HCPs who participated in this study pointed to some concrete steps that had been of use in their own settings. These included promoting a message that abortion care was a normal and essential form of reproductive health care, expanding the abortion care workforce to include non-consultant hospital doctors and

collaborating with allied health workers, in theatre, nursing, midwifery and sonography to ease the burden of work.

Conclusion

This paper critically analyses the walls experienced by HCPs in offering abortion services since the change of legislation. These walls or barriers include workforce issues, in both GP and hospital settings, staffing issues, mainly the shortage of staff in both the community setting and hospital setting. While there has largely been acceptance of the service within the GP and hospital communities, there remains an on-going need for managerial support for providers and for the integration of abortion within the broader portfolio and imagining of what health care involves. Peer support has been commended in some areas, particularly in relation to GP care, but the levels of peer support vary across settings. This research and other studies have noted professional isolation and lack of peer support as pronounced issues in hospital settings (Power et al, 2020). Overall, the issues outlined in this article are mostly linked to larger issues among the GP sector and Health Service Executive (HSE) more widely.

Approaching the cohort of HCP involved in the initial implementation of abortion services post-liberalisation as knowledge generators is significant as it expands their role in this discursive space beyond a moral or ethical commitment to providing abortion (although this is undoubtedly important) towards a source of learning about how and where abortion services require development. Their reflections draw health care institutions, health financing and the organisation of the healthcare workforce into sharper relief, highlighting these as impediments to abortion that are not addressed by the liberalisation of abortion.

The findings from our research resonate with existing arguments about the impediments to the implementation and delivery of abortion care. The broader economics of abortion, the impact of acceptance of abortion by HCPs on the operation of services, and the broader stratification of differing forms of reproductive health care according to hierarchies of importance are well documented as constraining the availability and accessibility of abortion in Ireland post-liberalisation and elsewhere (Coast et al, 2018; Fried, 2000; AUTHORS). Outside of abortion research, participants' comments on excessive workload, the challenges of integration, the need for managerial support, and competition over resources are all well-documented barriers in healthcare delivery.

Where our findings and analysis stand out from existing writing is in actively locating abortion-providing HCPs, and abortion care more broadly, within the interlinked contexts of health services and the post-liberalisation moment. This locating is directed by participants' description about the walls they face as shaped by the nature of abortion care, the process of liberalisation, and the Irish health service landscape. By positioning HCPs as generating knowledge about impediments to abortion which reflect abortion-specific and more general health service challenges, our intervention begins to shift the locus of conversation on HCPs and abortion beyond the professional experience of being a committed provider or the instrumental contribution to a newly-formed service.

Beyond the perspectives of providers regarding post-liberalisation abortion care, this article's intervention generates forward-looking questions for policy-makers and abortion service leaders in Ireland as well as academics, advocates and policy-makers working on abortion elsewhere. For the first audience, those working in Ireland, this article emphasises that, as the Republic of Ireland moves beyond the initial implementation moment, harnessing the perspectives of providers to

inform continued service improvement should be prioritised. For the second, this article queries whether discussions of HCPs providing abortion as abortion providers separates their role and position, as well as the dynamics of abortion care, from healthcare more broadly. Addressing this question is important not only to avoid siloing abortion but fundamentally to ensure that when we say abortion is a health issue we mean it.

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