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From a Constitutional Ban to Reproductive Justice? Trans/formations of Past and Present Abortion Governance in Ireland

Thesis presented by

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism and intellectual property.

Abstract

Following the Repeal of the constitutional ban on abortion in May 2018, abortion care in Ireland was implemented on 1 January 2019. Under the Health (Regulation of Termination of Pregnancy) Act 2018, abortion is now legally available during the first twelve weeks of pregnancy, in later cases where the pregnant person's life or health is at risk, and in cases of fatal foetal abnormality. Abortion provision remains criminalised for medical practitioners outside of those parameters. The legal, cultural, social, and political shift in governance after the repeal of the constitutional ban provides fertile ground to move away from moral understandings of abortion and to explore abortion care as policy, practice and lived experience for both service user and provider. This thesis examines the emergence of abortion care practices and norms under the transformed post-Repeal governance framework from 2019 to 2021, the period which is subject to the Government Review of the Health Act 2018. Drawing on existing publicly available information and ethnographic fiction, this thesis unpacks how abortion governance is put into practice and how this shapes service users' and providers' engagement with abortion care in Ireland. It critically examines how governance under the new legal context in Ireland is translated into the provision of abortion care, which systemic inequities and contexts shape access and provision, and evaluates to what extent abortion governance has moved towards reproductive justice.

The conceptual framework develops and employs the concepts of reproductive justice (Ross, 2017; Ross and Solinger, 2017), reproductive governance (Morgan and Roberts 2012), moral governance (Mishtal, 2015) and feminist understandings of biopower (De Zordo and Marchesi, 2015; Foucault, 1997a; 1997b; 1995; 1990). Together they combine to enable a situated reading of past and present abortion governance in Ireland and inform the entire research process. Abortion governance is historically contextualised through a reproductive justice frame and different ways of knowing and experiencing abortion care are foregrounded throughout the thesis. The methodological approach develops and deploys creative feminist and reproductive justice methods (Davis and Craven, 2016; Günel, Varma and Watanabe, 2020; Ross and Solinger, 2017). The methodology incorporates a reflexive and creative writing approach which seeks to capture embodied experiences with abortion care (Ingridsdotter and Kallenberg, 2018). Ethno-fictional vignettes provide the means to illustrate embodied experiences of service users and providers that can be difficult for

more dominant academic approaches to capture, and to critically appraise the first three years of abortion care provision from a reproductive justice perspective. As such, this thesis presents a new way of analysing and understanding contemporary abortion care in Ireland.

The research identifies four main post-Repeal governance mechanisms: the legal framework under the Health Act 2018, controlling of information and maintaining a culture of secrecy, framing of abortion as exceptional, and exclusionary and delaying processes of governance change. These mechanisms demonstrate central continuities between pre- and post-Repeal abortion governance, despite the transformative moment of the Repeal referendum in 2018. The legalisation of abortion does not guarantee an expansion of considerations of embodied experiences with care, nor does it significantly transform moral governance mechanisms of the past. The ethno-fictional vignettes give voice and visibility to often hidden experiences of abortion service provision and use. This unique approach to conducting research on abortion provision in Ireland reveals that abortion access and provision continue to be problematic and inequitable and highlights how lived engagements with care are intricately tied up with governance. This thesis thus shows that post-Repeal abortion governance in Ireland does not reflect reproductive justice and, moreover, impedes further transformations towards it.

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Miriam, mijn grote zus, you have always been an example for me. You challenged me to trust that I can do great things, most of all when I did not believe it myself.

For Ellie, whom I want to inspire the most.

List of acronyms

ARC	Abortion Rights Campaign
FFA	Fatal Foetal Anomaly
GP	General Practitioner
ICGP	Irish College of General Practitioners
IFPA	Irish Family Planning Association
IOG	Institute of Gynaecology
NWCI	National Women's Council Ireland
PLDPA	Protection of Life During Pregnancy Act 2013
PPSN	Personal Public Service Number
SPUC	Society for the Protection of the Unborn Child
TFMR	Termination for Medical Reasons
UnPAC	Unplanned Pregnancy and Abortion Care Study
WHO	World Health Organization

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Chapter 1: Introduction

Ethno-fictional vignette 1

I open the door to the GP practice and step inside. The familiar posters on the wall catch my eye as I walk towards the receptionist. "Get your flu shot," and "Have you had your COVID-19 booster?"

As I come up to the counter, Sheila sees me and she greets me, "Hi, how are you?" I hesitate for a moment before I respond, "I'm fine, how are you?" I stick to the socially accepted, polite version.

"How can I help you today? Do you have an appointment?"

"Yes, I'm scheduled with Doctor Murphy at nine."

"Right, I see you here," she looks at me again after she checked the computer screen and continues, "please just take a seat, love, the doctor will be right with you."

I take a seat in my favourite spot, the chair on the far left of the waiting room, with a good view of the desk and the window. I try to focus on my breathing as I look outside and watch the trees sway in the wind. I can feel my heart pounding in my chest as I breathe out "one, two, three, four," and breathe in, "one, two, three, four." It doesn't help. I can feel my heart quickening its pace and my panicked feeling is taking over my thoughts.

"Miss O'Brien?" Doctor Murphy pokes her head around the door.

No time to panic.

I offer her a faint smile as I stand up, legs a little wobbly, and walk over to her.

"Good morning. Come in." She greets me before gesturing me inside her office and the adjacent examination room.

I take the familiar seat by her desk on the left as she sits down across from me.

"Now, I understand you're probably a bit nervous, but it's all going to be okay. I will walk you through the procedure today and get you all sorted. Then you'll be able to come back in three days and that will be when you take the medication. I will be here with you every step of the way."

Sophie jolts up as the realisation hits her.

She feels the weight of the duvet on her legs, her mattress below her, supporting her body, and blinks open her eyes to adjust to the familiar room that surrounds her.

She had been dreaming. That was Clare's experience that she was thinking of.

Her friend had promised to drive her to the GP practice in Roscommon for her own consultation tomorrow. Sophie's own GP doesn't provide abortion care. She'd found that out the hard way, by having a very awkward, judgmental conversation with her. She'd barely gotten her to refer her to another doctor and had called the My Options phone line to find out where one of the nearest providing GP is. It was either Bundoran, which was closer, or Castlerea, which had an earlier availability. That was still an hour's drive away.

Her thoughts were interrupted for a second by the strange sensation in her chest. It seemed to constrict around her heart, but then somehow it found a way down to her stomach, tensing up even more. It made it hard to focus on anything.

"I am jealous," the thought finally crossed Sophie's mind. All this time, she had not allowed herself to fully lean into the feeling. She just pressed on and forced herself to focus on the practical side of things. Ticking off the items on the to-do list that she had made.

Make the appointment on a Friday, her day off work. Ask her mother to pick up Erin from school and mind her for the day. Confirm the appointment time and time to start the drive with Clare.

And then, three days later, she would have to do it all over again for the actual procedure.

But in this moment, just for a second, she felt jealous of her friend. Her friend who was so kind and helpful in all of this. Her friend who had been able to access her abortion with her own GP in Cork before she moved to Sligo.

Friday morning came and after dropping Erin at school, Clare picked her up and they drove to Castlerea.

Clare was trying hard and she appreciated her friend for it. She had brought snacks and played U2 on Spotify. Sophie knew she was probably supposed to hate Bono like every sane Irish person, but she had been a fan ever since her older sister had started playing U2's CDs when they were teenagers.

Despite all of Clare's best attempts, she kept feeling the knot in her chest. She couldn't get rid of the feeling that something was terribly wrong, and that she had no way of changing things.

They chatted a little bit about anything and nothing, until they get to the point.

The doctor clears his throat, "Right well, let's see how far along you are. We generally go off your last menstrual period. Do you remember when the first day of your last menstrual period was?"

"Yes, that was July15th."

"Hm, so that's nearly 10 weeks ago now?"

Sophie swallows before she answers, "yes."

"Right, well, I'll have to refer you for an ultrasound scan to determine the gestation age more precisely."

"But what if I'm not?"

"Excuse me?"

"What if I'm not under 12 weeks?"

"Oh, erm, we'll have to wait for the ultrasound scan to confirm. But I'm afraid that it's possible that you won't be able to have the termination in that case. I will send in the request with the ultrasound scanning service for you, and they will contact you about their availability to schedule an appointment."

So, she waited. Waited to hear when she could come in for the scan.

If she was already pushing the 12-week limit, what was she supposed to do now? Wasting all this time waiting for appointments?

If she presented at 10 weeks, would she be able to get an appointment before 12 weeks, would she still be able to have the abortion?

She went in for the scan on Tuesday. She called in sick at work. She took the bus. Made sure she could make it to the appointment and back again during Erin's school time.

And she waited. Waited to hear when the doctor would confirm the results with her.

She felt like she was getting pulled apart in a million different directions. Different doctors, different locations, different steps in the process. She just wanted the procedure over and done with. It was frustrating that it all felt so out of her control.

When Clare drove her to the next doctor's appointment again that Friday, they didn't play any music. They sat next to each other in the car, looking out over the road in silence for the entire trip.

When they got out and Sophie walked into the clinic, it was as if she could still feel the seatbelt on her body. Restraining her. Keeping her in place. Immobile.

"Deep breaths." "It isn't over until it's over."

In hindsight, it was easy to say that she always knew it wasn't going to work out. Her body had been trying to tell her, to prepare her. But she hadn't listened. Hadn't want to listen. She wanted to be hopeful. She wanted to believe that she finally would be able to access care at home, after all these years of struggle under the Eighth.

She couldn't look Clare in the eye. She felt ashamed that she couldn't manage to take care of this. That she couldn't now be one of the women who just accessed abortion in Ireland. That she had to disappoint her friend who had been so helpful.

"It's too late," she said, "I'm too far along already."

***

To: info@asn.org.uk
Subject: Irish woman needs to travel to England

Hello Abortion Support Network team,
I am emailing from the Republic of Ireland because I need to go to England to have an abortion, but I can't afford it myself. I am in need of some assistance. Please help me.

I know that people travel to Manchester or Liverpool, but could you please help with further details for clinics, and how to get financial assistance?

I look forward to hearing from you.

Kind regards,

Sophie O'Brien
+3530896017572

***

A week later, a light drizzle was coming down over London as Sophie opened the door of the clinic and stepped inside.

1.1 Engagements with abortion care in post-Repeal Ireland

This thesis examines the emerging abortion care in Ireland after the transformation of the abortion regime through constitutional change. After a 35-year-long constitutional ban, the Eighth Amendment to the Irish Constitution was repealed in May 2018 and the right to life of the unborn was removed from Article 40.3.3. With 'Repeal', the Health (Regulation of Termination of Pregnancy) Act 2018 was introduced to replace the Eighth Amendment. The law allows for abortion care on request up to 12 weeks' gestation and in later cases where the pregnant person's life or health is at risk, and in cases of foetal abnormality. Criminalisation for medical practitioners is retained and they risk prosecution if they provide abortion care outside of the legal parameters. Although the legalisation of abortion has been a huge transformation in reproductive governance in Ireland, there are many aspects within the new abortion regime that continue to complicate access and provision. As the ethno-fictional vignette above illustrates, the governance transformation has not eliminated difficulties for service users and providers. In the following chapters, this thesis takes a closer look at the transition to abortion as a legally provided healthcare service during the first three years of service provision under the Health Act 2018 through a reproductive justice framework. Moving beyond a mere consideration of the right to abortion, reproductive justice takes into account the structural circumstances and accessibility of abortion (SisterSong, no date). Centring the social political circumstances of access are crucial to better understand how moralities continue to influence understandings of who gets to access and provide abortion care in contemporary Ireland, and under which circumstances and conditions. The thesis critically assesses past and current formations of abortion governance, by reading the past abortion governance through a reproductive justice perspective. In that way, the history of abortion governance informs the analysis of the governance formations in the post-Repeal abortion regime and enables a critical assessment of the transformation of abortion governance. Ethnographic fiction is employed to call out ongoing issues within abortion governance by engaging with embodied experiences with abortion care, and it is a part of the situated and feminist approach to reproductive justice of the thesis. Ireland's post-Repeal abortion regime is thus critically assessed against the backdrop of pre-Repeal governance.

In this introduction, I situate the work within the sociohistorical context, and I explain the central aims and objectives of the research. I start with a brief overview of

the Irish history of abortion and the conceptualisation of the regulation and control of reproduction as a central area of governance for the Irish state. This is followed by an introduction to the theoretical framework, which draws on reproductive justice (Ross, 2017), reproductive governance (Morgan and Roberts, 2012), moral governance (Mishtal, 2015), and feminist Foucauldian understandings of biopower (De Zordo and Marchesi, 2015; Foucault, 1997a; 1997b; 1995; 1990; Deveaux, 1994). Subsequently, I introduce the methodological approach of the research and its basis in feminism and reproductive justice, and how ethno-fictional vignettes are part of the analysis. The methodology is followed by a brief statement on language and terminology. Finally, I include an overview of the chapters of the thesis and a brief introduction to their contents.

1.2 Understanding Irish abortion history as reproductive governance

Official, state-sanctioned, legal abortion governance in Ireland began in 1861 with the British Offences Against the Person Act. For the first time, this Act criminalised anyone procuring and providing an abortion. The British law continued to regulate abortion governance in the Republic of Ireland after independence from Britain in 1922. The first official governance of abortion thus pre-dated the close entanglement between nationalism, Catholicism and the State that came to dominate Irish abortion politics for the rest of the 20th century. From the establishment of the Irish State, women and pregnant people with unwanted or unplanned pregnancies have been marginalised. Many feminist researchers have discussed the Irish state and the construction of a moral, Catholic Irish identity and the centrality of 'Irishness' to the project of nation-building (Conrad, 2001; Smyth, 2005; Fletcher, 2001, 2005; Fischer, 2019; Luibhéid, 2006; Martin, 2002; Oaks, 2002; Smyth, 1995; Smyth, 2005). The phenomenon of leaving Ireland for Britain in order to hide a pregnancy, arrange an adoption or "leave the moral intolerance" (Earner-Byrne and Urquhart, 2019, 10) can be traced to the early Irish state at the least, as historians of gender Earner-Byrne and Urquhart write in "The Irish Abortion Journey" (2019). The particularly harsh circumstances in Ireland for unmarried pregnant women is also marked by the institutionalisation of forced labour and the incarceration of women in Mother and Baby Homes and Magdalene Laundries, some of which operated from as early as the late 18th century and as late as 2006 (Fischer, 2016; Hogan, 2019). These developments illustrate a long history of class and moral stratification of reproduction,

as well as financial interests involved in a system that marked unmarried mothers and women out as separate and other to the rest of society (Earner-Byrne and Urquhart, 2019, p. 14). Irishness, and its reproduction, have thus never been disconnected from intersectional political categorisations. Rather, the very political ordering of the Irish nation was based on particular reproductive exclusionary mechanisms from the start.

In the struggle to establish the Republic of Ireland as an independent state, separate from Britain, the Irish constitution was deployed as an important tool to establish and safeguard the national Catholic moral order, characterised by a certain sexual purity. The Irish state managed various potential threats to this order by prohibiting birth control and divorce, by banning information on abortion, and by ensuring the 'proper' place of a woman in the family and household (Earner-Byrne and Urquhart, 2019; Smyth, 2005). In a period of much political and social unrest after the struggle for independence and civil war in the earlier twentieth century, the construction and protection of the national identity based on Catholic morality served to mark Ireland out as different from and superior to Britain. Yet Ireland also increasingly came to stand out in stark contrast to other European countries where abortion legislation was introduced over the later course of the twentieth century.[1]

When the Constitution was enacted in 1937, it relied heavily on patriarchal, heteronormative notions of family informed by Catholic doctrine as the source and the future of the nation (Smyth, 2005). Women were constructed in maternal and domestic terms, particularly in Article 41.2 of the Constitution, where it is stated, "the State recognises that by her life within the home, the woman gives to the State a support without which the common good cannot be achieved" (Constitution of Ireland, 1937).[2] Similar to constructions of national identities in other postcolonial countries at the time (Kandiyoti, 1991; Yuval-Davis, 1997), Irish identity was constructed around gender and sexuality, with women as vital for biological as well as cultural reproduction across generations. Informed by this rationale women could be culturally subordinated, because it served the 'natural' and 'national' order. Together with a prior history of a sexual division of labour and sexual puritanism, the cultural

[1] For instance, Britain liberalised abortion legislation in 1967; Denmark in 1973; Austria in 1974; France in 1975; and Greece in 1986 (Nebel and Hurka, 2015).

[2] At the time of writing, a Constitutional Review was taking place to reconsider the place of family and women in the Constitution and to propose a replacement that would move away from the gendered and oppressive nature of Article 41. For more see the Irish Human Rights and Equality Commission's report: https://www.ihrec.ie/app/uploads/2018/07/IHREC-policy-statement-on-Article-41.2-of-the-Constitution-of-Ireland-1.pdf.

idealisation of women in subordinate, maternal and domestic terms was now fully politically and socially embedded in Irish society (Earner-Byrne and Urquhart, 2019).

In addition to the central place for women in bearing and rearing of the nation, religion provided Ireland with a sense of moral superiority (Smyth, 2005). Particularly in Ireland's colonial context, Catholicism provided a means of constructing and maintaining a national culture distinctively separated from British Protestantism. With the further consolidation of the Irish Republic, this Catholic nationalism was incorporated into the political structure of the State. In the 1937 Constitution, the State was defined as democratic and the nation as religious (Smyth, 2005, 63). Specifically, the prime position of the Catholic Church was enshrined in Article 44 of the Constitution. The special position of the Catholic Church in the nation-state was acknowledged and the Oireachtas[3] exercised a Catholic morality in the process of law-making (Smyth, 2005).

1.2.1 Framing the abortion debate in the later 20th century: deploying the constitution and constructing the 'pro-life' discourse

In the second half of the twentieth century, tensions with constructions of the Irish national identity arose. Yet tradition and conservatism continued to be part of Irish national identity. According to Smyth (2005, 67), "the opposition between tradition and modernity has operated as a major organizing theme marking the difference between Irishness and colonial culture," wherein the national culture was constructed as "Catholic, rural, familial, and conservative," in contrast with British culture as "Protestant, urban, individualistic, and liberal." Thus, over time, the consolidation of a national culture of Catholic conservatism grew, but so did contestations against that conservatism.

By the 1970s, as second-wave feminism gained momentum and force in much of Europe, the United Kingdom, and the United States (Earner-Byrne and Urquhart, 2019; O'Reilly, 1992; Barry, 1988), women's organisations in Ireland were campaigning for the legalisation of contraception. A key event in the history of grassroots movements in Ireland seeking to advance reproductive rights took place in 1972, when Irish feminist activists travelled from Dublin to Belfast by train to

[3] The Oireachtas is the Irish National Parliament, comprising of the Daíl Éireann, the lower house, and the Seanad Éireann, the upper house.

purchase contraceptives in Northern Ireland, which were still banned in the Republic of Ireland at the time (Kelly, 2020). When legislation on contraception was introduced in 1980, access was still dependent on medical practitioners' approval and proof of marital status (Barry, 1988). This type of highly regulated legal and medical gatekeeping of reproductive health services typified what was to follow in the Irish State's approach to policy changes in reproductive governance, and particularly in abortion governance in the decades that followed. The legalisation of contraception did, however, signify a breakaway of the position of the State from that of the Catholic Church.[4] The progressive move on contraception also brought about a renewed engagement on the opposite side of the political spectrum. New organisations were launched that brought together right-wing politics with Catholic teachings, such as the Society for the Protection of Unborn Children (SPUC) and Family Solidarity (Barry, 1988). Opposition to relaxation of legislative and moral sanctions relating to divorce, homosexuality, contraception, and abortion, were central goals for those groups (O'Reilly, 1992). They were responding to the "growing legitimacy of secular, liberal and feminist ideas in Ireland" (Smyth, 2005, p. 16) and the larger cultural shifts that had been taking place in other countries. Joining the European Economic Community in 1973 opened Ireland up for secular and liberal political collaboration, while the United States Supreme Court's decision in *Roe v. Wade*[5] in that same year demonstrated the possibilities for judicial arguments in expanding access to reproductive healthcare (Smyth, 2005). Britain had also legalised abortion in 1967, enabling Irish pregnant people to travel to access legal abortion care there.

By the early 1980s there was significant anxiety over the potential liberalising influences of these international developments, and the legalisation of contraception in 1980 turned abortion into the key issue for conservative forces. The Pro-Life Amendment Campaign was launched in 1983, in a move which established the use of the Constitution as a particular tool to uphold a moral order in Ireland. The goal of the campaign was to add an amendment to the Irish Constitution to ban abortion and to

[4] The first piece of legislation on contraception proposed and passed without consultation with the Catholic Church did not take place until the Health (Family Planning)(Amendment Bill) 1985, which aimed to legalise the use of condoms and spermicide creams which could be sold to anyone over the age of 18 without prescription at chemists, family planning clinics, maternity hospitals and VD clinics (Hug, 1999).

[5] *Roe versus Wade* was a landmark legal decision by the Supreme Court in the United States in 1973 that allowed a right to abortion on the basis of a right to privacy (Ginsburg, 1984; Pollitt, 2014).

assert ‘the right to life of the unborn’, despite the fact that it was already illegal under the 1861 British Offences Against the Person Act.

The anti-abortion campaign held an overwhelming political dominance at the time, setting the terms for the way in which abortion and the referendum on it were framed. Reidy (2021) describes the ‘absolutist’ messages that dominated the debates, framing abortion as inherently evil and murderous and the foetus as in need of protection. The Pro-Life Amendment Campaign and, in fact, abortion itself were thought of as moral and legalistic issues and being ‘anti-amendment’ was seen as quite radical (Smyth, 2005). The majority of political power was held by anti-abortion groups, and “the very fact that the amendment became known as the “pro-life”[6] amendment indicated the ascendant position of conservatives in politics” (Reidy, 2021, p. 31). Anti-abortion politics were so pervasive, that reproductive rights and freedom were barely even discussed as part of the opposition to the amendment. When the referendum was held on 7 September 1983, a two thirds majority of Irish voters voted in favour of inserting the anti-abortion clause into the Constitution (O’Reilly, 1992; Reidy, 2021). The turnout was quite high with 53.67%, and although the pro-abortion narrative was largely dismissed in public debates, 33.10% of voters voted against the Eighth Amendment (Smyth, 2005). Pro-abortion advocates and views were present, but they did not hold political power at the time.

The rise and dominance of conservative politics and the call for a constitutional ban on abortion also needs to be understood in relation to the ambiguity that existed under the Offences Against the Person Act, as legal scholar Carolan explained in 2016 (Carolan, 2016). The fact that there was no specific reference to the unborn as part of the Irish or the European Constitution, combined with the increasingly progressive developments in other countries, made the right to life of the unborn a pressing issue to be addressed and clarified in a modern Ireland that was still trying to position itself as an independent nation-state. The 1983 referendum put the unborn at the centre, placing a duty on the State to protect the life of the unborn, as it was introduced as The Eighth Amendment of the Constitution, or Article 40.3.3: “The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend

[6] I consider pro-life to be a self-identity, political term used by anti-abortion activists and advocates. The statement on language in the Introduction further clarifies the positioning of this thesis within abortion politics and the corresponding language and terminology throughout the thesis.

and vindicate that right" (Constitution of Ireland, 1983). Yet, at the same time, the constitutional protection of the right to life of the unborn was also strangely unspecific. The article did not provide any further laws to regulate matters that would relate to the various areas of reproductive health to which this could apply. Medical practitioners specifically, then, were left with a number of questions. Is it only about abortion? What does the unborn mean? What does the right to life of the mother mean? What should be done in situations where a conflict between those rights arises? In practice, the rigidity of the Constitution did the opposite of making things clear for medical practitioners and pregnant people. Paradoxically, the Eighth Amendment ensured that abortion was a prominent issue of debate over the next decades.

1.2.2 Moral regimes and the invisibilising of abortion: tools of control and techniques of shame

The Constitution mostly functioned as a tool to uphold a moral regime that worked to convey particular understandings of life, family, personhood, sexuality and gender. The Eighth Amendment and ensuing abortion ban contributed to a delegitimising of understandings and experiences that did not conform to the dominant norm in a fundamental way. As reproductive justice scholars Cullen and Korolczuk (2019, 6) point out, "abortion stigma, while observable as a global phenomenon, is constructed locally through various pathways and institutions, and at the intersection of transnational and local discourses." The pathways and institutions in Ireland were especially focused on state governance to create a disciplined, morally pure national character, sustaining a culture of shame and stigma, particularly (Fischer, 2016).

The abortion ban was one governance tool within the Irish moral regime, but the State employed a number of other techniques that worked together with this. Punitive places such as the Magdalene Laundries and Mother and Baby Homes, are indicative of the structural confinement of women and pregnant people as part of the formation of the Irish state (Hogan, 2019). The systematic silencing, invisibilising, and casting out of 'unmarried mothers' and 'fallen women' were part of the very foundations that organised economic, social, and religious life. This heavily institutionalised approach deeply instilled notions of stigma and shame as a central technique to govern reproduction during a very large part of Irish 20th century history.

Various scholars emphasise the connection between stigma and discrimination in sexual and reproductive health care and patriarchal notions of sexuality and gender. They highlight how this also implicates health professionals (Hussein and Ferguson, 2019) and how it creates a norm of silence around all reproductive experiences that challenge patriarchal notions (Kissling, 2018). Abortion, thus, is not a singular, isolated issue that is controversial, but rather the silencing of reproductive experiences pertains a multitude of sexual and reproductive health aspects and is at the heart of wider contestations over gender, sexuality, and reproduction. Engle, in her review of legal scholar Michelle Oberman's book 'Her Body, Our Laws: On the Front Lines of the Abortion Wars from El Salvador to Oklahoma' speaks on the cross-cultural and cross-temporal nature of gendered norms and how they induce silencing. "This important point highlights that it is not abortion *itself* that places women's reproductive bodies at the centre of social and political debates, but rather entrenched societal expectations of femininity and womanhood" (Engle, 2019, 126). Stigma and discrimination also applied to experiences with miscarriage or stillbirth, for example. Any experience that is considered to be transgressive and deviant from reproductive norms, are not openly spoken of.

What is left of the shaming, silencing and invisibilising when abortion governance fundamentally changes its form and formations? I explore the process that occurs when governance begins to change and is implemented, hence the reference to trans/formations in the title of this thesis. I bring new insights to the ways in which governance transformations shape engagements with abortion care from a situated, feminist reproductive justice approach. By considering past and present governance formations, and the disjunctures and continuities over time and place, the overlays of past and present formations become visible.

1.3 Reproductive governance transformed? Insights from a situated, feminist reproductive justice approach

By employing the '/' in 'trans/formations' in the title of the thesis, the continuities and changes between the different abortion governance frameworks can be explored. It draws attention to the simultaneous process which can encompass both change and continuity, or the mutually constitutive nature between a hegemonic system and subaltern voices, as I profile in my conceptual framework. This is a form of

highlighting and exploring the transformation of abortion governance through the legalisation and implementation of abortion care, but also a way to question whether this is actually based on transformations of the mechanisms of regulation of the regime. At the same time, it highlights one of the key objectives of the thesis: to identify the formations of the post-Repeal abortion regime.

Finding out more about how governance transformations play out in the long term and what the key foundations are for the new services in Ireland, it is important to know what might follow from monumental political change in reproductive governance. The years since the Eighth amendment was repealed and the Health (Regulation of Termination of Pregnancy) Act 2018 was introduced in Ireland[7] have been marked by many developments in reproductive politics around the world. Political parties and civil society groups advocating for stricter abortion laws have been rising in Hungary, Slovakia and Austria (Akhmedjonov et al., 2023). Conservative religious groups have gained power in Poland, where increasingly strict abortion laws have been introduced. On 24 June 2022, the Supreme Court in the United States overturned Roe v. Wade with the Dobbs Decision, bringing an end to the four decades of a constitutional right to abortion (Baden and Driver, 2023). These developments have led to an increasing amount of attention for and discussion of reproductive justice (Ross and Kumar, 2023; Kornbluh, 2023; The Guardian, 2023). While the legalisation of abortion was an important step for reproductive rights in Ireland, it is by no means a linear path towards reproductive justice. It is crucial to better understand how the current governance is experienced and how changes in governance shapes engagements with abortion care.

The main research question of this research, therefore, is: how does governance shape experiences in relation to provision of and access to abortion in Ireland? The implementation of abortion care in Ireland constitutes a new moment in time for reproductive governance. The key aim of the thesis is to critically examine Irish abortion governance through the lens of reproductive justice and to assess if, and to what extent, the Irish system reflects the principles of reproductive justice. To do so, this thesis analyses past and present abortion governance mechanisms. It captures the emerging context of abortion care, tracking the shifting governance through the

[7] 66.4% of voters voted 'yes' to Repeal the Eighth Amendment (The Irish Times, 27 May 2018). The referendum will be analysed more in Chapter 3.

recent change of legalisation, and critically analyses the present circumstances of abortion care to foreground what the experiences of users and providers can tell us about how governance is manifested. This thesis adds to existing research on reproductive governance and reproductive justice by critically assessing this shift in governance, and by foregrounding different ways of experiencing and knowing through a creative ethnographic methodology.

The situated feminist and reproductive justice approach I adopt (which I fully develop in Chapter 2), forms a conceptual framework which enables analysis of abortion governance on multiple levels. It considers how experiences of time and place shape abortion care for providers and service users and demonstrates lived realities of inequities in abortion care. The approach also provides a way to explore a new service area in healthcare through paying attention to the material tools of regulation and implementation, such as gestational limits under the law or the locations of healthcare facilities providing abortion care. By considering barriers and obstructions that remain in place or have been newly created under the new abortion legislation, I explore how these come into being materially and discursively; and seek to make sense of the nature of abortion providers' and service users' engagements with these barriers and obstructions. A situated feminist and reproductive justice approach also facilitates a macropolitical analysis of the first three years of abortion care as a new moment in Irish abortion history, scaffolding a critical analysis of shifts and continuities in the meanings that are attached to abortion. I critically assess to what extent moral governance of abortion has been transformed, and how moral understandings and incentives feature in post-legalisation discourses on further legal change and in the process of the government review of the Health Act 2018. Ultimately, in the Discussion and Conclusion, I return to the question of transformation and formations in abortion governance and formulate the response from this research.

1.4 Other ways of experiencing, knowing, and disseminating: ethno-fiction as feminist practice and methodology

During his presentation for the Citizens' Assembly in 2016, Professor John Higgins, an obstetrician at Cork University Hospital, evoked "Mary Murphy from Cork" as a fictional character to illustrate a fictional clinical history. Professor Higgins illustrated what could be a real-life scenario for someone receiving care for an emergency complication during pregnancy under the legislative framework before the Eighth

Amendment was repealed. The evocation of Mary Murphy who could, really, be anyone in Ireland, was a powerful way of giving some insights into the lived experiences that make up the complex legal and medical situations which were discussed in the Citizens' Assembly meetings. The visibilising and embodying of the people who provide and access abortion care, and of their knowledges and experiences, is not only a way to find out what the effects of governance are, but also to challenge and speak back to governance. Exploring how different voices have functioned to shape governance and vice versa is a central element to this thesis.

Fiction provides a different way of knowing, experiencing, and disseminating. The ethno-fictional vignettes offered in this thesis evoke embodied and situated accounts of users and providers of abortion care. This approach, however, emerged in a particular time and place. Rather than being the intention from the start, shifting circumstances of conducting research under the COVID-19 pandemic, emergent ethical considerations, and continuous adaptations, came together to form a different way of doing research. I will further discuss the changing circumstances and adaptations to the research in the methodology chapter (Chapter 4). The ethno-fictional vignettes in the thesis are a form of embodied engagement on behalf of the researcher and a way to convey the complexities of the abortion care landscape, and they are informed by extensive research and immersion in data. Working with and re-interpreting existing data is part of a longer history of feminist methodology that critically considers the situatedness of all data and the power dynamics involved in the valorisation of certain forms of data and ways of doing research (Haraway, 1988). The complexities and nuances of how abortion care comes to be lived by provider and service user are often lost in academic writing. The acts of gathering existing data, finding out and unearthing what is already recorded – and what is left out – and synthesising and disseminating that, is exactly what feminist research contributes to other methods. Refusing to return to vulnerable groups for research participation and instead finding other, creative ways of doing research is an important contribution of feminist methods.

1.5 Statement on terminology and inclusive language

I acknowledge that the terms 'women' and 'mother' are not neutral, but rather gendered terms with political implications. The language in reproductive politics

carries political meanings and consequences more broadly, as is analysed in Chapter 7 'The Politics of Language: Discursive Mobilisations of Health and Rights'. Names and terms are connected to governance and carry implications for lived experiences. Irish policies and programmes for pregnant people have been named differently in different times and instances – stemming from specific policy, economic, and political considerations. Although beyond the scope of this thesis, I recognise the need of further research into the experiences of people in minority positions.

In this work, I take inspiration from Brighton University's 'Inclusive Language Guidance' to terminology and language, focusing on inclusivity (University of Brighton, 2022). Although 'women' are referred to throughout this thesis, this is to explore how political categorisations of gender hold particular meanings and material consequences. I recognise, however, that transgender and non-binary people and genderqueer people can also be pregnant. Hence, I focus my own terminology around 'women and pregnant people' when referring to people who are directly implicated by the Health (Termination of Pregnancy) Act 2018.

Lastly, this research is not without its own positionality and politics. I am committed to emphasising that I think abortion is care, and that it should be inclusive and centred around reproductive autonomy. The writing in this thesis is therefore aligned with the language of the advocates who work towards inclusive abortion care and reproductive justice.

1.6 Overview of chapters

Chapter 2 clarifies the analytical concepts that I use to form a feminist reproductive justice approach. I draw on feminist theory and reproductive justice to build my theoretical framework. Biopower, moral governance and reproductive justice are the main concepts that inform my analysis. My situated reproductive justice feminist frame brings an alternative way of reading the history of Ireland's abortion governance and of assessing contemporary abortion care provision. This perspective is particularly sensitive to exploring power relations, and it interrogates how gender, sexuality, and reproduction are situated and become implicated in governance.

In Chapter 3, I discuss areas of past governance from the introduction of the Eighth Amendment to the Constitution in 1983 to the political processes in preparation of the referendum to repeal the Eighth Amendment in 2018. 'Contextualising Irish

abortion history: Reading past governance through a reproductive justice and moral governance lens' demonstrates how abortion has been an issue of governance throughout time and how the Irish state has approached the regulation of abortion. A high level of control and official state regulation have marked the long history of abortion governance. How the Irish state has responded to and accommodated contestations and challenges to its reproductive regime is indicative of how it continues to approach governance in the present. Furthermore, this chapter outlines how particular processes of change have been legitimised and facilitated by the state, forming the basis for contemporary policy. It presents an assessment of the sociohistorical context of abortion governance in Ireland, it introduces some key literature, particularly from Irish scholars, who have worked on reproductive governance historically, and it informs the analysis of chapters five to eight.

In Chapter 4, 'Developing and deploying a conceptually informed feminist methodology', I tell the story of how and why I came to employ a feminist reproductive justice methodology and found my way to ethnographic fiction. The reflexive writing and creative fiction pieces in the thesis are a form of embodied engagement of the researcher, a way to present the analysis differently to the reader and as a way of including the more invisible embodied physical and emotional experiences that can be lost it more traditional approaches to academic writing. I lay out the data that the thesis is based on to explain what constituted data collection, and the data curation process as a methodological and political exercise.

Chapter 5 and 6 each begin with an ethno-fictional vignette to illustrate the issues that come forward in the analysis undertaken in that chapter. The vignettes also convey the complexities of gathering existing data on lived experiences with abortion care and foreground different ways of knowing and experiencing alongside academic writing.

Chapter 5 'Identifying and mapping post-Repeal abortion governance' illustrates the abortion care landscape since its legalisation. It situates abortion care within the particular time frame of the first three years of provision. It gives an overview of what shape the provision of abortion care takes in practice, and what some of the experiences of providers have been.

Chapter 6 'The in/visibilising of abortion care services: the need for a more provider-centred approach' probes the steps that are taken to implement the abortion policy as a healthcare service in practice, and what is still lacking and continues to be

obscured. I delineate how information is made available for and about service users and providers. I discuss ongoing issues for medical practitioners, and I critically assess how information and knowledge are constructed and disseminated.

Chapter 7 'The Politics of Language and Discursive Mobilisations of Health and Rights' focuses on political and public discourses on abortion governance from 2019-2021. It shows the effects of discursive mobilisations of morality under the current legislative framework and demonstrates how discourses have shifted but continue to draw on moral governance in the new context of the post 2018 Act.

Chapter 8 '"We are not going to return to those days": Abortion governance through relations with the past' sets out to identify how biopower continues to be central to abortion governance and how issues of inequity are side-lined in political debates. The analysis argues that the legalisation of abortion is framed as a change in governance that marks a linear progression away from the past and denies ongoing issues with abortion care to be grounded in moral governance, yet this seems to be in tension with lived experiences of abortion care.

Chapter 9 'Continuities in governance mechanisms: Conceptual and methodological contributions to unpack limitations to transformations of reproductive justice' brings together the concluding discussion of the thesis. I evaluate the analysis of the previous chapters and I argue that Repeal and the subsequent implementation of abortion care was not a fundamental transformation of abortion governance, but rather a moral regime adapting its formations. I identify four main governance mechanisms that the analysis in this thesis brings forward: the legal framework, controlling information and maintaining a culture of secrecy, framing abortion as exceptional, and delaying processes of change. I expand on each main post-Repeal governance mechanisms and how they are (re)new(ed) formations of the pre-Repeal moral governance mechanisms rather than transformations. I identify the hypervisibilisation of political, legal and medical framings of abortion and the invisibilisation of personal, embodied, experiences with abortion as a central mechanism of past and present abortion governance. I consider the ensuing, ongoing issues in contemporary abortion care in Ireland. This is followed by a discussion of the methodological contribution this work has made to generate more inclusive and ethically considered ways of understanding experiences of abortion provision. Finally, the chapter concludes with policy and practice recommendations to further advance reproductive justice in Ireland.

In the Epilogue, I briefly reflect on some political developments after the publication of the findings of the Review of the Health Act 2023 in the Spring of 2023.

Chapter 2: Conceptual framework: a situated feminist and reproductive justice approach

2.1 Introduction

The conceptual framework is at the core of this research. It combines a number of concepts and theoretical elements which include feminist theory, biopower, moral governance, and reproductive justice, to build a situated feminist and reproductive justice framework. Different conceptual tools interrogate and spotlight the multilevel implications of governance that I outlined in the Introduction, and thus the tools themselves operate on different levels too. The multilevel conceptual analysis provides insights into how governance operates, how it is shaped by political, legal, and medical mechanisms, and how it plays out in experiences and engagements with care on the ground. The analysis facilitates the critical consideration of formations and transformations in abortion governance beyond legalisation as a transformative moment. My research argues that critically interrogating the moral framing of abortion which has dominated the public construction of the issue in Ireland to date, reframing abortion as a reproductive justice issue opens up opportunities to reimagine more inclusive conceptualizations of abortion provision as policy, practice and lived experience for both service users and service providers, something that scholars on reproduction in Ireland have started to highlight (Browne and Calkin, 2019; Fitzsimons, 2021; Rivetti, 2019; Sundstrom et al., 2019).

In this chapter, I lay out the different elements of this framework, I explain how I envision this new feminist reproductive justice perspective on abortion care in Ireland and how it will form the conceptual basis of this thesis. Firstly, I situate abortion within the nexus of power, politics and reproduction. Following Ginsburg and Rapp's (1991) influential work on the politics of reproduction, a Foucauldian analysis of the institutional regulation of reproduction reveals how biopower is central to the governance of reproduction, and it enables further analysis of how bodily categories of sexuality, gender, family, and personhood became sites of regulation and discipline (Foucault, 1990a; 1990b; 1995). Secondly, I expand on the conceptual tools of reproductive governance as it was developed by Morgan and Roberts (2012) to identify different reproductive governance mechanisms, and I draw on Mishtal's (2015) concept of moral governance to identify how this happens in a dominantly Catholic context. The concept of a moral regime brings together the Foucauldian

analysis of power - how norms and regulations work to govern a population - and the conceptual tools of reproductive and moral governance to spotlight how (moral) understandings of reproduction play a part in the surveillance, control, and normalisation of reproductive practices. Thirdly, to better understand how governance mechanisms have a direct effect on people's experiences with reproduction and reproductive healthcare, insights from feminist theory and subaltern theory add important considerations of agency. Although this research is primarily concerned with state power, it aims to highlight how political norms come to be inscribed into people's bodies and bodily experiences. A focus on women and pregnant people's experiences with abortion is necessary to thoroughly interrogate the transformation of post-Repeal governance. The feminist and subaltern informed focus further informs the analysis of the relational dynamics between a regime's normative powers, how those exclude and invisibilise non-normative experiences, and how negotiations and resistances to state power might bring about governance transformations. Fourthly, reproductive justice (Ross, 2017) is a framework that that reframes conceptualisations of what abortion rights and access look like, and how existing inequalities and wider social issues play into them. Intersectionality (Crenshaw, 1989) is a central element of the reproductive justice framework to bring out how rights and access are differently distributed among different people. To conclude, I bring the various conceptual tools together and explain how they form the basis for the upcoming contextual history of abortion in Ireland, the methodological approach of the research, and the analytical chapters of the thesis.

2.2 Power, politics and reproduction

The politics of reproduction arose as a research field in the social sciences in the 1980s. Feminist scholars started exploring how reproduction was situated within power and politics (D'Emilio and Freedman, 2012; Vance, 1992; Snitow, Stansell and Thompson, 2019). Particularly, Ginsburg and Rapp (1991) placed reproduction at the centre of social research by providing an analytical framework to investigate the multiple levels on which reproductive politics operate. Ginsburg and Rapp are American anthropologists who conducted ethnographic research on reproductive issues in the United States, which was not very common among anthropologists in the late 1980s and early 1990s. They were some of the first advocates for the application

of anthropology's core epistemology and methodology to reproductive politics in their home country. More importantly, they were some of the first scholars to conceptualise that reproduction is political, and they framed reproduction from a perspective of power relations. Their work has been hugely influential for scholars studying reproductive politics in any social discipline since then. The core innovative approach of the politics of reproduction was its engagement with the different political, economic, cultural and social forces that influence women's and pregnant people's reproductive decisions and the simultaneous agency that women and pregnant people enact when resisting or negotiating those forces. Ginsburg and Rapp used interdisciplinary methods from social history and Foucauldian analysis to consider the dialogue between the state, international organisations and institutions and the economic system and oppositions against them.

This dynamic and relational nature is key to Foucault's conceptualisation of power and his outline of a historical development from sovereign power to biopower. In his 'genealogy of the modern state', he develops his ideas around how state governing has developed since Ancient Greece to the 20th century (Lemke, 2001; Foucault, 1997a; 1997b). He analyses how state power has evolved from a direct, sovereign power over life and death, into a power which works to foster certain life and to "disallow" other life (Foucault, 1990a, p. 138). As Taylor (2014, p. 43) in their analysis of Foucault's concept of biopower notes, "biopower is able to access the body because it functions through norms rather than laws, because it is internalized by subjects rather than exercised from above through acts or threats of violence, and because it is dispersed throughout society rather than located in a single individual or government body". Normalisation and internalisation work through discipline and regulation. Disciplinary power is primarily enacted through institutions, such as schools, prisons and psychiatric institutions. Biopower is more concerned with the population, rather than the individual subject; it is about regulating life, a force "working to incite, reinforce, control, monitor, optimize and organize" (Foucault, 1990a, p. 136). A biopolitics of the population, thus, makes use of disciplinary technologies in order to regulate and control the population. Ultimately, biopower is concerned with control of the body-politic through the individual bodies of subjects.

Sex and reproduction are at the heart of biopower, as they are the primary sites for management of the population. The state determines which populations are deemed

to be fit for procreation, and reproduction has to be governed in such a way that certain segments of the population are incited to parenthood, whereas other segments are contained and prevented from this. Population control has been an integral aspect of state power since the beginning of state formations, but since the late twentieth century, most state apparatuses through which reproduction is governed have undergone crucial changes, as noted by feminist scholars of medical anthropology, such as Scheper-Hughes and Lock (1987). Many advances in economic development have increased reproductive choices for people. In turn, this has also led to increasing control and governance of reproductive health. The increased availability of contraception, for example, also led to more social surveillance and regulation of reproductive practices (Ginsburg and Rapp, 1995). The control and regulation of the population through reproduction thus often produces paradoxical effects (Ginsburg and Rapp, 1991).

To identify and disentangle the paradoxes of the ways in which power, politics, and reproduction play out in the governance of abortion in Ireland, multiple levels of analysis are necessary. The macropolitical decisions of governments and international organisations can have profound effects on local reproductive experiences for women and pregnant people, and it needs to be investigated how macro- and micropolitics are entwined. Foucault does this by starting with intrapersonal relations and interactions and moving towards larger circles, such as families, or work and education, to an organisation on a national level of norms and regulations (Foucault, 1990a; 1990b; 1995). Biopower in the realm of reproduction works through inculcation of certain biological and bodily categories of sexuality, gender, family, and personhood. These very personal and individual notions become sites of institutional regulation and self-discipline. Reproductive healthcare practices are thus sites where processes of regulation and discipline take place. In my study, I particularly want to draw attention to how these normative processes of biopower silence and render invisible the inherent tensions of more complex and personal experiences with reproduction.

2.3 Moral regimes and moral governance

Considering biopower in the realm of reproduction as a set of disciplining and normalising forces, makes clear that the governance of reproduction attains culturally and historically specific notions of gender, motherhood, femininity, kinship and

personhood (Andaya and Mishtal, 2016; De Zordo and Marchesi, 2015). Two different American anthropologists studying reproduction in Europe and Latin America, Andaya and Mishtal, more recently addressed scholars around the world in their engaging call to action for a renewed engagement with studies of abortion in the United States in *Medical Anthropology Quarterly* in 2016. They draw intricate connections between various political, economic and moral processes that undermine abortion rights in the US, but they also point out that it is a contested issue in various locations. As they state, "abortion in particular often invokes debates about gender roles, expectations of the (female) life course, ideas of moral personhood, and contested economic and political features" (Andaya and Mishtal, 2016, p. 42). Abortion has become a battleground for various ideological, legal, political and economic agendas (Ginsburg and Rapp, 1991; Mishtal, 2014; Morgan and Roberts, 2012).

The concepts of reproductive governance, moral regimes, and moral governance provide useful analytical tools to examine how legal-political and religious rationalities and agendas underlie discussions about abortion and how moral categories of gender and reproduction are mobilised politically (Mishtal, 2015; Morgan and Roberts, 2012). Reproductive governance was first coined by Morgan and Roberts as a tool to analyse the shifting relations in reproductive politics in Latin America, and, more specifically, to examine how different actors involved in reproductive politics work to influence those shifts.

Morgan and Roberts (2012, p. 241) define reproductive governance as:

> an analytic tool for tracing the shifting political rationalities of population and reproduction… [It] refers to the mechanisms through which different historical configurations - such as state, religious, and international financial institutions, NGOs, and social movements - use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices.

The shifts in what is considered desired or unacceptable, rational or irrational, reproductive behaviour, and the ways in which this is enforced on people, occurs in

line with broader interests of various actors, and how they come to work together in governing reproduction.

When the mechanisms through which reproductive governance operates are largely based on moral understandings, Morgan and Roberts invoke the idea of a moral regime, based on a Foucauldian regime of truth that relies on "historically specific mechanisms that produce the ideas that function as true" (Morgan and Roberts, 2012, p. 242). The crucial element of a regime of truth is this capacity to present particular social and historical formations as true. The point is that a regime of truth is "essentially historical and contingent" (Lorenzini, 2016, p. 73), as are its methods of enforcing its ideas on a population, but it works to obscure this from its subjects. That is how normalisation and internalisation become primary mechanisms of enforcing the regime's standard for its population's behaviour, connecting a moral regime to biopower as one of its prime ways of regulating the population. A moral regime is a particular power constellation which employs different mechanisms to favour and incite particular behaviour based on "the privileged standards of morality that are used to govern intimate behaviours" (Morgan and Roberts, 2012, p. 242).

Mishtal (2015) took this concept a step further and developed her idea of specific moral governance in the context of a predominantly Catholic country, Poland. Considering reproductive governance in a religious regime allows examinations of how *moral categories* of gender and reproduction are used in political agendas when they also connect to religion. This is useful to analyse how moral understandings are in fact based on Catholic notions, but also to examine how the Catholic Church is also another power constellation, at times collaborating with and at times opposing the State government. Particular attention needs to be paid to how moral and religious arguments are mobilised politically, and how moral categories determine reproductive governance through political, medical, legal, social and cultural norms.

It is also important to consider how these concepts come together in the realms of policy and practice. As mentioned, the point is to investigate the entanglements between macropolitical and micropolitical levels of power. A moral regime is not an autonomous actor, and at the core of Foucault's theories of power is that it is enacted in everyday practices and through individuals, communities, and institutions. Sharma and Gupta (2006) conceptualise this very clearly in their work on theoretical approaches to the state. But, before I look at how abortion practices are part of the Irish moral regime, I want to emphasize an element of Foucault's regimes of truth and

my understanding of moral regimes, which actually has been theorised to be fundamental to the modern nation-state: the role of invisibility.

> The state is, then, in every sense of the term a triumph of concealment. It conceals the real history and relations of subjection behind an a-historical mask of legitimising illusion; contributes to deny the existence of connections and conflicts which would if recognised be incompatible with the claimed autonomy and integration of the state. The real official secret, however, is the secret of the non-existence of the state (Abrams, 2006, p. 123).

The state and a particular moral regime take shape mostly in the practices of governance that it mandates. The reason why biopower is so effective is precisely because it operates through the self: it is not experienced as imposed by a visible political entity.

An important mechanism through which reproductive governance works to shape people's behaviour and to make alternatives invisible is through the production of knowledge and discursive practices. We need to pay attention to the "production, legitimisation and circulation of various forms of knowledge as well as how these knowledges are enlisted into political debates about women's health" (Andaya and Mishtal, 2016, p. 50). Particularly how certain "gendered scripts" of discourses on abortion work to produce and maintain moral categories of reproductive choices and continue to frame women and pregnant people as being incapable autonomous decisionmakers in this regard (Andaya and Mishtal, 2016, p. 50). Additionally, the value and legitimacy that is given to scientific knowledge and legal processes simultaneously delegitimise other forms of knowledge and authority. Rather than taking science and law as objective and neutral, it needs to be examined how they actually work to include and exclude particular voices, and how they are employed in a particular moral regime.

The moral regime in Ireland historically operated through various constitutional, political and legal disciplinary technologies, but also through stigma and silencing as more diffuse mechanisms of control. I follow Irish feminist scholar Ruth Fletcher (1995) in her ideas about the silence of the personal experiences of abortion: "an exploration of how post-abortion silence functions in these women's lives also necessarily engages a focus on the public discourse surrounding abortion.

The processes which produce silence at various stages in women's lives also influence the production of the political abortion rhetoric" (Fletcher, 1995, p. 45). She describes four explanations for women's silence on their abortion experiences: protection from possible repercussions, ambivalence towards the experience would be seen to signify wrongdoing, concern for the reactions of loved ones, and frustration towards the limited space for nuance in public discussions. All those explanations refer to anticipated consequences women and pregnant people would have to endure in both public and private spaces in different ways, and what they all have in common is a self-regulating effect on these women's silences. This is how silencing takes place on an individual level.

On the macropolitical level, Irish feminist legal scholar Enright (2020) provides an insightful analysis of transformative relationships between law, reproduction and politics during the Repeal campaign in Ireland. She argues that in order for the Irish moral regime, or as she describes it, "the police order of the Eighth Amendment" (Enright, 2020, p. 106) to exercise its governance, it has historically excluded, and de-legitimised women's demands for change of the abortion regime.

> Women's demands for legal change were silenced by the insistence that law reflected national consensus and could only be changed through national consensus. [...] Consensus ensures inequality because it seems to make dissent unnecessary; it claims to account for the whole citizenry without exception, and thus conceals those who disagree. [...] Second, in prevailing discourses of Irish abortion law, women's interventions were often unrecognisable as legitimate exercises of law-making agency; they were recast instead as screams of pain or rage.

Enright thus explains how political and legal discourses are not only rooted in a justification for their inherent inequalities, but also work to exclude and undermine voices for change. Rather than considering possible alternatives within the legal and political framework, challenges to the moral order are denied. Here I argue that the undermining and denying of legal and political transformations is in fact a central and necessary element of a moral regime. How the particular Irish moral regime developed, how it was challenged through the grassroots activism for abortion rights, and how it developed over the years when faced with challenges to its abortion ban,

will be explored more in depth in Chapter 3 'Contextualising Irish abortion history: Reading through a reproductive justice lens'.

However, Foucault (1990) also conceptualised that power does not exist without resistance, that is why it is important to consider: first of all, if and how people accept the policies that are imposed on them and internalise the underlying messages; and secondly, if and how they choose to resist and negotiate policies. As Foucault acknowledged, power and resistance are connected, and mutually enforcing: "where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (Foucault, 1990a, p. 95). Power is exercised precisely within the interplay of force and resistance, if the possibility of resistance would not exist, nor would power. Foucault's understanding of power and resistance has important implications for how we think about the need for a regime to exert power and disable resistance. Biopower is so effective because it works to normalise power relations at the individual, bodily level, yet it often works to marginalise particular groups or populations from the body politic. What happens when embodied resistance and negotiation transcend the individual level and are employed to challenge the public order of a moral regime? I now consider the dynamics of power and resistance, and the potential for change in a moral regime through feminist and subaltern theory. A feminist and reproductive justice consideration of healthcare must focus on the agency of the 'subaltern', female, and marginalised voices, including ill or disabled people (Valentine, 2003).

2.4 Feminist and subaltern theory: Accounts of agency

Since the 1970s, social scientists have developed practices of questioning dominant narratives and considering 'subaltern voices' (Spivak, 1988, Bhabha, 1994). The realisation grew that alternative narratives are important to counter hegemonic discourses but are also inherently part of the hegemonic system. Prakash (1994, p. 1477) summarizes how Gramsci coined the concept of 'subaltern' and what it entails, in that it "refers to the subordination in terms of class, caste, gender, race, language, and culture and was used to signify the centrality of dominant/dominated relationships in history". When people are subordinated on the basis of particular positionalities, they are also historically silenced and prevented from speaking about their experiences. Considering subaltern voices in the Irish histories of abortion highlights

that women's and pregnant people's stories have always been present in Ireland, even if they are left out of the state's official discourses. Rather than seeing this as a juxtaposition, subaltern studies suggest seeing this as part of an ongoing dynamic.

Around the same time, feminist scholarly inquiry also developed. Feminist theory and practice examines not just the position of gender and women in society, but also the role of gender in collective representations, how systems of inequality come about, how categorisations such as private, public, domestic and political work, and the tacit meanings of particular constructs re/produce inequalities (Strathern, 1987). The aims of feminist critique were to create a separate field of inquiry focused solely on feminism, while simultaneously transforming other academic disciplines. The perspective-transforming capacity of questioning dominant power dynamics and normative assumptions in hegemonic systems has been expanded over the last few decades through the work of feminist and queer theory scholars such as Butler (1989; 2002) Haraway (2016) Barad (2007), and Halberstam (2011).

Both subaltern and feminist theory leave us with two important things to consider. Firstly, both of these epistemological frameworks hold challenging ideas to dominant systems and official discourses. Secondly, the fact that the frameworks challenge the hegemony of a system does not mean they are not part of it. Rather, they are mutually constitutive and constituted; they are "constructed competitively in relation to one another" (Strathern, 1987, 285). The theoretical framework for this thesis incorporates those elements and applies them to the Irish history of abortion as well as to the current context. The situated feminist and reproductive justice approach focuses on the difference it makes when we consider things from a perspective that includes women and pregnant people's interests, personal stories, lived experiences, and perceptions of the body (Rapp, 1999; Scheper-Hughes, 1983; Strathern, 1987).

Feminist scholars in particular have analysed Foucault's concepts of biopower, and more specifically its effects on the body, as well as how categories and discourses of gender and sexuality are part of subjectifying processes of modern power regimes (Deveaux, 1994). The disciplinary and normalising aspects of biopower pertaining to sex, are concerned with the "anatomo-politics of the human body" (Foucault, 1990a, p. 139), or with creating useful and disciplined bodies out of the population. Through biopower and its concern with life and death, reproduction and sex, the body becomes a "political field" (Foucault, 1995, p. 25). The public body or the body politic becomes largely controlled through the regulations of physical, individual bodies. Critical

feminist analysis of Foucault's theories of power as being constitutive take into account the intricate relations between political and personal aspects of our lives and consider everyday practices as resistance to power (Deveaux, 1994). Thus, the individual body also becomes a site or a means of resistance, or, as Parkins (2000, 63) said, "we cannot think of agency without the body". By providing an alternative reading of how reproductive policies and access to reproductive healthcare is experienced by people accessing as well as providing it, this thesis aims to underline the body as a site of governance. Feminist scholarship has been key to bring up and reveal the uneven impacts of power within a Foucauldian perspective, and I expand on this by employing reproductive justice and intersectionality to provide a more situated reading of how the Irish abortion regime functions, and how it is potentially changing.

Feminist scholars have extensively analysed activists' use of art as exercising embodied agency in challenging the Irish abortion regime. Calkin (2019) and Enright (2020) delineate "how artworks act as the practice of feminist geopolitics, staging interventions that illustrate the way that geopolitical fictions are inscribed on bodies" (Calkin, 2019, p. 343). They both specifically pay attention to the embodied aspects of agency. A feminist consideration of agency thus focuses on personal, everyday, and embodied practices. To do so, it is necessary "to place the subject's interpretation and mediation of her experiences at the centre of our inquiries into the how and why of power" (Deveaux, 1994, 243). The legalisation of abortion provides a new context to explore how women and pregnant people and medical practitioners are exercising agency in the new legislative context. With the shift from the constitutional ban on abortion to the current abortion policy, a re-examination of how women continue to exercise agency and make use of their individual bodies to resist or mediate processes of abortion governance, is necessary. The ethno-fictional vignettes in this thesis give voice to the embodied experiences of the users and providers of abortion care services and bring embodied experiences to the centre of the analysis of abortion governance. The feminist methodology and ethics behind the ethno-fiction will be explained in Chapter 4 'Developing an Ethnographic Project of Time and Place'.

The negotiations, resistance and political and legal processes in the Irish abortion regime also brings us to the central role of medical professionals. Recent developments within medicine and how medical professionals have positioned themselves in public debates on abortion in Ireland have greatly affected the recent

legislative change (Taylor, Spillane, and Arulkumaran, 2020). Medical professionals form the link between the policy of the government and the practices of care on the ground; they are connected not only to the biopower of the moral regime, but also to women's and pregnant people's experiences with abortion. The disciplinary and the normalising aspects of the moral regime are enacted and inculcated through medical practices.

Medical practices, in turn, are influenced by an increasing acceptance and practice of routinised biomedical prenatal procedures. The development and availability of various technologies have had a significant influence on perceptions of pregnancy and the foetus (Casper, 1998; Mitchell, 2001; Oaks, 2000; Taylor, 2008). Those, in turn, have shaped discussions about the morality of abortion. Especially considering the historical legal context of abortion in Ireland, it is highly relevant to consider how scientific and medical production of knowledge helps create perceptions of foetuses with their own rights (Andaya and Mishtal, 2016). The foetus has become increasingly visible and material, which has facilitated representations of foetal personhood and the immorality of abortion. It is important to consider how the emphasis on the protection of the foetus continues to play out in political, medical, and social considerations of abortion since the legalisation (All Parry Oireachtas Life and Dignity Group, 2020). On the other hand, the increasing medical knowledge and routinised procedures have also benefited women's bodily autonomy and their options for reproductive healthcare. An increasingly medicalised approach to abortion is partly what helped to make the recent legalisation possible and what has helped achievements within women's rights globally (Calkin, de Londras and Heathcote, 2020; Morgan, 2017). The tensions between various competing effects of the scientific production of knowledge are precisely what is interesting to research.

That is also an important reason to hear from medical practitioners themselves. They have first-hand experience with service provision, and they have to implement policies into practice – they have to position themselves and their practice within the moral regime. How they construct abortion care is indicative of how abortion governance is managed and how the scientific production of knowledge takes shape (Lock, 2001). The experiences of medical professionals give insights into assumptions embedded in medical knowledge and practice, which, in turn, produce medical facts that inform abortion governance. Therefore, to critically examine abortion service provision, the underlying power dynamics and inequities affecting medical

practitioners have to be taken into account as well. Keeping in mind that, "all medical knowledge and practice is historically and culturally constructed and embedded in political economies, and further, subject to continual transformation both locally and globally" (Lock, 2001, p. 481), research needs to consider how and why certain representations of healthcare become dominant at a particular time and place. A Foucauldian analysis enables inquiry into how medical knowledge, facts, and practices construct and exercise power onto the body, and produce discourses that function as objective and true. The recently implemented abortion legislation in Ireland is both indicative of and a harbinger of change in medical knowledge and practice – how medicalisation of abortion continues to play out in post-Repeal political debates reveals how exactly medical knowledge and discourses are situated and contingent.

2.5 Reproductive justice and intersectionality

The term reproductive justice was coined in 1994 by 12 Black women in the United States in a statement that they published in the Washington Post.[8] Reacting to government plans for universal health care reform at the time, the women developed a feminist intersectional framework, combining reproductive politics with social justice:

> Reproductive justice has generated new theory and practices that explain the phenomena at the intersection of race, class, and gender in reproductive politics to coherently account for events across time and include multiple events. In doing so, reproductive justice has eclipsed the binaries and under-theorized pro-choice/pro-life frameworks among both women of color and predominantly white organizations. [...] Reproductive justice theory examines the meanings assigned to reproductive relations and externally imposed policies and practices. Such theory unmasks the power relations of the world in narrative forms (Ross, 2017, 287)

[8] For the full statement, see: https://bwrj.wordpress.com/category/wadrj-on-health-care-reform/. When the group of women came together ahead of the International Conference on Population and Development in Cairo in 1994, it was the first time that they introduced the concept of reproductive justice to raise awareness and make political progress toward the needs of women of colour and other marginalised people in reproductive rights.

Not merely a theory, reproductive justice praxis goes beyond the politics of reproduction and incorporates a human rights framework to put theory into action; it works from the connection between intersectional feminist theory and activism. Intersectionality is crucial for reproductive justice, as it considers the convergence of multiple oppressions: it does not consider diverse identities or positionalities per se, but the consequences of your many ascribed identities. These Black feminists wrote in reaction to the universalised understandings of concepts that white, middle class, Western feminists had developed in the 1970s and 1980s. They developed a way to challenge the dominant narrative by developing a theory and practice that was a better fit with their experiences. Reproductive justice is founded on three principles: firstly, it is a human right to maintain personal bodily autonomy; secondly, it is a human right to have or not to have children; and thirdly, it is a human right to parent the children we have in safe and sustainable communities (SisterSong, no date).

In the introduction to her edited volume, 'Reproductive Justice: A Global Concern' (2013), feminist psychologist Chrisler argues that if women cannot access a clinic, if they cannot access information about their options, or if they do not have the means to access services, there is no reproductive justice. In other words, reproductive rights guarantee that women are free to make their own reproductive choices, but they do not guarantee that they also have access to the resources that enable them to exercise their rights (Chrisler, 2013). Zanini et al. (2021) recently highlighted the importance of access to information in reproductive governance. The concept of choice has also been criticised by reproductive justice advocates, in that women and pregnant people might not experience reproductive decision-making as a choice and as an exercise of their rights, but rather as a painful and complicated process in which they do not always have full control over their own bodies. This is why reproductive rights are associated with an emphasis on negative rights, such as the right to resist state interference into what you can do with your own body. Reproductive justice, on the other hand, is associated with positive rights, such as the right to state support for a full quality of life. Taking women's experiences with reproductive healthcare as a starting point then, is a fruitful way of evaluating whether they have the resources and accessibility to exercise their right to abortion, as well as what matters to them in navigating reproductive processes.

Additionally, the concept of reproductive justice was created because the women who developed it believed that reproductive health services needed to be

included in women's healthcare and needed to be geared towards and constructed in line with women's and pregnant people's realities. This is where the emphasis on considering abortion among a set of reproductive issues, as well as wider contemporary social issues comes in (Ross, 2017; Thomsen, 2013). When abortion is considered as a stand-alone issue, or as only an issue of healthcare, the intersectional oppressions experienced by women trying to access abortion care are not adequately addressed. The influence of social justice on reproductive justice enables the exploration of how contraception, fertility services, pre- and postnatal care, intimate partner violence, marriage, divorce, financial situation and many other aspects of a woman's or pregnant person's life might shape their experience with abortion. Reproductive justice brings together the aspects of service provision and legal advocacy to examine the multiple forms of intersectional restrictions on women's ability to choose and act autonomously for their own reproductive health (Ross, 2017).

Kimberlé Crenshaw coined the term intersectionality to highlight the multidimensionality of marginalised subjects' lived experiences (Crenshaw, 1989). Intersectionality subverts binaries in the analysis of how various aspects in life, such as race, gender, class, sexuality, age, and migration background are "mutually reinforcing" (Nash, 2008, 2). Such an analysis brings us back to the historically silenced voices and how dominant discourses in a moral regime work to keep certain narratives 'subaltern'. The silenced voices and marginalised groups can only exist when there is also a dominant norm. The very existence and construction of categories of difference is part of biopower.

> The development of the concept of intersectionality coincided with Foucauldian perspectives on power that focused on dynamic processes and the deconstruction of normalizing and hegemonizing categories. Intersectionality seemed to embody a commitment to the situatedness of all knowledge. By providing a flexible framework that allows theorists to incorporate their own social location, intersectionality enhanced the possibilities for examining how categories of race, class, and gender are interdependent and mutually constitutive (Ross, 2017, 303).

Intersectionality provides a framework to examine how dominant and subaltern categories are situated and produced within a hegemonic normative system. It not only

studies the consequences of particular categorisations of people, but also how those categories are constructed in the first place and how they work to include or exclude people from certain public services.

Reproductive justice, then, also links reproductive rights to inequities in healthcare access:

> Reproductive justice is rooted in the belief that systemic inequality has always shaped people's decision making around childbearing and parenting, particularly vulnerable women. Institutional forces such as racism, sexism, colonialism, and poverty influence people's individual freedoms in societies. Other factors - such as immigration status, ability, gender identity, carceral status, sexual orientation, and age - can also affect whether people get appropriate care (Ross, 2017, 291).

This commitment to intersectionality can highlight unexpected connections between different public policies that affect access to abortion care. Abortion policies sit among a set of other public policies and classifications that may limit women's and pregnant people's access to abortion care. Thus, it is not only someone's positionality that shapes material realities of reproductive healthcare, but also the various policies that may affect them on the basis of their positionality. Experiences with abortion care are also shaped by policies regarding immigration, housing, health insurance, education, alimony, and criminal offences, for example, because they influence the agency a woman has over her own reproductive choices. With intersectionality at its core, a feminist reproductive justice framework acknowledges that reproductive healthcare access is rooted in inequalities. It reframes discourses on abortion to be more in line with women's and pregnant people's realities and takes their own reproductive desires, contexts and needs to inform possible improvements for service provision.

The struggles of the Irish feminist movements to make progress in abortion care shows that giving voice to women in Ireland does not necessarily focus on the power dynamics and systemic discrimination of their lives, but rather positions them as a homogenous, vulnerable category. Rather than creating nuance in the different experiences of women and highlighting how they experience intersectional oppressions differently, dominant discourses on women's rights in Ireland continue to conceal the various elements of positionality that shape women's experiences with

abortion. Instead, "[i]ntersectional analysis places power at the centre, analysing not what makes people vulnerable but taking a broader approach to conceptualising how power hierarchies and systemic inequalities shape their life experiences" (Lokot and Avakayan, 2020, p. 3). An intersectional analysis of abortion healthcare access and provision thus involves examining how "sex, age, race, economic status, geographical location, migrant status, disability, sexual orientation, gender identity and expression", and other life aspects together work to shape women's experiences with abortion healthcare (Lokot and Avakayan, 2020, p. 3). At the same time, it looks at the broader social and geopolitical forces that shape people's lives to critically situate people's experiences in a systemic analysis of power.

2.6 Conclusion

My conceptualisation of a feminist reproductive justice framework provides a useful approach to inquire where women and abortion service providers are positioned in Ireland at the moment. I have identified multilevel conceptual tools and theoretical frameworks that come together to facilitate a multilevel analysis.

To start, informed by the influential work of Ginsburg and Rapp (1991), abortion governance is situated within the politics of reproduction, and a Foucauldian understanding of biopower is at the core of the conceptual approach to identify the different forces that shape reproductive decisions. The dispersed nature of biopower and how it works through normalisation and internalisation are key to the analysis of post-Repeal abortion governance as it is further analysed in the subsequent chapters of the thesis. The inherent tensions and paradoxes in reproductive control and regulation becomes apparent in Chapters 5 and 6.

Furthermore, the concepts of reproductive governance moral regimes, and moral governance provide useful analytical tools to examine how legal-political and religious rationalities and agendas underlie discussions about abortion and how moral categories of gender and reproduction are mobilised politically (Mishtal, 2015; Morgan and Roberts, 2012). Reproductive governance as an analytical tool helps to identify what the mechanisms of pre- and post-Repeal governance are and connecting these to the concept of a moral regime provides a way to analyse how moral and religious understandings might be mobilised politically, particularly in the historically and culturally Catholic context in Ireland. Moreover, I identify the production and

discursive mobilisations of scientific and medical knowledge as an important post-Repeal governance mechanism and I further investigate how moralities are continuously involved in that mechanism (in Chapter 7 and 8).

Additionally, a significant feature of the moral regime is that it legitimises itself and undermines alternatives (Enright, 2020). The conceptual analysis of the legitimisation of the moral regime and the undermining of alternatives is part of what feeds into the ethno-fictional vignettes in the thesis. They give shape and voice to a different way of knowing – namely, lived and embodied experiences from women and pregnant people – that has long been delegitimised. My understanding of different ways of knowing and alternative voices is influenced by feminist and subaltern theory. Firstly, that means that it attends to different forms of marginalisation, such as gender, class, race, socioeconomic and age categorisations. Secondly, feminist and subaltern theory also draw attention to how we can conceptualise agency in a conceptualisation of (bio)power where people internalise power dynamics, but where resistance is also always present. Silencing and stigma, devaluation and delegitimisation of embodied experiences and of voices for change is linked to the dominant norm (Fletcher, 1995). The ongoing dynamic between state narratives and histories, and always present 'subaltern' voices will be further explored in the analysis. In this way, I explore how this power balance might have changed with the Repeal of the Eighth Amendment, and how it might have been transformed with the legalisation. The mutually constituted and constitutive nature of dominant and subaltern power and perspectives will be assessed in the pre- and post-Repeal governance context.

Moreover, to analyse power and reproduction on multiple levels, an understanding of the body as a political site is crucial. Feminist theory has importantly situated the body as a site of impositions of power, but also of resistance and agency (Deveaux, 1994). To place embodied experiences at the centre of analytical inquiry, is thus a third way in which contributions from feminist and subaltern theory are central to critically look into the workings of power and challenge the homogeneity of experiences. The ethno-fictional vignettes are a crucial part of the analysis of power and agency of this thesis and a way in which embodied aspects of abortion politics are foregrounded throughout the analysis.

For a further multilevel analysis of power in a reproductive regime, the analysis is also concerned with enactments of governance and put into practice by medical practitioners, and how governance translates to medical practices and formations of

medical knowledge (in Chapter 6). Increasing medical knowledge and technologies of abortion care can have paradoxical effects. One the one hand, they increase women's autonomy and options in reproductive healthcare, but, on the other hand, they also play into an increasing visibility of the foetus. I will analyse how this plays out in post-Repeal political discourses in Chapter 7.

Moreover, reproductive justice and intersectionality have been influential analytical frameworks since the 1980s and 1990s and with the transformation to post-Repeal abortion governance in Ireland, inequities in healthcare and reproduction need to be newly considered. This research sets out to investigate whether the principles of reproductive justice – the right to bodily autonomy, the right (not) to have children, and the right to raise children in a safe environment – are reflected in post-Repeal abortion governance. It analyses what the formations of change have been in the governance of the past and what types of formations of care are facilitated in the current abortion regime. The overall landscape of care will be analysed in this thesis and a critical appraisal of legal rights are conducted in order to consider wider reproductive and social issues that are influential for people's experiences with abortion care. Intersectionality in particular reveals how biopower operates in creating inclusions and exclusions, and the conceptual analysis considers how multiple marginalisations are mutually reinforcing. A conceptual analysis that incorporates reproductive justice and intersectionality acknowledges that reproductive healthcare is rooted in inequalities and further analyses how those inequalities are created and perpetuated, facilitating further considerations of possible improvements for abortion care, and what formations of accessibility are.

I argue that this intricate conceptual framework aptly identifies discourses and practices that reinforce a normative moral framework around abortion and reveals how such a framework is constructed and maintained through mechanisms of moral governance. It will facilitate a systematic analysis of power in the post-Repeal abortion regime. With a commitment to intersectionality, it exposes the various positionalities that impact women and pregnant people's experiences with abortion care and how the ability to exercise the right to abortion is unevenly distributed. This approach empowers previously marginalised voices of women and pregnant people, but it also pays attention to situated knowledges of abortion of medical practitioners. In doing so, this framework ensures that research outcomes can go beyond academia alone and contribute to improvements in healthcare access and policies. The conceptual

framework will be used as a lens through which we can view the Irish history of abortion politics to highlight the perspectives and experiences that have been invisibilised, silenced, de-legitimised and de-valued historically. The outcomes of the analysis will spotlight transformations and formations in abortion governance in post-Repeal Ireland. The analytical focus will be used to critically examine Irish abortion care through the lens of reproductive justice and to assess if, how, and to what extent the Irish system reflects the principles of reproductive justice.

Chapter 3: Contextualising Irish abortion history: reading past governance through a reproductive justice and moral governance lens

3.1 Introduction

The conceptual framework that I developed in Chapter 2 supports an intricate, layered conceptualisation of how lived experiences, knowledge production, discursive practices, and governance work together. This framework enables conceptualising and contextualising of the mutual influence of experiences with abortion care, public and political discourses on abortion, and medical and popular knowledge. A Foucauldian approach to biopower and reproduction also illuminates how governance is an interconnected process that is constituted and produced by experiences, discourses, and knowledge while simultaneously reproducing particular discourses and constituting experiences and knowledge of politics.

In this contextual chapter, I trace the history of Irish abortion governance and feminist scholarship on abortion in Ireland from a reproductive justice lens. More than summing up the developments that make up the history of law and politics on abortion, I actively draw on the conceptual tools of biopower, moral governance, and reproductive justice to bring a theoretically informed perspective to the story. In doing so, this chapter gives a deeply contextual understanding of the long history of abortion politics in Ireland and demonstrates how a reading of the pre-Repeal history from a conceptual perspective within the post-Repeal present brings new insights. This consideration of the historical context of Irish abortion governance informs the subsequent analytical chapters of the thesis (Chapter 5-8) and sets the stage to explore the significance of time and place for an understanding of contemporary abortion politics in Ireland, and how it might have transformed earlier governance formations.

The boundaries for this contextual chapter are set by the two important frameworks that mark the start of two different dominant governance mechanisms in the Irish abortion regime at the time that they were introduced: The Eighth Amendment when it was inserted into the Constitution in 1983 and the Health (Termination of Regulation of Pregnancy) Act 2018 which replaced the Eighth Amendment. More than constitutional and legislative tools only, these frameworks are the key formations of the abortion regime and its governance mechanisms. The texts themselves therefore unfold much about the workings of the regime, its underlying moralities, and how it functions. The constitutional provisions are included below to

ground the two transitions of the regime in time and place and to facilitate the contextualisation of the transition that has taken place over the 35 years that passed between the two governance frameworks. This chapter traces how the particular Irish moral regime under the Eighth Amendment developed, how the constitutional ban was challenged over the years, and how the state developed different legal and political responses over the years when faced with challenges and resistance. This chapter thus forms a socio-historical, political, and a scholarly basis which informs the analysis of the post-Repeal regime in Chapters 5 to 8. I set out here to engage with the trans/formations to which I refer in the title of the thesis, in that I delineate the formations of the pre- and post-Repeal abortion regime and critically consider in what sense they might rely on different or similar moral governance mechanisms.

I look specifically into the work of previous feminist scholars to identify shifts in power and to outline emerging inequalities under abortion governance over time. A number of issues around access and provision of abortion care in these earlier political developments under the pre-Repeal abortion regime come to the forefront again in the post-Repeal abortion landscape, which is the focus of the analysis in Chapter 5 'Regime transformations: Identifying and mapping post-Repeal abortion governance' and Chapter 6 'The in/visibilising of abortion care services: The need for a more provider-centred approach'. Additionally, I synthesise the different framings and discourses around abortion that emerged over time as an issue of morality, politics, law, human rights and healthcare respectively. This further facilitates my analysis of how these discursive themes continue to inhibit a feminist reproductive justice approach in Ireland since the legalisation of abortion in Chapter 7 'The politics of language and discursive mobilisations of health and rights'. The changes in power and continuities in inequalities under the post-Repeal governance framework will be further examined in the analysis in Chapter 8 '"We are not going to return to those days": Abortion governance through relations with the past'. Hence the conceptual reading of the background and history of Irish abortion governance facilitates the analysis in the contemporary context.

In this chapter, I first discuss the selection of sources and literature. The curation of a data archive that brings together pre-Repeal and post-Repeal data for this study is further discussed in the methodology (Chapter 4). Here, I focus on the reading of the sociohistorical and political context of Irish abortion governance by tracing certain political events throughout the history between 1983 and 2018. Secondly, I

consider a number of public challenges to the Eighth Amendment to illustrate how the governance under the Eighth Amendment worked, which discourses and whose voices were heard in public contestations, and how spaces to contest the regime were narrowly defined legal and political arenas. Thirdly, I discuss state interventions and responses to a number of challenges to the regime. Finally, I take a closer look at the ongoing dynamic between governance, resistance to it, and the mutual constitution of the governance mechanisms and grassroots efforts to transform the regime.

3.2 The Eighth Amendment and the Health Act 2018

The Eighth Amendment to the Irish Constitution 1983 (Government of Ireland, 1983) "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

The Health (Termination of Pregnancy) Act 2018 (Government of Ireland, 2018) "An Act to provide for and regulate termination of pregnancy; to make provision for reviews at the instigation of a pregnant woman, or a person on her behalf, of certain medical opinions given in respect of pregnancy; to make available without charge certain services to women for the purpose of termination of pregnancy in accordance with this Act and, for that purpose, to amend the Health Act 1970 and certain other enactments; to provide for offences in respect of the intentional ending of the life of a foetus otherwise than in accordance with this Act; to amend the Bail Act 1997 ; to repeal the Regulation of Information (Services outside the St ate for Termination of Pregnancies) Act 1995 , the Protection of Life During Pregnancy Act 2013 and provisions of certain other enactments; and to provide for matters connected therewith."

3.3 Pre-Repeal governance as sites of knowledge and power: feminist praxis of selecting and curating historical sources

Critically considering historical continuities in the framing of abortion "as part and parcel of a long-term, systemic regulation of women's fertile bodies" (Delay, 2019, p. 23) is part of feminist efforts to reflect on the Irish abortion regime over time (Quilty, Kennedy, and Conlon, 2015), and is a much-needed approach within qualitative research. A conceptual reading of past governance enables the critical analysis of the transition to post-Repeal abortion governance as part of the long-term, systemic regulation of women's fertile bodies. Keeping embodied experiences at the centre, the Irish abortion history is a history of violent and visceral material consequences for the

people who have been denied reproductive rights. It leaves no doubt that the bodies of women and pregnant people are sites where struggles over power took place in the past and continue to do so in the present.

Working with pre- and post-Repeal material is part of the feminist commitment of this work to investigate how silences not only produce gaps in knowledge, but also reveal the operation of power within the silencing, excluding and de-legitimising of certain voices (Morgan, 2022). In the historical moral regime, legal and political documents were generally presented as sites of rationality and sites of the production of legitimate knowledge and information, whereas embodied experiences were kept outside of that. I follow here Morgan's (2022; 2021; 2004) idea of archives as sites that make information discoverable and knowable through what is not included. Challenging the idea of the archive as a neutral and objective record, Morgan argues for the need to take into account who might do the archiving, in which social and historical context it takes place, and which political goals it might serve. Silencing and invisibilising are not only a matter of leaving things out – they are active processes. Considering how this took place in the pre-Repeal abortion regime and how, over time, the disclosure of embodied experiences was fundamental in bringing about changes in abortion governance, shows that historical sources and literature can speak to the contemporary data. Subsequently, looking for experiences that are (not) recorded in official historical documents and those in the present statutory records is a way to explore the transformations in power relations in Irish abortion governance.

The historical context that I will develop here is informed by my conceptual framework. Equally, the selection of the literature is not objective, but rather, it is politically and theoretically informed by the critical conceptual concepts such as biopower, moral governance, and reproductive justice. The political dimension of this work, both in its historical and contemporary context, draws on my specific conceptual framework as developed in Chapter 2. My rationale for what to include in this chapter is based on my conceptual and methodological positioning, as I will further explain in my methodology chapter (Chapter 4). The material included in this chapter therefore comprises legal and political documents produced by Irish institutional governing bodies and feminist scholarship on Irish abortion politics.

3.4 Legal Challenges to the Eighth Amendment: what the legal and political history of contestations to the regime reveal about mechanisms of moral governance

After the introduction of the Eighth Amendment, the processes of challenging the abortion regime followed a certain legal history. There are a number of women who challenged the Irish State in the Supreme Court (in 1992) and in the European Court of Human Rights (in 2010) which I will consider here. These cases illustrate some of the consequences of the Irish abortion regime for women and pregnant people's experiences with pregnancy, as well as some of the lived experiences of abortion and abortion care. Furthermore, the historical legal procedures and decisions are indicative of the particular context of moral governance and how this has developed since the Eighth Amendment. Tracing these cases is helpful in trying to understand how legal and political mechanisms worked and changed over time to govern abortion. More importantly, many of the issues that arose in these cases resonated in the debates on the Repeal of the Eighth Amendment and had to be accounted for in the current abortion legislation. Some of them continue to shape the abortion care experiences of women and pregnant people and medical professionals.

The four cases I include in this section took place between 1983 and 2014. I will first discuss the first questioning of the provisions of the Eighth Amendment in the *Attorney General (SPUC (Ireland) Ltd.) v. Open Door Counselling Ltd.* case (1988). The case was initiated in the Irish High Court by the Society for the Protection of Unborn Children (SPUC) in 1985, when they sought to stop the activities of two sexual and reproductive health organisations, Open Door Counselling and Well Woman Centre. Those two organisations were providing pregnant women with information about abortion services in other countries. The case showed the immediate effects of the Eighth Amendment on the communication and interaction between healthcare professionals and pregnant people.

Secondly, I consider the X case in 1992 and the related constitutional amendments. The Supreme Court ruled in *Attorney General v. X* that a 14-year-old girl, known as X, pregnant as a result of rape, faced a real and substantial risk to her life due to threat of suicide and this threat could only be averted by the termination of her pregnancy. Therefore, X was entitled to an abortion in Ireland.

The third case considered is the discussion of *A, B and C v. Ireland* from 2010. A, B, and C were three women who took their cases directly to the European Court of Human Rights. For C, the ECHR ruled that Ireland's failure to implement the existing

constitutional right to a lawful abortion when a woman's life is at risk was violated under Article 8 of the European Convention on Human Rights. The ECHR also ruled that the three women did not have an effective remedy available to them under the Irish legal system.

The last case I will discuss is not a legal case, but the death of Savita Halappanavar as a result of the Eighth Amendment's influence on medical practice. Savita Halappanavar died in 2012 of the consequences of sepsis when she was refused a termination, during what would be an inevitable miscarriage, because a foetal heartbeat was still detectable.

The four cases discussed here are by no means exhaustive of the legal history of abortion cases in Ireland.[9] The complexity and legal particularity of the various cases sometimes obscures the similarities of the ways in which control over people with the capacity to be pregnant has been imposed throughout the years. Yet the withholding of information, the exceptionalisation of permitting abortion only in cases that have been deemed 'legitimately risky and harmful' to the pregnant person, State violations of reproductive rights, and the disregard for women and pregnant people's autonomy come up in most of these cases. Additionally, the legalistic history conceals the continuous consequences of constitutional and legislative orders on experiences with abortion care beyond the legal right to abortion. What remains of many of these cases is the legal record and public discussions in media, but the personal experiences of these people and embodied engagements with abortion under the Eighth Amendment are less visible. My selection of sources of literature, policies and cases in this chapter is based on drawing out the main concepts from the conceptual framework – the focus on particular 'high-profile' cases facilitates the investigation how and why certain cases became publicly discussed and became part of a dominant narrative of abortion governance, and others did not. The selection of the cases here is made to focus on the which cases drew out governance responses and which elicited adjustments in the governance mechanisms. In that way, both the dominant

[9] For a legal overview at the time of the Citizens' Assembly in 2016, see the Final Report on the Eighth Amendment of the Constitution Appendix E Volume 1: https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Appendix-E-Volume-1.pdf , and the Joint Oireachtas Committee in 2017, see the Report of the Joint Committee on the Eighth Amendment of the Constitution: https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Joint-Oireachtas-Committee-on-the-Eighth-Amendment-of-the-Constitution-/Report-of-the-Joint-Committee-on-the-Eighth-Amendment-of-the-Constitution-.pdf or the IFPA's 'History of abortion in Ireland': https://www.ifpa.ie/advocacy/abortion-in-ireland-legal-timeline/

governance framework and different alternative experiences and resistances to that framework can be discerned.

The cases raise a number of questions. How was it determined whether an abortion was lawful, what were the procedures for this? Who were the key stakeholders in determining whether an abortion was lawful? How did the battles between competing rights of the mother and the foetus play out? What were the implications for medical practitioners? In what ways did the different actors involved in reproductive governance, such as the Irish government, the Irish High Court and Supreme Court, the European Court of Human Rights, the local hospitals, pro- and anti-abortion organisations, politicians and activists, influence women and pregnant people's reproductive healthcare? Using the conceptual tools of biopower, moral governance, and reproductive justice to explore these questions is instrumental in informing the analysis of the post-Repeal abortion care landscape. Whether those issues have been resolved and if the answers to these questions have changed, will be further addressed in the analytical chapters (Chapters 5 – 8).

Table 3.1: Overview of documents discussed

Political and policy documents	- **Green Paper on Abortion (1999)** - **HIQA Patient Safety Investigation report into services at University Hospital Galway (UHG) and as reflected in the care provided to Savita Halappanavar (2013)** - **Citizens' Assembly Report (2016)** - **Joint Oireachtas Committee Report (2017)**
Legal documents	- Article 40.3.3 to the Constitution (1983) - Attorney General (SPUC (Ireland) Ltc.) v. Open Door Counselling Ltd. X case (1988) - Attorney General v. X (1992) - Information Act 1995 - Travel Act 1995 - Protection of Human Life in Pregnancy Bill (2002) - Protection of Life During Pregnancy Act 2013 - A, B, and C judgment (2010) - Health Act 2018

3.4.1 The Eight Amendment's far-reaching implications: *Attorney General (SPUC (Ireland) Ltd.) v. Open Door Counselling Ltd.* in 1988

The first questioning of the provisions of the Eighth Amendment came with the *Attorney General (SPUC (Ireland) Ltd.) v. Open Door Counselling Ltd.* Case in 1988, in which the Society for the Protection of the Unborn Child tried to stop the Open Door Counselling and Well Woman Centre from continuing their services (Quilty, Kennedy and Conlon, 2015). It was the first application of the constitutional ban after its introduction and also the first introduction to how far-reaching the consequences of the Eighth Amendment were. The case was more than the questioning of provisions alone, it was also the first example that the Eighth Amendment now allowed for the prosecution and shutting down of organisations that provided information on abortion (Hug, 1999). I mention this case to illustrate the wider regulation and systemic nature of the control that was exercised by powerful actors in the moral regime in Ireland in the 1980s. The aim of conservative anti-abortion organisations such as the Society for the Protection of the Unborn Child was to target sexual and reproductive health more broadly, to ban contraception, and to shut down family planning organisations (O'Reilly, 1992). It shows how a wide range of organisations and people involved in reproductive care were implicated in the abortion regime.[10]

It shaped the grassroots activism that reproductive rights activists were engage in to assist women and pregnant people to access abortion care abroad. They continued their activities illegally (Hug, 1999). This speaks to the long history of the State withholding information and using legal measures and delays to prevent healthcare practitioners from helping and informing people. In the absence of State support, it strengthened the involvement of advocates and activists in forming informal networks to provide information and help directly with accessing care. It also set the tone for the climate of stigma and fear that applied to healthcare practitioners involved in abortion provision (O'Reilly, 1992). Smyth (2005) describes how the years following the 1983 referendum were marked by censorship and self-censorship due to this fear

[10] It was only four years later that injunction was lifted when the European Court of Human Rights ruled that it interfered with the right of the two organisations to provide information about pregnancy-related options and with the ability of women to receive information (European Court of Human Rights, 1992; O'Reilly, 1992).

and stigma for healthcare practitioners. The targeting of healthcare practitioners and injunctions against organisations intensified the culture of secrecy around abortion.

3.4.2 The X case: the threat to life takes centre stage

The X case in 1992 highlighted the possible effects of the Eighth Amendment on women and pregnant people very publicly, perhaps for the first time. It also invoked a change in abortion governance where a threat to the life of the mother was concerned. Lisa Smyth analyses the case extensively in her book 'Abortion and Nation' (2005). Her analysis of how abortion is tied up with Irish nationalism is a key piece in the scholarly work on abortion in Ireland. The X case has also received a relatively large amount of attention, because it was a first public discussion which revealed so much of the underlying political interests, social norms, and cultural meanings of gender, family and sexuality (Fischer, 2019; Gilmartin and White, 2011; Hug, 1999; Martin, 2002; Mullaly, 2005; Smyth, 1992).

Briefly, it involved a 14-year-old girl from Dublin who had become pregnant through rape. When her family inquired about the potential for evidence in the proceedings of the trial of the rape, the Irish High Court issued an injunction preventing the girl from traveling to obtain an abortion. The rights of the foetus under the Eighth Amendment were in need of state protection, according to the Attorney General (Smyth, 1992, p. 164). X was diagnosed as suicidal and placed under medical supervision, but the risk to her own life and health was considered "much less and is of a different order of magnitude than the certainty that the life of the unborn will be terminated" (Smyth, 2005, p. 13).

The Supreme Court lifted the injunction by a majority of four judges to one. The decision indicated a reinterpretation of the Eighth Amendment, giving due regard to the mother's right to life. In this case, it was ruled that suicide did constitute enough threat to a pregnant woman's right to life to allow for an abortion. Abortion became constitutionally permissible in a way that would be crucial for abortion discourses in the following decades: "if it is established as a matter of probability that there is a real and substantial risk to the life as distinct from the health of the mother, which can only be avoided by the termination of her pregnancy" (Smyth, 2005, p. 14). The framing of a 'real and substantial risk' and the need to determine, and medically certify, the permissibility of abortion still echoes in the Health Act (2018). Framing (mental)

health justifications as a substantial risk to allow for an abortion, became a way of institutional exceptionalisation of the procedure which is carried over into the post-Repeal abortion governance.

Eventually, the government convinced X's family to lodge an appeal against the injunction with the Supreme Court and offered to cover all legal costs. This highlights the intricate ways in which reproductive governance can work and how different actors are involved alongside each other. The High Court, the Supreme Court, and the State demonstrated different interpretations of the constitution, but were all involved in exercising control over women and pregnant people's bodies.

Furthermore, the X case brought about national and international criticism on the role of the Irish State in significantly limiting reproductive behaviours and harming women and pregnant people. The national abortion regime became increasingly tied up with international politics and a morality clause was added to the Maastricht Treaty in 1992 to exempt European influence on the Eighth Amendment (Mishtal, 2014). It was clear, however, that the majority of Irish people were in favour of increased economic connections with the rest of Europe, and this outweighed abortion as an issue that would compromise European collaboration (Smyth, 2005). There was also still significant pressure from the Catholic Church as an international organisation, although its moral authority in Ireland began to decrease, particularly with the onset of various scandals involving the Catholic Church in Ireland (Smyth, 2005).

Subsequently, battles of 'competing rights' became a central trope in debates on abortion and in strategies to advance women's and pregnant people's rights. The case generated discussions on the right to travel, the right to information, the right to life of the pregnant person, and how they might compete with the right to life of the unborn. It exposed conflicting ideas of what the duties of the State are in guaranteeing or protecting certain rights over others. The risk of suicide added a tension to these conflicting rights in a way that was not about fundamental basic human rights for any Irish citizen, but rather framed the conflict as a matter of a pregnant person's life as the only legitimate questioning of what might outweigh the rights of the foetus:

> The High Court ruling had held that in the event of a conflict between the constitutional right of a woman to travel and the constitutional right of a foetus to life, the right to life of the foetus would outweigh the right to travel of the woman. This issue was not resolved by the Supreme Court in its ruling, which

> lifted the injunction against X travelling not on the grounds that travel is a basic right of all citizens in a democratic state, but rather on grounds of a threat to X's life, as well as on the grounds of family privacy (Smyth, 2005, p. 22).

These legal rulings over competing rights grew into a persistent theme within abortion debates of (risk of) suicide, and the particular terminology of a 'real and substantial risk'.

The X case ruling resulted in the government organising three additional referenda held together on 25 November 1992 (Smyth, 2005). The 12th Amendment would remove the risk to life, with a risk of self-destruction, as a criterium that would allow for abortion in the Constitution. This was rejected. The 13th Amendment proposed that the right to travel would not be limited by the State. This was accepted. At the time, thousands of Irish women and pregnant people travelled to access abortion care – Emeritus Associate Professor in University College Dublin Ursula Barry writes that the official numbers from Irish addresses at UK clinics was around 5000 in 1988 but that "estimates put the total figure at 10,000" (Barry, 1988, p. 58). Lastly, the 14th Amendment proposed that the right to information would not be limited by the State, which was also accepted and brought forward additional legislation with the Regulation of Information (Service Outside the State for Termination of Pregnancies) Act 1995 (Government of Ireland, 1995). The separate framing of these rights in the Constitution further contributed to ideas that only in exceptional circumstances could women and pregnant people make a claim to these. Yet Irish voters rejected the proposal to take out the risk to life, showing a fundamentally different position than the anti-abortion forces at the time. Even with the three additional referenda, the practical implications of the governance under the Eighth Amendment remained unclear. What criteria had to be satisfied to make abortion permissible? Who were to make that decision? How would people know they might fall within the parameters? These questions remained unanswered, and the consequences would come up time and again in the years following 1992.

3.4.3 *A, B, and C v. Ireland*: searching for certainty and clarity

All three women had already travelled to Britain for an abortion when they took their claims to the European Court directly to ask for compensation by the Irish State in

2010. This indicated new strategies of contesting the abortion regime's governance through the employing of increasing reproductive technologies and an international legal pathway to seek compensation. In this case, A and B had very similar claims that focused on the inability to procure legal abortions in Ireland in cases where they knew their foetus had a genetic malformation. C's case was slightly different, because she was undergoing chemotherapy during her pregnancy, and her claim concerned the lack of information on obtaining assistance to find out what the risks of her pregnancy were to her health and life. Although A's and B's claims were dismissed by the ECHR entirely, and C's partly, the ECHR did take issue with the Irish government's position that there were certain situations under the Eighth Amendment in which an abortion in Ireland would be lawful, but no legislation had been enacted for this. In case there was a life-threatening situation such as an abdominal pregnancy, for example, there were no clear guidelines for the medical profession (Ward, 1994). The human rights violation in the case of C was thus that the State failed to provide clear criteria for the circumstances in which an abortion might be lawful in Ireland (Erdman, 2014).

The cases of A and B point to complications due to increased screening and scanning availability and how this sits in tension with restrictive abortion legislation. C particularly made the argument that there was a lack of clarity under the Eighth Amendment, so that it wasn't clear how exactly the right to abortion could be determined. The European Court was reluctant to rule in such a way that clear expansion of abortion rights in Ireland would be the outcome, and it concluded that local institutions in Ireland would be better suited to work with the particularly sensitive issue (Erdman, 2014). There are two issues in this case that are important to note for considerations of abortion governance. Firstly, the ECHR did rule that the lack of clarity and further legislation under the Eighth Amendment inhibited the provision of abortion care, even under the limited circumstances that the Eighth Amendment allowed for. The unclarity for medical practitioners will continue to come up in post-Repeal governance. Secondly, A, B, and C were enacting agency in the claims that they made against the Irish State by making use of the ECHR as an international human rights institution. Addressing abortion as an (international) issue of human rights has both benefits and pitfalls, as will be further explored in the analytical chapters. Perhaps the *A, B, and C v. Ireland* case pointed out the dire situation in Ireland, but it was not necessarily successful in bringing about change in governance. As I will discuss below, in response to the A, B, and C case, an Expert

Group was established in 2011 in response to the A, B, and C judgment to advise the government on the judgment's implications for reproductive healthcare. Just before the Expert Group could publish their recommendations, "tragic circumstances intervened", as Erdman notes (2019, p. 25).

3.4.4 Savita Halappanavar: the case that sparked public action and outrage

Savita Halappanavar was 17 weeks pregnant when she self-referred to University College Hospital Galway in October 2012. She eventually died from the septic shock that she developed in relation to the complications of the miscarriage (Boylan, 2019) The consultants attending to her in the hospital had refused to provide her with an abortion, because a foetal heartbeat was still detectable, and the Eighth Amendment prevented them from terminating the pregnancy. From the different reports that came out to assess what had happened, the conclusion was clear that the Eighth Amendment with its protection of the right to life of the unborn, and no further guidelines as to how to determine a 'real and substantial risk' to the life of the mother, had had a direct impact on Halappanavar's death (HIQA, 2013; Boylan, 2019; McCarthy, 2016). It would have been likely that her death could have been prevented if an abortion had been carried out during the first two days of her complications (Boylan, 2019).

The impact of the Catholic moral authority and how it infringed on healthcare practices, with the Eighth Amendment as a major tool to enforce this, had probably not been as pronounced before Savita Halappanavar's death. Moreover, it was an undeniable example of how voices of women and pregnant people became marginalised and ignored, as Joan McCarthy (2016) points out in her feminist analysis of the case. The general unease with women's reproductive capacity, the Catholic norms in healthcare practice, and the denigration of women's and pregnant people's moral authority and agency had fatal consequences in this case. Savita and her husband repeatedly asked for an abortion before her death, a request that was denied because the legal situation when there was not a clear threat to life, was too uncertain (McCarthy, 2016). Again, the lack of clarity was a significant deterrence for abortion care. Some of the wider concerns around the Halappanavar case, namely the mismanagement in the hospital, the work circumstances of nurses and midwives, and the lack of professional authority ascribed to nurses and midwives, are problematic structural circumstances that have not necessarily been resolved since and have come

up under the post-Repeal circumstances of abortion care provision. Even with abortion legislation in place, these issues continue to shape healthcare provision and have an impact on abortion care experiences, as will become clear in the analytical chapters.

McDonnelly and Murphy (2019) analyse the media responses to Savita's death and identify a number of crucial discursive framings of the issue, outlining that the frames that were dominant in the media provided an opportune way of engaging with abortion politics at the time. It could now be seen as a public tragedy that there were no clear medical guidelines, enabling politicians to somewhat sidestep to issue of abortion as such, but rather call for the need to provide legislation without denying the right to life of the foetus entirely. A 'protectionist discourse' (McDonnelly and Murphy, 2019, p. 10) concerning women could now be used to successfully frame the need for policy change in such a way that did not necessarily outright advance reproductive autonomy and agency. Additionally, the dominant cultural frame of Ireland as an anti-abortion nation was unravelling amid the international critique that they received.

3.4.5 Governance paradoxes: high levels of regulation and control of embodied experiences, but lack of legal and medical clarity under Eighth Amendment

Ultimately, the public cases that have challenged or contributed to discussions of the Eighth Amendment illustrate that public discussions on abortion governance had not ended with the abortion ban. Instead, abortion governance was debated frequently, and different national and international governing bodies were involved in asserting their take on the governance of abortion at multiple occasions. On the one hand, the constitutional ban seemed to provide a very clear state mandate to protect the life of the unborn, but on the other hand, it clearly lacked precise clarifications on what it actually meant for abortion care on the ground. Furthermore, all the different legal cases revealed the hardships that the Eighth Amendment imposed on people in practice. Medical professionals operated in a difficult area of undefined laws and ethical guidelines and were not clear on which responsibility in providing abortion care rested with the State, or with them. Any consideration of the harms that the Eighth Amendment was imposing, as well as the acknowledgment that abortions were still taking place, and were even condoned or allowed in certain circumstances, were dealt with through legal and political regulation. Considerations for women and pregnant

people and their personal circumstances did not lead to more reproductive autonomy. Rather, disclosure of reproductive experiences was responded to with more governance, as is fitting for reproductive governance (Morgan and Roberts, 2012).

The shifts in reproductive governance due to these high-profile cases reveal which reproductive behaviours have been historically incentivised or discouraged, and how this happened (Morgan and Roberts, 2012). Certain standards of morality are upheld by governing reproductive behaviour through, among other things, legal incentives. The constitution and the law are two authoritative and public ways of policing a moral order, but the interesting thing about court cases is that they also provide a space for people to contest the moral order. The arguments on the basis on which these legal cases have been decided reveal much about what was considered morally accepted reproductive behaviour and how this was framed in a particular context. The case of Savita Halappanavar, particularly, generated public outrage, and provided a clear example of a victim of the regime that by 2012 had already been internationally challenged and criticised by the European Court of Human Rights and the United Nations. The next section takes a look at some of the governance responses to these developments over time.

3.5 State interventions[11] for change: stalling and procedures of democracy

The increasingly visible consequences of the Eighth Amendment and public challenges to the abortion regime ultimately required acknowledgment and some level of accommodation from the State. Some of the state interventions discussed here have been directly in response to the high-profile cases discussed in the previous section, as it became increasingly difficult for the Irish state to uphold the constitutional ban on abortion and non-engagement with issues of reproductive rights. The statutory responses included in this chapter are the Green Paper on Abortion in 1999 (Department of the Taoiseach, 1999)) and a subsequent All-Party Oireachtas Committee (McAvoy, 2013; Kennedy, 2000); the Protection of Life During Pregnancy Act of 2013 (Government of Ireland, 2013); the Citizens' Assembly on the Eighth Amendment in 2016 and the Join Oireachtas Committee on the Eighth Amendment in 2017. These State interventions illustrate the processes of governance change in the

[11] See Appendix 2 for Dr Carolan's (2016) chronology of the evolution of Article 40.3.3 as it was submitted to the Citizens' Assembly.

abortion regime from the introduction of the Eighth Amendment in 1983 to its repeal in 2018. Again, my choice to highlight these interventions is informed by the conceptual framework and aims to delineate which mechanisms the State has historically drawn on to govern the population and reproduction and to illustrate changes and developments in the State's approach to abortion governance over time (Morgan and Roberts, 2012). The transformation through the repeal of the Eighth Amendment and the formations of the post-Repeal governance are then deeply contextualised rather than seen as ultimate breaking points with the past.

3.5.1 Increasing bureaucratisation of governance considerations: the Green Paper on Abortion 1999 and the Report of the Oireachtas Committee 2000

The X case in 1992 and a District Court case in 1997, involving a 13-year-old known as Miss C, had generated a significant number of responses from anti-abortion and pro-abortion advocates (Oaks, 2002). Like X, Miss C's case involved a minor who had been a victim of rape and sought an abortion in England: a complex case, in which miss C was placed in foster care and applied to the Children's Court to be allowed to travel for an abortion. The case became increasingly complicated as it demonstrated that no clear legislative framework had been put in place after the X case ruling (Oaks, 2002). Both pro-abortion and anti-abortion groups wanted clarification from the government on the abortion law and the Department of Health and Children set up an Interdepartmental Working Group on Abortion, which would consider submissions on the "constitutional, legal, medical, moral, and ethical issues which arise regarding abortion" (Oaks, 2002, p. 323). The goal was to set out different options to 'resolve' "the situation regarding abortion" (Oaks, 2002, p. 323).

The Green Paper (Department of the Taoiseach, 1999) concluded this consultation process with recommendations of how to proceed to govern abortion (Bacik, 2013). The options ranged from "an absolute constitutional ban on abortion (which they also rejected as unsafe) to legislation allowing for abortion "on request" (Bacik, 2013, p. 390-391). The Green Paper was reviewed by an All-Party Oireachtas Committee on the Constitution, which in turn drew up recommendations to the government (Kennedy, 2002). The committee convened public hearings, and Oaks (2002, p. 323) notes: "the lengthy recommendation process was interpreted by some as a stalling tactic, yet others surmised that it represented the government's desire to

resolve this difficult policy dilemma in a "democratic" way". The set-up of multiple committees, public hearings, and reports as legitimate procedures for political change would be repeated many more times in the decades to come, continuing also after the Health Act 2018 was implemented up until 2023.

Although the government had been forced to acknowledge ongoing issues around abortion access, little change on the ground was required or facilitated through the Green Paper (Department of the Taoiseach, 1999) and the Oireachtas Committee. In discussing 'medical tourism', Gilmartin and White (2011, p. 277) remark on the situation that had taken shape by the late 90s, in which, paradoxically, the right to travel in some ways facilitated non-action or a passive engagement of the government with abortion:

> Because women have "won" the right to travel, the Irish state has been excused from any responsibility to provide safe, legal, and affordable abortion services in the years since 1992. The publication of a (discussion only) Green Paper in 1999 and a Constitution Progress Report in 2000 represent the state's only foray into these issues. In the meantime, Irish women are forced to pay the emotional and financial costs of traveling to the United Kingdom to secure an abortion—to become "abortion tourists".

"Winning" the right to travel refers to the referendum after the X case in which this was explicitly established, the 13th Amendment to the constitution. As the quote by Gilmartin and White makes clear, the ambiguous situation where women and pregnant people travelled to England was upheld for a long time. The compromise of navigating between non-engagement, stalling, and democratic policy change would be echoed in the years to come throughout various processes of State interventions and attempts to facilitate governance interventions. All the while women and pregnant people continued to be mostly excluded from these political processes and continued to travel or find other means of accessing abortion care.

However, different members of the Oireachtas Committee were committed to creating a programme specifically dedicated to 'crisis pregnancy' and this resulted in the set-up of the Crisis Pregnancy Agency. This was a significant development for the governance of reproduction, now engagement from the State with 'crisis pregnancy' and a government agency to provide support and information (Bacik, 2013). This is

important to keep in mind when the policy landscape post-Repeal is identified and mapped in Chapter 5. Some of the structures of the post-Repeal abortion care provision stem from these earlier State structures. Agreement on further legal change was more challenging and remained focused around the question of whether suicide be considered a legal ground for abortion. Largely shaped by the X case and its ruling, the discussions on abortion would continue to revolve around death and remained deeply misogynistic (Bacik, 2013).

3.5.2 Continued anti-abortion political influence: Referendum on the Protection of Human Life in Pregnancy Bill 2002

To take the final decision on suicide risk as a legal ground for abortion, another amendment was put to a vote by the population. Effectively, the issue was similar to that in one of the referenda following the X case in 1992: to establish suicide risk as a legal ground for abortion. Christina Quinlan notes in her chapter 'Ireland: Narratives of Motherhood and Abortion' (2019, p. 122) that "the fact that this referendum, as well as the previous two, was held is indicative of the power and strength of the anti-abortion lobby in Ireland at that time". The referendum was intended to dismiss the risk of suicide as a legal ground for abortion, but a small majority of the voters voted against this proposal (Quinlan, 2019).

Reidy (2021, p. 33) remarks that the referendum was significant for two reasons: "it was the last occasion on which anti-abortion groups could leverage majority support to push their agenda in parliament" and "it was the second time a conservative proposition had been rejected by the electorate" (Reidy, 2021, p. 33). However, the anti-abortion defeat still did not guarantee actual advancement of reproductive rights. It did, importantly, signal that the combined power of the Catholic Church and the anti-abortion movement did not have a full grasp on Irish society anymore, but no additional progress in reproductive justice was made. In the following years, more legal cases followed and there was a sustained attention for the topic in that sense, but none of these generated a political breakthrough until the A, B, C judgment in 2010. That led to the establishment of an Expert Group on that decision in 2011, which reviewed the judgment and its implications for reproductive healthcare to advise the government how to proceed and address the matter (Bacik, 2013, p. 394). A framework for legislation was set out, clarifying under which circumstances

abortions could be carried out in Ireland to save a pregnant person's life (Bacik, 2013). Just before the Expert Group report was published in November 2012, Savita Halappanavar died, and her death changed the course of political action.

3.5.3 Normalisation of 'protection' and 'life' narratives in governance: Protection of Life During Pregnancy Act 2013

After Savita Halappanavar's death there was a renewed awareness of the need to implement a legislative framework that would accommodate a 'real and substantial risk' to a mother's life as grounds for abortion. Peter Boylan, an obstetrician gynaecologist and former Master of the National Maternity Hospital in Dublin, remarks that at that time there was no way for medical practitioners to quantify the risk to life, no medical guidelines had been established, and criminalisation was still looming (2019, p. 73). The committee that had been established for the implementation of the X case ruling (1992) in the C case in 1997, had not yet further developed a legal framework. Now, a separate jury set up in 2012 also investigated the Halappanavar case, and the previous work that had been started on introducing legislation, continued under draft legislation for the Medical Treatment (Termination of Pregnancy in Case of Risk to Life of Pregnant Woman) Bill 2012 (Houses of the Oireachtas, 2012). The name of the Draft Bill is a testament to the continued anti-abortion influences in politics and demonstrates the gendered nature of considerations of governance change.

For all the inquiries and reports that were taking place at the time, there was no input from women and pregnant people themselves, something that was acutely highlighted through Savita Halappanavar's case. Boylan (2019, p. 106) describes the blatant disregard for the pregnant person's needs, "the current situation did not allow for a nuanced approach, and neither did it allow for any input by the woman herself, a unique situation in the practice of obstetrics". The government's response was a consultation with experts, comprised by legal, medical, and interest-group members, which by now resembled a pattern of regulation of governance change in itself. Women and pregnant people and their experiences were still not considered at the core of the political processes. The involvement of different stakeholders in political deliberations also sustains the anti- and pro-abortion binary in governance, as

advocates and Church representatives were heard in addition to medical and legal experts (O'Sullivan, Schweppe and Spain, 2013).

In the end, the Protection of Life During Pregnancy Act (PLDPA) 2013 (Government of Ireland, 2013) that was introduced, renewed the criminalisation of abortion, with a prison sentence of up to 14 years for anyone involved in providing abortion care outside of the legal parameters (de Londras and Markicevic, 2018). The circumstances which might allow for an abortion, and the medical gatekeeping of those, remained largely the same. What changed was that now abortion would be permitted where two doctors certified that the pregnancy put the life or health of a woman at 'real and substantial' risk (Carnegie and Roth, 2019). Doctors would be central in determining such risk, and the centrality of doctors as gatekeepers to abortion access continues in post-Repeal governance. Globally, it remained one of the strictest abortion regimes at the time (Felzmann, 2014).

Multiple parts of the setup of abortion care under the PLDPA 2013 (Government of Ireland, 2013) remain relevant for the formations of the Health Act 2018. Firstly, a notable influence is that it was probably the most conservative interpretation of the X (1992) and C (1997) rulings that could be made (Felzmann, 2014). It did not extend Irish abortion law, but merely gave effect to the Supreme Court and ECHR Court rulings in that the risk to the life or health to a pregnant person legally allowed for an abortion, but the grounds to the legal right to abortion were not expanded (Murray, 2016). Nonetheless, Boylan (2019) describes that physicians at the time were happy that that the processes to establish a real and substantial risk to life were finally set out, which is indicative of how desperate the situation was. No further guidelines were specified for how doctors were supposed to determine this, but it was an improvement that it was now a matter for best medical practice rather than legal regulation. Secondly, some preliminary discussions on gestational limits emerged. The government asserted that in later pregnancies, women and pregnant people would be offered early delivery rather than an abortion, foreshadowing some of the issues that would also apply to the Health Act 2018 (Government of Ireland, 2018). Thirdly, medical practitioners were implicated in a contentious and ambivalent way. On the one hand, they had the threat of criminalisation hanging over them, and had a very limited range in which they could operate. On the other hand, they were now also more targeted by anti-abortion politicians (Boylan, 2019). Furthermore, problematic discourses on women and pregnant people as untrustworthy came to the forefront too.

The narratives of suicide were still central to the discussions of the Act, and debates often suggested that women would manipulate doctors into believing that they were suicidal in order to obtain an abortion (Boylan, 2019; Murray, 2016). The misogynistic elements in these discourses remained pervasive and perpetuated ideas of women and pregnant people as manipulative and incapable of making their own autonomous decisions.

From 2012 onwards, resistance to the Eighth Amendment and public calls for change in abortion governance from civil society and activist groups grew (Enright, 2019; Reidy, 2020). The tensions between the strict abortion regime and people's reproductive experiences were increasingly shared publicly, as women and pregnant people began to share their stories (Quilty, Kennedy and Conlon, 2015). The public contestations also swayed politicians to call for reform, which made abortion a government-formation issue in 2016 and placed it centrally on the political agenda (Reidy, 2021).

3.5.4 Informed decision-making of citizens at the basis of governance change: Citizens' Assembly 2016

The government announced its intention to hold a Citizens' Assembly to consider the Eighth Amendment to the Constitution, a process of deliberative democracy that had been effectively used before for marriage equality in 2015. The Taoiseach at the time, Enda Kenny, had responded to pressure from the public in Ireland and the international bodies to address legal matters of the Eighth Amendment (Side, 2020). Irish legal scholars De Londras and Markicevic (2018, p. 89) suggest that the Citizens' Assembly was initially introduced in 2016 as a delaying tactic, but it marked the start of significant governance change, nonetheless. While it resulted in providing a fundamental basis for the introduction of abortion legislation, the framing of the Citizens' Assembly (in the period directly after the Repeal of the Eighth Amendment) as a major turnaround and a pivotal shift away from official governance processes, needs to be nuanced (Side, 2020; Carolan, 2020; de Londras and Enright, 2019; Dražkiewicz-Grodzicka and Ní Mhordha, 2019). The final recommendations of the Citizens' Assembly (2017) demonstrated that there was broad support for legal abortion care. Nonetheless, an analysis from a feminist and reproductive justice perspective brings out a number of issues concerning the set-up of the process; how

equity and inclusion were considered in the Citizens' Assembly itself and within considerations of abortion care; and the framing of abortion, knowledge, expertise, and governance.

The Citizens' Assembly on the Eighth Amendment held five different sessions of meetings from November 2016 to April 2017.[12] The participants consisted of ninety-nine randomly selected citizens in order to be broadly representative of Irish society. Legal scholar Carolan (2020), who presented for the Citizens' Assembly on the particular constitutional history and background to Article 40.3.3 and who has carried out studies on deliberative democracy processes, notes that a significant over-representation of people of a certain socioeconomic standard, degree of education, and ability and capacity has to be considered, nonetheless. The work was unpaid and voluntary; thus, it is plausible that the participants did not represent Irish society accurately. No further efforts were made to ensure an equitable representation and participation (Carolan, 2020).

In the course of the Assembly's considerations, there was a notable shift in the discussions of abortion and its broader context from a previous focus on shame and tragedy, to an acknowledgment of abortion as a lived experience at the very least (Side, 2020). This was demonstrated, for example, by the presentation of Dr Brendan O'Shea (O'Shea, 2016), who represented the Irish College of General Practitioners. He spoke of the "cumbersome clinical guidelines" under the regulation at the time, the Protection of Life During Pregnancy Act 2013 (Government of Ireland, 2013), and particularly the stratified reality of access that doctors see in general practice (O'Shea, 2016). In this way, he placed abortion within medical practice just like any other aspect of care: "Inequality is writ large across most aspects of health service, and this area of care is no exception". Speaking publicly of issues around abortion in healthcare in this way, holding space for both the inhibitive legislative framework, while also considering abortion care as any other healthcare service, opened up new ways of publicly discussing abortion.

Yet, abortion itself was still largely framed as a highly contentious and contested issue. The chair of the Assembly, Ms Justice Laffoy, introduced the Eighth Amendment as "arguably the most difficult topic" among a set of issues that were put

[12] Recordings and transcripts of the Citizens' Assembly sessions and all materials that were made available for the participants can be accessed here: https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/The-Eighth-Amendment-of-the-Constitution.html.

through the same deliberative processes (Laffoy, 2016). The other topics were climate change, the ageing population, the manner in which referenda are held, and fixed term parliaments.[13] Justice Laffoy continued, "I have reflected on the 'arguably', and I think it would be more correct to say 'definitely'. It is definitely the most difficult topic we have to address" (Laffoy, 2016). The continued emphasis on discussions of abortion governance as complex and contentious, perpetuates a perception of abortion as a stigmatised issue, and continues to affirm its status as an issue of morality.

Carolan (2020, p. 503) furthermore outlines that the formal, administrative and "institutionally bound and conspicuously legalistic in character" process of the Citizens' Assembly was still a highly regulated governance procedure. The process and discussions of the assembly were still organised by the Irish State, and the participation in these efforts to consider the implications of the abortion governance at the time, and to re-imagine this, were disciplined along the very principles of that regime. As Side (2020, p. 10) mentions, the deliberative process as legitimising mechanism consolidates the power of the regime: "in many ways, state bodies confirmed their power as arbiters and decision-makers over citizens' bodies and embodiment (Chambers, 2009: 324) and used their powers to exclude non-citizens". Not reflected in this institutional procedure, was the longer process of working towards political change by grassroots activists who had created alternative networks for care and advocated for reproductive rights for decades, nor the evidence that personal narratives were much more important for people's decision-making on the issue (Carolan, 2020; De Londras and Markicevic, 2018; Dražkiewicz-Grodzicka and Ní Mhordha, 2019). Advocacy and personal experience accounts were not considered by the Citizens' Assembly, but they would be considered by the subsequent Joint Committee of the Houses of the Oireachtas.

The strong hold of the regime on what constitutes a legitimate call for change becomes more pertinent when we think more about whose bodies and whose voices were excluded. Although the Citizens' Assembly received approximately 13,000 public submissions, these were not incorporated in the Citizens' Assembly meetings, despite Justice Laffoy's emphasis in her opening talk that the public submissions also provided an important opportunity for people who were not directly represented, to

[13] For all these different Assemblies and their proceedings, see https://2016-2018.citizensassembly.ie/en/Home/.

convey their views, such as people from the diaspora or those under 18 (Laffoy, 2016). De Londras and Markicevic (2018, p. 90) analysed more than 1,000 of the submissions, and point out that:

> These submissions made remarkably little impact on the Assembly, at least in the formal proceedings. While the secretariat to the Assembly prepared a sample of some of the submissions and distributed them to the members, and while they expressly identified the submissions that were made from advocacy groups and from people who declared first hand experience of abortion care (or the lack thereof) (Citizens' Assembly, 2017, 78), there was no systematic engagement in the formal and public sessions with these submissions, although it seems they were discussed in private session (Citizens' Assembly, 2017, 78).

The fact that the public submissions were seen as important and the members of the Citizens' Assembly were encouraged to take note of them, they did not make up the 'evidence' or 'expertise' that was followed to justify and determine governance changes. This reveals the values placed by the State on legal and medical knowledge and expertise as legitimate facilitators for change in the abortion regime, whereas embodied experiences with abortion were perhaps considered consequences of circumstances that complicated provision of care, but not as legitimate reasons for policy change or bases for reproductive rights claims. Again, this points to the need for insights and knowledges from sources that do more to capture this embodied way of knowing.

Even so, the Citizens' Assembly's final recommendations reflected a very broadly accessible abortion care framework, rather than conservative legislation for the "so-called 'hard cases'" (de Londras and Markicevic, 2018, p. 95). The majority of the Assembly voted to repeal the Eighth Amendment from the Constitution and to replace it with a specific constitutional provision that authorises the Oireachtas to legislate for abortion care. Their final recommendations were to have abortion available without restrictions as to reason until 12 weeks' gestation (although it was a close vote with only a small percentage difference to allow for this up to 22 weeks) (The Citizens' Assembly 2017). For a risk to the pregnant person's health or where there was a diagnosis of a fatal foetal anomaly, the majority of the participants voted

to allow for this with no gestational age limit. The way that the voting ballots were designed made for complex and multiple rounds of votes on different grounds and gestational ages, and thus it is difficult to make sense and keep track of the Citizens' Assembly final recommendations, and how the Joint Oireachtas Committee subsequently considered those. For an example of one of the voting ballots, see figure 3.1 below. The complexity and difficulty in which the potential legal framework was approached and framed for recommendations is a particular feature of governance and contributes to the exclusionary ways in which governance change has been institutionalised. It makes it possible for very minimal change to actually be enacted in the end, even though the Citizens' Assembly recommendations called for more structural and transformative change to reproductive governance.

What's more, the differentiation in the law between 'real and substantial risk' and 'serious risk', as well as physical and mental health, are particular legacies from previous legislative pieces, as has been discussed in this chapter. The particular governance history eventually led to a "peculiar piece of legislation, which must be understood in its political context" as Donnelly and Murray (2020, p. 128) argue, particularly for the ensuing ethical and clinical guidelines for medical practitioners after the Repeal referendum.

Additionally, the final report of the Assembly included five ancillary recommendations, which are crucial for considerations of reproductive justice in that they include a broad range of reproductive health services and situate abortion care within a set of related issues. This illustrates the framing of abortion as part of a range of healthcare, and social and cultural issues, rather than an exceptionalised procedure. The recommendations included improvement in sexual health and relationship education, improved access to reproductive healthcare services (including contraception), access to a certain standard of obstetric care, improvement to services of counselling and support, and further considerations as to who would carry out and fund terminations of pregnancy. The attention for ancillary recommendations and the situating of abortion among a set of broader issues were a success of the Citizens' Assembly, but many of the recommendations would be improved under the post-Repeal abortion governance.

Figure 3.1: Voting ballot 4B from the Citizens' Assembly

Original Draft Ballot Paper 4B:

Ballot 4B		Mark X in one of the five boxes below for each of the 8 reasons				
		Recommendation				
		A	B1	B2	B3	C
	Reasons	Never for this reason	Up to 12 wks gestation only	Up to 22 wks gestation only	With no restriction as to gestational age	Prefer not to state an opinion
1	Real and substantial physical risk to the life of the woman					
2	Real and substantial risk to the life of the woman by suicide					
3	Serious risk to the physical health of the woman					
4	Serious risk to the mental health of the woman					
5	Pregnancy as a result of rape					
6	The unborn child has a foetal abnormality that is likely to result in death before or shortly after birth					
7	The unborn child has a significant foetal abnormality that is not likely to result in death before or shortly after birth					
8	Available on request (i.e. no restriction as to reasons)					

Source: Final Report on the Eighth Amendment of the Constitution (The Citizens' Assembly, 2017)

3.5.5 Control and regulation as integral to the processes of governance change itself: Joint Committee of the Houses of the Oireachtas 2017

The Citizens' Assembly and their recommendations were considered by a parliamentary committee, the Joint Committee of the Houses of the Oireachtas on the Eighth Amendment of the Constitution. The cross-party committee with members of both Houses held weekly meetings from September 2017 to December 2017 (Committee on the Eighth Amendment of the Constitution (32nd Daíl). The majority of the Joint Committee members were in favour of most of the Citizens' Assembly recommendations, and constitutional change was, in fact, the intention from the outset of the committee meetings, albeit in a 'watered down' version (see Table 3.2

‘Overview of Citizens’ Assembly and Joint Oireachtas Committee final recommendations’ for an overview of the recommendations of the Citizens’ Assembly and the Joint Oireachtas Committee, and how they differ). Advocates ‘on both sides of the debate’ have criticised the Joint Committee for being a political farce. Pro-abortion activists argued that it was a mere stalling technique, or in one of the initiators of the national Coalition to Repeal the Eighth and the Abortion Rights Campaign, Ailbhe Smyth’s words, “a cosmetic exercise” to delay a referendum. Anti-abortion advocates stated that the outcome of the processes was pre-determined, and that change was inevitable (much against their liking), “but they just have to do it to go through the different steps”.

The Committee meetings largely existed of presentations by more legal and medical professionals, reproducing the legitimate values and voices for change that had also been dominant at the Citizens’ Assembly meetings. De Londras and Enright (2019) have put forward that legal and medical expert knowledge allowed more secular arguments, rather than those based on religious ethos, to be widely accepted. Whereas this might have been true and a helpful development to some degree, it did less to disrupt moral governance of abortion. The only advocacy organisation that was invited to speak before the Committee was ‘Termination for Medical Reasons’ (TFMR), a group who support women, parents and families with foetal anomaly diagnoses o in addition to campaigning for legal change. Their advocacy has been crucial and hugely influential in the Repeal referendum campaign, but advocates post-Repeal have called for the exceptionalising effects of this group being a major voice in debates and that it need not be dependent on (disclosure of) tragic experiences. This continued the long line of emphasising tragedy and hardship when publicly discussing abortion, and it constructs a hierarchy of legitimacy of reasons for abortion (Walsh, 2022). Both of those are detrimental for reproductive justice in that they do not contribute to the normalisation of a wide range of experiences with abortion, including positive and autonomous decisions as common experiences.

The legalistic nature of the Citizens’ Assembly was not improved in the Joint Oireachtas Committee, and the Council of Europe criticised Ireland for “hiding” in law-making in a 2017 (Side, 2020). The process was also dominantly expert-led and continued to contribute to the silencing of embodied voices. The practicalities of access to reproductive care and nuanced reproductive experiences were not highlighted. Their final recommendations included stricter gestational limits than the

Citizens' Assembly had recommended, and they included more restricted circumstances for legal abortion, justified by invoking particular legal pathways that had to be adhered to: "the Joint Committee has considered the balance to be struck between certainty and flexibility in law-making and the need to comply with Ireland's obligation under international human rights law" (Houses of the Oireachtas, 2017, p. 6). Rather than the Citizens' Assembly recommendation to replace Article 40.3.3 (upholding the protection of the right to life of the unborn) with an explicit constitutional provision that authorises the Oireachtas to address termination of pregnancy, the Joint Oireachtas Committee recommended a 'repeal simpliciter', or 'simple repeal', thus not explicitly guaranteeing the right to abortion. The final report explains:

> The Committee understands this recommendation to represent an effort to remove the complex and divisive issue of abortion from the narrow and inflexible confines of a constitutional provision, in favour of empowering the Oireachtas to legislate unconstrained by potential judicial intervention. Whilst the Joint Committee agrees with the substantive basis for this recommendation, it disagrees with the Citizens' Assembly as regards the manner in which this purpose can best be achieved (Houses of the Oireachtas, 2017, p. 5).

And they quite literally state that this is because the transition would otherwise be too extensive:

> Having regard to the profound, and relatively unprecedented, effect a provision such as that recommended by the Citizens' Assembly would have on the separation of powers as it is traditionally understood under the Irish Constitution, the Committee is unwilling to recommend the removal of this important supervisory jurisdiction of the Courts in an area which, without such a constitutional amendment, would so clearly fall within their jurisdiction (Houses of the Oireachtas, 2017, p. 6).

The governance transformation proposed by the Joint Oireachtas Committee was thus, once again, limited. Rather than introducing structural changes to the abortion regime, its formations were adjusted without challenging the systemic nature of control and

limited reproductive agency for women and pregnant people. Instead, I argue that the core formations of the pre-Repeal regime – systemic control of reproduction and limited agency for women and pregnant people through moral governance – were continued in the Committee's recommendations in two ways.

First of all, many of the Committee's final recommendations focused on the regulation and hierarchy of medicine as a governance mechanism. The Committee tried to hold a position that leaned somewhat towards progressive approaches to reproductive healthcare, yet they did not entirely move away from regulation and control either. There was no accommodation of full reproductive autonomy or agency. Best medical practice, for example, was used as an argument why abortion in cases of rape should fall under the general provision of abortion 'without reason' up to 12 weeks' gestation:

> In view of the complexities inherent in legislating for the termination of pregnancy for reasons of rape or other sexual assault, the Committee is of the opinion that it would be more appropriate to deal with this issue by permitting termination of pregnancy with no restriction as to reason provided that it is availed of through a GP-led service delivered in a clinical context as determined by law and licencing practice in Ireland with a gestational limit of 12 weeks (Houses of the Oireachtas, 2017, p. 9).

While this is seemingly a strategy concerned with employing legal and medical practices to the best interest of women and pregnant people, it allows moral governance to continue through limiting the availability of abortion care past 12 weeks' gestation in case of rape, and in doing so, it reinforces the moral difference between abortion in the first and later trimesters. Not only did the Joint Oireachtas Committee recommendations use medical regulation as a way to curtail reproductive rights, the medical gatekeeping also reproduces the moral framing of abortion care.

I argue that, secondly, the medicalised approach that the Committee proposed shifted moral governance from predominantly legal to medical mechanisms. The reliance on medical governance mechanisms has huge implications for medical practitioners, as I will explain in Chapter 6 'The in/visibilising of abortion care services: the need for a more provider-centred approach'. The Joint Oireachtas Committee voted to allow for abortion in case of foetal anomalies only if these are

deemed to be "fatal" by two medical specialists. Fatal, in this case, has been defined as "likely to result in death before or shortly after birth", shortly after being defined as 28 days (Houses of the Oireacthas, 2017, p. 11). The unworkability for abortion service providers and the harm that this puts on service users is will be further explored in the analytical chapters.

The Joint Oireachtas Committee's final report formed the basis of the ensuing Draft Bill and political trajectory that the government would follow to enact the recommended changes. By January 2018, the referendum was announced to take place in May and the government was likely to follow the Committee's recommendations, but it was still unclear what exact legislative procedure they would follow, and this was not without controversy.

Table 3.2: Overview of Citizens' Assembly and Joint Oireachtas Committee final recommendations

	Citizens' Assembly	**Joint Oireachtas Committee**
Issue		
Repeal Article 40.3.3	Article 40.3.3° of the Constitution should not be retained in full	Article 40.3.3° of the Constitution should not be retained in full
Form of constitutional change	Article 40.3.3° should be amended or replaced	The Joint Committee recommends that Article 40.3.3 be repealed simpliciter (removal of Article 40.3.3 from the Constitution without the introduction of any replacement or amendment text)
Constitutional provision instead of Article 40.3.3	Article 40.3.3° be replaced with a Constitutional provision explicitly authorising the Oireachtas to address termination of	

	pregnancy, any rights of the unborn and any rights of the pregnant woman	
What to include in legislation; reasons and/or circumstances for lawful abortion	Termination of pregnancy without restriction should be lawful up to 12 weeks' pregnancy	Termination of pregnancy lawful where the life or health of the woman is at risk and that a distinction should not be drawn between the physical and mental health of the woman; provision for gestational limits for termination of pregnancy should be guided by the best available medical evidence and be made by two specialist physicians
	Real and substantial physical risk to the life of the woman	
	Real and substantial risk to the life of the woman by suicide	
	Serious risk to the physical health of the woman	
	Serious risk to the mental health of the woman	
	Serious risk to the health of the woman	
	Risk to the health of the woman	
	Pregnancy as a result of rape	Termination of pregnancy that is the result of rape to be lawful up to a 22-week gestational limit
	The unborn child has a foetal abnormality that is likely to	It shall be lawful to terminate a pregnancy

	result in death before or shortly after birth	without gestational limit where the unborn child has a foetal abnormality that is likely to result in death before or shortly after birth
	The unborn child has a significant foetal abnormality that is not likely to result in death before or after birth	The law should not provide for the termination of pregnancy on the ground that the unborn child has a significant foetal abnormality where such abnormality is not likely to result in death before or shortly after birth
	Socioeconomic reasons	The law should be amended to permit termination of pregnancy with no restriction as to reasons provided that it is availed of through a GP-led service delivered in a clinical context as determined by law and licencing practice in Ireland with a gestational limit of 12 weeks

Sources: Final Report on the Eighth Amendment of the Constitution (The Citizens' Assembly, 2017) and Report of the Joint Committee on the Eighth Amendment of the Constitution (Houses of the Oireachtas, 2017)

3.5.6 The Referendum on the Repeal of the 8th Amendment

Although the Citizens' Assembly and the Joint Oireachtas Committee may have had a limited influence on people's voting, they did have quite significant political consequences. The Taoiseach at the time, Micheál Martin, came out in favour of

abortion liberalisation, and the overall political mood was to support legalisation due to the recommendations from the Assembly and the Committee.

However, when a Draft Bill was published "on the theory that people wanted to know what they were voting for if they voted to remove the Eighth Amendment from the constitution" (Carnegie and Roth, 2019, p. 114), this was more restrictive in its provisions for abortion than either the Citizens' Assembly or the Joint Oireachtas Committee recommendations. It would allow for abortion without restriction as to reason up to 12 weeks. Termination of pregnancy would only be allowed up to 22 weeks in case of a risk to life or a serious harm to health of the pregnant person. Non-fatal anomalies were not legal ground for an abortion. A mandatory three-day waiting period was also introduced.

The groups on either side had become well-known throughout the decades before. Although the anti-abortion campaigns were still framed in similar absolutist terms as they had been before, there were now some different regulations or common practices in place about giving the same amount of airtime to each side on public broadcast platforms. In the weeks leading up to the referendum, most images of cities were dominated by the posters of the 'Yes' and 'No' campaigns side by side. "While there were some technical and legal debates reminiscent of earlier referendums, the campaign coverage featured extensive personal testimony of women affected by abortion on both sides of the debate, with notable discussions on *The Late Late Show* on RTÉ1 Television and the radio programmes *Today with Sean O'Rourke and the Ray D'Arcy Show*" (Reidy, 2021, p. 40).

In her article 'Voting on Abortion Again and Again and Again' in the special issue of Eire-Ireland on reproductive justice of the Fall/Winter of 2021, Theresa Reidy looks at the effects of the different timelines of abortion campaigns. She considers campaigns since 1983, the events starting with the Citizens' Assembly, and, finally, the last few weeks before the referendum in May 2018. An emphasis on the temporal and repetitive elements of the process of the Repeal of the Eighth Amendment highlights the controlled and regulatory organising of constitutional change.

To understand the outcome of the 2018 referendum, she argues that "a long view must be taken, with referendums since 1983 examined collectively as a single long campaign" (Reidy, 2021, p. 24) and "most voters had made their vote decision before the referendum was announced" (Reidy, 2021, p. 41). Her research on Irish referendums shows that just 17% of voters arrived at their final decision during the

referendum campaign, which speaks to the longer exposure people had at that point to abortion as a political issue.

The longer history of the dominant narratives also remained present during the campaign in 2018, despite a noticeable shift to discuss abortion as an issue of healthcare. The previous debates around risk, suicide, and the protection of the unborn and of women and pregnant people, remained prominent themes. The advocacy group, Termination for Medical Reasons, had a large public presence since Savita Halappanavar's death in 2012, and this also contributed to a lingering focus on abortion as a particularly tragic experience.

Still, most people noted that it was either their exposure to experiences from people they knew, or stories they had received through media that determined their vote. In the end, the turnout was 64% and more than 66% of voters were in favour of the Repeal of the Eighth Amendment. The proposed Bill had passed relatively quickly through the different stages in the Daíl and Seanad of the referendum, and once the draft proposal of the legislation was voted for by a majority, it could be signed into law relatively quickly in December 2018.[14]

Throughout these processes of government engagement with constitutional and policy change a particular abortion politics has emerged, in which politicians choose to defend certain reproductive rights, but are not committed to ensuring reproductive justice. For example, the Minister for Health at the time, Simon Harris, committed to making abortion free (for those with a PPSN[15]), but chose to permit the mandatory three-day waiting period to remain in the law. Similarly, the Joint Oireachtas Committee recommended to make foetal anomaly a legal ground for abortion, but only in cases where it can be considered fatal. These negotiations by the various actors that were involved in the different stages of governance allowed for some provisions, yet widespread accessibility to abortion care was not ensured. Generally, there was hesitancy to move away from the draft version that people voted for. Instead, "the health committee hearings and debates in the Daíl and Seanad (the Irish Houses of Parliament) became painful exercises in repetition, as the same appeals to evidence and human rights were rejected over and over again" (Carnegie and Roth,

[14] For a timeline of the various stages of discussions of the Bill, see https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/The-Eighth-Amendment-of-the-Constitution.html

[15] The Irish Personal Public Service Number is a personal reference number needed to access public services. An Irish address is needed to be able to apply.

2019, p. 115). Conflict in abortion politics also continued, with anti-abortion advocates contesting the referendum results, and pro-abortion advocates mobilising to work towards further policy change.

In short, the more recent State interventions of change in abortion governance are marked by a high level of control and regulation of the process of change. I consider the processes of constitutional and legislative change to be governing mechanisms in and of themselves. Enright (2020; 2019; 2018) has written extensively on the conservative spaces in which these interventions take place, limiting the potential for change and the re-imagining of the Irish abortion regime, as I mentioned above, for certain aspects of the Citizens' Assembly and the Join Oireachtas Committee specifically. Additionally, the mechanisms of regulating change have a significant temporal dimension in that they work to draw out the very process through which change is considered and ultimately enacted. Rather than seeing weariness and confusion as unintended side-effects, I put forward that these experiences are precisely intended to dominate for those who are engaged in the work of transforming the moral abortion regime. Although this has now largely been separated from former connections to the ethos of the Catholic Church, other governance mechanisms such as the withholding of information, the exceptionalisation of abortion, a disregard for pregnant people's autonomy, and drawn-out governance processes, continue to have quite similar effects. The ongoing issues of Safe Access Zones is an example of this and will be discussed in Chapter 7.

3.6 Conclusion

Scholars who have worked on feminist analyses of the landscape before and after the Repeal referendum in 2018, such as the contributors to the special issue of *Feminist Review* on Abortion in Ireland of Spring 2020, have noted that the post-Repeal abortion regime fails "to break decisively" with the pre-Repeal governance (de Londras, 2020, p. 33). This contextual chapter situates the Irish pre-Repeal abortion governance within a long history of State regulation, and it reads this past governance through the lens of biopower, moral governance, and reproductive justice. That particular reading situates the formations of the past abortion regime under the framework of the Eighth Amendment and it signals a number of key mechanisms of Irish abortion governance across times and places.

In my discussion of four 'high-profile' cases, I identified the withholding of information, exceptionalisation of abortion, State violations of reproductive rights, and a disregard for pregnant people's autonomy as important pre-Repeal mechanisms in abortion governance. The challenges and public discussions around the Eighth Amendment illustrate the history and a number of the challenges, discourses, and changes in abortion politics between 1983 and 2018. Firstly, the SPUC case (1988) illustrated the systemic and hegemonic nature of the regime under the Eighth Amendment. Additionally, the X case (1992) was a first public confrontation with the embodied experience of someone who could be harmed and suffer under the restrictive and coercive governance of the Eighth Amendment. The discussion around health and risk to suicide made some lasting connections between tragedy, exceptionalisation, and allowing for abortion under very limited circumstances that echo in the post-Repeal governance and debates. The referenda that were introduced in response to the X case (1992) ensured that there was an explicit right to information and a right to travel under the Eight Amendment, sustaining the ambiguous situation for the next decades where pregnant people mainly travelled to England to access abortion care. Notable challenges to the status quo came up with A, B, and C. v. Ireland (2010), for example, of which only applicant C was successful in her claim that the Irish State had violated her right to an abortion in Ireland. Unfortunately, the death of Savita Halappanavar in 2012 made the visceral and material realities under the Eighth Amendment so prominent that it had to be addressed. Her case shows blatant ignoring of voices of women and pregnant people, not considering them full moral and agentic – as well as structural problems in healthcare. Savita Halappanavar's death facilitated possibilities for political change in that governance changes could now be made in order to 'protect women'.

A long history of drawn-out political processes, non-decisive engagement with abortion, and many committees and reports started with the Green Paper on Abortion (Department of the Taoiseach, 1999) and the following Report of the Oireachtas Committee (2000). Alongside the Green Paper, the multiple referendums held in 1992 and in 2002 signify the inability of the Irish government to address and advance issues around health and suicide under the Eighth Amendment that became increasingly important to the population. The influence of anti-abortion efforts was common and normalised to a large extent and ensured that little gains were made in improving reproductive rights over the years after the 1983 referendum. When more definitive

legislation was finally brought in with the Protection of Life During Pregnancy Act in 2013 (Government of Ireland, 2013), the mainstreaming of anti-abortion morality through the central concepts of 'protection' and 'life' became legal formations that would be influential beyond the later Repeal of the Eighth Amendment. The language and set-up of the Health Act 2018, which is still focused on permitting abortion under particular conditions and with authorisation of two medical experts, demonstrates the continued influence of the mainstreaming of anti-abortion morality in post-Repeal governance.

The government mandated processes for governance change through the Citizens' Assembly on the Eighth Amendment (2016) and the Joint Oireachtas Committee on the Eighth Amendment (2017) show the persistent and pervasive approach of legalistic, expert-driven, and exclusionary procedures that took place over a number of years in preparation for the referendum in 2018. The increased political traction of abortion as an issue of healthcare that affected people's lives in a very real way did not correspond with an increasing legitimisation and authorisation of women and pregnant people. Rather, the state remained strongly positioned as the arbiter over the population's bodies and the political procedures largely resulted in more gatekeeping from political and medical authorities.

All in all, the contextual reading of the past governance makes clear that the developments in Irish abortion governance since 1983 have not been linear, and they have been deeply influenced by the particular context of Irish society, international and national politics, and the contestations and challenges to the abortion regime. The ongoing delegitimising of alternative voices and the mainstreaming of anti-abortion influences are deeply rooted in Irish the Irish abortion governance, the traces of which ring through in the contemporary post-Repeal governance.

Chapter 4: Developing and deploying a conceptually informed feminist methodology

4.1 Introduction

My research is embedded in various disciplines and scholarly fields, reflective of my own educational background. I was trained in Anthropology, History and Religious Studies during my undergraduate degree, after which I continued my training in Cultural Anthropology during my research master's on abortion activism leading up to the referendum on the Eighth Amendment. The interdisciplinary nature of my theoretical and methodological training enables me to take on fresh perspectives and highlight unexpected angles to the study of abortion in Ireland. This disciplinary intersectionality fits well with feminist scholarship, characterised by new and transformative ways of breaking down disciplinary and epistemological boundaries to enhance the possibilities for empowerment that come from seeing connections rather than incompatibilities (Butler, 1990; Haraway, 1988; Harding, 1987). As detailed in my conceptual framework, in situating abortion at the intersections of governance, social justice, and healthcare, I propose a relatively new and unexplored way of studying abortion in Ireland (Fletcher, 2018; Nyberg, 2020). As Fletcher (2018, p.233) notes, "figuring out #RepealedThe8th will take many tellings" and "we need to feel our way through repeal's production of legal change so that this success is not reduced to some generic transferable set of legal instructions". I offer one particular telling of an examination of the transformation of the Repeal of the Eighth Amendment and I do so by "broadening and contextualising" the legal change through a reproductive justice lens (Nyberg 2020, p. 123).

The period in time which I investigate is bounded by key moments in abortion governance. The start of the historical period that forms the basis of the contextual reading of abortion governance (Chapter 3) for what I consider the 'pre-Repeal abortion regime' is 1983, when the Eighth Amendment was introduced to the Constitution. The end of this governance period, and the transition into the contemporary 'post-Repeal abortion regime', is marked by the referendum on the Repeal of the Eighth Amendment in May 2018 and fully consolidated with the implementation of the Health Act 2018 on 1 January 2019. Under the Health Act 2018, a statutory review of the operation of the act was included to be conducted three years after the implementation of the Act. The first three years of abortion care under the

post-Repeal framework therefore constitute a key period in governance and also marks the period of data collection for the Review of the Health Act 2018. The analysis in this thesis is therefore primarily situated within this three-year period, as subject to the statutory Review, from 2019 to 2021. However, I continued my data collection to include some political developments until December 2022 to further contextualise the process of governance around the Review of the Health Act 2018. Since the publication of the Review of the Health Act 2018 was delayed until April 2023, I could not include the findings of the Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018 (Department of Health, 2023) in my analysis, but I reflect briefly the developments in the Spring of 2023 in the Epilogue.

The COVID-19 pandemic provided a challenging context for research. The start of my PhD in April 2020 was at the height of various and unprecedented COVID-19 restrictions and required rapid adjustments to the original research plan I had been setting up with my supervisors since September 2019. Due to the first international lockdown in both my home country of The Netherlands and Ireland, I was not able to move to Ireland in April 2020 to conduct my research in-person. The key focus of the first year of my research was thus on developing my theoretical framework, applying for ethics approval from the Social Research Ethics Committee at University College Cork, and gaining online learning and teaching experience. It helped to a degree that all education and research was taking place online – whether that was from within or outside of Ireland. Yet the ongoing insecurity and unpredictability of the situation weighed on me and caused significant distress during the first 18 months of my PhD. I initially moved to Cork in September 2020, only to move back to The Netherlands when it became clear that Ireland would be going into an extended lockdown period. Eventually, I returned to Cork in September 2021 and stayed there for the remaining time of the PhD research.

In this chapter, I first discuss the methodology and overall epistemological underpinnings of this study, which include feminist methodological approaches, reproductive justice as a methodology, and studying abortion as healthcare. Secondly, I present the research context, including the intended research plan, recruitment, methods and institutional ethical approval as they were set up in September 2020. Subsequently, I contextualise what the research context under the COVID-19 pandemic was like, and how this affected the research plan, data collection, and

methods. I also further contextualise the political context of abortion in Ireland at the time of the research and how this informed my research practices. Thirdly, I discuss the research methods and analysis, which include a textual analysis of legal, political, medical and public documents. I expand specifically on my approach to ethnographic methods and ethnographic fiction, and how I developed this as a responsive and ethical approach to the research context. Lastly, I introduce the key textual data for my analysis.

4.2 Mapping the research methodology: illustrating the epistemological research landscape

In this section I set out the methodological and epistemological underpinnings of the research. The basis for my methodology was the theoretical framework outlined in Chapter 2, bringing together concepts of biopower, moral governance, reproductive justice, and intersectionality. The epistemological underpinnings of my understanding of what constitutes a feminist methodology, reproductive justice, and critical medical anthropology facilitate the research methods, data collection and analysis to work with the key analytical concepts of the theoretical framework. Below, I explain how tending to power dynamics, social justice issues, intersectionality, and a critical approach to biomedicine informs my methodology.

4.2.1 Positionality

As a feminist researcher, I reflect on my own positionality and how this relates to the research. My immersive, reflective approach to the research is also informed by my wider engagement with abortion politics as a researcher and activist. Many of my scholarly activities, such as conference participation, informed the analysis and discussion of the research, for example at the Reproductive Justice Research Network Conference at the University of Cambridge in April 2023, the Duke Feminist Theory Workshop at Duke University in March 2022, and the LOVA workshop on feminism and motherhood in Amsterdam in December 2021. The connections and conversations with advocates, activists, and researchers were thus one strand of my sustained engagement with abortion in Ireland and informed my broader knowledge and understanding. I build on my longer engagement with reproductive rights and justice in Ireland since 2017, when I first came to Cork to conduct six months of ethnographic

fieldwork. I am thus well-versed with the Irish context and I have strengthened my connections over the last two years by living, working, and doing research in Cork.

4.2.2 Considerations for a feminist methodology

This thesis firstly draws on feminist methodological approaches to spotlight participants' experiences of abortion which significantly differ from dominant legal, medical, and political discourses about it (Calkin, 2019). Prioritising lived experience can provide nuance to the analysis of gender and reproduction as key organising principles for regimes of power. As such, my feminist methodology contributes to more complete and situated ways of knowing that empower research participants to make their needs and experiences heard and understood. The contribution to more situated knowledge and research participant empowerment is grounded in feminist methodological commitments to critically appraise knowledge production. Brought to the centre of feminist scholarship by Donna Haraway (1988), situated knowledges acknowledge that knowledge is not neutral and objective, but rather partial and highly dependent on who has acquired it how, when, and where. Haraway specifically challenged the role of scientific research in claiming to produce objective facts. In a feminist approach that considers knowledge to be situated, the researcher is considered an active agent in the construction of knowledge (Harcourt et al., 2022; Buikema, Griffin and Lykke, 2011; Fonow and Cook, 2005; Valentine, 2003; Harding, 1992). Moreover, the boundaries between research subject and object are seen as dynamic and fluid, as are the boundaries between personal experiences and objective science. Rather than striving for objectivity, the researcher's subjectivity is considered openly and transparently (Davis and Craven, 2022). Additionally, the feminist methodology of this thesis attends to social constructions of gender and their intersections with other social categorisations, and the effects of gendered power dynamics (Braidotti, 1991; Delphy, 2002). Furthermore, the feminist principles that guide my research are to pay attention to ethical and political implications of research, to carefully consider representations of data, and to strive toward making contributions to social justice.

The key features of the feminist methodology of this research also place inquiries into social constructs around gender and sexuality at the centre (Lavinas Picq and Rahman, 2020; Letherby, 2020; Boelstorff, 2007; Bordo, 1993; Sawicki, 1991). Dominant understandings of gender and sexuality and how they are constructed and

reproduced within the biomedical system are clearly influential for abortion care access and provision. Feminist methodologies critique medical, political, and discursive gender dichotomisation and investigate what it means to hold a gender binary based on biological sex as the organising principle for healthcare (Krause and De Zordo, 2012; Murphy, 2012; Martin, 2002). In this way, investigations around how gender is both affirmed and contested through law, policy and practice around abortion becomes possible. A feminist methodological approach is thus well-suited to explore how categorisations of gender and sexuality work and how gendered power dynamics are reproduced in abortion care policies. I introduced the political nature of language around gender and sexuality in the Introduction and the theoretical framework (Chapter 2), and this is a distinct area in the analysis of the data.

4.2.3 Reproductive justice as methodology

Reproductive justice as a methodological approach provides an important further level of analysis to feminist research:

> Using the concept of multiple lenses to express polyvocal standpoints, reproductive justice allows reframing of values and demands that multiple audiences perceive as vital and fundamental to their human rights. [...] Instead of focusing on who is excluded by traditional feminist theories, reproductive justice is a sophisticated methodology ample enough to be universally adaptable, offering little purchase for claims of exclusion (Ross, 2017, p. 303).

Ross (2017, p. 301) emphasizes that there is not one way of 'doing' reproductive justice, and that, in fact, the framework's very power lies in its dynamism and inclusive approach. Reproductive justice brings a radical focus on intersectionality and inclusivity, on reproductive rights as an issue of social justice, and on abortion as part of people's broader reproductive desires (Chrisler, 2013; Ross and Solinger, 2017; Thomsen, 2013; Smith, Sundstrom and Delay, 2020). There are a number of methodological implications that stem from this focus of reproductive justice, pertaining to intersectionality and reproductive rights and as an issue of social justice, such as considering multiple viewpoints and representations in analytical work, paying attention to people's positionality for their accessibility of reproductive healthcare,

tending to people's reproductive desires, dreams, and hopes, not singular events in their healthcare trajectory, and making academic work accessible for academic and non-academic audiences.

By addressing intersectionality as a core concept within methodology, the multiplicity of marginalisations people might experience in exercising their reproductive rights can be addressed, as well as the historical and social particularity of which categories cause marginalisation and discrimination in the first place. When Crenshaw (1989) first coined the term intersectionality, it was distinctly for her legal analysis in the context of the United States. Since then, scholars of reproduction have focused on how various factors in people's circumstances and background influence their ability to exercise reproductive rights, or 'choice' in significant ways (Petchesky, 1990; Sleebaum-Faulkner, 2010; Murphy, 2012; Bell, 2014). Particularly for the research here, it is a way to interrogate how gender as a political category tends to conflate other influences on people's reproductive experiences, such as class, race, socioeconomic status, age, and abilities, for example. The application of intersectionality in methodology centres lived experiences to assess the complex ways in which inequities are reproduced and reproductive justice is limited (Sundstrom et al., 2019). Gender is a crucial organising and differentiating axis of power, but it does not work the same for all women or female identifying people. Reproductive justice scholars have importantly added to earlier feminist work by focusing on inclusivity of all different gender experiences and identities and by advocating for this within research as well as policy.

Many of the social justice issues that affect abortion care mentioned above, also affect care for people who choose to carry their pregnancies to term. Rather than seeing abortion as 'other' or distinct to other reproductive decision and other reproductive healthcare procedures, abortion can better be understood when it is seen in connection to people's broader reproductive life experiences. As Sallie Han (2013) contends, we also need to pay attention to how 'normal' reproductive experiences play out. Abortion, then, is situated also within a range of reproductive experiences and it should not be seen as separate or different from the social justice issues that go into this. Abortion is placed among the other reproductive experiences people may have had in the past, or the ideas they hold about possibilities in the future. Therefore, this research will analyse which factors specifically influence the accessibility of abortion care after the legalisation, which barriers to abortion care are identified during the first

three years of service provision, and how abortion care is incorporated into broader reproductive healthcare.

4.2.4 Studying abortion as healthcare

A critical inquiry into the medical and healthcare contexts is crucial for studies of abortion in Ireland, because it engages with the recent shift that occurred in Ireland with the legalisation of abortion. I look into the change towards abortion as a healthcare service and how abortion can now be explored as a practice and a lived experience for the people involved in its access and provision. I explore what it means for abortion seekers and providers that abortion is now part of the healthcare system by identifying and mapping abortion care as it is implemented under the Health Act 2018 (Government of Ireland, 2018) and by analysing service providers' and service users' experiences and pathways in primary and secondary care (Chapter 5). I also analyse how medical discourses are mobilised in post-Repeal political debates (Chapter 7). Thomsen (2013) and others (Morgan, 2017; West, 2009; Zampas, 2017) flag the issue that advocating for reproductive rights and advancing political change has often required activists to adopt a strategy based on "privacy, government intrusion, and health", rather than social justice (Thomsen, 2013, p. 149). Similar analyses have been made about the Together for Yes campaign on the Repeal of the Eighth Amendment in Ireland (Calkin, de Londras and Heathcote, 2020). Larger issues of autonomy and agency continue to be unaddressed within considerations of reproductive rights as an issue of government regulation and healthcare. The analysis of the healthcare context of post-Repeal abortion care in this thesis seeks to better understand how regulatory processes of reproduction side-line autonomy and agency. I highlight three further epistemological areas which will be employed to do so; lifting abortion out of biomedicine, bodies and embodiment; and the fragmentation of women's health.

Previous studies have looked at the role of online activism, digital engagement with abortion care, and what the online provision of early medical abortion pills through websites such as Women on Web have meant for abortion access and provision. Existing research explores the potential of abortion pills to expand reproductive rights (Jelinska and Yanow, 2018; Kasstan and Crook, 2018) and has concluded that self-managed medical abortion through telemedicine is highly effective

(Aiken, Gompers, and Trussell, 2017), but that there is high demand for access to information and support (Endler, Cleeve, and Gemzell-Danielsson, 2020; Foster, Wynn and Trussell, 2014) when this is not always available to all women and pregnant people (Jelinska and Yanow, 2018). The context in which telemedicine became State mandated during the COVID-19 pandemic provides a unique situation in abortion governance and the role of the State in access and provision. The shift to telemedicine is placed in the longer history of abortion governance and the analysis will consider service users' experiences with telemedicine to critically assess State considerations of agency and autonomy in the expansion of abortion care.

Additionally, research regarding reproductive health requires attending to the body in a more pragmatic way. Feminist social studies (Neyer and Bernardi, 2011), feminist critiques of healthcare regulation (Fletcher, Fox and McCandless, 2008), and medical anthropology (Whittaker, 2018) have always directed our attention to embodiment, and particularly the individual, social, symbolic, and political readings of bodies. Feminist social research on reproduction takes as the core of analysis, "an assumption of the body as simultaneously a physical and symbolic artifact, as both naturally and culturally produced, and as securely anchored in a particular historical moment" (Scheper-Hughes and Lock, 1987, p. 7). As Foucault conceptualised the body as a site where biopower is imposed, expressed, and resisted, the body cannot be considered entirely neutral or natural, nor can bodily experiences be considered universal (Foucault, 1997b; 1990). As Fonow and Cook (2005, p. 2216) state on feminist theory's influence on feminist methodologies, "contemporary feminist theory has added new ways to think about the body, and feminists now speak of writing the body, reading the body, sexing the body, racing the body, enabling the body, policing the body, disciplining the body, erasing the body and politicizing the body" (Fonow and Cook, 2005, p. 2216). The way that bodies are perceived and treated, is rooted in the particular socio-political system in which they exist, and the treatment of bodies works to reproduce the system (Fletcher, 2005; Grosz, 1994; Butler, 1989).

The fragmentation of women's and pregnant people's bodies and general health, as brought forward by Davis-Floyd (2003) and Martin (1987), conveys the idea that women's reproductive health and the accompanying healthcare are somehow different and separate from other bodily experiences and healthcare. This reinforces moral assumptions regarding abortion and crisis pregnancies. Additional fragmentation is important to consider for reproductive justice in Ireland:

fragmentation between women's bodies and health, and transgender, non-binary and intersex abortion-seekers. Thus, significant attention needs to be paid to the different levels of embodiment that are relevant for reproductive healthcare: the embodied experiences of people accessing and providing care; the stratification of bodies based on different social categories, such as age, gender, and race; and the management of the body politic through reproductive health policies. In the context of this study, that means that the research is concerned with the collection and analysis of different levels of data, such as lived experiences with abortion care, legal, medical, and political documents, and political discourses, without privileging one over the other.

4.3 Research context

Various qualitative research methods have been regularly used by feminist and reproductive justice scholars to address the themes that I identified above. In my initial research plan, I set out to use qualitative methods with semi-structured interviews with service users and service providers of abortion care at the core of my data collection. I received ethical approval for the research plan from University College Cork's Social Research Ethics Committee in September 2020 (Log 2020-141). I planned to follow a reproductive justice-based list of interview questions to make sure I would address particular topics but allow for enough flexibility in the interview for whatever would be brought up by participants (see Appendix 10 for the lists with interview questions that I intended to use). The interviews would be supplemented by more informal conversations with participants, participant-observation at various public events, as well as discourse analysis of the abortion policy documents and content analysis of available information on abortion. I planned to conduct interviews with 20 to 30 informants, comprising of 10 to 15 women and pregnant people who have accessed abortion in Ireland and 10 to 15 medical professionals who are providing abortion in Ireland. I was to use purposive and snowball sampling to gain access to research participants through at least two advocacy organisations that I had been in touch with for my master's research, the Abortion Rights Campaign and Doctors for Choice. However, the onset of the COVID-19 pandemic radically disrupted this plan. The COVID-19 pandemic and ensuing public health measures had a lasting impact on research practices, and I had to make various adjustments to contend with the circumstances of largely online and remote research. Moreover, I became increasingly

attuned to the care and ethics I wanted to enact in conducting research on abortion in Ireland. The particular historical political context of asking people to share their stories in statutory governance processes as I described in Chapter 3, combined with the impact of a global pandemic, sparked further reconsideration of my research methods.

4.3.1 Unstable times and spaces: Research context under the COVID-19 pandemic and reimagining the research plan

When the pandemic broke out in March 2020 and restrictions were imposed on people's movements, many people experienced an enormous change in their daily lives. All of a sudden, we were confined to our homes and our time was no longer spent doing many of the activities we used to engage in in the ways we had become accustomed to. For abortion care, this had huge implications. Access to healthcare in general was now restricted and difficult. Most healthcare facilities had extremely high levels of occupation and many other medical services were suspended or delayed. In addition to the COVID-related complications to abortion services within Ireland, there were many people who still had to travel outside of the state to access abortion care due to the ongoing restrictions under the legislation (Chakravarty et al., 2023). With international travel restrictions in place and varying regulations in different countries, this was also increasingly complex. Furthermore, medical practitioners had to grapple with developing a relatively new range of services for which long-standing practices of medical education, training and abortion had not yet been developed. The pressure of providing urgent care combined with limited patient capacity was hugely exacerbated during the COVID-19 pandemic and pressure on medical professionals increased significantly (Vizheh et al., 2020).

Within this context I grappled with the question of how I, as a feminist researcher, could navigate the rapidly changing and unsettling landscapes of abortion politics, pandemic life, and research requirements? Foremost in my deliberations were concerns about how, in the context of a pandemic that was radically disrupting abortion care and all other health services, I could ethically ask participants to take part in research?

In response to the national and international COVID-19 pandemic regulations in the spring of 2020, I adjusted my research to conduct interviews and participant observation through online and digital technologies. I also shifted the focus of my

research to include how the digital and telemedicine engagement, which emerged in response to COVID-19 restrictions, impacted abortion care. I would do my interviews online through Teams or Zoom, and I would attend public meetings virtually too. I thus set out to conduct my research through mostly online and digital methods, with interviews still firmly at the core of my data collection. I started with purposive and snowball sampling to find research participants through the contacts I had among abortion advocates and activists.

4.3.2 Attuned considerations: continuous engagement and conversations

While my calls for participants for online interviews were shared on social media and circulated by advocacy organisations by the summer of 2022, they were not getting any traction, prompting me to reflect on why that might be. I continued attending online events and gathering digital material. I had been noticing a recurring theme: the fatigue, trauma, and emotional labour that pregnant people and reproductive justice advocates have experienced was a prominent topic for speakers at events, such as the Rebels Reactivate Repeal online series organised by the Rebels for Choice in Cork in the summer of 2021. It was also discussed during the Abortion Rights Campaign meetings from February to March 2021, when I participated in the writing of the Joint Submission from Abortion Rights Campaign (ARC), Abortion Support Network (ASN) and Termination for Medical Reasons (TFMR) for the 29th Session of the UPR Working Group (ARC, 2021). Not only had they experienced the impact from the long history of political activism to legalise abortion and from the many continued discriminations within sexual and reproductive healthcare, but they were also hugely impacted by the need for self-disclosure and storytelling in bringing about political change in reproductive healthcare and reproductive rights in Ireland (Murphy, 2020). On top of that, the gendered effects of the pandemic (Connor et al., 2020) compounded these experiences and brought them sharply to the forefront of daily life for most people involved in some type of reproductive justice activism or advocacy. These findings during the participant-observation process sparked reconsiderations of my approach to data collection.

The discussions on the impact it can have on people to disclose their personal experiences for research and for political change (Healey, 2008) encouraged me to take a deeper look at how feminist research can ethically and politically accommodate

participant engagement. The particularly taxing context of the pandemic, in combination with the particularly taxing topic of experiences with abortion care, drew my attention to and encouraged me to re-conceptualise, my research design and methods. I was committed to look for different ways of collecting and engaging with data. Rather than placing more strain on people by asking them to participate in online interviews, I decided to focus on textual data collection through an online form where people could submit their own written stories of their abortion experiences. In that way, they could enact more agency over when and for how long they chose to dwell on their experiences, and they could share their stories in their own words. I received ethical approval for this adjusted research plan in June 2022 (under Log 2020-141A1).

Many researchers adopted remote, online, digital methods rather than doing in-person qualitative research during the COVID-19 pandemic. However, digital ethnography has generated attention for some time in the social sciences (Burrell, 2016, Boelstorff, 2012). Virtual or digital ethnographers have been at the forefront of looking at online research methods and how online experiences interact with offline social experiences (Boelstorff, 2012; Pink et al., 2015). More recently, anthropologists working with queer, crip, and intersectional approaches, among others, have proclaimed re-imaginations of 'the research field' and ethnographic data to accommodate for more adaptable, creative, and situated research methods (Durban, 2022).

In addition to this, Günel, Varma and Watanabe (2020) have outlined the need to rethink "fieldwork as a process that entails spending a year or longer in a faraway place" in their Patchwork Ethnography Manifesto published on the Society for Cultural Anthropology website. They take the COVID-19 pandemic as a turning point to address feminist and decolonial critiques about immersive, qualitative methods that were already present, but continued to be side-lined. They contend that COVID-19 has made impossible for many scholars what already was extremely difficult before (Günel, Varma and Watanabe, 2020). The factors that were previously mostly perceived as obstacles to conducting in-depth, qualitative research and were often sought to be minimised, if not overcome entirely, became increasingly discussed as potentially transformative for qualitative research methods to be more inclusive and accessible. An increasingly flexible and adaptive, mostly digital and remote approach to qualitative research and a recalibration of the values placed on particular methods,

also opened up possibilities for a feminist researcher to take a more ethical approach. I explain how I did so and what this meant for my particular research methods.

While I kept waiting for responses to my requests for written stories on abortion experiences to come in, I engaged with data that was already being published. This included research reports from studies by the National Women's Council (Kennedy, 2021), Abortion Rights Campaign and Grimes (2021), and later the government-endorsed Unplanned Pregnancy and Abortion Care Study (Conlon, Antosik-Parsons, and Butler, 2022), and the stories shared by people in online meetings organised by the NWCI, ARC, and the local Cork pro-abortion group Rebels for Choice[16] throughout 2020 and 2021. I also reflected on the idea of seeking out alternative ways of collecting data. I approached my many experiences outside and inside Ireland as a constellation of places where experiences with abortion are stored, shaped, shared, and can be heard and read. That consisted of engaging with online library collections; scouring digital repositories; scanning digital government platforms; attending online activist meetings; clicking on Twitter threads; sifting through government documents; closely reading advocacy reports; paying attention to news articles; listening to radio and tv fragments and podcasts; and having conversations with friends, strangers, supervisors, colleagues and students. These were multiple research and data collection methods through which I developed a better and richer understanding of the complexity, the vulnerability, and the fragility of the research topic and area, and an awareness of where data could be found.

With this increased understanding also came an increasing discomfort. The doubts I had about ethical and political implications of asking people to narrate their experiences kept gnawing at me. Particularly in a context in which a statutory review of abortion care was taking place and where historically people had to lay bare grief and hurt in order to ask for understanding, empathy, compensation, and political change from the State.[17] My ongoing reflections on the implications of asking people to narrate their experiences with abortion care were more and more informed, and also became more attuned to the particular circumstances of the people I was asking to

[16] Rebels for Choice are a pro-abortion activist group in Cork. They are a local branch of the Abortion Rights Campaign and were part of the Together for Yes campaign for the Repeal of the Eighth Amendment.

[17] See for example an interview with Karen Sugrue on Safe Access Zones on NewsTalk on 10 August 2021, Elaine Loughlin's article on 7 August 2021 in the Irish Examiner on the same issue, and the work by Murphy (2020) on the visceral impact of campaigning for the Repeal of the Eighth Amendment.

participate in my research. Most importantly, however, responses to the calls for written contributions also remained absent. That was perhaps the most powerful signal potential participants could send me. In relation to the feminist methodology outlined in this chapter, the abovementioned developments required reflection of how feminist research seeks to capture women and pregnant people's voices and what this might mean ethically in practice.

4.3.2 Ethical feminist practices and ethnographic fiction

A number of British sociologists working on reproduction and family life suggest that it is possible that the best way to enact care for interlocutors during the pandemic was to *not* ask them to participate in research (Faircloth, Twamley and Iqbal, 2020). In the history of qualitative research on reproduction, scholars of reproduction have also noted that reproductive experiences are research topics that require a particular caring and ethical approach (Rapp, 1999). Continuously increasing my understanding of the research context and topic, I finally added up the different factors: firstly, the considerations about how to re-imagine methods for research under pandemic circumstances on personal, sensitive, political topics while also caring for research participants; secondly, the embodied consciousness and awareness I was developing throughout my research; and thirdly, the signals I was picking up on from my participant-observation. Rather than asking people to re-tell and re-live their experiences – whether that is in an interview or through a written account - I turned to the methods of ethnographic fiction, drawing on the work of Davis (2005), Ellis and Bochner (2006), and Ingridsdotter and Kallenberg (2018), in addition to focusing on the analysis of reports and documents, participant observation and fieldnotes.

I was first exposed to the concept of autoethnography as a feminist methodology in a lecture by Professor Christine Davis at University College Cork in November 2021. As part of her time as a Fulbright scholar conducting research on identity and female bodies in Ireland, Professor Davis gave a number of talks on feminist methodology, body politics, and palliative care. It immediately appealed to me in the way it seemed to enable researchers to work their own positionality and reflexivity into their written work, in that it provides a way to critically approach how knowledge is generally produced through accepted genres of academic writing, and how it holds space for more embodied experiences and knowledges to surface. Her

lecture provided a powerful introduction to different genres of ethnographic writing, such as Davis' work on ethnographic fiction, as well as that of her mentors and supervisors, Carolyn Ellis and Arthur Bochner.

Ellis and Bochner have been pioneers in writing about methodologies for experimental and creative ethnographies. They have written and edited extensively on autoethnography (Bochner and Ellis, 2002; Ellis and Bochner, 2006; Ellis, Adams and Bochner, 2011), but also on finding different creative, reflective, aesthetic practices of thinking about, doing, and writing qualitative research. Furthermore, ethnographic fiction has been identified as "crossdisciplinary, epistemological, feminist, holistic, meaningful, social, reciprocal, inclusive, deeply felt, rooted in our past, not always rational, oftentimes messy, and rebellious" (Boylorn, 2016, p. 14). What autoethnography, narrative ethnography and ethnographic fiction all have in common, is that they are a way for the researcher to account for positionality, reflexivity, and ethics; a way to convey embodied experiences "and to contain and represent the complex, emotive, fluid and dynamic nature of these experiences" (Inckle, 2010, p. 27). Moreover, it is also a commitment to engage with audiences beyond academia and disseminate research outcomes in different settings and platforms (Boylorn, 2016). Questions of representation and dissemination in academic writing are not new (Clifford and Marcus, 1984; Fassin, 2014), but more recently, scholars especially tried to work with different forms of writing to reproduce and imagine data, analysis, and knowledge differently and ethically (Haraway, 2013; Ticktin, 2019; Meek and Neely, 2023; Yates-Doerr, 2020).

The analytical process of generating ethno-fictional vignettes involved a nuanced interplay of ethnographic inquiry and creative expression. Unlike autoethnography, which often relies on the researcher's self-reflection on their own experiences, ethno-fictional vignettes weave together imaginative storytelling with ethnographic insights and thematic analysis. Drawing inspiration from Davis and Ellis (2008), this approach employs fictional narratives as a methodological tool. I first analysed the available data (documents and fieldnotes from participant observation and conversations) through the conceptual framework, identifying dominant topics and themes through the six-step process that Braun and Clarke (2006) developed. Once I had coded for and identified dominant themes, rather than incorporating quotes into the analysis, I engaged in creative writing to write narrative fiction in the first and third person. Ethno-fictional vignettes, therefore, offer a blend of critical thinking, analysis,

and scholarly observation, presenting a textured understanding of the researched context. In comparison to feminist speculative fabulation, ethno-fictional vignettes share a creative dimension (Nash, 2020). However, while feminist speculative fabulation often ventures into the speculative or fantastical realms, sometimes based on a lack of (archival) data, ethnographic fiction maintains a closer connection to existing data. It seeks to illuminate cultural nuances and societal dynamics through a creative lens without fully departing from the empirical foundations of existing data which has been collected previously.

Despite the innovative potential of giving voice through ethnographic fiction, it is crucial to critically reflect on its limits. The idea of 'giving voice' often assumes a level playing field, overlooking power dynamics inherent in research, and the tension between representation and creative expression calls for a careful ethical navigation. While ethno-fictional vignettes hold the promise of a more engaging and empathetic research narrative, they must be approached with a conscious awareness of issues around representation in ethnographic texts, as has been a longstanding issue in ethnographic research (Geertz, 1973; King, 2007).

I engage with ethnographic fiction as an inquiry into the different types of data and as data - a critical reflection of how official discourses and lived experiences are related and how we can read larger political, cultural and social dynamics in people's experiences. It is a way of "both conducting and representing research" (Inckle, 2010, p. 28). Ethnographic fiction enables me to connect the macrolevel politics of abortion to the granular everyday reality of people accessing and providing abortion care (Ingridsdotter and Kallenberg, 2018). My approach contributes to work on reproductive justice and intersectionality by foregrounding different ways of knowing and making embodied experiences and knowledge visible.

Although many of the authors working on ethnographic fiction often still collect primary data through semi-structured interviews, I bring a different approach to this methodology. I highlight that ethnographic fiction is also a particular feminist practice, and it fits with earlier calls from feminist researchers about the re-using and re-imagining of data (Meek and Morales Fontanilla, 2022; Haraway, 2016). Working with textual, publicly available data brings up critical reflections on the implications of knowledge creation and the position of the researcher. For this reason, working with publicly available data has been propagated as an insightful and ethical research practice by feminist scholars since long before the COVID-19 pandemic and the recent

calls for situated research methods. Haraway (1988) famously shed some light on the re-using of data in reminding us that it is much more about creating situated knowledges and looking into different ways of producing knowledge outside of the hegemonic structures of academia, not about how much or how little we know of a topic.

My own feminist understanding of knowledge production had made me aware that I would not be able to provide an exhaustive overview of all factors that go into people's experiences with abortion care. Nor did it seem ethically appropriate to ask for first-hand accounts of lived experiences in my research context. Yet, what I could do is use qualitative research and qualitative methods for deep inquiry and reflection and to convey the meaning of people's experiences in a creative way. I did have three conversations with a general practitioner and a medical specialist who provide abortion care, and a counsellor who works with people with an unplanned pregnancy.[18] These people were known to me through my activism work in the Cork area and the conversations helped me to better understand the context and how abortion is implemented as a healthcare service. Through fieldnotes and these informal expert conversations, and my ongoing reflective engagement in advocacy and activist activities, I engaged with my research data in a very personal, embodied way. I see the ethnographic fiction in this thesis as testimonies of my immersive research engagement with abortion governance and experiences with abortion care. It is informed by my situated ways of knowing and understanding, and constituted into textual data, which often do not find a way to the surface in academic publications.

4.4 Introducing the key publicly available documents

The methodological approach and the feminist commitment to ethnographic fiction, and working with qualitative methods in ethnographic fiction, led me to work with the following data. My political positioning through my conceptual framework and through Chapter 3 'Contextualising Irish abortion history' has informed my rationale for what to include as data. The corpus of data that is produced in this thesis works as a form of political archive which might be a resource for future researchers. The data collection is thus politically and ethically informed based on the conceptual as well as the contextual understanding of abortion in Ireland. The conceptual and contextual

[18] See Appendix 1 for more details on the conversations with these (anonymous) professional experts.

basis of Chapter 2 and Chapter 3 also inform the textual analysis of publicly available documents. Following Fonow and Cook's (2005) process-driven methodology, I read and re-read public documents (3 legal documents, 10 policy documents, 5 medical guidelines, transcripts of 6 political debates, 10 research reports, 4 press releases, and 14 online and offline resources for service users) and coded for the core analytical concepts of my conceptual framework (biopower, moral governance, reproductive justice) in NVivo to analyse if and how these themes emerged.

The corpus of data is comprised of a number of different materials. A complete overview of the data is included in Appendix 1. The various research reports and submissions that have been submitted to the government Review by various pro- and anti-abortion advocacy organisations are important sources of data. The reports inform the processes around governance and how various actors involved in abortion care engage with abortion politics. The pro-abortion organisations that submitted reports to the government for the Review advocate for expanding access to abortion care. Empirically, the data in their reports identifies the continuing barriers, obstructions, gaps, and limits of Irish abortion law and provision. Submissions from anti-abortion organisations argue for the acknowledgment and examination of negative outcomes of the legislation and the reduction of the number of abortions taking place in Ireland. The Unplanned Pregnancy and Abortion Care (UnPAC) Study (2022) commissioned by the Health Service Executive as part of the Review of the Health Act 2018 and conducted by Dr Conlon, Dr Antosik-Parsons and Dr Butler at Trinity College, is a key source in the corpus of work considered in this chapter. Other important research is the report by the National Women's Council (Kennedy, 2021), the Abortion Rights Campaign and Grimes (2021), the European Abortion Access Project (Mishtal et al. 2022b; Zanini et al., 2021) and the publications resulting from the WHO commissioned research on the implementation of abortion care in Ireland (Chakravarty et al., 2023; Mishtal et al., 2022a).

Since the enactment of legalisation of abortion and the commencement of service provision, two separate Bills have been proposed by two different cross-party initiatives. One is the Safe Access to Termination of Pregnancy Services Bill 2021 and the other is the Health (Regulation of Termination of Pregnancy) (Foetal Pain Relief) Bill 2021.[19] It is very telling that the two legislative proposals that have been brought

[19] Hereafter referred to as Safe Access Zones Bill and Foetal Pain Relief Bill respectively.

forward concern the issues of safe access to abortion services and foetal pain relief as part of abortion services. These developments show the contrast of two opposing anti-abortion and pro-abortion discourses and political standpoints inherent to the relational notion of power within a moral regime, as I explained in my theoretical framework. The debates on these two Bills that have been held in the Dáil and the Seanad form the basis for the data of the political debates in the dataset. Additionally, the Oireachtas Committee on Health meetings on the Review of the Health Act 2018 are included too.

The role of medical professionals in implementing abortion policies and shaping the practices of care are considered through the documents on clinical guidance that have been set out for abortion provision. By using the medical guidelines that have been made available to date, I map out how the production of medical knowledge and standards for medical practice are set out in compliance with the abortion legislation. Additionally, secondary research articles on providers' experiences (Calkin and Berny, 2021; Dempsey et al., 2021; Grimes et al. 2021; Spillane et al., 2021; Horgan et al., 2021; O'Shaugnessy, O'Donoghue and Leitao, 2021; Power, Meaney and O'Donoghue, 2021; Taylor, Spillane and Arulkumaran, 2020; Duffy, Pierson and Best, 2019) are insightful for the ways in which medical practitioners have adapted to the new professional landscape.

Furthermore, news articles give a sense of the public debates around abortion, they demonstrate how the discussions of these legal, medical and political issues are addressed in popular platforms. They are a source to see how knowledge gets (re)produced. I took a look specifically at news articles (the search included The Irish Times, the Irish Independent, the Irish Examiner, RTÉ News and The Irish Medical Times) around the anniversaries of Repeal in 2019, 2020 and 2021 in order to gain a sense of how Repeal continues to be discussed in relation to the unfolding the service provision.

4.5 Conclusion

In this chapter, I first explained the epistemological underpinnings to the methodology of this study. The methodological approach combines understandings of feminist methodology with a focus on power, gender and sexuality, and facilitates the exploration of how social constructions and categories of gender and sexuality are

produced and reproduced in abortion governance (Davis and Craven, 2022; Lavinas Picq and Rahman, 2020; Letherby, 2020). The embodied, lived experiences with abortion care, as different from political, legal, and medical governance, are placed at the centre of research. The feminist principles guiding this methodology are informed by the ethical and political implications of research, the situatedness and partiality of the research and researcher. Additionally, reproductive justice as methodology focuses on intersectionality and inclusivity, exploring how multiplicities of marginalisations work together to shape people's access to reproductive care (Ross, 2017; Ross and Solinger, 2017). For this research, this means that multiple factors in the accessibility of care and provision are investigated together and that abortion is framed among other reproductive experiences and social issues. This methodological focus particularly informs the ethno-fictional vignettes. Moreover, studying abortion as healthcare from a feminist perspective means to take a critical approach to any medical regulatory mechanisms (Krause and De Zordo, Whittaker, 2018). Since the legalisation, abortion can now be considered and studied as a healthcare service and practice, and this requires a critical consideration of how biomedical practices also exercise control to an extent. Understandings of how bodies and embodiment are relevant on different levels, from the body-politic to the embodied agency and autonomy an individual enacts, inform how this thesis considers bodily experiences and regulations (Fletcher, Fox and McCandless, 2008). The fragmentation of women and pregnant people's health, through which dominant understandings of (female) reproductive healthcare is seen as separate from other healthcare services, is especially pertinent for abortion (Davis-Floyd, 2003). By analysing different types of data – political and public discourses, policy documents, and lived experiences – the methodology accounts for the political implications of healthcare.

Furthermore, I have contextualised what the research context was under the COVID-19 pandemic and how this affected the research plan. With adjustments for online and digital methods, the intended research plan in September 2020 included ethnographic research methods facilitated through online and digital technologies, with remote interviews still at the centre. I struggled and grappled with questions of how to ethically ask people to participate in research, when the COVID-19 pandemic was a taxing context for anyone, but particularly for abortion service users and providers. I found support in other ethnographic researcher's approaches who were finding ways to adjust traditional ethnographic research methods and to recalibrate the

values that are places on particular methods and data over others (Durban, 2021; Faircloth, Twamley and Iqbal, 2020; Günel, Varma and Watanabe, 2020). I approached my data collection holistically and immersive in a constellation of places and spaces, online and in-person, where information on abortion care was discussed, shared, stored, and distributed.

My increasing understanding of the political context and history of abortion in Ireland also increased my discomfort in asking research participants for disclosure of their experiences for a research project. I first adjusted my data collection to focus on textual, written accounts that people could anonymously submit, but when responses remained absent, I considered this a powerful signal from women and pregnant people, as well as service providers, that I needed further adjustments of my research methods. All the developments in the research context required reflection of how feminist research seeks to capture people's voices, what this might mean ethically in practice, and how researchers can take a flexible and adaptive approach throughout their research.

The considerations about how to re-imagine methods under pandemic circumstances on personal, sensitive, political topics while also caring for research participants, the consciousness and awareness I was developing throughout my research, and the signals I was picking up on from my participant-observation, led me to work with ethnographic fiction as a research method in addition to the analysis of reports and documents, reflective engagement and fieldnotes (Ingridsdotter and Kallenberg, 2018; Inckle, 2010; Davis, 2005). The ethno-fictional vignettes are also data, based on my immersive and reflective engagement with abortion politics in Ireland. I see these different types of data as adding to and supplementing each other, not as hierarchical. My approach is interdisciplinary, intersectional, and creatively messy as it continuously developed and emerged within the research context and circumstances.

The research methods, analysis and data collection are thus politically and ethically informed based on the conceptual as well as the contextual understanding of abortion in Ireland. The full overview of all data is included in Appendix 1. In this chapter, I introduced some of the key publicly available documents, which include various research reports, such as the Conlon, Antosik-Parsons and Butler (2022) UnPAC Study, ARC and Grimes (2021), Kennedy (2021), and the WHO research conducted by Mishtal et al. (2022a). Additionally, policy documents and political

debates around the two Bills that have been introduced between 2019 and 2021, the Safe Access Zones Bill and the Foetal Pain Relief Bill, as well as scholarly research on service providers' experiences constitute key data. With this situated and conceptually informed methodology in mind, I turn to the analysis in the next chapters.

Chapter 5: Regime transformations: identifying and mapping abortion governance post-Repeal

5.1 Introduction

This chapter illustrates the abortion care landscape since the enactment of legalisation in 2019. The analysis of data from research reports from the UnPAC Study (Conlon, Antosik-Parsons and Butler, 2022), Mishtal et al. for the WHO (2022a), and ARC and Grimes (2021) gives an overview of how the 'new norm' of abortion services has been laid out. Situating abortion care within the particular time frame of the first three years of service provision, the analysis captures the delivery of services and gives an overview of how abortion care has taken shape in practice. I connect the macrolevel and microlevel perspectives here, in how moral governance is continued through high-level barriers as part of the law, but also how this becomes experienced by service users and enacted by service providers. In the conceptual framework, I referred to reproductive governance as an analytical tool to identify which actors are involved in abortion governance and which governing mechanisms they employ (Morgan and Roberts, 2012, p. 241). Politicians, abortion providers and abortion service users, pro-abortion advocates, anti-abortion advocates, international bodies such as the World Health Organisation, non-providing physicians, the general public, as well as the legislative controls, economic incitements and other governance technologies themselves, are all part of an assemblage of abortion governance in Ireland. I identify and map the important actors and technologies involved in abortion governance, which allows me to reveal ongoing difficulties in abortion care for service users and service providers.

In addition to research reports on service provision, I draw on the information and data that has been published by the Irish government, but also by advocacy groups, such as the National Women's Council, Abortion Rights Campaign, Sligo Action for Reproductive Rights Access, Amal Women's Association, and professional medical organisations and programmes, such as the Royal College of Physicians of Ireland.[20] I do not aim to create a complete picture of abortion provision in Ireland, rather I bring forward how knowledge production is inherently partial and situated (Strathern, 1987; Haraway, 1988). However, I do wish to draw attention to the gaps and absences in the State's discourses on abortion care. The government's statutory data collection on

[20] See Appendix 1 for the complete data overview.

abortion services, which is published yearly in an Annual Report around the end of June, includes the number of abortions that have taken place, their location, and the grounds on which the abortions were performed (Department of Health, 2020; 2021; 2022). No additional demographic data about the service users is collected, hence very little is known about the people who access abortion care and their experiences. Mapping out the available data and information on abortion in Ireland is thus a means to demonstrate where gaps in our knowledge of abortion are located, how knowledge is created in collaboration with the digitally available information and data on abortion services, and to mark out areas of production and dissemination of knowledge to explore in the subsequent analytical chapters.

In this chapter, I first employ the second ethno-fictional vignette of the thesis to connect the issues that the analysis of the chapter identifies to embodied experiences of the analytical outcomes. Secondly, I introduce the Health (Regulation of Termination of Pregnancy) Act 2018 as a key document for the process of mapping and identifying abortion service provision. The specific grounds for abortion and how they shape the set-up of care provision are outlined. In the third section of this chapter, I analyse the information on abortion providers by first discussing hospital provision and subsequently community care provision. Fourthly, I analyse the information on abortion service users. I critically appraise the statutory data from the first three years of service provision to address ongoing issues for service users. In the fifth section, I discuss a particular problematic feature of post-Repeal abortion care, namely the ongoing travel abroad for abortion seekers. I analyse how the ongoing need to travel for abortion care is a particular consequence of post-Repeal abortion governance, and how it is a continuation of pre-Repeal governance formations. In the conclusion, I will bring together the key findings from the identifying and mapping of post-Repeal abortion governance, reflect on how the vignette illustrates these findings, and what the conceptual implications are for the further analysis of discursive developments in abortion politics during the first three years of service provision.

The ethno-fictional vignette below illustrates some of the difficulties that come with gaps in service users' knowledge of abortion care, a lack of clarity on available services and how they work, and the multiple barriers that shape care experiences and access. The difficulty in trying to find information and understand everything that is available through service providers or women's health services can cause significant distress and delays for abortion seekers. I want to highlight the material reality for

abortion seekers first, before turning to the rest of the analytical outputs, in order to primarily acknowledge the consequences for women and pregnant people.

Ethno-fictional vignette 2

Her phone rings as she is getting ready for the telephone appointment. With a sigh she swipes the red icon over the screen and watches "mama" move away and give way to her phone's home screen. She goes to the bathroom one last time before she has to leave. She knows it's unlikely, but she can't help and check for blood a few times every day.

The cold surface of the toilet seat touches her thighs as she sits down and checks her underwear. The black fabric seems to stare back at her mockingly. No sign of blood.

She sighs and resists the urge to cry. She pulls her underwear back on, zips up her jeans and washes her hands.

She looks at herself in the mirror. Her large brown eyes look back at her. Skin blemish-free, with a few freckles on her nose. A familiar sight. Nothing in her face shows what is going on inside of her.

She leaves the bathroom of the student accommodation and goes back into the bedroom. She closes the door behind her quickly, not in the mood to talk to any of the other students with whom she shares the living room, kitchen, and bathroom.

She lies on the bed for a while, tracing the circles of mould and moisture on the ceiling.

Her phone rings again. This time the screen shows a number that she doesn't know. "Hello?"

"Hi, is this Mariana? This is Maureen from Gianna Care."

"Hi, yes, this is Mariana. Thank you so much for calling me."

"No problem at all, love. Now, would you tell me a little bit about yourself and your baby?"

She feels a strange tug in her stomach when she hears the word 'baby.' She hasn't allowed herself to think of it as such, to think of it as anything, really. She remembered the biology classes in secondary school; the foetus is about the size of a bean right now. A sense of discomfort comes over her, but she remembers how hard it was to make sense of the different centres and services.

She had arrived in Cork about a week ago to do her Master's in University College Cork. The first few things that she had done after she arrived were get an Irish sim card, set up a bank account, request a PPS number, and sign up for the English language course that the university provided for students. It had been hard to make sense of the information when she Googled 'pregnancy and abortion Ireland,' as she still wasn't fluent in English and a lot of the biological and medical terms were unfamiliar to her. Gianna Care was one of the first organisations that had come up and they were available 24 hours a day.

"Ehm, well I, I just found out that I am pregnant, but I really have no way of taking care of a baby. I would like to know where I can get an abortion."

"Right, and that is completely understandable, but maybe I can talk some of it through with you? I understand the pregnancy was unexpected, but there might be more help and support for you to continue the pregnancy than you might realise. You owe it to yourself to be informed of all your options, and to make the decision that is best based on all the available support. We might first talk about some of the

symptoms of your pregnancy, or whether you have already done a test to confirm? We can help you with that too, if you need a test to be sent to you just to make sure, or you can call in to us. Then we can take it from there and we could perform a free ultrasound too. And if you need any financial support, we have availability of that as well. We just want to make this all easier on you."

Mariana felt the tug in her stomach pull tighter.

"Oh... Thank you, that's very kind, but can you actually get me an abortion? I know that it can be done with pills, so I am just trying to find where I can get them."

"But sure, you should try and think that over? Why don't you just let us help you to confirm the pregnancy and the baby's health first? Take some time to think about it. This will be the best thing that ever happened to you!"

Before she fully realised what she was doing, she hung up and threw the phone onto her bed. Shock filled her and she could feel the tense feeling in her stomach rise up to her chest. She'd read about rogue centres, but she somehow just hadn't expected to encounter them here, in Ireland.

"What am I going to do now?"

* * *

The university website lists the services their Student Health offers. 'Women's Health' is on there, but what does that exactly include? Contraception and Sexually Transmitted Infections are mentioned separately, but nothing on other reproductive health services. Mariana realises that she is going to have to call them to find out. She feels a little nauseous. After the phone call with the rogue centre, she had to gather her courage all over again to come up with another plan of accessing information.

She sighs.

It's difficult to talk to strangers on the phone in English, but it's even harder now that she isn't sure what to expect.

Will they give her information? Will they be judgmental? Will they try to convince her not to have an abortion? Will she have to explain herself?

She takes another sip of her coffee, and then dials the phone number on the website on her phone. Focusing on her breathing, she waits as the line rings.

"Student Health Department, good morning. How can I help you?"

As Mariana explains her situation to her and asks for information, the response she gets this time is entirely different. She feels understood, heard, and reassured. She is left with the phone number and a web address for My Options, where she supposedly can get the contact details of a doctor who provides abortion care. She cries a little afterwards, and finishes her coffee outside in the September morning sun.

* * *

She looks at the short, white building. There is only a small sign next to the door, confirming that she has the right place.

Although it had taken two more phone calls, one to My Options and one to the General Practice that they had referred her to, she finally managed to make an appointment with a GP who was supposed to provide her with an abortion.

When she sits inside the consultation room and listens to the doctor making small talk, the relief that she felt initially when she talked with the Student Health Department, slowly starts to move through the rest of her body. She feels her muscles relax, her shoulders lower, and her breathing becoming deeper and more even.

The doctor reassures her and explains that she will be able to take the medication home with her. She will have to take the first medication when she comes back to the clinic after three days. 24 hours later, she will take the second medication at home. She receives a leaflet that explains the procedure to her, and it outlines what the doctor is explaining to her about the amount of bleeding and pain that she can expect. Two weeks after the abortion, she will take a low-sensitivity pregnancy test to confirm of the abortion was complete.

The doctor takes a urine sample to confirm the pregnancy, and they talk about when she realised she might be pregnant. The doctor establishes that it has been six weeks. She won't need a scan, because it's still a very early pregnancy. He tells her that her situation is relatively straightforward, and that she doesn't have to worry about the procedure. It feels nice to be reassured.

Afterwards, in the waiting room, she stares at the blank space by 'PPSN' on the registration form of the practice. She submitted a request for a PPSN on the MyGovID website last week, but she hasn't received anything yet.

She asks the assistant at the reception desk.

"Hm right, well you will need it to be able to receive the medication. We need to register your number for the administration of the claim.

"I have applied for one, but I don't know when I will get it."

"I tell you what, why don't you leave it now, but fill out the rest of the form. Then I will look into it for you and call you back tomorrow."

"Alright…" she mutters, as she can feel her shoulders tense up again.

***

"Mariana? Hi. This is Erin from the GP practice with Doctor O'Connor."

"Hi, Erin."

"I am so sorry, but we will not be able to help you without a PPSN, unless you can pay for the procedure yourself. Otherwise, you will have to wait until you receive one and get back to us then."

***

She sits on the bench overlooking the water. She looks at the modern buildings on the other side of the river, the trees, and the people walking by.

She likes Cork. She likes how she feels here. Like she gets to make a fresh start.

That feeling is now overshadowed by the sickening unease she feels. Like she is separated from her body, out of control of her own insides somehow. She can't believe that she has something inside of her, growing with every second.

She looks at her phone. She's really grown to hate the small device over the past few days. It has been a source of information and hope, but also of disappointment and limitations. And now, she has to call her friend back home.

She quietly scolds herself for not being able to figure this out on her own. She hadn't wanted to tell anyone.

She selects Michelle from her contacts list and presses the green icon.

"Maia! How are you? How is Ireland?"

"Hey, Michelle, it's fine, but I am calling you for something important." She figured it was best to get it out of the way as quickly as possible.

"Oh… of course! What is it?"

Taking a deep breath, Mariana briefly explains her situation, sticking to the most important and skipping over any details.

Of course, her friend wanted to know more about what had happened and how this has been for her, but she didn't press her on anything. She was incredibly kind and supportive. She also immediately knew what to do.

"You have to go to this website; it's called Women on Web. They will send you the pills."

"And Maia, take it easy on yourself, okay? This isn't your fault. It's not your fault."

The fictional vignette analyses four issues in abortion care access in Mariana's experience. Firstly, it becomes clear how trialling locating and navigating information (and misinformation) can be. Secondly, the vignette features an encounter with a rogue pregnancy agency. Anti-abortion 'rogue crisis pregnancy agencies' play into the difficulties in accessing and making sense of information by communicating misleading messages and misinformation on abortion care and related reproductive healthcare services. These agencies have been present since before abortion was legalised (Nic Gabhainn and Batt, 2004), but their services and presentation of information are more similar to abortion care providers since the legalisation of abortion care. A third issue in the vignette is language as a barrier to access. Especially for non-native English speakers, it is challenging to make sense of the legal and medical information. However, the legal and medical language can be just as difficult for native English speakers. Lastly, the vignette calls attention to the need for a Personal Public Service Number to access State-funded abortion care services, and the limitations this requirement places on service users and service providers. GPs sometimes try to provide the care regardless and find a financial solution later (Chakravarty et al., 2023, 7), but this is not guaranteed and does not always happen. The four different barriers in Mariana's experience explain why people continue to access abortion medication through alternative care networks, such as Women on Web, when the services in Ireland fail to provide for them. In the analysis below, I show more of how and why this happens, and what the implications are for abortion service users and providers.

5.2 Key document for the mapping and identifying of service provision: Health (Regulation of Termination of Pregnancy) Act 2018

The abortion law defines different legal grounds for abortion, some based on circumstances of a pregnancy and others on gestational age. In case a medical practitioner provides abortion care outside of the scope of the sections of the Health Act, they are subject to a prison sentence of up to 14 years. The legal grounds on which an abortion can be accessed are set out as follows in the Health Act 2018 (Government of Ireland, 2018):

- Section 9: risk to life or health

"A termination of pregnancy may be carried out in accordance with this section where 2 medical practitioners, having examined the pregnant woman, are of the reasonable opinion formed in good faith that—

(a) there is a risk to the life, or of serious harm to the health, of the pregnant woman,
(b) the foetus has not reached viability, and
(c) it is appropriate to carry out the termination of pregnancy in order to avert the risk referred to in paragraph (a)."

- Section 10: risk to life or health in an emergency

"A termination of pregnancy may be carried out in accordance with this section by a medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that—

(a) there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman, and
(b) it is immediately necessary to carry out the termination of pregnancy in order to avert that risk."

- Section 11: condition likely to lead to death of foetus

"A termination of pregnancy may be carried out in accordance with this section where 2 medical practitioners, having examined the pregnant woman, are of the reasonable opinion formed in good faith that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth."

- Section 12: early pregnancy

"A termination of pregnancy may be carried out in accordance with this section by a medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy."

As will become clear throughout the analytical chapters of the thesis, the particular legal grounds for abortion have many implications for the experiences with abortion

care provision and access. Under the clinical guidelines for the Health Act 2018, the following overview can be laid out for when service users can access *which* procedure *where*, as this is divided into community care and secondary care:

- Up to 9 weeks + 6 days' gestation: abortion services can be provided by way of medical abortion by general practitioners or by medical doctors in family planning or women's health clinics (Duffy et al., 2022).
- Between 9 weeks and 0 days' and 12 weeks + 0 days' gestation: GPs and medical doctors refer patients to hospital settings to access abortion services. Mostly these will be performed by way of medical abortion.
- Up to 12 weeks + 0 days' gestation with a clinical indication: medical or surgical abortions can take place in hospital settings.
- 12+ weeks' gestation: abortion services only provided in hospital settings.

The implementation of abortion provision and how this is set up in healthcare settings will be further considered in detail in this chapter.

5.3 Abortion providers

The set-up of the provision of abortion care in Ireland is focused around 'community provision' (Conlon, Antosik-Parsons and Butler, 2022; Mishtal et al., 2022a). Following the advocacy of Doctors for Choice during the campaign to Repeal the Eighth Amendment and the role Irish physicians had in arguing for abortion care throughout the processes of the Citizens' Assembly and the Join Oireachtas Committee meetings, it was argued that it was important for abortion care to be embedded in the existing healthcare system. The Health (Regulation of Termination of Pregnancy) Act 2018 (Government of Ireland, 2018) sets out the grounds for abortion which are based on different gestational limits. Different health care providers and health care locations are associated with the different sections under which an abortion is legally accessible in Ireland.

Abortion providers are legally defined as general practitioners, medical doctors in family planning clinics or women's health clinics, and medical doctors in hospital settings. There is, of course, a range of staff involved in abortion care provision in all these settings, such as nurses and administrative assistants, but they are not legally defined as providers. However, responsibility for decision-making around section 9 and 11 of the Health Act 2018 lies explicitly with obstetricians and other medical

specialists, but the clinical guidelines from the Royal College of Physicians also include the importance of interdisciplinary teamwork and the support of a wide range of staff in the provision of abortion care (Interim Clinical Guidance Risk to Life or Health of a Pregnant Woman in relation to Termination of Pregnancy, 2019; Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions Diagnosed During Pregnancy, 2019). The tension between the Health Act 2018 and the clinical guidelines creates a situation in which it is unclear to what extent multidisciplinary teams might work together and can facilitate both limited consultation with other staff and rather lengthy deliberative processes that can delay care.

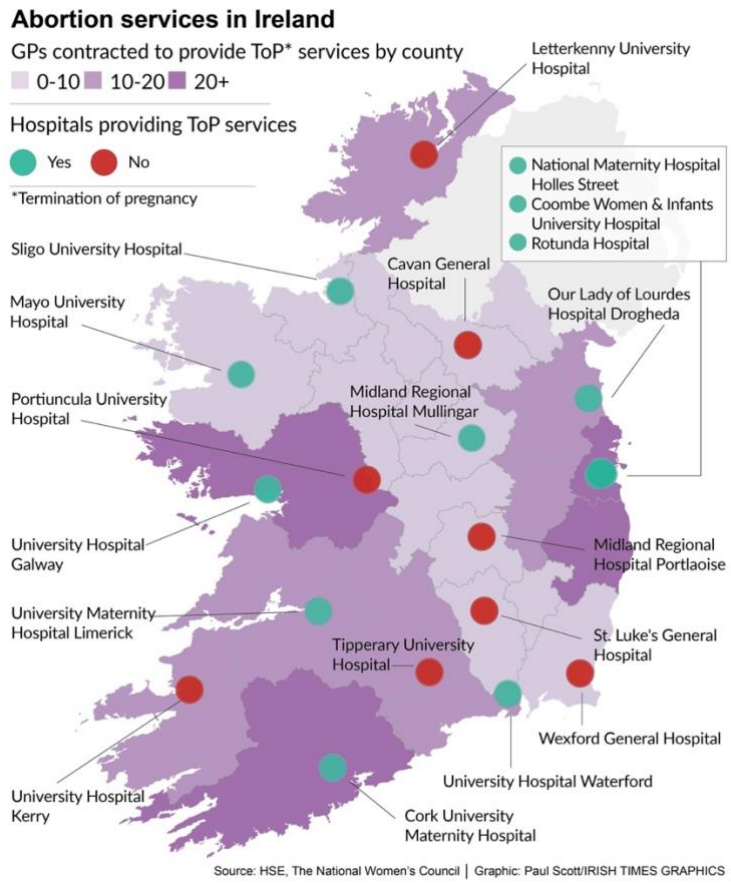
5.3.1 Abortion providers: Hospital setting

At the start of the implementation of services, on 1 January 2019, nine out of nineteen Irish maternity hospitals provided abortion services. On 1 January 2022, provision had expanded to ten hospitals and at the time of writing eleven hospitals were providing the full range abortion care (HSE, no date). Maternity units in Donegal, Galway, Laois and Sligo, respectively, only provide abortion care under sections 9 and 11 of the Health Act, that is in cases of a fatal foetal anomaly or an emergency (Mishtal et al., 2021, p. 9). Figure 5.1 illustrates which parts of Ireland are particularly underserved, and which parts have a dense coverage of abortion services. The map shows a division between more urban and rural areas and it demonstrates that many general practitioners do not want to provide abortion care when there is no nearby hospital that provides secondary care. The fragmented and partial service provision at the start of the implementation of abortion care speaks to the short time frame between the referendum and the start of service provision (about seven months) and the expectation placed on medical practitioners to provide a service for which structural training and support had not been provided before and was still in development. This is disappointing considering the long history of deliberation over change in governance. How this has been perceived by medical practitioners will be further explored in the Chapter 6 ‘The in/visibilising of abortion care services: the need for a more provider-centred approach’ and further issues of non-providing hospitals are discussed in Chapter 7 ‘The politics of language and discursive mobilisations of rights and health’.

The increasing service provision over time is an indication that further expansion of services might follow, and that time is necessary for the full development

and implementation of a new care system. Nonetheless, it is concerning that State institutions continue not to conform to the legal abortion landscape under the Health Act 2018 in that it demonstrates problems with accessibility and provision of care that the State is legally obliged to provide, and the operational and practical issues at the heart of this suggest a change in moral governance, but not a move away from this entirely. It is illustrative of the abortion regime and the new governance context, in which the government is committed to abortion care yet cannot guarantee the provision in all hospitals.

Figure 5.1: Overview of abortion services in Ireland



Source: The Irish Times,12 July 2022.

5.3.2 Abortion providers: Community provision

In the analysis of data and information on abortion providers in community provision, the following key findings are identified: the uneven distribution of community care provision across Ireland; the lack of information for potential service users, and the

introduction of telemedicine provision as exacerbating existing uneven access to care for early abortions compared to at a gestation age later than 10 weeks. I discuss these findings first from the analysis of abortion services provided by general practitioners, followed by family planning clinics, and lastly, I analyse telemedicine provision as it was introduced during the COVID-19 pandemic.

5.3.2.1 General practitioners

Less than one in nine General Practice surgeries are providing abortion services, according to Freedom of Information (FOI) figures released to NewsTalk on 1 February 2022. They show that out of approximately 3,500 general practitioners active in Ireland, 405 provide abortion services. That means that approximately 11 per cent of general practitioners in Ireland provide abortion care. With such a small number of providing GPs – and many of them located in urban areas such as Dublin and Cork as Figure 3 above indicates– it is perhaps not surprising that community service provision is very unevenly distributed across Ireland. This will be discussed further in section 6.1. County Sligo, for example, did not have any GP providers until April 2022 (GPs and hospital now providing abortion services in Sligo, 2022). Thus, similar to abortion care in hospital settings, local access remains a key issue in abortion governance.

The local group in the Southeast, the Southern Taskgroup on Abortion and Reproductive Topics (START), have been crucial in setting up training and support among community providers. START is a growing group with over 250 members (NWCI, 2021, p. 18); Dempsey et al., 2021). The group grew out of the advocacy and activism of Doctors for Choice, which was a group of medical practitioners campaigning for the repeal of the Eighth Amendment since 2012. Doctors for Choice and START have been spearheaded by a number of very engaged practitioners and have been active in setting up training and educational support for healthcare professionals. Although they organised a number of training and support sessions within the ICGP (Mishtal et al., 2022a), this is a small group of practitioners and there is not a national structure in place that ensures the same level of support and a network for GPs across Ireland.

Another contributing factor to uneven accessibility and provision of care is a lack of clear information for potential service users about where they can access abortion services. Community provision is supported through the HSE's My Options

website and phoneline. This was set up along with service implementation as a first access point through which service users can receive information and a referral to an abortion provider. It includes information and provision of contact details of community care providers, counselling options and medical advice provided by clinical nurses. The conscious considerations and efforts of organising a State-provided information service and helpline are a progressive development in the Irish State's abortion governance, and a contrast to the pre-Repeal management of information. However, Grimes et al. (2022) report from people's experiences with My Options that many were not aware of the service, and some also describe a lack of clarity about the scope and nature of its service. Respondents to the Abortion Rights Campaign (2021) survey, which was conducted anonymously with service users between 2019 and 2021, the NWCI's paper on the provision of abortion services (Kennedy, 2021), which explores service provision through interviews with abortion care providers, campaigners and activists, as well as the UnPAC Study (Conlon, Antosik-Parsons and Butler, 2022), the HSE mandated research on service users' experiences with abortion care between 2019 and 2021, also describe confusion over access to abortion care through GPs, especially in cases where people contact their own family doctor, and this doctor is not a service provider. Clarity around referral pathways is lacking in this context and could be further improved.

5.3.2.2 Family planning clinics

The Irish Family Planning Association and Well Woman's Clinic offer abortion care as part of community provision. However, the locations of clinics that provide medical abortion care is largely limited to Dublin and its surrounding areas. Although the Irish Family Planning Association has ten locations across Ireland where they provide pregnancy counselling, only their Tallaght and Dublin based clinics provide abortion services (IFPA, 2022). The Well Woman's Centre has three clinic locations in Dublin City, two of which provide abortion services (Dublin Well Woman Centre, no date). Again, it stands out that the geographic location of abortion care provision is unevenly distributed across Ireland and this points to a further difficulty in accessing local services in more rural areas specifically.

5.3.3 Telemedicine

During the pandemic, telemedicine was made available as part of community provision for abortion services through medication up to 9 weeks' gestation (Ryan 2020). This meant that the two medical consultations needed for an abortion, with the 72-hour mandatory wait period in between, have been available through a phone consultation with a medical practitioner. Although this relieved service users from in-person visits to a service provision location for the two medical consultations, the medication for an early medical abortion generally still needed to be picked up at the abortion service location, thus not entirely eliminating the need to travel to access abortion care. As initial research on the COVID-19 pandemic and the consequences for reproductive healthcare show existing barriers to access and provision have been exacerbated (Lokot and Avakayan, 2020; Nandagiri, Coast and Strong, 2020; Romanis and Parsons, 2020). In their article on the implications of the COVID-19 pandemic for sexual and reproductive health in development and humanitarian contexts, Lokot and Avakayan (2020) adopt an explicitly intersectional lens to explore those issues. They argue for the wider application of an intersectional lens to focus on the systemic and multiple oppressions that might shape the impact of COVID-19 on communities, and they conclude that "it is important to recognise that barriers to SRH are not "new" but represent existing, highly entrenched inequalities" (Lokot and Avakayan, 2020, p. 4). Additionally, in their work on thinking through the implications of structural violence as an analytical concept in abortion research, Nandagiri, Coast and Strong (2020, p. 83) contend:

> People seeking contraceptives and abortion have always dealt with a range of barriers: laws comprising a range of restrictions or conditionalities, social and legal sanctions, lack of resources, poor quality of care and refusal or unavailability of services. Rather than creating new crisis conditions, COVID-19 lays bare existing fault lines and inequities embedded in the interlinked structures of health systems, social institutions (including the economy), and governance and law.

The emphasis is thus on the pre-existing barriers and inequities in reproductive healthcare which have been revealed and worsened by the COVID-19 pandemic.

The public health mandates around reproductive and abortion care during the pandemic also revealed longstanding stratifying and exclusionary mechanisms of healthcare access (Hodge, 2021; Romanis and Parsons, 2020). Despite the recognition of access to abortion care as a human rights imperative, disparities in access thus existed before the COVID-19 pandemic broke out and were often worsened by the public health mandates of movement restrictions (Romanis and Parsons, 2020). In Ireland, telemedical services for abortion were implemented, thus facilitating 'clinical' abortion care through the healthcare system, not including the transnational services that provide medication abortion by post, such as Women on Web. Nor did it include abortion care under sections 9, 10 and 11 of the Health Act 2018. While the use of telemedicine is thus a welcome addition to abortion care, it is not without challenges and some limitations. Due to the early gestational limit for which telemedicine is provided and the arrangement of the pick-up of the medication at a healthcare facility that provides abortion care, the extent to which telemedicine allowed pregnant people to overcome some of the barriers to abortion care access remained limited.

The efforts of the government to allow abortions to permanently continue through telemedicine beyond the COVID-19 pandemic suggests a shift in deeming abortion care to be essential health care at all times and is a very positive governance practice (Spillane et al., 2021; Conlon, Antosik-Parsons and Butler, 2022). The Health Act 2018 was newly interpreted to include the possibility for telemedicine consultation in the existing legislation under section 12:

> A termination of pregnancy may be carried out in accordance with this section by a medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy.

'Having examined the pregnant woman' is not further specified and thus it was decided that the examination could also sufficiently take place through a phone or video consultation, rather than through a physical, in-person only consult. This is in line with WHO recommendations for safe abortion care (WHO, 2022). The new interpretation of the legislation is a promising indication of the scope within the legal framework for a more progressive reading and application of abortion governance.

However, at the time of writing, telemedicine had not yet been fully extended to be a part of abortion care beyond the COVID-19 'public health emergency period' (Houses of the Oireachtas, 2022e). Moreover, the longstanding experiences with remote, online consultations and postal distribution of medication abortion pills from organisations such as Women on Web are not being utilised by the Irish government. The realities of people's experiences with accessing abortion care are thus not fully considered within politically legitimate mandates over telemedicine, nor is the autonomy for pregnant people over their options for abortion care expanded. The introduction of telemedicine under the COVID-19 pandemic was a biopolitical mandate of care for the population, not an active consideration of governance change to improve inequities in abortion care access.

5.4 Abortion service users

The following information is the data the Irish government has published in their three Annual Reports on Notifications with the Health Act for the preceding year in June 2020, June 2021, and July 2022 (Department of Health, 2022; 2021; 2020). The annual notifications comprise the statutory data on abortion care that the Irish government has made available before and separate from the research that has been conducted as part of the Review of the Health Act 2018. Abortion providers are legally obliged to record and file the date, the grounds on which the abortion is provided, and the county of residence of the service user to the Health Service Executive.

Table 5.1: Termination of pregnancy carried out by section of Act in 2019, 2020, and 2021

Section of the Act	**Number of terminations notified**		
	2019	2020	2021
9 – Risk to life or health	21	20	9
10 – Risk to life or health in an emergency	3	5	2
11 – Condition likely to lead to death of foetus	100	97	53
12 – Early pregnancy	6542	6455	4513
Total	6666	6577	4577

Source: Department of Health (2022; 2021; 2020)

Table 5.2: Termination of pregnancy carried out by location

County	Number of terminations notified		
	2019	2020	2021
Carlow	74	56	46
Cavan	77	107	70
Clare	73	83	82
Cork	606	645	408
Donegal	127	128	90
Dublin	2493	2414	1618
Galway	280	274	206
Kerry	48	110	103
Kildare	295	264	165
Kilkenny	96	83	64
Laois	79	60	46
Leitrim	27	28	22
Limerick	226	278	186
Longford	47	52	41
Louth	213	220	160
Mayo	111	105	83
Meath	252	240	169
Monaghan	36	54	46
Offaly	67	67	49
Roscommon	43	53	38
Sligo	59	60	54
Tipperary	174	161	128
Waterford	149	158	124
Westmeath	104	108	76
Wexford	165	159	147
Wicklow	138	141	145
Northern Ireland	67	36	5
Other	15	8	2
No county/place received	525	425	204
Total	6666	6577	4577

Source: Department of Health (2022; 2021; 2020)

The little data that the Irish government collects on service users and the way in which they present the data in the Annual Notifications, points towards noticeable gaps in the knowledge of service users and their experiences, as well as a lack of details around provision. For example, publishing the data of the counties of residence of service users makes it look like abortions are provided in all counties, but the location where the abortion took place is actually not provided. This speaks to limited knowledge of how and where service users actually access abortion care, what their travel pathways within Ireland might look like, and how providers engage with patients and might communicate their provision.

The National Women's Council interestingly compare the numbers from the Annual Reports from the Health Act 2018 with the data that is available from the Notifications under the Protection of Life During Pregnancy Act (PLDPA) 2013, the governing law prior to the legalisation of abortion (Kennedy, 2021, p. 27).

Table 5.3: The number of abortions per year performed in Ireland under the Life During Pregnancy Act 2013

Year	Number of abortions
2014	26
2015	26
2016	25
2017	15
2018	32

Source: Government of Ireland (2013)

At the Committee on Health Meeting on the Review of the operation of the Health Act 2018, on April 27, 2022, the NWCI and the IFPA argued that the numbers show that the sections 9 and 10 under the Health Act 2018, concerning a risk to life or serious harm to the health of the pregnant woman, are being interpreted within the same restrictive framework as was common before the legalisation of abortion. Members from the NWCI and IFPA presented before the Committee on Health to discuss their findings and experiences with abortion under the new legislative framework. The similar phrasing of the sections 9 and 10 of the Health Act 2018 to the pre-legal

exceptions that allowed for 'therapeutic abortions' point to a continuation of a conservative and narrow phrasing of the law, as well as a consequently conservative application in medical practice.

Before the implementation of abortion care, the governance under the Eighth Amendment saw few exceptions that allowed for legal abortions to be performed in Ireland. Particularly during the last decade of the constitutional ban, with the Protection of Life During Pregnancy Act 2013 (Government of Ireland, 2013), governance was moving towards a mandate for allowing abortions to take place under extremely restricted circumstances. Maeve Taylor, the Director of Advocacy and Communications for the IFPA, explained that the specific legal legacies from the PLDPA 2013 were carried over into the post-Repeal framework: "the [Health] Act [2018] is modelled onto the Protection of Life During Pregnancy Act, and this was a restrictive, criminal statute. And that framing gets in the way of access and choice" (Taylor, 2022). The little change that has been made in the wording of the sections 9 and 10 under the Health Act 2018 with the legalisation of abortion, continue that exceptionalisation of abortion care, and the need to justify legal access within Ireland.

When pregnant people are beyond 12 weeks' gestation, they can only access abortion under the narrow grounds of a risk to their life or serious harm to their health, or if there is a fatal diagnosis for their foetus. The continued restrictive grounds beyond 12 weeks' gestation do not contribute to pregnant people's agency in these situations, which is so crucial for reproductive justice (Ross, 2017; Thomsen, 2013). It indicates that reproductive decision-making continues to be fraught with painful and complicated processes, in which women and pregnant people might not experience reproductive decision-making as a choice. The link to the past in abortion governance under the former constitutional ban, particularly through the language used in the law, is addressed more in Chapter 7 'The politics of language and discursive mobilisations of health and rights' and Chapter 8 '"We are not going to return to those days: Abortion governance through relations with the past'.

It is also particularly relevant for the analysis here that the Irish government does not provide the comparative figures from before 2018, nor does it seem to conduct any historical analysis of how the current legislation and provision of abortion relate to the clinical practice before legalisation. This more in-depth work comes from the pro-abortion advocacy organisations in their research reports (ARC and Grimes, 2021; Kennedy, 2021), or in their appearances before the Committee on Health in their

work on the review of the Health Act 2018. I further discuss the continued advocacy work in post-Repeal engagements with abortion governance in Chapter 6 'In/visibilising of abortion care services: the need for a more provider-oriented approach'.

5.5 Abortion service users: Travel

Geographical information about where abortion services are accessed and how much travel is involved for service users is very limited. As mentioned above, the county of residence for abortion service users is reported, but no information is gathered about where they accessed abortion care, nor is it officially recorded how many people still have to travel abroad to access abortion care. The statutory data on abortion thus conceals a significant part of service users' experiences in accessing care. It does not show the specific pathways people might have to follow in order to access care and the enablers and barriers faced on these pathways.

The research report by ARC and Grimes (2021) shows that typically people have to travel up to one hour to access abortion services. In their anonymous survey of service users, 30% of respondents travelled between 4 to 6 hours, and 57% of respondents said that they needed to travel longer than 6 hours to have an abortion (ARC and Grimes, 2021, p. 8).

An overview provided to the NWCI by the Health Service Executive from all General Practitioners signed up for My Options ("some 408")[21] and where they were located on 1 March 2022 shows the following coverage (NWCI, 2022).

Table 5.4: The range of GP providers in each county

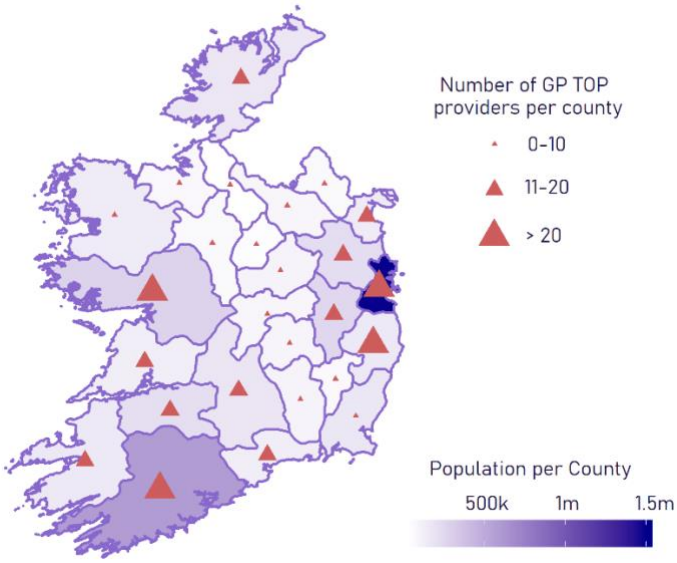
County	Number of GPs contracted to provide ToP services by range 0-10, 10-20 or 20+
Cavan	0-10
Cork	20+
Donegal	10-20
Dublin	20+

[21] See Appendix 3 for the full response and data on registered abortion providers in general practice.

Galway	20+
Kerry	10-20
Kilkenny	0-10
Laois	0-10
Leitrim	0-10
Limerick	10-20
Longford	0-10
Louth	10-20
Mayo	0-10
Meath	10-20
Monaghan	0-10
Tipperary	10-20
Waterford	10-20
Westmeath	0-10
Wexford	0-10
Wicklow	20+
Sligo	0-10
Leitrim	0-10
Roscommon	0-10
Carlow	0-10
Clare	10-20
Kildare	10-20
Offaly	0-10

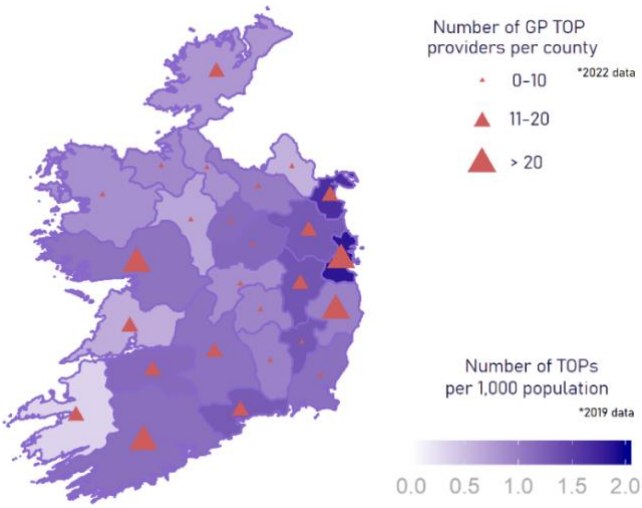
Source: NWCI (2022)

Figure 5.2: Map showing population density and number of GP providers in 2022



Source: NWCI (2022) Map developed by ICGP

Figure 5.3: Map showing ordinary county of residence for termination versus number of providers (TOP/1000 population is 2019 and TOP provider info is from 2022)



Source: NWCI (2022) Map developed by ICGP

On the basis of this information, the HSE stated that they are "satisfied there is a good geographic spread of GPs taking part, enough to meet the needs of people who may need to access the service, with GPs providing the services in each county" in a response to a request from the National Women's Council about more information about the regional breakdown of data (NWCI, 2022). Even so, the ranges are wide enough that they do not provide very helpful information. The range of 0-10 GP providers could mean that in that particular county there might be only one providing GP – or none, before County Sligo had a registered providing GP in April 2022 – which could result in difficulties making timely appointments and might still force women and pregnant people to travel further to access abortion care.

Additionally, research shows that people still travel outside of Ireland (ARC and Grimes, 2021; Calkin and Berny, 2021; Mishtal et al., 2022a; 2022b; Taylor, Spillane, and Arulkumaran, 2020; Kennedy, 2021). Data from the United Kingdom National Statistics show that Irish people continue to travel the UK to access abortion services.[22]

Table 5.5: The number of terminations notified in Ireland for 2019, 2020 and 2021 and the number of Irish addresses that were registered by people accessing abortion care in the UK in 2019, 2020, and 2021

	2019	2020	2021
Number of terminations notified in Ireland	6666	6577	4577
Number of people who registered an Irish address when accessing abortion in UK	375	194	206

Sources: The Department of Health and Social Care (2019; 2020) and the Office for Health Disparities and Improvement in the United Kingdom (2021)

Although the 375 people who registered an Irish address when accessing an abortion in England or Wales in 2019 is a significant drop from the 2879 people in 2018, it means that there was still at least one person traveling to the United Kingdom to access

[22] For the full statistics and statutory data see https://www.gov.uk/health-and-social-care/abortion#research_and_statistics.

an abortion every day for the first year after abortion was legalised in Ireland (Kennedy, 2021, p. 34).

Moreover, the data from the UK government also shows that people who registered with an Irish address who accessed abortion care in the UK sometimes did so under 9 weeks' gestation. The number declined from 2019 to 2021, with 65 people registered in 2019 with a gestational age between 3-9 weeks (see Appendix 4 for Abortion statistics for England and Wales, 2019, Table 12c), 11 people with a gestational age between 3-9 weeks in 2020 (see Appendix 5 for Abortion statistics for England and Wales, 2020, Table 12c), and 7 people with a gestational age of 2-9 weeks in 2021 (see Appendix 6 for Abortion statistics for England and Wales, 2021, Table 12c). That 17%, 6%, and 3% respectively of all residents from the Republic of Ireland who registered in the UK for an abortion did so when they were under 9 weeks' pregnant points to a significant experience worth exploring. Even people who are supposed to be able to access abortion care in Ireland with no restrictions, still have reasons to travel abroad to access abortion care.

Table 5.6: Amount of service users with registered address in the Republic of Ireland accessing abortion care in the UK under 9 weeks' gestation and percentage of total service users with registered address in the Republic of Ireland

Characteristics	2019	2020	2021
Gestational age under 9 weeks	65	11	7
Percentage of total	17	6	3

Sources: The Department of Health and Social Care (2019; 2020) and the Office for Health Disparities and Improvement in the United Kingdom (2021)

The majority of women and pregnant people who registered with an Irish address when they accessed an abortion in the UK, did so under the statutory grounds that "the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman" (Abortion Act 1967 s1(1)(a)).

Table 5.7: Characteristics of majority of service users with registered address in the Republic of Ireland accessing abortion care in the UK

Characteristics	2019	2020	2021
Age	35-39	35-39	35-39
Gestational age	13-19	13-19	13-19
Statutory grounds	Continuation of pregnancy would involve risk	Continuation of pregnancy would involve risk	Continuation of pregnancy would involve risk and substantial risk of physical or mental abnormalities

Sources: The Department of Health and Social Care (2019; 2020) and the Office for Health Disparities and Improvement in the United Kingdom (2021)

There is an interesting comparison between the English and the Irish legal grounds for abortion care, and there seems to be a group of people that is excluded from accessing legal care in Ireland beyond 12 weeks' gestation. This points mostly to the difficulty in working with section 11, which necessitates a fatal risk for a diagnosis of the foetus, whereas the statutory grounds in the UK define "a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped" (Abortion Act 1967 s.1(1)(d)).

Providers' fear around the strict legal parameters often leads to a conservative interpretation of test results and a diagnosis (Power, Meaney and O'Donoghue, 2020), which in turn contributes to service users travelling to England to access care. There, the grounds for foetal anomaly are based on a risk of physical or mental abnormalities, without this needing to be fatal per se. Confirming the consequences of a restrictive legal framework even when abortion is legal, Garnsey, Zanini, De Zordo et al. (2021) found that a narrow timeframe and circumstances under which legal abortion can be obtained causes people who live in countries across Europe to seek care in England or Wales.

The painful reality of the difficulties in accessing abortion care under section 11 is illustrated by the experiences that some of the participants of the UnPAC Study (Conlon, Antosik-Parsons and Butler, 2022), Mishtal et al. (2022b) and ARC and Grimes (2021) studies share. The UnPAC Study specifically details the varying

circumstances of the participants that may determine experiences with abortion care after 12 weeks' gestation, all of whom sought access to abortion care for reasons of foetal anomaly (Conlon, Antosik-Parsons and Butler, 2022). The concerns may arise during the first trimester, but for many it is not detectable until a specific anomaly scan around 20 weeks' gestation.[23] This automatically puts Irish women and pregnant people who do subsequently not receive a *fatal* diagnosis, outside of the legal grounds for abortion care within Ireland.

For instance, in the UnPAC Study's (Conlon, Antosik-Parsons and Butler, 2022, p. 140) section on 'Not Qualifying for Care in Ireland Following Detection of Anomaly at First Trimester Scan', we can read from the interview with Emily who describes how early scans are not conclusive for a fatal foetal diagnosis:

> So we went into the hospital. I suppose I was 11[weeks] and three [days pregnant] or something like that by the time they could meet us, … and we discussed the options and the results of the test, the genetic test said that it was 95% sure of this particular foetal abnormality. … But because it's not a diagnostic test, it's a screening test, you know there's that 5% chance that it's not.

Once the diagnosis of the foetal abnormality could be confirmed, "at that point it's far too late to get anything done in Ireland. So, our only option was to go to England" (Conlon, Antosik-Parsons and Butler, 2022, p. 141).

Moreover, the UnPAC Study shows that there are also people who choose to travel to England to access their preferred method of abortion, demonstrating that reproductive justice is limited not just due to legal factors, but also other aspects that would improve women and pregnant people's agency and accessibility in abortion care (Conlon, Antosik-Parsons and Butler, 2022). Martha, another UnPAC Study participant explains, "this is again one of the problems with the current legislation, is that even though the test came back, so the rapid results came back within three days, we would still have to wait to get the full [diagnostic results] back. So this was another week and a half of waiting. And in the meantime, like I'm still pregnant… mentally it

[23] For more on tests and scans that are available during pregnancy, see https://www2.hse.ie/pregnancy-birth/scans-tests/

was very difficult" (Conlon, Antosik-Parsons and Butler, 2022, p. 138). Martha further explains that the decision making was especially difficult because of a lack of information:

> And it's really hard to access any information on the websites in Ireland as to what, if you are in a situation like we were, after 12 weeks and forced with this really difficult decision as to what's actually going to happen to you, as a woman what, like what part do you have to play and what part is the hospital there to play. All the HSE website says is that the termination will be done in a hospital. Now that is … not adequate information (Conlon, Antosik-Parsons and Butler, 2022, p. 138).

Many of the tensions between the legal framework, medical practices, and lived experiences of people trying to access abortion care come together in Martha's story. The fact that section 11 of the Health Act 2018 allows for abortion in case of fatal foetal anomalies and that section 11 is based on the 12-week gestational limit, poses a complex situation for people who are dependent on different screening tests and diagnostic results for the diagnosis of a fatal foetal anomaly. The risk is that once the diagnosis comes in, it might not be considered fatal, yet at this point in time the 12-week gestational limit may have passed, excluding the pregnant person from legal access to care in Ireland. Emily's and Martha's interviews in the UnPAC Study make vividly clear how difficult it is for pregnant people and their partners to wait and weigh their options while they have to navigate such strict legal conditions and complicated medical pathways (Conlon, Antosik-Parsons and Butler, 2022).

5.6 Conclusion

In this chapter, I have mapped out the available data and information on abortion in Ireland as a means to visually demonstrate where gaps in our knowledge of abortion are located and how knowledge is created through (also digitally) available information and data on abortion services. For the first three years of post-Repeal abortion care, structural issues in provision and access are created by a complex interplay between legal and clinical factors that create structural issues in abortion care. The analysis of the service provision firstly shows an uneven distribution of

abortion care provision, both in the hospital and the community setting. Crucially, not all maternity hospitals provide abortion care, and the lack of local access to secondary hospital care also restrains general practitioners from providing abortion services. Furthermore, the lack of information for service users and the unclarity around existing information, creates difficulties and delays in access. Additionally, the lack of statutory data and information about service users reveals little about service users' particular pathways and experiences of care. Moreover, the law itself and the ways in which the legal grounds for abortion later than 12 weeks' gestation are organised around fatal foetal anomalies, as well as their intersection with access to tests and diagnosis timeframes, proves to be an enormous additional barrier for both service users and providers. Thus, despite progressive developments around My Options and telemedicine, significant barriers to abortion care access and provision remain.

More importantly, the conservative interpretation of the law and conservative application to clinical practice by medical specialists, become an additional barrier for abortion seekers to overcome. The consequential ongoing travel abroad by service users to access care, is a major finding and phenomenon on its own to further analyse in the following chapters. The limited time frames of access to care, and the issues in provision for anyone trying to access abortion care past 12 weeks' gestation, combined with the uneven geographical distribution of care, force people to continuously travel to the UK and Europe for abortion care. Yet abortion seekers also registered in the UK when they were less than 9 weeks pregnant, which means that also for reasons of autonomy and agency in abortion method, people continue to seek this outside of Ireland out of necessity.

The ethno-fictional vignette at the beginning of the chapter highlighted the embodied aspects of seeking access to abortion care and portrayed more of the personal experience that is so lacking in the statutory data. It thus creatively explores the regulation of knowledge and information in post-Repeal abortion governance and how it shapes embodied experiences.

The next chapter, 'The in/visibilising of abortion care services: the need for a more provider-centred approach' captures the abortion care landscape from the implementation side. The analysis focuses on the materials that are available for medical practitioners, the research that has been conducted to date on service providers' experiences, and the medical information that is made available to the general public. It therefore connects and expands on this chapter to situate the post-

Repeal abortion care landscape. The governance mechanisms under the Health Act 2018 are further illustrated and abortion providers' experiences are explored in the third ethno-fictional vignette. Thus, Chapter 5 and 6 complement each other in the critical consideration of how abortion care has unfolded in the first three years of service provision.

Chapter 6: The in/visibilising of abortion care services: the need for a more provider-centred approach

6.1 Introduction

The invisibility of the availability of abortion services concerns the information that is available for service users and providers, and the information that is available about service users and providers. Governance of information is a significant strategy within reproductive governance (Zanini et al., 2021). As Sinéad Kennedy remarks in the report on abortion service provision with the NWCI, "a central, though largely unexamined, feature of the Irish State's central maintenance and enforcement of Ireland's punitive abortion regime was the regulation and control of knowledge" (Kennedy, 2021, p.7). The ways in which information about abortion care is managed and delivered by the government on a national and local level, and various other actors on a transnational level - such as advocacy organisations, activists, international abortion care providers, nongovernmental organisations, and others - is significant for people's experiences with accessing local abortion care and decision-making around travel to access care. Available information or lack of information directly impacts people's (delayed) access to care (Zanini et al., 2021). This chapter examines how the regulation and control of knowledge continues to be an important post-Repeal abortion governance mechanism.

In the Irish context, there are multiple levels on which this governance of information plays out. In the previous chapter 'Identifying and mapping abortion governance', I have analysed the available data and information about abortion providers and service users, and I identified gaps and barriers in (knowledge of) abortion care provision from 2019 to 2021. In this chapter, I delve deeper into the implications of those gaps and barriers to demonstrate how abortion services and its underlying structures, practices, and norms are developing. I examine the ways in which the abortion governance is translated into the practicalities and material realities of healthcare, by drawing on research on providers' experiences, medical guidelines, and information and resources for the general public.[24]

My analysis focuses on the relations between the State, medical practitioners, and the general public in the navigation and translation of knowledge on abortion.

[24] A complete overview of the data and which documents are analysed in this chapter is available in Appendix 1.

How is knowledge made available for service users and service providers? To what extent has abortion care become more visible through its implementation into healthcare services? Which factors contribute to the invisibilisation of (experiences with) abortion care? Here, I probe the steps that are taken to implement the abortion policy as a healthcare service in practice, and what is still lacking and continues to be obscured.

This chapter captures more of the experiences of service providers and the third ethno-fictional vignette below illustrates some of the issues that come forward, firstly, in the analysis of providers' experiences in the WHO study (Mishtal et al., 2022a); secondly, in the research by Dempsey et al. (2021) on providers' experiences across GP and hospital services, the research by Power, Meaney and O'Donoghue (2021) on foetal medicine specialists' experiences, and the research by Mullally et al. (2021) on abortion services in general practice; thirdly, from participant observation in the Rebels for Choice online meeting series 'Reactivate Repeal' in June and July 2021, and, lastly, in the interviews that I conducted with a providing GP, a crisis pregnancy counsellor, and a medical specialist. The chapter also captures some of the ongoing strategies from anti-abortion activists and explores protests at clinics and hospitals as a practical experience before the political discourses on the issue of Safe Access Zones are analysed in Chapter 7 'The politics of language and discursive mobilisations of health and rights'.

Ethno-fictional vignette 3

"Right, just keep your head down and walk quickly."

The sounds started to reach her.

"This is not the answer. God will show you the way."

"Blessed are thou among women and blessed is the fruit of thy womb Jesus."

"Keep walking."

They brought a new sign today. It says, "help women choose life" and it shows an illustration of a female figure with a baby in her arms.

"Keep your eyes on your feet."

Emily clutches her bag closer to her body and swallows, trying to force down the disappointment she feels in herself. She should be doing something. She should at least hold her head up as she passes them.

Last week she shared a photo with the activists working on safe access zones. She didn't feel entirely comfortable to take on an activist role, no matter how small, but she had felt so exasperated by the constant presence of people outside the clinic that she finally felt like it was her only option. She didn't feel brave enough to confront them directly face-to-face though.

"Stupid Donnelly for still not having brought it in. And stupid Harris for not just including it in the Act directly."

She'd been following the news on the abortion law closely since before the referendum. During the campaign, she had been happy to chat with the pro-choice canvassers that came to her home in Wexford. Some of her friends had been involved in Repeal. She didn't consider herself very political, but she knew she would be providing abortion care as soon as Repeal was won. She wanted that to be available for women as a normal part of healthcare. She had been worried about protestors right from the start though. Once she had seen the anti-abortion activists campaigning against the referendum, she had expected them to keep up the same work after repeal. "And sure look, here they are."

Once she closes the door of the practice behind her, at least she can no longer hear the sounds of their prayers and chants. But in a way, the resistance was only just beginning.

She greets Mary at reception and walks straight into her office. She hangs up her coat, turns on the heating, and takes a seat at her desk. She starts her computer as she checks WhatsApp for any messages. She opens the START doctors' group.

Paul: Having difficulties referring for scan atm. Long waiting times for patients here in Cork. Is anyone else having problems too?

Joy: [sad face emoji] Haven't noticed anything here in Galway, most patients presenting at 6-7 weeks for now

Una: Same here. Was thinking of contacting clinical lead about it. Maybe everyone who is having issues can send a quick reaction so I have an idea of the numbers? Might be stronger case that way

Paul: That would be great Una! Thanks a mill

Emily quickly scrolls down to see that a few people have responded already. At least it's good that they all get to support each other through the group.

She moves on and checks her calendar. She has been trying to get one of her patients referred to hospital for an abortion. She is over 9 weeks pregnant, so Emily herself is not allowed to administer the full medication for a medical abortion to her. The patient knew she was pregnant at 6 weeks already back in December 2018, but she had been waiting for the rollout of abortion services this January. That put her at 9 weeks and 6 days now, to Emily's calculations.

The implementation of the services was not without its hiccups yet, and it was especially difficult to establish a good working relationship with the local hospital. Although there is one obstetrician who is very pro-abortion and a huge advocate, the majority of the staff involved are conscientious objectors or at least very reluctant to be involved. When she called last week, no one had wanted to speak to her on the phone and they told her to put in an email request. She did that, but she still hasn't heard anything back.

In the meantime, Emily worries for her patient, but also for what might happen if she is somehow implicated in the referral of someone who is over 12 weeks.

She calls the hospital again. This time, she gets hold of one of the more supportive nurses. "It's been really hard to see women coming in, knowing that they struggle and not being able to help them."

Two days later, the patient, Lisa, is admitted to hospital when she is 10 weeks and one day pregnant. Emily had given her the mifepristone first, and the next morning she was admitted to the hospital for the second medication, misoprostol. She stayed there and was monitored for the rest of the day.

Three weeks later, she sees Lisa again for her follow-up consultation. Lisa indicated that she would like to discuss contraception, and Emily was happy to evaluate the abortion care experience with her.

"They put me in the labour ward without a private room," Lisa starts telling her. "I was there in a bed surrounded by people who were excited and happy with their pregnancies! I basically had to deliver the baby I didn't want in a room full of pregnant people." She takes a breath and continues, "I hadn't imagined it would be like this."

Emily looks at her and isn't entirely sure what to say.

Lisa continues, "I thought that, because they now insist that it is healthcare and it is available in Ireland, I thought that… at least I would be treated with some dignity."

"I'm sorry you feel that way, Lisa," Emily finally responds. "I know it is horrible, but at least you were able to get the care you needed here, in Ireland. At least you didn't have to do anything illegal, or travel, do you know?"

She feels her own anger raging inside of her, but it wouldn't be helpful for Lisa to lose control of her emotions. She has to focus on just being supportive to her now. Acknowledge her experience. Validate how she feels. Care for her.

Remembering a different situation, Emily's thoughts go to another one of her patients, Caroline. She had been refused by her own GP because she was so close to 9 weeks. That GP had referred her to get an ultrasound scan, but when Caroline reached out to Emily instead, Emily got hold of the other doctor and managed to get them to agree on their consultation to count as the first appointment. That way, Emily could still prescribe Caroline mifepristone and misoprostol right away.

Sometimes, it worked. But most of the time, she was just tired.

The ethno-fictional vignette analyses the following key elements in Emily's experiences as a GP providing abortion services in community care. Firstly, the importance of the network between providers. Secondly, the tensions between governance as defined in the Health Act 2018 and the provision of care in practice. This shows up in two ways. To start, the difficulties of gestational limits in care provision show how legal elements become interpreted and mandated in clinical practice in a more conservative way than it was originally set up in legally. Additionally, how conscientious objection is used in practice – and how, again, the interpretation and use in practice leads to more restricted abortion care than the legal boundaries and definitions of conscientious objection set out to do. The third key element in Emily's experience is the issues around referral, the delays involved in this

process, and unclear care pathways between community and secondary care. Furthermore, the vignette also illustrates service users' experiences, and it illustrates some of the disappointment and shame that service users experience when they still struggle with their care experience under the Health Act 2018. The difficulties of that shame and disappointment for service users are exacerbated because the expectation was that the legalisation of abortion would bring a positive care experience.

6.2 Medical governance based on statutory practices and the need for a better service provider-oriented framework

The implementation of legalised abortion through healthcare services implicates medical professionals in these processes in complex ways, yet they are often homogenously presented as an expert category, without consideration of their individual experiences and perspectives, or the hierarchies within medical practice. Their experiences with abortion care are connected to how abortion governance is managed, and how they, in turn, inform abortion governance through medical knowledge and practice, as I explained in my conceptual framework. Medical practitioners form an important link in enacting the biopower of the State, in shaping the influence of the state through their clinical and institutional practices within biomedicine. This raises questions about how service providers navigate and negotiate the State's abortion policies.

In the research that has been done on medical practitioners' experiences with abortion care since its legalisation in Ireland, a major issue that comes forward is the lack of structural support, resources and training that medical practitioners receive from the Health Service Executive (O'Shaugnessy, O'Donoghue and Leitao, 2021; Power, Meany and O'Donoghue, 2021). Considering that many of the practicing medical professionals were educated and received their training and work experience during the constitutional ban on abortion, it is likely that very few of them have significant experience with abortion care, and that any experience that has been accrued has most likely been obtained abroad.

In their study on staff knowledge and training, O'Shaughnessy, O'Donoghue and Leitao (2021) designed a questionnaire based on the interim clinical guidelines for abortion care under 12 weeks' gestation to explore knowledge and understanding of the legislation, information, and clinical practice of abortion care. They collected their

data between June 2019 and March 2020, with participants working as clinical staff in a large maternity hospital. The questionnaires were distributed in various work areas and 133 respondents have been included in the results. The questionnaire consisted of general demographic questions and five questions on the knowledge of the legislation, including multiple choice and true or false questions. The participants' opinions about the inclusion of different aspects of abortion care education in curricula for students were asked, as well as what they believed to be important aspects of abortion care provision. Additionally, they were asked about challenges and barriers to the implementation of abortion care.

One of the findings was that a large majority of the respondents had not received training on termination of pregnancy services, with "only 26% stating that they had previously received training or education on the topic" and a mere "11.4% stated that they had received training specifically for the introduction of the termination of pregnancy service" (O'Shaughnessy, O'Donoghue and Leitao, 2021, p. 3).

The respondents also indicated that they thought that medical and healthcare students should be given more training on abortion care regarding a wide range of issues, from general knowledge to legal aspects and counselling, for example (O'Shaughnessy, O'Donoghue and Leitao, 2021, p. 4). As I highlighted in 'Identifying and mapping abortion governance' (Chapter 5), medical practitioners indicate a significant problem with the training and resources to implement abortion care services that is made available by the HSE on a structural level.

Furthermore, in their study on what it is like for foetal medicine specialists to work with the diagnosis and management of fatal foetal anomalies under section 11 of the Health Act 2018, Power, Meany and O'Donoghue (2020) found that foetal medicine specialists experienced difficulties when implementing abortion services in the absence of institutional support. Between November 2019 and January 2020, Power conducted semi-structured interviews with 10 people out of a total of 27 foetal medicine specialists in Ireland were interviewed, thus representing a significant part of the professional group, although the study mentions that there is varied involvement in abortion care from all 27 specialists. Thematic analysis was used to analyse the interview transcripts.

Four themes are identified in the study, first of all, under the theme 'not fatal enough', participants shared their fear of prosecution and scrutiny around the

diagnosis of a foetal anomaly, and whether it is fatal. Secondly, in 'interactions with colleagues', the medical specialists highlighted the crucial role that multidisciplinary teams play and how important midwives are in abortion care provision for patients, and for peer support among colleagues. However, difficulties and frustration in implementing abortion services were also mentioned, as well as the negative effects of conscientious objectors and conscientious 'obstruction', as it was referred to by some of the participants. Thirdly, under 'support for pregnant women', the participants expressed the importance in how they delivered news to patients about an FFA diagnosis and their encouragement for pregnant people to have support when they receive the diagnosis. Fourthly, the theme 'internal conflict and emotional challenges' concerned the internal conflict that almost all foetal medicine specialists experienced in their work. It is clear that it is experienced as a burden at times do be involved in their line of work, even when they acknowledge that it is 'the right thing to do' and that they want to provide the full range of care for women and pregnant people.

What further stands out is that foetal medicine specialists describe that they had to 'self-prepare', which is a theme that also emerges from general practitioners who provide abortion care (Mullally et al., 2020). The medical practitioners who stepped up as 'champions' of abortion provision are hugely important, and they point to a group of medical practitioners who distinguish themselves in exercising their agency in organising abortion care (Mishtal et al., 2022a). Yet the need for individual providers to step up also indicates a structural problem with provision overall. Successful provision is heavily dependent on individual doctors, nurses and midwives, and is far from being guaranteed across Ireland.

In addition to insufficient training and resources to provide what was a new service, medical practitioners are also struggling in a generally overworked system (Kennedy, 2021, p.17). Doctors' commitment to providing abortion care, "in spite of the daily pressures experienced by doctors working within HSE where maternity services are under severe pressure, gynaecology waiting lists are long, all of which has been compounded by the stresses of Covid-19, the problems with CervicalCheck and recruitment of doctors, nurses and midwives" (Kennedy, 2021, p. 17), is an undue burden that they should not have to carry for successful care provision. A providing GP shared in the WHO study: "People have felt very snowed under" and "they feel that they've no more space in their life to take on an extra role" (Mishtal et al., 2022a,

p. 17. The resources and standards for reproductive care were already lacking before abortion care was implemented and doctors struggle to take on additional work.

Keeping in mind the longer, ongoing issues in healthcare provision, it becomes clearer how little abortion governance is centred around providers' experiences and reflects their engagements with care. The swift implementation of abortion services on 1 January 2019 after the referendum on 25 May 2018 is commendable in terms of the priority that was given to the service implementation (Donnelly and Murray, 2020), but it illustrates tensions between governance interests of the State and the experiences for care providers on the ground. Medical practitioners who were committed to providing abortion care have had to rely on their own and their colleagues' input and initiative (Mishtal et al., 2022a; Mullally et al., 2020; Power, Meany and O'Donoghue, 2020). Before the provision of care was implemented, some medical practitioners, such as foetal medicine specialist Keelin O'Donoghue, indicated that issues would result from the short time frame in which abortion care had to be implemented (Irish Examiner, 2018). It seems that there was very little consideration by the government to accommodate these experiences from medical practitioners into a provider-oriented framework for care provision.

6.3 How the law regulates care provision: Issues experienced from the legislation

The legal distinction between medical abortion care in community provision under 10 weeks' gestation, and medical or surgical abortions in hospital setting thereafter, also contributes to stigma as an additional challenge for medical staff involved in abortion care. Dempsey et al. (2021) theorise that this might have to do with the particular moral taint that is attached to surgical abortion methods more so than non-surgical methods. This complicates the role of providers in offering abortion care, because they have to navigate two additionally stigmatising work circumstances: abortion as such and surgical abortion specifically. Even when surgical abortions between 10- and 12-weeks' gestation fall under section 12 of the Health Act 2018, which allows abortion care in early pregnancy 'on request', there is still the stigmatising aspect of the surgical methods. The singling out of surgical abortion plays into the ongoing moralisation of abortion, despite legalisation and implementation of abortion care services. Still, that the law creates a difference between the grounds for an abortion before and after 12 weeks' gestation also sustains the centrality of the foetus.

However, an intriguing extension of this argument lies within the Irish hospital context, where a notable inclination toward medication abortion persists for a multiplicity of reasons and circumstances. The dynamics of abortion methods become clearer when considering the constraints on access to operating theaters and the intricate challenges posed by hospital staff, including midwives and nurses who often play dual roles as theater managers (Stifani et al., 2022; Donnelly and Murray, 2019). Considering this wider perspective on the work for medical staff in abortion provision offers valuable perspectives into the complexities of decision-making within Irish hospital settings, illuminating a nuanced interplay of factors that influence the prevalent choice of medication abortion over its surgical counterpart.

For foetal medicine specialists specifically, significant issues arise from section 11 in the Health Act 2018, regarding a condition likely to lead to the death of the foetus. There is evidence to suggest that the governance of only legitimising abortion care for a *fatal* foetal diagnosis, places stress and anxiety on the medical practitioners who are responsible for providing this diagnosis. For example, Power, Meaney and O'Donoghue's study (2021) with foetal medicine specialists found that foetal medicine specialists experience uncertainty, anxiety and fear of potential consequences over the diagnosis of an FFA. In an area of medical practice where "'there is never any certainty' when death will occur and there is always an 'outlier'" (Power, Meaney and O'Donoghue, 2021, p. 679). The law seems to set parameters for clinical practice in a way that is too rigid for medical practitioners to enact their medical knowledge and expertise. Instead, they have to work with the fear of 'getting it wrong' and the difficulty in establishing whether there are grounds for an abortion.

For early medical abortions too, the law remains an uncomfortable influence on clinical practice and the care that practitioners can provide to their patients. In her address to the Committee on Health on the session on 'Engagement to discuss issues that may be relevant to the Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018' on 27 April 2022, Dr Caitriona Henchion from the IFPA described that abortion more so than any other procedure, required the law to be so clearly present during medical consultations: "In no other consultation do you talk so much about the law as in abortion" (Henchion, 2022).

I further discuss particular elements of the Health Act 2018 and their effects in the subsequent chapters, but a crucial influence to consider for medical practitioners' experiences is the ongoing criminalisation of abortion care that is contained within the

legislation (under section 23 of the Act). In the same address to the Committee on Health, Director of Advocacy and Communications with the IFPA Maeve Taylor explains,

> outside sections 9 to 12, abortion is subject to prosecution and to harsh punishment on conviction. Criminalisation of abortion relegates it to the margins of healthcare and the European Court of Human Rights recognise this in the A, B, C vs Ireland case. Criminal laws, even when they are not aggressively enforced, create a chilling effect on healthcare providers (Taylor, 2022)

Practicing a complex area of care under the constraints of a restrictive legislation that provides for criminalisation of medical professionals causes fear among medical practitioners. As another practitioner highlights in Power, Meaney and O'Donoghue's study (2020), "[P]eople are nervous about being that first person who might be prosecuted... when people have to put their name on something or their head is on the line there is a fear for sure," (direct quote from a participant in Power, Meaney and O'Donoghue, 2021, p. 678).

That exceptionalisation of abortion care and its relegation to the margins of healthcare, is another form of non-acknowledgment of the normalisation of abortion care by the Irish State. Although abortion is within healthcare provision, as a medical practice, it continues to be set apart from other medical practices. Abortion continues to be exceptionalised within medical care and the legal governance continues to be highly restrictive and regulated, thus severely impacting abortion providers. Through the way the law is present within all practices of abortion care provision and specifically how abortion care is legislated for – through distinguishing earlier and later gestation and by legally defining the fatality of a foetal anomaly, for example – demonstrate the ongoing moralisation of abortion, also within healthcare. That moralisation also facilitates the ongoing invisibilisation of abortion care services, and the experiences of those who provide and receive them.

On the other hand, the law proved to be open to interpretation to allow for telemedicine during the COVID-19 pandemic. In the Dáil Éireann debate on Emergency Measures in the Public Interest (Covid-19) Bill on 26 March 2020, the Minister for Health framed the introduction of telemedicine as an issue of ongoing

access to abortion care and said that abortion care, "is and should be no different from any other health service in this way" (Donnelly, 2020). He deemed that the sections of the law pertaining to doctors' consultations did not contain any specific stipulation that the consultations have to take place in-person. The selective attitude towards abortion care as 'normal' healthcare in the case of ensuring ongoing access during pandemic circumstances, while the potential for criminalisation of abortion providers continues, paints a complex and ambiguous picture of how the Irish State regulates abortion care. Tension emerges between sometimes arguing for access but continuing with a restrictive law at the same time, as well as tension between the attention to the experiences of service users, but less so to service providers. The emerging paradoxes within the post-Repeal abortion regime will be further explored through the analysis of dominant political and public discourses in Chapter 7 and 8.

6.4 Connections between governance and practice: clinical guidelines and hierarchies among medical practitioners

With the introduction of abortion legislation, the Institute of Obstetricians and Gynaecologists created three separate guideline documents, firstly, the Interim Clinical Guidelines on Termination of Pregnancy Under 12 Weeks (2018), secondly, the Interim Clinical Guidance on Pathway for Management of Fatal Fetal Anomalies and/or Life-Limiting Conditions During Pregnancy: Termination of Pregnancy (2019), and, thirdly, the Interim Clinical Guidance on Risk to Life or Health of a Pregnant Woman in Relation to Termination of Pregnancy (2019). Additionally, the Irish College of General Practitioners (ICGP) created the Interim Clinical Guidelines on Termination of Pregnancy Services (2018). In all of the Institute of Obstetricians and Gynaecologists' guidelines, multidisciplinary team discussions, made up of a range of medical staff, are underscored as important in facilitating abortion care. Under the COVID-19 pandemic "increasing task-sharing, by permitting nurses and midwives to carry out TM [telemedicine] abortion consultation" was facilitated (Spillane et al., 2021, p. 381). However, legal responsibility remains with the medical specialists, as the Health Act 2018 specifically defines that the circumstances for sections 9, 10 and 11 need to be determined by two medical experts. That contributes to the anxieties described by foetal medicine specialists in being legally responsible to determine whether a foetal diagnosis is *fatal enough*. Although the clinical knowledge

and experiences point to the benefits of a collaborative approach among medical practitioners with various specialisms, the legal requirements that a physician – for some sections two – needs to determine the lawfulness of the procedure, complicate such a way of working. The law disincentivises a more collaborative way of providing care in limiting key decision-making to medical specialists, in opposition to the clinical guidelines from the IOG and the ICGP.

Mullally et al. (2020) reflect on the first 18 months of community service provision in their article 'Working in the shadows, under the spotlight – Reflections on lessons learnt in the Republic of Ireland after the first 18 months of more liberal Abortion Care'. They contend that while most of the set-up of services in community care has gone well, "one of the most important barriers to expanding GP provision in Ireland now is the lack of standardised national referral pathways into and out of secondary care" (Mullally et al., 2020, p. 306). In Mishtal et al.'s (2022a) research on the lessons from the implementation of abortion services in community care, unclear or slow referral pathways to hospitals also came forward as one of the main remaining challenges in community abortion care. To further examine and visualise care pathways and referral pathways, the tables below are based on the HSE Draft Model of Care for the Termination of Pregnancy Services (2018) as disseminated by the Irish General Practice Nurses Educational Association. The full overview of care pathways is included in Appendix 7, 8 and 9.

Firstly, when it is an early medical abortion in community care, the following key decisions are important for medical practitioners.

Table 6.1: Brief overview of key steps in community care pathway

	Community Care key steps
Visit 1	• Dating pregnancy • Potential referral for ultrasound
Visit 2	• Re-certify gestational age • Explain the procedure • Administer first medication – mifepristone • Advise & provide written information on what to expect/possible complications • Provide information for My Options

	• Notification of record
Visit 3 (optional)	• Potential fruther after care and/or referral

Source: Irish General Practice Nurses Educational Association (2018) HSE Draft Model of Care for the Termination of Pregnancy Service 18.12.18

Additionally, the secondary care pathway outlines a distinct pathway for both medical and surgical abortions. For a medical abortion, the pathway starts off similar to community care provision, but develops distinctly when the pregnant person is between 9 and 12 weeks pregnant. In that case the second medication for a medical abortion, misoprostol, is taken in hospital rather than at home. The service user is referred to hospital during Visit 1 in Community care.

Table 6.2: Brief overview of key steps in secondary care pathway for medical abortion

Secondary Care medical abortion key steps

Visit 2	• Provide ultrasound if clinically indicated • Re-certify person not exceeding 12 weeks, if a different doctor sees the person at visit 2 • FBC/rhesus testing • Obtain informed consent • Administer first medication – mifepristone • Advise & provide written information on what to expect/possible complications/pain medication
Visit 3	• Administer second medication – misoprostol • Monitor and re-administer medication, as required (admission for up to 8 hours in the hospital, if required/overnight stay may also be required on rare occassions)
Visit 4 (optional) Community or Secondary Care	• Aftercare consultation as Visit 3 under Community care

Source: Irish General Practice Nurses Educational Association (2018) HSE Draft Model of Care for the Termination of Pregnancy Service 18.12.18

Moreover, surgical abortions under 12 weeks' gestation also follow a distinct pathway.

Table 6.3: Brief overview of key steps in secondary care pathway for surgical abortion

	Surgical abortion pathway key points
Visit 1 **Community Care**	• Certify that prengnacy is not exceeding 12 weeks • Refer to hospital
Visit 2 **Secondary Care**	• Provide ultrasound scan if clinically indicated • Re-certify person is not exceeding 12 weeks, if a different doctor sees the person at visit 2 • Access elective surgical care pathway (according to local hospital policy) if general anaesthesia is required • Surgical TOP as day case
Visit 3 **Community or Secondary Care**	• Aftercare consultation as per Visit 3 under Community care

Source: Irish General Practice Nurses Educational Association (2018) HSE Draft Model of Care for the Termination of Pregnancy Service 18.12.18

In all of these pathways, the many different layers of care are all grouped together without distinction as to how a team can best divide the work. For example, maybe the consultation might be done by a nurse or midwife, whereas the prescription for contraception and referral to further care would be done by a physician. Especially for surgical care, a team would be involved with many different aspects of care involved – from administration to anaesthesisa – which is not necessarily visible in the outlined care pathways. The guidelines, then, as well as the law, invisibilise this collaborative,

multi-layered aspect of abortion care provision in that it only specifies the role of the medical practitioner who is the key decision-maker. This stands in contrast to the collaborative approach between various healthcare professionals that is recommended by the WHO (WHO Abortion care guideline, 2022).

6.5 Views on care and morality: conscientious objection

An analysis of how conscientious objection features in ongoing moral governance will be further discussed in Chapter 7 and Chapter 8. Here, I focus on what its practical impact is for service provision. Conscientious objection is defined under the Health Act 2018 in section 22, subsection 1:

> nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to participate in carrying out, a termination of pregnancy in accordance with *section 9*, *11* or *12* to which he or she has a conscientious objection.

Under the grounds of early pregnancy, a risk to life or health, or a fatal foetal anomaly, medical professionals are legally allowed to refuse to perform an abortion. However, in the case of risk to life or health of a pregnant person in an emergency, all medical professionals are legally bound to treat that person.

It is further defined that medical professionals still have a duty to refer the pregnant person:

> A person who has a conscientious objection referred to in *subsection (1)* shall, as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the termination of pregnancy concerned.

A more situated understanding of conscientious objection, how it might come up in medical practice, and how it has to be managed within a healthcare setting, is not part of the legal framework. Although there is a legal obligation for a non-providing practitioner to transfer the care of the pregnant person, experiences from abortion providers still confirm the transfer of care can cause serious delays (Power, Meaney

and O'Donoghue, 2021; Mishtal et al., 2022a). Some of the foetal medicine specialists in Power, Meaney and O'Donoghue's (2021) research acknowledged that they are frustrated with the opposition and delays from conscientious objection, and that they feel undervalued and underacknowledged in the difficulties that are associated with their work.

Two legal scholars in University College Cork, Donnelly and Murray (2020, p. 129) lay out what is expected from a medical practitioner who chooses not to provide abortion care if it conflicts with their ethical or moral values:

> The Guide affirms clinicians' ethical entitlement to refuse to provide or to participate in the carrying out of a procedure, lawful treatment or form of care which conflicts with the clinician's 'sincerely held ethical or moral values' (para. 49.1). It then sets out what clinicians who have a conscientious objection must do. This includes informing patients, colleagues and employers as soon as possible (para. 49.2); informing the patient that s/he has a right to seek treatment from another doctor and giving the patient enough information to enable him or her to transfer care (para. 49.3).

'The Guide' is the eighth edition of the Medical Council's Ethics Working Group 'Guide to Professional Conduct and Ethics'.

The lack of a central database and further clarity on what the management around conscientious objection should look like, makes it difficult to gather information on whether medical practitioners follow the Medical Council's ethics guidelines. It also makes it impossible to enforce a proper course of action or any kind of follow-up in case any issues around conscientious objection arise. This relative invisibility of conscientious objection and how it is practiced implicates, potentially, other structural issues around provision. It is sometimes impossible to identify where there is a capacity or infrastructure issue at play, or perhaps an issue of conscientious objection, as was discussed on 27 April 2022 during the Committee on Health debate with the IFPA and the NWCI to address issues for the Review of the Health Act 2018. As Maeve Taylor, Director of Advocacy and Communications with the IFPA summed up:

> the legislative framework is creating barriers regarding conscientious objection. It privileges refusal as the only exercise of conscience and this can play into the wider "abortion ecosystem", to use that phrase (Taylor, 2022).

Dr Caitriona Henchion, Medical Director with the IFPA, further outlined the problems with the relative invisibility of how conscientious objection is practiced:

> It is also important for someone to be able to expect to go to his or her GP for any basic healthcare. Not all GPs fit intrauterine devices, for example, but they should be able immediately to direct the patient where to go and offer any assistance the patient may need, whether it is a prescription or whatever. That is where the difference is. Patients should not have to call reception and be told they cannot see the doctor because a given service is not provided there, without being given anything else. In fact, that would not even be recorded as a refusal of care because the person would never even get to see a doctor. If a patient rings a GP practice, which takes a lot of courage, and is just told "No", that will never be recorded anywhere (Henchion, 2022).

A key part to better facilitate this standard of care is to improve education and medical training. There is an opportunity instead to reframe conscious provision, and to work on education and values clarification with medical professionals.

A database, however, or some type of registration to visibilise conscientious objectors is perhaps not recommended. At the same meeting of the Committee on Health on April 27, 2022, Allison Spillane, Senior Policy and Research Officer for the IFPA, explains that this has had some unintended consequences in Italy:

> It has been a barrier to access to abortion in Italy, where there is a register of objectors. What has happened there is it has become the default. When someone qualifies as a doctor, he or she goes on the register because abortion is stigmatised. It involves additional work and perhaps some additional training, and if a doctor wants to progress his or her career within medicine, he or she will go on the register because people do not want to be associated with that type of healthcare (Spillane, 2022).

Spillane illustrates here how conscientious objection can become more widely embedded in healthcare provision, and how a system can also be significantly inhibiting for medical practitioners to become abortion providers. When conscientious objection is a central part of abortion care provision, and thus perpetuates the exceptionalisation and the moral framing of abortion care within medicine, doctors are disincentivised from providing, rather than encouraged to do so.

In short, abortion providers have to navigate a complex legal, medical, and social landscape – and often receive insufficient support, training and resources from the Irish State to do so. Conscientious objection is a clear example of how moral governance continues under the Health Act 2018, in addition to the stigmatisation of surgical abortion methods and the diagnosis of an FFA as discussed above. Some of the defining parameters for abortion care, namely the Health Act 2018, and care and referral pathways, are not conducive for care provision.

6.6 Conclusion

This chapter examined how the regulation and control of knowledge continues to be an important post-Repeal abortion governance mechanism. I draw on providers' experiences, medical guidelines, and information and resources for the general public to analyse the relations between the State, medical practitioners, and the general public in the navigation and translation of knowledge on abortion. The ethno-fictional vignette 3 captured experiences for service providers. Emily's story illustrates some of the difficulties that abortion providers might encounter, and how they need to navigate the tensions between legal definitions of abortion care, protests around healthcare facilities, and the type of care they want to enact for their patients. It also shows how important a support network among abortion providers is.

Primarily, the analysis makes clear that there is a need for a more provider-centred approach to abortion care provision through a number of issues. Firstly, research on experiences of abortion providers identifies a lack of support and resources for medical practitioners (O'Shaugnessy, O'Donoghue and Leitao, 2021; Power, Meany and O'Donoghue, 2020). Secondly, the Health Act 2018, and particularly section 11 on fatal foetal anomalies, are insufficiently set up for best medical practice to be the guiding principle in abortion care (Power, Meany and O'Donoghue, 2020). Thirdly, the exceptionalisation of abortion continues through legal elements that

substantially restrict medical practice, such as the distinction between medical abortion for up to 10 weeks' gestation in community care and in hospital care for 10-12 weeks' gestation and the definition for fatal foetal anomalies under section 11 of the Health Act 2018. The ongoing criminalisation for abortion providers causes significant fear and nervousness for providers, also in early medical provision, according to Maeve Taylor from the IFPA.

Moreover, I have identified connections between abortion governance and its implementation in practice. The legal requirement for two medical specialists to identify the grounds for an abortion under section 9, 10, and 11, and the definition of an abortion provider as excluding nurses and midwives, significantly limits the multidisciplinary collaboration and provision of care. Additionally, the referral and collaboration between community care and secondary care, show significant discrepancies in care pathways as they are officially set up. This invisibilises the teamwork that makes up abortion care in practice, and it limits the further expansion of care as it is recommended by the WHO abortion care guidelines (WHO, 2022).

Furthermore, conscientious objection as it is included in the Health Act 2018 and regulated becomes a significant obstacle for care provision, in that it can be widely applied by medical practitioners (arguably in a way that it was not intended to do) and becomes a significant barrier to care or an enactment of obstruction. The relative invisibility of conscientious objection, the lack of regulation and possibility for follow-up with medical practitioners, makes this a barrier that is unique to abortion care.

Besides the practical impact for service provision, Chapter 7 explores various legal and clinical elements form barriers and obstructions through post-Repeal discourses on abortion care. Chapter 8 analyses the subsequent reluctance from the government to engage with the practical issues in service provision that emerged during the first three years after the implementation of abortion care services, and how stalling and delaying of further change has been perpetuated through the process of the Review of the Health Act 2018.

Chapter 7: The politics of language and discursive mobilisations of health and rights

7.1 Introduction

The politics of language on abortion is a decisive area of analysis for this thesis. Paying attention to language and which actors use particular words at particular times guides the investigation of which discursive practices deny, embody, and enlist agency, and how they do so (Calkin, 2019; Deveaux, 1994; Enright, 2020). There are, of course, political implications to terminology and use of language (Foucault, 1990b). With the transition to legal abortion services, discourses have shifted from a pre-Repeal focus on abortion as a legal and moral issue, to a focus on abortion as healthcare (see Calkin, 2019; Cullen and Korolczuk, 2019). As feminist scholars and researchers working on reproductive justice have argued, framing abortion as healthcare has been fundamental in advancing reproductive rights, but it has also limited the acknowledgment of reproductive autonomy as a fundamental human right (Morgan, 2017). I take a closer look at how abortion as an issue of healthcare offers a seemingly useful strategy to advance reproductive rights, but also nurtures a lingering moral framing of abortion that hinders reproductive justice.

In this chapter, I examine the political and public discourses that emerged around the government's Review of the provision under the Health Act 2018, and the two Bills that have been introduced during the first three years of abortion provision, the Safe Access Zones Bill and the Foetal Pain Relief Bill. I pay attention to particular effects of a politics of language in debates on abortion in Ireland in three ways. I first investigate how issues around agency, accountability, responsibility, and autonomy are constructed and featured in discourses. Particularly, I examine how the Irish State (and its abortion regime) is able to employ a language that largely absolves the State from direct responsibility. Secondly, I look into how personhood and the position of the foetus are featured discursively. This marks a significant move away from past discourses and the previous regime's reliance on 'the right to life of the unborn' as compromising reproductive rights for women and pregnant people, and foetal personhood is now connected to the regulation under the Health Act 2018, as will be examined here. Thirdly, I examine how pregnant people are homogenised in the debates on 'abortion as healthcare'. I show how intersectional and stratified experiences are not taken into account in the dominant discourses on 'women's

healthcare'. Normative notions of sexuality and family are reproduced to obscure more diverse factors that determine experiences with abortion care and to continue the regulation of reproduction. While there is thus a significant shift in discursive mobilisations of different understandings of abortion since the implementation of abortion care, competing moral concepts are remade and made new in post-Repeal political discourses.

7.2 Language to un/do agency: Barriers and obstructions in abortion care in the Review of the Health Act 2018

As I outlined in my conceptual framework, the particular production of discursive practices focused on objective, neutral, operational processes, is one of the mechanisms through which a moral regime operates (Lorenzini, 2016; Morgan and Roberts, 2012). The Irish State has adopted a language around abortion provision and the Review of the Health Act 2018 (considering the first three years of provision under the Health Act 2018) that creates a certain distance between the State and abortion care, focusing on structural and logistical elements of provision. The State's discourses on (un)agentic factors in the execution of the abortion care framework mostly places issues of access and provision outside of State governance. For instance, the Minister for Health, Stephen Donnelly, stressed in his opening statement about the Review of the Health Act 2018 to the Joint Committee on Health on 8 December 2021: "It is important to say that, in the first instance, the review will focus on the operation of the legislation, rather than on the policy underlying the Act" (Donnelly, 2021a). This reluctance to engage with the underlying policy of abortion care reinforces the notion that abortion 'as healthcare' can somehow be separated from larger issues around reproductive justice, issues of gender equality and inequities in healthcare. Instead, the information and experiences that indicate that there are ongoing issues with abortion care (as identified by ARC and Grimes (2021), Kennedy (2021) and Mishtal et al. (2022a)) are treated as operational matters that need to be addressed separately from the legislation.

Knowledge of ongoing issues with abortion care – some of which, such as the uneven distribution of care, the lack of information on abortion services, unclear care and referral pathways, and delays in the provision of care, I have already revealed in my previous Chapters 5 and 6 – has already been acquired and communicated in

political debates, as the Minister for Health himself pointed out in the same meeting in which he announced the commencement of the Review of the Health Act 2018:

> I am not currently satisfied with the level of provision geographically across the country. From my perspective, it is a part of our healthcare system that should be as easily accessible as possible. We have quite rightly provided for conscientious objection given the unique nature of this service. I do not believe we have achieved the level of geographic coverage and ease of access that is required. […] This is exactly the kind of issue that we will be looking to the review in terms of the best way of achieving broader coverage (Donnelly, 2021a).

The acknowledgement from the Minister that the geographic coverage and ease of access that were intended under the law have not been achieved during the first three years of abortion provision, generated considerable critique from members of the Oireachtas Committee on Health during the meeting about the scope and structure of the Review of the Health Act 2018. One of the Deputies replied that it seems "that it has been possible to frustrate the objectives of the legislation", and that it is "unsatisfactory from the point of view of the legislated position that three years after its operation there is still a serious intermittency in its application" (Durkan, 2021). When Minister Donnelly further confirmed this, the Deputy asked why an earlier intervention had not been acted on, considering that the Act has been proven to be ineffective even before the Review had commenced. A question to which he received no definitive answer, other than that efforts have been initiated by the Department of Health and would be reinitiated.

The history of abortion governance in Ireland as discussed in Chapter 3 and the service provision in Chapter 6 show that there was a notable shift in debates on the Repeal of the Eighth Amendment campaign and that medical professionals took a more prominent role in public. Especially Doctors for Choice have been instrumental in the legalisation of abortion since their inception in the early 2000s, and framing abortion as a matter of healthcare. The processes of the Citizens' Assembly (2016) and the Joint Oireachtas Committee (2017) saw many medical experts present and a general framing of abortion as a healthcare procedure was fundamental in ensuring the legalisation of abortion. In the aftermath of the implementation of abortion care,

however, the State also largely placed responsibility with the provision of care with healthcare providers, distancing themselves from involvement in provision, despite significant issues in implementation being flagged by healthcare professionals, as I have shown in Chapters 5 and 6. As one foetal medicine specialist sums up in a piece in the Business Post on 7 July 2019, "there has been no leadership, little resourcing, limited education and a fundamental failure to recognise the complexities involved" (O'Donoghue, 2019). The lack of State resources and support in implementing abortion services leave abortion care mainly as the responsibility of providers. Moreover, it constructs abortion care as separate from the legislation that underpins it, as a logistical and operational process that can be addressed without the underlying political contestations. Referring to the Review process, Minister Donnelly commented that "we need to be very clear that this is not a review of the policy. The policy is agreed. It is a review of the operation of the policy. If the operation of the policy uncovers issues that require recommendations on the policy, that is in scope" (Donnelly, 2021a). Thus, the Minister does not entirely exclude the option of "recommendations on the policy", but the need for recommendations on the policy would first have to be 'uncovered' through the review (Donnelly, 2021a).

Yet a number of studies (Mishtal et al. (2022a); Kennedy (2021); ARC and Grimes (2021); Conlon, Antosik-Parsons and Butler (2022)) have clearly identified a number of elements *within* the law as barriers to abortion care. According to findings from these studies, and as discussed, the law itself places significant restrictions on abortion care access and provision and a number of legal aspects significantly shape abortion provision in practice, namely, the ongoing criminalisation of abortion and abortion providers; conscientious objection and the lack of legal registration for it; the 12-week gestational limit for an abortion upon request; and the 72-hour waiting period between the first appointment and the abortion procedure. These legal elements mark abortion as a significant exception in law compared to other medical procedures. How then, are issues of provision and access constructed as operational, rather than inherently political?

To take a closer look at how abortion care access and provision might be *politically* contentious, I identify barriers and obstructions to abortion care as two distinct experiences. A barrier can be any aspect of the legislation or clinical practice that increases difficulties and complications for a service user to gain access to abortion care. I take barriers to be structural, systemic elements of law and policy that

affect the accessibility of care. Here, wider social issues that affect women and pregnant people's ability to choose and to act autonomously also come in (Ross, 2017). Barriers include the structural elements that reproductive justice importantly adds to considerations of agency in reproductive health and rights. Besides barriers, I consider an obstruction as any intentional action of an actor involved in abortion care to increase difficulties and complications for a service user to gain access to abortion care. Following this distinction, it is clear that an obstruction is agentic, mediated by whomever engages with it directly, and thus also highly localised and particular to a specific context. It is important to make this distinction because it ensures that moral governance can be examined on both the macropolitical and the micropolitical level. Moral governance plays out on both those levels and works through larger structures as well as everyday acts from individuals. Who is ascribed and takes on agency and when, is important.

Sometimes, multiple agentic acts – sometimes, but not always intended as obstruction – can become entangled with other barriers and form a systemic barrier. It might take one conscientious objector in a hospital, an agentic act, to limit the care that is available at a hospital as an institution and a healthcare facility. The implications of this reach beyond the walls of that building when the hospital then cannot provide secondary care to local general practices. GPs have described that they cannot provide community abortion care if they do not have availability of support from a nearby hospital (Mishtal et al., 2022a). As Mullally et al. (2020, p. 306) report in their study of providers' experiences: "one of the most important barriers to expanding GP provision in Ireland now is the lack of standardised national referral pathways into and out of secondary care." Due to the lack of a standardised referral pathway and no guarantee that institutions will provide care, multiple agentic acts of medical practitioners' conscientious objection can consolidate systemic barriers based on geographical location. My second and third ethno-fictional vignettes of Sophie's and Mariana's stories illustrate how this compounding effect of multiple obstructions can affect people in their access to care. The vignettes bring out the embodied tensions that pregnant people might experience when they navigate information on abortion care, making sense of what care they are eligible for, medical consultations and scans, doctors who can be helpful or obstructive, travel to a healthcare facility, and more. My analysis of the barriers to abortion care access is importantly presented in the ethno-

fictional vignettes in order to better convey the consequences of barriers and obstructions to abortion care for the people experience them.

In political and public debates on ongoing issues in abortion care and access provision, different descriptions of agency are invoked in order to advocate for the expansion of access. In the context of the emerging abortion services, there is a tension between the agency that pregnant people and service providers exercise and the structural elements that impede access and provision. At times, the structural, systemic barriers are highlighted by pro-abortion advocates. For example, the Chief Executive of the Irish Family Planning Association, Niall Behan, identified the mandatory waiting period and the 12-week gestational limit to "unacceptably undermine access for care" (Behan, 2021). Similarly, the National Women's Council note the law itself to act as a barrier, homing in on the legal framework itself: "From listening to women, we can see that, instead of creating an enabling legal framework, the law acts as a barrier, creating a series of obstacles that impede access to abortion" (O'Connor, 2022). The obstacles that are created by the law are, for example, the 3-day mandatory waiting period in section 12 and the definition of a fatal foetal anomaly in section 11 (Kennedy, 2021). Here, 'listening to women' is even set out in opposition to the law as a barrier. Alternative forms of knowledge, the embodied experiences from service users, speak to the systemic issues in the legislation. In this sense, agency of pregnant people can newly be enlisted to speak to necessary improvements to abortion as a legal healthcare service. Different forms of knowledge about women's healthcare are legitimised in the new context under the abortion legislation and through the process of the Review of the Health Act 2018.

However, a thorough examination of what accommodation, negotiation and contestation of moral governance looks like under the Health Act 2018 is necessary to understand how barriers and obstructions work. Focusing on systemic and agentic issues separately, obscures the more complex, structural effects of treating abortion as a morally contentious issue. This becomes clear through discursive mobilisations of conscientious objection. At an online activist meeting in June 2021 organised by the group Cork Rebels for Choice[25], abortion rights advocates argued for the use of 'refusal to provide care' or 'conscientious obstruction' instead of conscientious

[25] Rebels for Choice are a pro-abortion activist group in Cork. They are a local branch of the Abortion Rights Campaign and were part of the Together for Yes campaign for the Repeal of the Eighth Amendment.

objection, a call shared by many pro-abortion advocates since legalisation. Advocates' attempts to highlight the agentic capacities of medical practitioners, and their obligation to refer people at the very least, points to friction within the debates on abortion as a part of healthcare, and who is responsible for the delivery of that care. Emphasis on individual medical professionals and their refusal to provide abortion care, is mobilised by anti-abortion activists as well. In June 2022, the Iona Institute[26] reports that "Conscientious objection to abortion remains strong in Irish hospitals" (Bottone, 2022) after a study by Stefani et al. (2022, p.1) found that "conscientious objection is a persistent barrier to expanding abortion services". Regardless of the political position that activists hold, they construct a prominent position for individual responsibility and agency of conscientious objectors. It is precisely that agency *together with* existing, structural inequities in healthcare that contribute to the current landscape of uneven access and provision. The emphasis on conscientious objection and individual responsibility takes attention away from the State's overarching accountability in healthcare provision, marking it out as different from other medical services and continuing the invisibilisation of women and pregnant people's experiences.

In an effort to rethink negotiations of abortion governance, Donnelly and Murray (2020) suggest expanding the notion of conscientious care into an ethical framework for provision – to reclaim notions of conscience also in arguments *for* provision, rather than against it. They identify the ways in which "the emerging legal, ethical and clinical landscape impedes the conscientious provision of abortion care" (Donnelly and Murray, 2020, p. 127). Thinking through the multiple structural contexts that are relevant for abortion care – legal, ethical, and clinical – indicates the multiple areas of governance that construct abortion as healthcare under the Health Act 2018 and how conscientious objection might seem a matter of individual agency but is actually determined and contributes to forming by a number of social structures. As long as the legacy of morality lingers in the multiple governance frameworks, whether that is through conscientious objection or a three-day waiting period, it remains possible that entire State institutions (hospitals) still do not provide abortion

[26] Iona Institute is a national organisation that promotes anti-abortion values as part of their belief in Catholic social teachings.

care more than three years after it was implemented, even under State supervision and evaluation.

The State remains committed to their "triumph of concealment" that features in the conceptual framework: the process of the Review of the Health Act 2018 "contributes to deny the existence of connections and conflicts which would if recognised be incompatible with the claimed autonomy and integration of the state" (Abrams, 2006, p. 123). By not making the intricate connections between the issues in the operationalisation of the abortion law, the law's inherent barriers, and the situated history through which it has been produced, the further connections between obstructions and barriers under the abortion regime remain out of scope for critical consideration.

7.3 Language to un/do personhood: Safe Access Zones and Foetal Pain Relief

In past abortion governance, the protection and the rights of the foetus featured prominently in discourses on abortion. The move away from abortion as a moral issue, and to approach it as an issue of healthcare has been fundamental in advancing legal abortion in Ireland, has had implications for how abortion care subsequently became discussed. In the debates around the two Bills that have been proposed during the first three years of abortion provision, shifts in discursive mobilisations of concepts and meanings associated with abortion as healthcare can be detected. The Safe Access to Termination of Pregnancy Services Bill 2021 (Houses of the Oireachtas, 2021c) was successfully progressed by the Seanad and was undergoing pre-legislative scrutiny at the time of writing. Further consideration of the Health (Regulation of Termination of Pregnancy) (Foetal Pain Relief) Bill 2021 (Houses of the Oireachtas, 2021e) was suspended in the Daíl in December 2021 in order to allow for the Review of the operation of the Health Act 2018 to first bring forward its results. I assess the two Bills and their debates to trace shifting discourses on human rights, the protection of the foetus, and how competing effects of the scientific production of knowledge and current representations of healthcare play out in post-Repeal politics.

The issue of safe access zones has marked a transition in debates on competing rights. Advocates for safe access zones support the marking of an area around healthcare facilities to be free from protest, similar to what currently happens in

Ireland at polling stations at elections.[27] They base their approach on the right to healthcare, and to privacy and dignity. Central to the discourses on safe access zones are the traumatic effects of protest and harassment around healthcare facilities, and the *place* of protest. The legal status of abortion, and the construction of abortion as healthcare, is central to this, as the Minister for Health himself commented on the issue in a Seanad Debate: "nobody should be harassed, insulted, intimidated or interfered with in any way when accessing healthcare services in our country" (Donnelly, 2021b). Now that abortion is a part of legal healthcare, women and pregnant people have a right to abortion as a right to healthcare. This grants pregnant people a new type of acknowledgment of their personhood, as subjects under the law, in a way that did not occur under the Eighth Amendment.

Even so, formations of moral categories are not eliminated entirely through the new focus on healthcare. Rather, morality now comes to mean that the legitimate enforcement of the post-Repeal reproductive regime guarantees access to medical consultation. The new regime is required to demonstrate the break from the past by committing to the safe access to healthcare, whereas the harassment at healthcare facilities signifies a continuation of past harms, as supporter of the Safe Access Zones Bill Senator Lynn Boylan explains to the Seanad:

> Women have been treated with disrespect, distrust and disdain since the foundation of this State. Forcing them to run the gauntlet through protestors just so they can enter or leave healthcare facilities is nothing more than a continuation of that treatment (Boylan, 2021).

There is thus a noticeable shift in how categorisations of rights and healthcare are entwined with morality and personhood. The new moral order needs to be distinguished from the past reproductive regime of the State, where women and pregnant people's autonomy were not acknowledged. The attempted distinction from the past abortion regime and relations to the past governance mechanisms will be further explored in Chapter 8.

[27] The Electoral Act 1992 section 147 defines a zone of 100 meters around polling stations in which "a person shall not interfere with or obstruct or impede an elector going to or coming from or in the vicinity of or in a polling station" (Government of Ireland, 1992). Advocates for Safe Access Zones argue that there is thus legal precedent and an example to follow in terms of how to legislate for Safe Access Zones around healthcare facilities and how to enforce the zones.

However, morality and personhood are further entangled with rights and healthcare in post-Repeal political discourses. Anti-abortion discourses have also adopted medical and scientific arguments to implicate the place and personhood of the foetus, most notably in debates on the Foetal Pain Relief Bill. The premise of this Bill shows that the medical and scientific production of knowledge is sometimes mobilised to substantiate moral claims. Anti-abortion politicians continue to evoke discursive mobilisations of foetal personhood such as they did before the legalisation of abortion, albeit in different medicalised and scientific discourses. The proposal for a Foetal Pain Relief Bill draws on scientific concepts and developments to argue for the continued need to protect the foetus. As Deputy Carol Nolan introduces when she put the Bill forward on behalf of nine other co-sponsors:

> The infliction of unnecessary or avoidable pain on human beings, especially those with no capacity to resist, is something that all compassionate societies should seek to avoid. Thankfully, in most areas of modern medicine, this principle is routinely adopted in practice. This is why medical ethics require that surgical procedures, both routine and major, are carried out with the use of anaesthetics and analgesics […] an increasing body of scientific research, from approximately 2007 onwards, has suggested the brain and nervous system develop at a rate which means unborn babies may feel pain as early as 13 weeks (Nolan, 2021a).

The moral incentive not to inflict pain on a foetus is connected to scientific research which is supposed to contribute to the personhood of a foetus and justify legal tools to address this explicitly. Deputy Carol Nolan continues:

> Against the backdrop of the latest medical evidence, this leaves us with the possibility that every child subjected to a surgical abortion procedure after 12 weeks on these grounds [fatal foetal abnormalities or a threat to the life or health of the mother] not only has his or her life ended but has it ended in a manner in which he or she could be subjected to horrific pain and suffering in the process (Nolan, 2021a).

Although the medical evidence that is actually referenced in the Bill is a review of literature on foetal pain (Derbyshire and Bockman, 2019), rather than newly conducted scientific research, the construction of a medical and scientific justification is completely interwoven with emotive constructions of the foetus as a child. This discursive strategy is similar to pre-Repeal anti-abortion discourses, but now it has moved provision to focus on foetal personhood under the new legal and medical landscape of abortion provision.

However, the reactions in the debates indicate that most politicians no longer accept and support constructions of foetal personhood. As Holly Cairns argued against the proposed Bill, "the Bill is cloaked in language of compassion when in reality it is trying to drag us backwards and to have the debate all over again" (Cairns, 2021a). The discursive resistance to the anti-abortion focus on the foetus now has a fundamental trope: the Eighth Amendment with its protection of the foetus has been removed from the Constitution and has been replaced by a law providing for abortion care. The previous reliance of the State on foetal personhood competing with women and pregnant people's rights is no longer the central theme – or at least this is no longer condoned by a political majority. Instead, discourses of competing rights have become centred around rights to dignity and privacy on the one hand, and a right to protest and religious freedom on the other. The dominant political discursive mobilisations of morality have thus shifted to constructions of scientific knowledge and discussions on healthcare. Moral incentives are now rallied in the abortion regime to insist on women and pregnant people's rights to access healthcare, and for compassion for women and pregnant people. Yet ideas around foetal personhood are present in elements of the Health Act 2018 and new formations of foetal personhood can be found in the post-Repeal governance through the 12 week gestational limit, the difference between medical and surgical abortion methods, the definition of fatal foetal anomaly, and conscientious objection, as I analysed in Chapter 6. Although it is an understandable strategy to focus on the legal rights of individuals, nonetheless, a rights-based approach to abortion access brings to mind reproductive justice critiques of the pro-choice framing in the 1990s as too one-sided and ultimately ineffective in guaranteeing the accessibility of abortion care (Nyberg, 2020; Ross, 2017).

7.4 Language to un/do intersectionality: "We have to trust women"

With the provision of abortion care, the ongoing dynamics of governance and voices for change have shifted too. There is space for lived experiences as legitimate sources of knowledge, as people have been accessing legally available care. Since the implementation of abortion services, different forms of knowledge of 'women's healthcare' are now legitimised and circulated. From a feminist reproductive justice perspective, however, there are a number of ongoing issues in these discourses on women and pregnant people's lived experiences. To start, the continued debates on abortion, and the calls to 'trust women' and 'hear from women' invoked in debates around the Review and the Safe Access Zones and Foetal Pain Relief Bills, reproduce and reinforce normative and paternalistic understandings of *who* has abortions, and who has a right to this in Ireland. These calls obscure how power works differently for people and tend to gloss over how gender intersects with other social markers such as class, age, race, and immigration status. Not only do the calls to 'trust women' not fully consider intersectionality and how it shapes access to care, but it also contributes to the ongoing invisibilising of *certain* women and pregnant people. Moreover, the discursive theme to 'trust women' also obscures the ongoing control over reproduction and lack of autonomy for women and pregnant people that are present in abortion governance, through the three-day waiting period and the necessity for two medical experts to approve abortion care. Those governance mechanisms point to a reluctance to 'trust' women and pregnant people and grant them reproductive autonomy.

Firstly, I address the discursive theme of 'trusting women'. The concept 'trust' has similar effects to what the concept of 'choice' generated in earlier waves of feminism, as reproductive justice scholars have since pointed out (Ross, 2017; Chrisler, 2013; Thomsen, 2013; Petchesky, 2000). Relying on the notion of trust as an argument for access to healthcare ignores the differences there are between women and pregnant people and their experiences, the access they have to information and the resources that determine their ability to access healthcare. As the National Women's Council mention in their report on barriers to abortion access, "abortion is too often isolated from issues such as socio-economic inequities, health inequalities, barriers to active participation and inequality of opportunities and of outcomes" (Kennedy, 2021, p. 42). The right to housing, issues of sexual and gender-based violence, socioeconomic inequality or other social issues are rarely or not at all mentioned in the political debates on the Review. Because abortion provision and the

operationalisation of the law are not considered in this larger context, issues of reproductive justice are depoliticised, and 'women' become a homogenised group as service users.

Bypassing the ways in which women and pregnant people are differently affected by the abortion regime, enables the continuation of reproductive injustices. As Anja Nyberg (2020) argues for both the Republic of Ireland and Northern Ireland, their abortion regimes are a reproductive oppression that is unevenly experienced, it is gendered ánd classed ánd raced. In addition to issues of gender, class, and race, people who might be transgender or genderqueer, and disabled people, for instance, are differently implicated under the abortion regime. Under the allusion of 'trusting women', a (seemingly) human rights-based approach is presented, while the inequalities that too often significantly narrow down 'options' in reproductive health remain unaddressed.

The second discursive theme I review are the calls 'to hear from women' in the political discussions of the Review of the Health Act 2018. When the Minister for Health announced the start of the Review, he emphasised that, "most important are women's experiences of termination of pregnancy services and their views on how the system has operated since it commenced on 1 January 2019" (Donnelly, 2021a). The reliance on the need for lived experiences to function as evidence in a process of official evaluation of the law perpetuates firstly the marginalisation of 'women and pregnant people's voices' and, secondly, the further marginalisation of different intersections of class, race and ethnicity, ability, and sexual identity with gender. To start, women and pregnant people's embodied experiences are still constructed as less valuable than scientific facts and knowledge. The situatedness and contingency of all knowledge (Lock, 2001; Lorenzini, 2016) is not acknowledged. Instead, scientific knowledge and State-governed processes, such as that of the Review of the Health Act 2018, are still seen as more legitimate and *legitimising of* other knowledges. The calls for change that have already been heard during and before the completion of the Review process, the voices of women and pregnant people where they have chosen to express them on their own terms, are not considered until the official procedures have been finalised. There is a state process that needs to be completed first for the lived experiences to be considered legitimate data.

What is more, the inclusion of marginalised groups and alternative voices in data collection or consultation processes remains limited. When the Minister for

Health was asked about the specific mechanisms that would be put in place to make sure to reach marginalised groups, his answer did not provide further details on any specific measures that would be taken:

> It is an important question in terms of accessibility to the consultation process, be it people living with disabilities, people living with mental health issues or vulnerable groups who would not normally be checking in to statutory public consultation processes. Not only will we make sure that there are efforts made here, this group will be one of the most important groups that are listened to. As we find in healthcare, as in most things in our society, this is the group for whom things do not tend to work. This is the group we need to listen to most carefully in terms of ensuring that the operations are sufficient and meet their needs (Donnelly, 2021a).

The Minister is right to state that vulnerable groups need to be most listened to, but he shows no commitment to further strategies on how to make sure that actually happens.

When the UnPAC Study was published, then, the problem that uncovering stories from vulnerable or marginalised people is largely dependent on who finds their own way to statutory public consultation processes had remained (Conlon, Antosik-Parsons and Butler, 2022). The study lists the following shortcomings to their participant recruitment (Conlon, Antosik-Parsons and Butler, 2022, p. 25):

> • As research interviews were conducted verbally through English only, lack of proficiency in English was a potential language barrier, though English was a second language for some study participants;
> • No Traveller people are represented in the study;
> • No undocumented migrants participated in an interview;
> • No participant in the study was under the age of 18, reflecting parameters set by Research Ethics Committees;
> • No participant in the study was living out of home, including in emergency accommodation;
> • No interview participant self-identified as transgender or non-binary;
> • No participant in the study accessed care on the grounds of risk to the life or health of the pregnant person.

Although the shortcomings might be somewhat compensated by reports from civil society organisations, such as ARC and Grimes (2021), the National Women's Council (Kennedy, 2021), and other more locally organised groups (SARRA, 2021) this ongoing reliance on non-government organisations to gather that information and continued 'othering' of many non-normative experiences demonstrates little change to the State intervention and governance processes of the past. As the UnPAC Study (Conlon, Antosik-Parsons and Butler, 2022) was the HSE commissioned research as part of the Review of the Health Act 2018, the limitations to inclusivity in the study represent the failed attempt of the State to improve the inclusivity of statutory data collection processes and how the State fails to be inclusive of non-statutory data.

Examining these (re)new(ed) discourses around abortion as women's healthcare from a reproductive justice framework, challenges the notions of health and rights that are put forward by the State in the abortion regime. If we reconsider and recentre agency, we can see a very different picture emerging of reproductive healthcare access. Tacit understandings of normative reproductive experiences are eminent in shaping expectations of women and pregnant people. Moral understandings of pregnancy and foetal personhood continue to govern abortion care. Hierarchical, gendered notions of knowledge set the standards for 'women and pregnant people's voices' to emerge as legitimate sources. Political discourses that require personal disclosure as a necessary condition for policy change, while at the same time defining the circumstances under which personal disclosure will be considered legitimate input, bring to mind the governing mechanisms of the past reproductive regime.

7.5 Conclusion

In this chapter, I took a closer look at how abortion as an issue of healthcare offers a seemingly useful strategy to advance reproductive rights, but also nurtures a lingering moral framing of abortion that hinders reproductive justice. I examined how this occurs in the political and public discourses that emerged around the government's Review of the Health Act 2018 and around the two Bills that have been introduced during the first three years of abortion provision, the Safe Access Zones Bill and the Foetal Pain Relief Bill. I paid attention to particular effects of a politics of language in debates on abortion, and how issues around agency, accountability, responsibility, and

autonomy are constructed in discourses on abortion. First, I focused on how the State obscures their own accountability in the creation of systemic barriers to abortion care. Additionally, I analysed how foetal personhood is mobilised in political discourses. Moreover, I analysed how women and pregnant people become homogenised in political debates on 'women's healthcare'.

To start, I examined how the Irish State (and its abortion regime) is able to employ a language that largely absolves the State from direct responsibility. The dominant political discourses on the Review of the Health Act 2018 focus on the operationalisation of the abortion law, excluding the legal mechanisms underlying the operationalisation, and denying the direct impact from the 3-day waiting period, the 12-week gestational age limit for abortion on request, the definition of fatal foetal anomalies, and conscientious objection. The State's reluctance to engage with the governance mechanisms that are involved in, if not the cause of, ongoing issues with access to care denies the State's agency and contribution to barriers to care. To better facilitate a critical analysis of the compounding factors in the abortion regime that complicate access and provision, as was laid out in Chapters 5 and 6, I identified and defined barriers and obstructions as distinct issues in abortion care. I showed that barriers – unagentic, structural elements of governance and provision – and obstructions – agential acts of individuals – work together to create systemic barriers for people seeking abortion care. That the State does not take responsibility for the ongoing, structural issues in abortion care (such as the uneven coverage of access and the limited number of Maternity Hospitals providing a full range of abortion care) is a mechanism of the moral regime (Foucault, 1990a; 1995; Morgan and Roberts, 2012). The political discourses and processes the State puts forward, conceal the governance mechanisms that work to control and regulate reproduction, and the role of the State in this.

Secondly, I looked into discursive features of women and pregnant people's rights and foetal personhood. The new political landscape, with legislation to provide for and regulate abortion, marks a significant move away from past discourses and the previous regime's reliance on 'the right to life of the unborn' as compromising reproductive rights for women and pregnant people. In the emerging discourses around the Safe Access Zones Bill, the right to healthcare and the right to protest and religious freedom are competing. In the emerging discourses around the Foetal Pain Relief Bill, scientific and medical knowledge is mobilised by anti-abortion politicians to

emphasise foetal personhood. Both Bills and their debates are thus framed by a new context of abortion, where it is a part of healthcare. In this new context, pro-abortion arguments centre around the right to healthcare, and to access this in safety and dignity. Anti-abortion arguments centre around constructions of foetal personhood based on medical developments. Cutting across the two opposing sides are the limited effects that legal rights and discourses have on supporting reproductive justice. The functions and framing of competing rights are inherently flawed and ill-suited to advance wider reproductive accessibility and autonomy (Morgan, 2017). Although the Safe Access Zones Bill was near implementation in May 2023, the amount of time it took since the referendum in 2018 to make progress with the Bill shows how complicated and arduous rights-based claims are in processes to advance access to abortion care.

Thirdly, I examined how pregnant people are homogenised in discursive framings of the need to 'trust women' and to 'hear from women' in debates on the Review of the Health Act 2018 and the two Safe Access Zones and Foetal Pain Relief Bills. The discursive theme of 'trusting women' conceals intersectional experiences with abortion care, and how diverse they can be based on factors that differentiate women and pregnant people's experiences, as I explored in the conceptual framework in Chapter 2 (Crenshaw, 1988; Ross, 2017). Discourses on 'trust' invisibilise the simultaneous ongoing distrust that is present in governance mechanisms, most notably in the 3-day waiting period and the certification by two medical experts for an abortion. Presenting abortion care as a matter of 'trusting women' leaves further reproductive justices unaddressed, because it ignores that reproductive regulations are unevenly experienced to begin with (Nyberg, 2022). Furthermore, the call to 'hear from women' to identify and justify further improvements in abortion care continues to place the burden of disclosure with people who have been historically marginalised and harmed by the State (as I explained in Chapter 3). To ask to 'hear from women' perpetuates women and pregnant people's marginalisation, but it also obscures further marginalisation when intersectional experiences are not taken into account by presenting 'women' as a homogenous group. The two dominant discursive themes around the Review of the Health Act 2018 invisibilise more diverse factors that determine experiences with abortion care by reproducing normative notions of sexuality, family, and reproduction to obscure more diverse factors that determine experiences with abortion care. While there is thus a significant shift in discursive

mobilisations of different understandings of abortion since the implementation of abortion care, competing moral concepts are still remade and made new.

Taken together, these three ways in which the politics of language in abortion discourses take effect demonstrate the changes and continuities in discursive formations of abortion during the first three years of abortion provision. The shift to abortion as healthcare meant a shift in discursive frames, including new mobilisations of the right to healthcare and scientific and medical evidence, yet it does not present a significant transformation toward reproductive justice, nor a transformation of moral governance.

Chapter 8: "We are not going to return to those days": Abortion governance through relations with the past

8.1 Introduction

Political debates on abortion since the Repeal of the Eighth Amendment continue to invoke different futures. This chapter explores the temporal relations in post-Repeal discourses, and how the post-Repeal regime and its governance mechanisms are constructed as decisively different from the pre-Repeal regime and its governance mechanisms. In a Foucauldian sense, the post-Repeal abortion regime is naturalised through a discourse of what Enright (2018, p. 4) calls "National Homogenous Time", a distinct, linear progression that shapes Ireland as a nation and a democracy (Fischer, 2019). I start by considering the Review of the Health Act 2018 and its commencement in December 2021. I analyse how this process is similar and different from past processes on governance change as I have contextualised them in Chapter 2. Furthermore, I identify a dominant temporal theme in political discourses in the post-Repeal regime of 'leaving behind Ireland's dark past'. I show how this is employed by anti-abortion and pro-abortion politicians, how it adheres to the narrative of 'national homogenous time', and how it conflates the medicalisation and legalisation of abortion with a transformation of moral governance. Additionally, I analyse how, instead, moral formations live on in the particular discussions of the Review of the Health Act 2018. Lastly, I bring forward to embodied experiences as challenge to the 'national homogenous time'. I bring all of this together in this chapter to offer a particular formulation of how time features in governance transformations – and how a Foucauldian analysis helps to understand how the narrative of 'national homogenous time' is imposed through mechanisms of time to regulate reproduction and bodies that reproduce.

The two quotes below illustrate the construction of a post-Repeal abortion regime that has started with the referendum result and Repeal in May 2018. I want to start the chapter with these quotes marked out similarly to the Eighth Amendment and the Health Act 2018 in Chapter 2, in that they are defining narratives (where Chapter 2 contained texts or legal frameworks) for the abortion governance, and they illustrate how both anti- and pro-abortion advocates call on the past to imagine a different future. Anti-abortion and pro-abortion politicians engagement with the temporal narrative shows the mutually constitutive nature of abortion politics. In this way, the quotes set

the tone for the exploration of post-Repeal political discourses in this chapter, and how anti-abortion and pro-abortion narratives relate to the past, to the present abortion governance, and to possibilities of governance in the future.

> "None of us in this House really wants to go back to those days pre-2018 when those of us who had daughters – and I have two – would face the prospect of those girls growing up under the chill of the eighth amendment, as so many of us did."
>
> Deputy Ivana Bacik, on the Foetal Pain Relief Bill in the Dáil Debate at Second Stage, (Bacik, 2021)

> "One third of the electorate voted to recognise that an unborn child has a right to life and that this right should be protected by the law and society. […] that cause will endure and see better days because the true human rights position is that we ought to treasure every human being."
>
> Senator Rónán Mullen, on the Safe Access Zone Bill Seanad debate at Committee Stage (Mullen, 2022)

8.2 The process of governance evaluation under the Review of the Health Act 2018: Continuations of structural inequities

Similar to State interventions and processes to accommodate governance changes under the Eighth Amendment, the process of evaluation of the Health Act 2018 through the Review (commenced in 2021 and completed in 2023) shows techniques of controlled transformation. As I discussed in Chapter 3, scholars have critiqued past processes to evaluate the legal framework of abortion for their exclusionary organisation and effects (Carolan, 2020; Side, 2020). The question under the Review process remains whether there is a significant effort to move away from how previous interventions, such as the Citizens' Assembly, were "elite-framed, institutionally bound, and conspicuously legalistic in character" (Carolan, 2020, p. 503). The post-legalisation discussions around the operationalisation of the Act might be less legalistic in nature, but consequentially the sole focus on operationalisation takes away possibilities to consider how the specific legal history of the Health Act 2018 has deeply influenced the current law. Some of the current issues in abortion care are specific results of the longer legal history, rather than healthcare provision or 'operationalisation' of the Act. Not considering the past's influence over the present

in this area takes away from the contingent and situated nature of the Health Act 2018 and its governance.

As Enright (2020) theorised about the relationship between law, reproduction and politics before the Repeal referendum, instead of considering possible alternatives within the legal and political framework, challenges and alternatives to the dominant moral order are allowed only within the parameters that are set out by that order. Dominant political and legal discourses are not only rooted in a justification for their inherent inequalities, but also tend to work in such a way that they do not include alternative or marginalised voices. Control and regulation of the very processes that might bring about change in governance is then crucial to consider changes within the regime, without considering actual alternatives to the regime itself. The setup of the Review of the after Repeal follows patterns that are similar to the 'controlled transformations' in the governance before Repeal.

Although there is a significant difference in the type of information that is considered for the Review – with service users' and providers' experiences of abortion care now available - the setup of what constitutes a politically legitimate procedure shares similarities with the process of State interventions in the past. Firstly, the type of high-level, regulatory and procedural oversight of considering input for evaluation (Houses of the Oireachtas, 2021b). The Review is comprised of two distinct phases: the first one involves strands of public consultations, experiences of service users, and experiences of service providers; in the second phase, an independent chair will assess the findings of the three strands (public, service users' and providers') of the first phase, as well as peer-reviewed research, and will conduct further consultations with stakeholders. Secondly, the government's own lack of data collection and invisibilising of the services for a large part, as described in Chapter 6, stand in contrast to State's calls for data, evidence, and knowledge based on lived experiences. This perpetuates the fashioning of embodied experiences with care as separate, other, from statutory data. Thirdly, similar to State interventions in the past (such as the Green Paper on Abortion 1999 and the following Oireachtas Committee in 2000) the government did not provide a clear commitment as to what will be done with the outcome of the Review. As the Minister for Health announced at the commencement of the review: "I cannot give any answer about what changes may be required. We have to let the work happen. We have to see what policy recommendations come back

and then we can consider those" (Donnelly, 2021a). Hence, the actualisation of potential changes to abortion governance remains open for the time being.[28]

8.3 Ireland's dark past can/not be left behind

The legalisation of abortion and subsequent implementation of the provision of abortion care have been surrounded by discourses of the time before the referendum in 2018 as Ireland's 'dark past' that can now be left behind. As Enright (2018, p. 46) contends: "Part of the common sense of the contemporary Irish state is the understanding that we are living in *new times*: that Ireland has *decisively emerged from a past* in which Church and State power were so tightly intertwined as to be indistinguishable from one another" (emphasis my own). 'Post-Repeal Ireland' forms a distinctly different time in which "the generations which shamed women are over," as Senator Mary Seery Kearney said during the Seanad debate on the Safe Access Zones Bill (Seery Kearney, 2021). Many of the politicians who are currently in the Oireachtas, have been active in politics since the time of the referendum on the Eighth Amendment in 1983 and therefore call on their own memories, as well as a collective memory, when they discuss the pre-Repeal past:

> For far too long those services were denied to us under that chill of the eight amendment. Let us not take so long about the review this time either. Let us not take as long as it took us to repeal the eight amendment. […] It was a relief to so many of us of my generation to see the eight amendment finally repealed in 2018. We do not want to go back. We want to ensure we move forward, build on the services that are available and build on the legislative provisions clearly set out in the 2018 Act (Bacik,2021).

The references to time and history are employed to construct a current Ireland that no longer follows the same governance techniques as it did before the 2018 Repeal referendum. How time and place feature in these discourses reveal much about the

[28] At the time of writing, in February 2023, the submission of the Review by the Independent Chair was due. However, no timeline for the Review to be published and for follow-up action to take place had been communicated. Eventually, the Department of Health published the report on 26 April 2023 (Department of Health, 2023).

presentation of a modern, secular, medicalised abortion regime that has progressed away from the religious, moral regime of the past – a discursive presentation that does not necessarily correspond to lived experiences and embodied knowledges of abortion care.

In my analysis of the constructions of a post-Repeal Ireland, I follow Irish feminist legal scholar Máiréad Enright's (2018) work on the Irish state, temporality, and trauma. She wrote a particularly insightful book chapter on collective trauma, legacies of symphysiotomy in Ireland and national homogenous time in *Law and Time*, edited by Beynon-Jones and Grabham (2018). Enright posits that there is a narrative of a 'National Homogenous Time' that the Irish state needs to uphold. National Homogenous Time dictates that certain issues of historical institutional gendered abuse are a thing of the past, therefore, the state's response to these so-called 'legacy issues' are instrumental in marking the difference with that past. These legacy issues, such as the incarceration of women in Magdalene Laundries, the maltreatment of unmarried mothers, and the abuse and neglect of pregnant people and their children in Mother and Baby Homes formed a particular "outsourcing of particular coercive biopolitical functions to a Church eager to discipline citizens' sexual and reproductive lives", as Enright states (Enright, 2018, p. 46). National Homogenous Time follows a one-directional movement away from the past entanglement of State and Church over reproductive matters to a contemporary Irish society that no longer relies on the Catholic Church to govern people's sexuality and reproduction. A State that now distances itself from the abuse in the past and any ongoing consequences this may carry over into the present; instead, it enables "the state to corral certain historicised abuses within a distinct regulatory space and accordingly to achieve 'closure'" (Enright, 2018, p. 47).

A referendum then, provides a momentous occasion for such a division between issues of the past and the present; a moment in time to signal a before and an after, to mark the position of the Irish people as leading the way forward. The Repeal referendum is placed in a longer (but still recent) history of progress within Irish society, marked by discourses of linear, progress forward - in time and in the collective progressiveness of society - consolidated through referenda of divorce, marriage equality, and Repeal. "The state imagines its history in linear terms, neatly divided into religious past and secular present," (Enright, 2018, p. 47). Rivetti (2019) notes that the idea of modernity was critical to pro-abortion advocates before Repeal, but

imaginations of modernity live on after the referendum and among anti-abortion politicians too. The Repeal referendum marks a moment in time that divides the past and a more modern present – and that there is no coming back from this. Proponent of the Foetal Pain Relief Bill Michael Healy-Rae notes in the Daíl on 15 December 2021:

> A vote took place in this country. A decision was taken. We live in a democracy. We are entitled to our opinion at the time. Other people won the vote on that. We are not standing up here today looking to rewrite history or to rewrite that vote because we cannot do that (Healy-Rae, 2021).

Rather than going back to the past, the focus is on working to shape the future. On the opposite side of the debate, Bríd Smith also calls on the historical change of the referendum: "People should not forget how earth-shattering that movement and outcome [Repeal] were. It was absolutely groundbreaking stuff in terms of the history of this country and the shape of the future" (Smith, 2021). The construction of a clear pre-Repeal past, a post-Repeal present, and a yet to be determined future, has particular effects for the activism and resistance that were present throughout the entire 'pre-Repeal' era under the Eighth Amendment.

Constructing this clear before and after removes the situated, feminist, grassroots resistance that was also there in the past. The situated, historical nature of the activism in the months leading up to the Repeal referendum as a very particular moment in time and a sub-activity of the longer grassroots efforts that preceded this, which were minimised in presentations of a moment in time rather than a much more in-depth, complex process. The Repeal referendum itself is a-historicised and de-politicised by framing it as 'a landslide win' that ushered in a new time for Ireland (Leahy, 2018). While it is not untrue that a large majority of mostly young people voted to repeal the Eighth Amendment, the politicians' presentation of the referendum as a moment in *national time*, dismissed the feminist efforts that resisted State governance and had taken up an alternative network of care for three decades. By presenting the referendum as a win for the national body-politic, the embodied work done by feminist activists and the everyday experiences of women and pregnant people living under the pre-Repeal regime were subordinate to the more important framing of the win for Ireland as a nation.

The Minister for Health at the time, Simon Harris, reflected after the Repeal result:

> In this movement [taking place at ground level across the country], people were talking about a subject which many people in political circles still preferred approaching with their fingers in their ears and all the time this movement was gradually building a groundswell of support.
>
> When the political system took its first step towards joining them, many saw it as a tentative one at best and a cynical one at worst. Many feared that the Citizens' Assembly was a stalling tactic. A process in which to park a difficult and divisive issue – and I can understand and appreciate the scepticism. But now after the successful referendum outcome, I believe the Citizen's Assembly was THE best next step our country took and I take the opportunity today to recognise the stewardship of my fellow panelist Ms Justice Laffoy here and to thank her for it. We have now seen how a model of citizen engagement, and civil society and political structures working together, can successfully consider complex issues, address what are seen to be as the difficult social issues and then bring about historic change (Harris, 2018).

Repeal is made into a national win; through a model of political engagement and participation via the Citizens' Assembly this has been made possible. It is presented not a feminist win, but one that is placed in the national narrative of Ireland as a political nation moving forward in time. The fact that many of these feminist activists active at ground level across the country were also already organised at the time of the adoption of the Eighth Amendment in 1983 is also left undiscussed and that the outsourcing of care that the State refused to provide was largely taken up by activist networks for so long.

Following Enright, discourses of progress over time, with a post-Repeal era marking a stark difference to the past, affirm the biomedical and scientific production of knowledge as an inherently linear and secular progression, one that advances women and pregnant people's rights and guarantees a move away from the religious control over women's health issues. The secular nature of the abortion regime

is then assumed to separate the politics from a historically Catholic morality. The fraught, long and complex history of grassroots feminist activism and alternative networks of care are not implicated in the national narrative. Rather, the post-Repeal abortion governance is marked by progression over time which favours, secular, objective science and democracy over religious morality, positing those as mutually exclusive, or a dichotomy.

8.4 New formations of pre-Repeal abortion governance

The distinction between a religious past and a modern present, where religious freedom is observed but modern, medicalised healthcare governance is assumed to be secular, is also noticeable in discussions of Safe Access Zones. Senator Gavan summarised his argument for the need of the legislation:

> The right to religious freedom is key to our vision of Ireland as a diverse and inclusive modern country, however, people accessing healthcare find it upsetting, intimidating and distressing that anti-choice activities are occurring outside medical centres under the guise of prayer. We think there is a time and a place for such activities and want to find the balance to protect anyone's rights (Gavan, 2021).

Religion is still implicated in modern governance of a secular Ireland. It is acknowledged as a human right among other rights; however, it is no longer a core part of State governance. It is not supposed to infringe on other human rights, such as the right to privacy and healthcare. The distinction between past and present, and linear, secular progress, is equated to a move away from moral governance too.

In fact, the pre-Repeal moral formations continue to shape the current discourses on abortion governance, they just have moved into the current time in a different mode of operation through governance structures and practices. The (re)new(ed) focus on abortion as healthcare works to form a different guise for pre-Repeal dynamics to continue in the discourses on abortion. Medical and scientific knowledge are mobilised towards different political ends as analysed in 'Politics of language and discursive mobilisations of health and rights'; they are used in both anti- and pro-abortion discourses.

In the Daíl debate on the Foetal Pain Relief Bill, Deputy Carol Nolan, one of 10 co-sponsors of the Bill, argued for intervening in medical practice precisely to safeguard patient-centred care:

> We cannot simply rely on an approach that states it is for medical guidelines alone to deal with such matters. While that position can have some merit, for certain important issues it remains a totally artificial legislative construct that we must overcome. We have all kinds of patient-centred legislation that mandates, where appropriate, how our hospitals and healthcare system should operate. We demand the implementation of certain standards and we make laws to ensure that those standards become a reality. In this light, for us to continue insisting that the Government must have no hand, act, or part in shaping a principled approach to medical guidelines is simply not sustainable (Nolan, 2021b).

This illustrates how discourses of patient-centred care are also mobilised by anti-abortion politicians. A medical framing of abortion as healthcare does not guarantee its separation from underlying religious or moral anti-abortion understandings. It also legitimises any practitioners who still do not provide services or control the extent of services they offer.

With abortion now rooted in a medical framework, it becomes clear through people's experiences with abortion as healthcare whether that biomedical framing of abortion ('abortion as healthcare'), is also experienced as 'progress' or an advancement of reproductive rights. Embodied experiences in the present, reminiscent of the past, or even embodied experiences of the past in the present, seem to counter the larger narrative of a post-Repeal era that forms a contrast with the past of the constitutional ban on abortion. As Enright also notes for the experiences and testimonies of symphysiotomy: "there is no clear line between past and present" (Enright, 2018, p. 47).

8.5 Embodied experiences and re-thinking temporalities

Following more feminist scholars on how we can re-think temporalities, I propose we take a look at how moral governance and biopower continue to shape experiences with abortion access and provision, despite the ushering in of a "shift in how Ireland responds to women's healthcare" (Donnelly, 2021a). Particularly, I want to unpack the idea of governance of the past as dissonant to the national time which has progressed Ireland into an abortion regime that has decisively broken with the past. The pre-Repeal mechanisms of governance live on in experiences with post-Repeal abortion care.

A glimpse of a few newspaper headlines on the subsequent anniversaries of the Repeal referendum during the first three years of abortion provision counter the idea of a decisive break with the past. The Irish Times reported one year after the referendum result, on 25 May 2019, "Concerns remain a year after abortion referendum; More than 300 general practitioners have signed up to provide abortion services". One year later again, on 29 May a regional newspaper, the New Ross Standard, reported that there was no Sligo GP registered to provide abortion services, leaving County Sligo without a provider two years after legalization. Subsequently, three years after the referendum, in 2021, the Irish Examiner headlined: "Obstacles to abortion remain three years after repeal of the Eighth". Headlines such as these confirm *ongoing* problems with abortion care since it was implemented in 2019. Similarly, the report for the third anniversary of the Repeal referendum, "Legal abortion: Why are women still travelling to the UK every day?" in the Irish Times on 21 May 2021 conveys the idea that the 'outsourcing' of abortion care of the past should not have been carried over into the present, should not hold a place anymore in a post-Repeal Ireland. Repeal and the implementation of abortion legislation was supposed to solve the issues with abortion from the past – yet somehow it did not.

Women and pregnant people describe a direct link to the past in their experiences of being forced to travel for abortion care. In the UnPAC Study, Emily's[29] testimony describes that it feels like she is reliving the past in the present (Conlon, Antosik-Parsons and Butler, 2022, p. 142):

[29] All names are pseudonyms.

> it's just like the past, you feel like you're a criminal getting on a plane and not telling a soul and sneaking off to England like, I mean that's what they had to do 50 years ago like and we're still having to do it.

The forced travel abroad to access care abroad – mostly due to the 12-week gestational limit under section 12 of the Health Act and the mandatory three-day waiting period – follows the pre-Repeal pattern of reproductive exile from Ireland (Mishtal et al., 2022b; Singer, 2020). Additionally, the ongoing criminalisation for medical professionals continues to circumscribe the care that they can provide. Emily goes on to explain what it was like when she went back for follow-up care after she had gone to the UK:

> I went back for a follow-up, I think it was 10 days or two weeks later or something like that. Just checked to make sure all the tissue was gone; they did a scan. … The same people. The same team yeah. … they just asked me how it went. They couldn't really, again I could sense they were bound, they were very professional, they just say how, the last time we were talking to you, you were talking about travelling, so they don't talk to you too openly about it, you know, it's kind of behind closed walls…. There was a warmth from the nurses, no doubt about that. But they were, you know they were well trained into what they could and couldn't say. And I mean I know that's just from the way they were acting or whatever, that they, you know they were very sympathetic and nodding. But they weren't responding to, you know certain things, you know they just couldn't talk about it very openly, do you know.

The fact that the full extent of abortion care experiences remain undiscussed within healthcare provision, breaks with the idea that post-Repeal Ireland would have moved away from the secrecy and shame around abortion that marked the moral regime of the past.

The discursive production of traveling to England to access abortion care as the source of shame, and therefore a reason to legalise abortion in Ireland was fundamental in the debates to Repeal the Eighth Amendment (Olund, 2019; Taylor, Spillane, and Arulkumaran, 2020). Yet these itineraries of shame and secrecy are echoed in post-Repeal experiences of abortion governance. Mishtal et al. (2022b, p.

3) pose that "the environment of secrecy that women had to navigate while waiting and making their travel arrangements" will continue, since "exceeding the gestational limit has been shown through multi-country research in Europe to fuel cross-border abortion travel" (2022, p. 2). Ironically, the main causes for the ongoing travel are the very features of the Health Act that continue to be based on moral categorisations and the exceptional position of abortion within medical practice.

8.5 Conclusion

Post-Repeal abortion care continues to be contested; its future still seems up for debate. In my analysis here, I have first considered the ongoing discussions on abortion governance related to the Review of the Health Act 2018 and the conditions for change that come forward in those discussions. I have identified a main temporal theme in post-Repeal political discourses on abortion of 'leaving behind Ireland's dark past'. Following Enright's (2018) analysis of Irish 'National Homogenous Time' – a linear, progressive movement away from the past with its religious, moral reproductive governance – Subsequently, I analysed what the invocations of time *do*: they establish a boundary between past and present abortion governance, they erase grassroots, feminist activism, and deny ongoing moral mechanisms in post-Repeal abortion governance. Lastly, I contrast the effects of the invocations of time with service users' embodied experiences of abortion care since Repeal. Keeping the embodied experiences at its core, I propose a re-thinking of temporalities in considerations of abortion and abortion governance.

The Review of the Health Act 2018 process was marked by strict conditions for change and mechanisms of controlled transformations of abortion governance similar to the State facilitated processes in the past (Chapter 3). To start, the focus on the operationalisation of the Health Act 2018 obscures the direct ways in which the law influences abortion provision, as I made clear in Chapter 6. Additionally, the high-level, regulatory and procedural oversight of input for the Review is reminiscent of the ways in which submissions were considered by the Citizens' Assembly in 2016. Furthermore, there is no clear commitment from the government as to what will be done with the outcomes of the Review. Therefore, the State does not take full accountability to actually act on the findings from the Review.

The main temporal theme and invocations of time in political discourses shows a significant concern with affirming and re-affirming the difference between pre- and post-Repeal abortion governance. When Ivana Bacik addressed the Dáil and spoke to the desire not to go back to the past on 15 December 2021, she also spoke to efforts to work towards a better future for abortion rights:

> It was a relief to so many of us of my generation to see the eight amendment finally repealed in 2018. We do not want to go back. We want to ensure we move forward, build on the services that are available and build on the legislative provisions clearly set out in the 2018 Act (Bacik, 2021).

What rings clear from Bacik's words is that political pro-abortion efforts are focused on working towards further improvements in abortion governance – and that these are still necessary. Despite the legalization of abortion, embodied experiences with abortion care illustrate that the supposed break with the past is less clear and more contingent in practice.

Yet I also showed how the construction of a linear 'National Homogenous Time' in which Ireland moves forward, obscures the ways in which moral governance mechanisms continue to restrict abortion rights and reproductive justice. The continuities between post-Repeal and pre-Repeal governance is an issue of ongoing, repetitive harm. The tensions between on the one hand claiming abortion as healthcare and on the other not taking legal action to guarantee Safe Access Zones, for instance, shows the Irish State's reluctance to commit fully to reproductive justice. This is also precisely what the State has done in the past, stalling, delaying and allowing uncertainty or vagueness or unclear policy to persist. Even so, dominant political discursive constructions of pre- and post-Repeal Ireland are centred around the break between the two. Although the legalisation and medicalisation of abortion have contributed to a new abortion regime, that regime has not necessarily moved away from previous governance mechanisms. It continues to be a site for transformation – in multiple directions. This is also why it is relevant to affirm and re-affirm the contrast with the past, if it would be unquestionable to turn abortion rights back, there would not be a discourse of not returning to the past.

The embodied experiences with post-Repeal abortion care analysed here often feature similar experiences and narratives to the pre-Repeal experiences with abortion

care, mainly of being forced to travel abroad to access care. Many of the narratives of travel abroad as featured in the UnPAC Study demonstrate the disappointment, shock and loneliness that Irish women and pregnant people feel when they find out that they still cannot access abortion care in Ireland (Conlon, Antosik-Parsons and Butler, 2022). Their experiences indicate that the pre-Repeal governance mechanisms are not far removed from the post-Repeal abortion governance at all.

Looking at the longer temporalties in abortion governance in Ireland shows that progressive change in abortion politics does not guarantee an expansion of considerations of embodied experiences with abortion care. Discursively presenting abortion as an issue of healthcare does not equal guaranteed abortion rights, let alone reproductive justice. Focusing on the continuities with the past in the present in people's embodied experiences with care is a way to critically consider transformative legal and political change in abortion politics. When restrictive developments in abortion rights are framed as an immediate return to the past, it also obscures how progressive developments do not guarantee reproductive justice and the accessibility of care. Not only is it a misrepresentation of the past to put forward that a return to it will occur through restrictive politics in the present, but it also obscures how the influences from the past live on in present governance mechanisms in multiple ways. In the following Discussion chapter, I critically evaluate the main post-Repeal governance mechanisms and how they relate to the past.

Chapter 9: Continuities in governance mechanisms: conceptual and methodological contributions to unpack limitations to transformations of reproductive justice

9.1 Introduction

This study explores how governance shapes engagements with abortion care after the Repeal of the Eight Amendment in Ireland. Specifically, it questions how governance shapes experiences in relation to provision of and access to abortion in Ireland. The analysis in this thesis unpacks the mechanisms of abortion governance and considers how these formations shape engagements with abortion care. This analysis demonstrates how the effects and influences of pre-Repeal moral governance mechanisms continue to exercise a hold on contemporary abortion care. Significantly, it shows how these lasting moral formations in governance hinder the extension of the Irish abortion regime towards reproductive justice.

The methodology employed in this thesis foregrounds embodied ways of knowing and experiencing abortion care and presents ethnographic fiction as an innovative and previously unused way of understanding contemporary abortion care in Ireland. The formation of the independent Irish State was partly dependent on the denial of women and pregnant people's knowledge, experiences, autonomy, and agency. Foregrounding different ways of knowing and experiencing abortion care as service user and service provider, constitutes a form of feminist research praxis that offers an ethical approach to research on abortion governance and delivers a situated, feminist critique of power in contemporary Ireland. The ethno-fictional vignettes are deployed as a method of giving voice and visibility to often hidden experiences of abortion service provision and use. As such they are treated as data which articulates ways of knowing about abortion care. This unique approach to conducting research on abortion provision in Ireland, reveals that abortion access and provision continue to be problematic and inequitable, and highlights how these issues are constituted in practices of governance which in turn shape these practices. In other words, it reveals the ways in which, governance of, and lived engagements with abortion care, mutually shape each other.

In Chapters 5 and 6 I set out to map and identify abortion care as it was implemented in 2019. In my analysis, I found that invisibilising and visibilising are central concepts in the theorisation of post-Repeal Irish abortion governance, and its

continuities with the past. I assess here how the hyper-visibilisation of political, legal and medical framings of abortion and the invisibilisation of personal, embodied, experiences of abortion, are implicated in the main post-Repeal governance mechanisms.

In my analytical evaluation below, I identify four main governance mechanisms that the analysis in this thesis brings forward: the legal framework, controlling information and maintaining a culture of secrecy, framing abortion as exceptional, and delaying processes of change. For each post-Repeal governance mechanism, I discuss how it is a continuation of pre-Repeal governance and how ensuing issues in the access and provision of abortion care shape the lived engagements with abortion care, and vice versa. In arguing that the legalisation and implementation of abortion care was not a fundamental transformation of moral governance, I emphasise the longer temporality and connections between pre- and post-Repeal governance, and care engagements, despite the transformative moment of the referendum on the Eighth Amendment in 2018. This is followed by a discussion of the methodological contribution this work has made to generate more inclusive and ethically considered ways of understanding experiences of abortion provision. Finally, the chapter concludes with policy and practice recommendations to further advance reproductive justice in Ireland.

9.2 Visibilising trans/formations and continuities of governance in post-Repeal abortion provision

9.2.1 The legal framework: The Health Act 2018

Within the regulation and medicalisation of abortion care under the Health Act 2018, the law is an active, visible influence on the engagements of providers with their patients and with their practice, as I identify in Chapters 5 and 6. The hypervisibilisation of the law within medical practice restricts abortion providers in their engagements with best professional and medical practice. Additionally, the focus on hierarchy and the designation of physicians as the only legitimate abortion care providers, prevents wider engagements from different medical practitioners, such as nurses and midwives, with abortion care, and makes these medical professionals and their work invisible in the process. Moreover, the refusal of care through conscientious objection is privileged as the only possible exercise of conscience within the law. The

lack of visibility of conscientious provision as a valid legal and moral option plays into the wider medical and cultural understandings of abortion, in which abortion continues to be constructed as an issue of morality in a negative way (Donnelly and Murray, 2020). The legal regulation of abortion is thus not inducive to the widening of abortion care provision.

The remaining disciplinary mechanisms in the Health Act 2018, particularly the provision to enact criminal proceedings against medical practitioners (in section 23) represents a continuity with past governance mechanisms and a missed opportunity for the State to enact a new approach to abortion provision informed by a commitment to reproductive justice. The fear of prosecution and the conservative interpretation of the law as a result of criminalisation, combined with the unregulated use of conscientious objection to obstruct care, create a continuing emphasis in medical practice on fear, risk and potential negative consequences, creating a restrictive environment rather than one that sets abortion providers up to engage in their best medical practice and care for their patients, as became clear in Chapter 6 and in the third ethno-fictional vignette. Medical practitioners are left to their own devices, and they lack institutional and structural support in service provision; their practice is highly dependent on individual input and thus varies greatly across care settings and locations.

Considering the long process of governance change leading up to the drafting of the Health Act 2018, with the Protection of Life During Pregnancy Act 2013, and more directly the Citizens' Assembly (2016) and the Joint Oireachtas Committee on the Eighth Amendment in 2017, it is not surprising that the Health Act 2018 continues to be a visible and restrictive framework for care provision. The Health Act 2018 is not so much a transformation of previous governance and legal regulation, as it is a product of its history and shaped by the previous processes and marked by control and regulation as integral to governance change. The continued framing and understanding of abortion as contested and contentious throughout the Citizens' Assembly and the Joint Oireachtas Committee facilitated the legal framework to continue to be based on restrictions rather than leading to any focus on the expansion of abortion care provision and access.

The further disciplinary mechanisms affecting service users create significant barriers to abortion care, as identified and mapped in Chapter 5. For example, the similar phrasing of sections 9 and 10 of the Health Act 2018 to earlier legislation such

as the PLDPA 2013, based on 'a risk to the life or health of the mother', follows the narrow and conservative legal grounds of creating conditions under which abortion is 'permitted' rather than expanding the right to abortion and reproductive autonomy. The second and third ethno-fictional vignettes identify a multitude of barriers that service users might encounter in trying to access abortion care, and many of them are legal barriers, namely the mandatory three-day waiting period, the 12 weeks' gestational limit, and the requirement of a PPSN. The practicalities of FFA testing and diagnosis, combined with the narrow framework in which a foetal anomaly permits a pregnant person to access abortion care (the diagnosis by two medical specialists that the foetus is likely to die within 28 days after birth), as well as the 12 weeks' gestational limit, creates a very narrow space for legal access to abortion care in cases of foetal anomalies.

The contingent and historical nature of the post-Repeal legal framework significantly inhibits the range of medical practices available to service providers, limits the accessibility of care for service users, and continues the surveillance and monitoring of medical care. By tracing the longer history of pre-Repeal legal governance of abortion and the processes for change that preceded the referendum, the continuities between past and present become clear and the particular legal mechanisms that now prevail can be identified as moral governance.

9.2.2 Controlling information and maintaining a culture of secrecy

In my analysis in Chapter 6, I examine the regulation and control of knowledge as a key mechanism in abortion governance. I argue that the partiality of the statutory data and information that the State collects and disseminates as part of post-Repeal abortion care, is consistent with the long history of withholding information as a reproductive governance mechanism. The discussion in Chapter 2 of *SPUC v. Well Woman* case (1985) and *A, B, C v. Ireland (2010),* for example, shows that withholding information was key for the State's approach to enforcing their abortion governance, but also in diminishing challenges to their authority. The case of *SPUC v. Well Woman* (1985) was the first legal case under the Eighth Amendment, and it showed how far-reaching the consequences of the constitutional ban could be in the prosecution and closure of sexual and reproductive health organisations. This was the starting point of the wider, systemic nature of moral regulation and a culture of secrecy that became core to

abortion governance. *A, B, C v. Ireland* (2010), on the other hand, was the first time that the lack of information regarding the more specific legal conditions that might allow for an abortion in Ireland was legally challenged. For A and B, their case was related to genetic malformations of the foetus, and in the case of C, it was specifically about the lack of information to find out what the risk of the pregnancy might be to C's life and health. The ECHR ruling for C's case was that the State failed to provide clear criteria for the circumstances in which an abortion might be lawful, in other words, a lack of clarity and information. Controlling and withholding information from women and pregnant people has been a core part of pre-Repeal abortion governance and severely limited, if not prevented, people's access to care in the past.

The analysis of the post-Repeal abortion care landscape in Chapters 5 and 6 shows that the statutory data on abortion providers and service users is lacking and excludes significant details, such as where abortions take place, where people travelled from, and what happens to people once they are denied care on the grounds of section 12 (if they are over 12 weeks' pregnant). Additionally, there is no in-depth comparative and analytical work that includes data from the United Kingdom or other countries in Europe (Zanini et al. 2021). This lack of publicly available information and reluctance to engage with embodied experiences of care is a key part of governance, and a continuation of the systemic control of information and maintenance of a culture of secrecy around abortion care. Without a publicly available list of abortion providers on the My Options website, a sense of secrecy around abortion is kept in place. The argument of necessary protection for abortion providers, who if identified, might be subject to anti-abortion protests and harassment, demonstrates how a continued moral framing of abortion care provision as negative and morally questionable, is woven into the governance framework. Obscuring spaces of abortion care and shrouding service provision and service use in secrecy, produces barriers to care and referral, and perpetuates historical connotations of abortion as a shameful practice, while, at the same time, not progressing on safeguarding providers as evidenced by little or no progression on safe access zones. This failure to surface and clarify the practices and processes of abortion care and referral, negatively impact the experiences of both service users and providers, it creates a barrier to the normalisation of abortion care, and it perpetuates stigmatising cultural and social understandings of abortion care.

Ethno-fictional vignettes 2 and 3, 2 particularly, show how difficult it is for service users to navigate the available information and to acquire knowledge. The culture of secrecy and lack of information consequentially shapes their engagements with care, how they experience the process, but also how they find their way to care. The complex pathway of access to care can make them feel shameful and like they are doing something wrong, and therefore they are more reluctant to speak up and to ask for help. The governance of abortion has a direct influence on these lived care engagements. The way that conscientious objection is legislated for makes it possible for medical practitioners to merely refuse to provide care to people who first consult with their own GPs about abortion care, without further help, information, or referral. This confusion around abortion in community care, including not being able to avail of it everywhere and the lack of transparency around care access and pathways, maintains a culture of secrecy around abortion care. It leaves those attempting to access abortion with very little recourse and at a loss as to how to proceed, as time moves on.

In the historical context in Chapter 3, I show the paradox of the Eighth Amendment as a clearly defined constitutional mechanism which has in effect created a lack of clarity for medical professionals, working with exceptions under the ban. This became increasingly clear through the various legal contestations between 1983 and 2018. The lack of clear guidelines for foetal conditions, particularly in combination with advancing screening and scanning technologies, were highlighted as problematic in practice, as I uncovered in Chapter 3. At the same time, the guidelines that were in place were identified as "cumbersome" (O'Shea, 2016) and restrictive of medical practice. The lack of clarity and difficulty for medical practitioners under the Eighth Amendment was a particular point of discussion for the Citizens' Assembly in 2016. At that time, it was ground-breaking that legal and medical experts were invited to speak before the Assembly and argue for the need to Repeal the Eighth Amendment in order to clarify medical guidelines and legislate better for abortion.

However, since the legalisation of abortion the Irish State has left much of the responsibility for the provision of care with the medical professionals. The ensuing work of creating a system of training and support for provision, of re-organising work responsibilities, and of creating clear guidelines, was left with medical professionals. As the third ethno-fictional vignette illustrates and as Mishtal et al. (2022a) have

reported, abortion care provision is largely dependent on individual medical practitioners who are dedicated to the service. The provision is not sufficiently statutorily mandated and regularised. This has provided opportunities for anti-abortion medical practitioners to obstruct care. Most of all, however, the invisibilisation of care and referral pathways, and guidance, and information for medical practitioners, places an undue burden on abortion providers. To expect medical practitioners to do this on top of their normal workload, is harmful and problematic, and constitutes a mechanism of governance.

As the analysis in Chapter 8 showed, Repeal and the legalisation of abortion care, are placed in a national narrative of progress in dominant political discourses, in which medicalisation of abortion and a focus on healthcare have been important in bringing about governance change. As I mentioned above, however, the State largely leaves responsibility and accountability for care provision with medical practitioners. The lack of accountability and regulation within provision also means that there is no way to enforce a responsibility to provide systematic care on medical practitioners or institutions. The responsibility to care, and for care, is left with the medical practitioner and facilities on a local level. Doctors for Choice are an excellent example of medical practitioners demonstrating agency and taking responsibility for support and training among peers. Interestingly, it is an initiative that grew out of resistance to the State's abortion ban. Resistance and agency in post-Repeal abortion provision are thus still closely linked. It is almost in opposition to the State governance that further medical knowledge and training are developed and shared.

The controlling of information, lack of clarity for service users and service providers on how to operate under the Health Act 2018, and the lack of State accountability and responsibility in care provision has broader effects. The gap between the legislation, implementation, and the production of knowledge also enables a paternalistic and risk-averse approach to abortion governance to continue. Rather than focusing on abortion as a routine procedure and as a part of someone's broader reproductive experiences, the exceptional framing of abortion continues, through the lack of transparency and with serious consequences for care engagements.

9.2.3 Framing of abortion as exceptional

Throughout the political processes in preparation for the Repeal referendum discussed in Chapter 3, the exceptionalisation of abortion as a medical procedure, tragedy, and hardship remained at the centre of the debates and considerations for policy. This is in opposition to reproductive justice principles that construct abortion as a service that is normal and safe and should be accessible. From the X case in 1992 to the discussion of the Joint Oireachtas Committee in 2017, the framing of abortion was that it was contested, contentious, and morally charged. Women and pregnant people were barely consulted, and if they were it was within strict State-defined parameters, as mentioned in the discussion of governance mechanisms and the legal framework above. Furthermore, they were not trusted to be the main voices to inform governance change. Conversely, when personal experiences were taken into account, the hypervisibility of tragedy and hardship dominated public discussions and representations of abortion.

One of the ways in which the exceptionalisation of abortion within medical practice is sustained, is its ongoing criminalisation under the Health Act 2018 – mentioned above as a significant part of the disciplinary mechanisms that continue in post-Repeal governance. Similarly, the legal parameters in which service provision takes place contain phrasing that resembles the previous legal frameworks, such as the Protection of Life During Pregnancy Act 2013. The basis of exceptionalisation for the permissibility of abortion, particularly in sections 9 and 10 of the Health Act 2018 regarding the risk to life or health of the pregnant person, maintains the framing of abortion as morally charged and extreme.

Beyond the legal framing, however, in Chapter 7, I focused on the politics of language and how abortion is discursively framed in post-Repeal debates. The effects of protest and harassment around healthcare facilities are central to the arguments for Safe Access Zones, and while this may be a productive strategy to counter anti-abortion activity around healthcare facilities, it also emphasises difficulties for people when they access abortion care. Debating why people should not have to go through additional hardship, when they are ‘already’ accessing abortion care, implies the hardship of abortion. In a very different way, the debates on the Foetal Protection Bill hold ideas of abortion as ‘painful’ and particular notions of foetal personhood at their core. Although these two Bills are brought in by opposing factions of pro- and anti-abortion advocates and I do not want to conflate their discourses or their advocates, I do wish to draw the connection to the framing of abortion as exceptional in both of the

two major post-Repeal political and legal issues. That the exceptionalisation of abortion is pervasive in anti-abortion as well as pro-abortion discourses is concerning, precisely because it indicates how systematically essentialised this exceptional framing has become and continues to be.

The ongoing use of invisibilising as a governance mechanism in turn enables different discursive mobilisations of rights and health to impede further transformations towards reproductive justice, as I explore in Chapter 7. While abortion is legislated for and accessible as healthcare since 2019, this has not necessarily diminished the high level of control over reproduction. The legal and medical regulation of abortion still restricts people's reproductive autonomy. Biopolitical notions of reproduction, gender, and sexuality are reframed in the current context as a matter of healthcare – yet ultimately remain under the control of the State and the biomedical system. With this lack of visibility of alternative abortion experiences (such as self-managed abortions), dominant discourses reproduce the need for control and regulation echoing pre-Repeal debates over legalisation. The framing of abortion as necessary healthcare, the consequences of women and pregnant people accessing abortion care illegally under the Eighth Amendment, and the increasing availability of abortion medication through transnational care networks, were effective in bringing about political support for the legalisation of abortion. Still, similar discursive mobilisations of health and rights play out in restrictive rather than expansive ways in post-Repeal abortion politics in that they continue to exercise control over people's reproductive experiences, rather than expand their options.

Moreover, the discursive mobilisations of health and rights are not separated from moral understandings, as I argue in Chapter 7. Although originally discursive mobilisations of health and rights were strategies to argue for abortion rights, anti-abortion advocates have adapted these discourses to work with their own mobilisations of healthcare and human rights. The moral understandings that lie at the basis of this, have not been left behind, and the battle over competing rights has shifted instead to a focus on healthcare. This dynamic, of opposing sides that are mutually influential, continues to restrict reproductive justice. The input of anti-abortion mobilisations of health and rights shape the parameters in which debates on reproductive politics take place. The State continues to feel the need to accommodate those voices and does not commit to a clear framework that would make reproductive justice the centre of their approach to abortion care by, for example, centring the public submissions and

experiences to drive follow-up action in the process of the Review of the Health Act 2018.

9.2.4 Delaying processes of change

The post-Repeal processes of further change and the Review of the Health Act 2018 show similarities with previous processes of governance change such as the Citizens' Assembly (2016) and the Joint Oireachtas Committee (2017). The previous exclusions of particular marginalised groups of people and the highly legalistic and medical character of discussion topics, are echoed in the debates around Safe Access Zones, the Foetal Pain Relief Bill, and the Review of the Health Act 2018. The invisibilising of certain people and certain experiences runs through pre-Repeal and post-Repeal governance as discussed in Chapter 3 and 8. The set-up of committees and deliberations with exclusionary mechanisms, again do not acknowledge many of the claims, experiences, and challenges of women and pregnant people as legitimate exercises of agency and ways to work towards political change, as Enright has conceptualised (2020).

Moreover, the ongoing issues since the introduction of the Health Act 2018 are met with similar stalling mechanisms of governance processes used in the past. Legal and political mechanisms and processes are used to delay a more reproductive justice-based approach. For example, legislation for Safe Access Zones was promised to be brought in at the time of Repeal in 2018 yet had not been successfully carried out by the Spring of 2023. The State has made conscious choices not to make it a part of the original legislation and has since then delayed or not been pro-active about following up on the issue. The Bill was eventually introduced by a cross-party initiative, largely spurred on by activists and advocates who formed the group Together for Safety, to launch a national campaign on the issue in 2021. Once again, it has been grassroots feminist efforts that are the driving force of political and legal change, not the State itself.

Considering that grassroots anti-abortion activists were the driving force in introducing the Eighth Amendment, as illustrated in Chapter 3, the State's shifting position between accommodating anti-abortion and pro-abortion activists since the 1980s does not demonstrate a commitment to reproductive justice. Moreover, the emphasis on legislation and health invisibilises politicians' and policymakers' role in

ensuring abortion care. During the first three years of abortion provision, stalling and dismissing efforts for further change were still central to political engagements with abortion care, rather than efforts to advance reproductive justice. The Foetal Pain Relief Bill was dismissed under the argument that the Review of the Health Act 2018 was under way and that its findings needed to be considered first. Post-Repeal processes of evaluation and legitimisation of governance change are still a key part of the Irish State's abortion governance, facilitating the perpetuation of opposing discursive mobilisations of health and rights and the impediment of reproductive justice.

9.3 Barriers and obstructions in post-Repeal abortion care: the fragmented nature of provision, uneven coverage and ongoing necessity to travel

The main governance mechanisms outlined above create and perpetuate ongoing issues in post-Repeal abortion care access and provision. The moral governance mechanisms contribute to discursive and material barriers and obstructions to abortion care. The particular invisibilities and visibilities have set up the provision of abortion care as abnormal and obscure, rather than normal, accessible, and transparent. In the evaluation of the current provision of abortion care, I especially pay attention to how places and spaces of care feature in governance mechanisms. Place features differently under post-Repeal abortion care compared to the abortion governance under the Eighth Amendment, and arguably represents the biggest change in abortion governance that has taken place in the no longer dominant place of the Catholic Church in defining abortion. That women and pregnant people can now be taken care of 'at home' was a significant trope in debates on the legalisation of abortion. However, caution is warranted in celebrating Ireland as a place that has moved away from the Catholic-dominated moral governance of the past. It is a transformation that early medical abortion is now available in community care, but we need to ask what those places and spaces of abortion care in Ireland actually look like, where they are located, how they are controlled by medical practitioners, and by whom they are accessible.

That it is possible for hospitals not to provide this full range of care five years after the implementation of abortion care speaks to how far removed the State governance is from lived engagements with care on the ground. This is not new or

specific to abortion, but it indicates larger issues in State governance of healthcare and Catholic moralities. It is essential to understand the past governance to understand how a system can emerge so fragmented in current times. The fragmented nature of provision is a reflection of the past and how more situated actors – such as GPs and women's health clinics – have often been the crucial actors in care networks, not the State or religious or medical institutions. Yet abortion governance does not reflect or accommodate the important role of those situated actors. Abortion has been legalised, but much of the context in which the implementation has been introduced has not been transformed. The limitation of places where abortion care is provided in Ireland, the complexity of communications across places – between GP practices and hospitals, for instance – and the bureaucracy and governance inherent in the locations of care, are all place-oriented obstacles and limitations in abortion care in Ireland.

The patchy coverage of care across Ireland causes people to travel long distances across counties, as the data analysed in Chapter 5 and 6 demonstrates. Travel abroad in particular, however, shows that there are lasting and emerging issues with the accessibility of abortion care. Although issues of foetal anomalies are the reason for the majority of people accessing care in the UK, the choice of method is also a reason why people continue to travel abroad. The reasons for people travelling when they are under 12 weeks' pregnant – and would thus be legally permitted care in Ireland – remains the most puzzling, but at the very least indicates serious issues with the access to care in Ireland.

The ongoing travel is particularly poignant for the culture of secrecy around abortion, which I also mentioned in regard to the controlling of information as a governance mechanism. Mishtal et al. (2022b) importantly argue that the continued travel also keeps up a sense of shame and secrecy for women and pregnant people. It maintains the idea that you are doing something wrong, something that you should not be doing. Besides the practical repercussions of not being able to access abortion care in Ireland, the forced travel thus also contributes to the ongoing moralisation and exceptionalistion of abortion.

There are limited places of care in Ireland, and Ireland is not yet a safe space for abortion care access and provision. For many people, their place of care might not have changed compared to what it would have been before Repeal – it might still lie across borders in a different country, or in their own space if they still self-manage their abortion and access medication through an alternative care network.

Yet it is problematic that the State continues to deny or minimise the ongoing issues in abortion care, under as demonstrated through the discursive themes that I analysed in Chapter 8. Dominant post-Repeal discourses on abortion as healthcare, ignore the intersectional experiences of marginalisation that underlie healthcare access and the complex ways in which morality lingers in medical structures in Ireland. Science and law are often presented as neutral and objective, but they actually work to include and exclude particular voices. The value and legitimacy that is given to scientific knowledge and legal processes simultaneously delegitimises other forms of knowledge (Enright 2020; Lock 2001). The experiences that show how stratified access to healthcare is in the first place, and even more so for abortion care, are side-lined in the construction of a "post-Repeal" Ireland where abortion is legally available.

An intersectional analysis of the place-oriented obstacles and the stratification of access to abortion care reveals how different people are impacted differently. Access to abortion care can look radically different depending on where you live, whether you have access to transportation, your age, your support system around you, whether you already have children, your ethnicity or your race, your work, your socioeconomic status, your sexual orientation, how able-bodied you are etc. The need to travel to access abortion care is incredibly discriminating and disregards so much of the privilege, ability, and capacity that influences who is able to travel. Who are the people who continue to be excluded from care, even abroad, and what happens to them? As I come to the end of my analysis, I am left with concerning questions about the people who are still not taken care of in Ireland.

The legalisation of abortion in Ireland signified a significant transformation in the explicit and overt collaboration between State and Church on matters of reproduction, yet the conflation of legalisation and medicalisation with a secular, justice-based system is misleading. In this sense, Ireland is an important case study of what happens after abortion is legalised, whether that also is a significant transformation of moral governance mechanisms, and to what extent legal change works towards reproductive justice. Feminist scholars have already pointed out how a human rights framework is not always sufficiently in tune with challenges of wider reproductive justice issues and that legislation is limited in its guarantees for accessibility of abortion care (Chrisler 2013; Morgan 2017). How this takes place in practice, however, and how governance is intricately tied up with care engagements and experiences, is an important contribution of this research. This thesis, importantly,

conceptualises not coming out clearly in favour of abortion and in support of service users and providers *as* moral governance. Non-engagement with abortion, stalling within political processes, reluctance to enact further governance change in abortion care, and setting up a system that does not reflect the best interests of service users and service providers are all forms of moral governance that sustain reproductive injustices. These mechanisms need to be actively called out as such, and this thesis does so.

As a wider contribution to the conceptualisation of governance change and reproductive politics, looking at the longer temporalities in abortion governance in Ireland shows that the legalisation of abortion does not guarantee an expansion of considerations of embodied experiences with care. Critically appraising the continuities between past and present governance despite legal change is a way to consider the implications of governance change for lived engagements with abortion care. The concept of trans/formations is thus a way to consider the paradox of a transformation in abortion governance and the continuities of past governance mechanisms that might follow such a transformation. Not diminishing the importance of the right to abortion and the difference it makes when abortion is legalised, the relational aspect encapsulated in trans/formations is a reminder that legal change is situated, contingent, and born out of particular histories and precedents. The embodied experiences and lived engagements with abortion care are much better indicators to critically assess to what extent a regime and its governance might have been transformed.

9.4 Creative methodology as feminist critique

Ethnographic fiction and the use of ethno-fictional vignettes is a unique approach to qualitative research on abortion care in Ireland. My methodological approach is informed by and offers an ethical approach to research on abortion rather than asking people to disclose their personal experiences. The ethno-fictional vignettes illustrate the consequences of the governance mechanisms and how they shape care engagements and experiences. The vignettes highlight the secrecy, shame, and fear that are perpetuated under the post-Repeal governance mechanisms, and they underline that those experiences are precisely a continuation of what women and pregnant people and medical practitioners experienced under the pre-Repeal abortion governance. In this way, the ethno-fictional vignettes offer two important critiques.

Firstly, they critically illustrate how the hypervisibilisation of legal and medical regulation continues, and how this simultaneously invisibilises embodied knowledges and experiences of care. Particularly this consideration of the longer history of abortion governance and the 'legacies' of invisibilisation of abortion and reproductive experiences under the Eighth Amendment informs the research's critical approach to data collection of abortion care. The ethno-fictional vignettes centre service user and service provider perspectives in the analysis of abortion care to counter the legitimisation and visibility of political, legal and medial discourses and knowledges. Secondly, the vignettes critique the limited statutory data collection on abortion services and the ways in which the Irish government approaches testimonies and lived experiences in the Abortion Review. Earlier processes for change discussed in Chapter 2, such as the Green Paper on Abortion (1999), the Citizens' Assembly (2016) and the Joint Oireachtas Committee on the Eighth Amendment (2017), excluded or severely limited women and pregnant people's lived realities as main considerations for governance change. The lack of data and knowledges the State gathers about the services is a continuation of that same delegitimising and exclusionary way of approaching experiences with care and embodied knowledges. This thesis constitutes a different approach to think about data, experiences, and legitimacy of knowledge.

9.5 From a constitutional ban to reproductive justice?

The contemporary abortion regime in Ireland still does not reflect the principles of reproductive justice. The State's lack of a holistic perspective and unwillingness to adhere to reproductive justice as a commitment to normalise abortion contribute to systemic barriers to care. Critically applying a reproductive justice framework to the Irish context of past and present governance, underlines the situatedness and specificity of the particular history and model of abortion care as it was implemented in 2019.

Mishtal et al. (2022a) and Taylor, Spillane, and Arulkumaran (2020) argue that abortion was transformed from an abstract moral issue into an issue of women's health through the Repeal of the Eighth Amendment. I suggest that past moralities have been transformed under the abortion legislation: they are, indeed, no longer abstract. However, abortion as an issue of women's health has moved moralities into legal and medical structures for abortion care that determine the material circumstances of

access and provision. The formations of past governance mechanisms re-appear in contemporary engagements with health and rights, and the first-time provision of national abortion services has been problematic in execution and delivery due to the ongoing moral governance. The legal and medical structures that shape abortion care do not enable the full realisation of regularised, structural abortion provision and access, nor does it enable or incentivise further improvements within the care system. Abortion is continuously framed and provided as something abnormal.

Through the legal framework under the Health Act 2018, the controlling of information and maintaining of a culture of secrecy, the framing abortion as exceptional, and exclusionary and delaying processes of governance change, the Irish State continuously governs abortion as a moral, tragic, and risky issue that needs to be highly controlled. The main ensuing issues in abortion care access and provision further limit the framing of abortion not as a moral conundrum but as a common reproductive experience (one among many) and a safe, routine, medical practice. That the ongoing moral governance impedes further transformations of abortion governance and reproductive justice is a fundamental contribution of this work.

9.6 Further advancing reproductive justice: Policy and practice recommendations

In order to improve abortion care in Ireland and work towards the accommodation of the principles of reproductive justice, I offer a number of suggestions based on my research. My first set of suggestions relate to how to further improve the current care system. My second set of suggestions relate to how to transform the underlying formations of governance.

For the first set of recommendations relating to the improvement of the abortion care system, I add my voice to the researchers and advocates who have been calling for these changes since before the implementation of care and since then, such as O'Shaughnessy et al. (2022), ARC and Grimes (2021) and Kennedy (2021). The most important starting point is within the Health Act 2018, with the removal of the three-day waiting period, the 12-week gestational limit, and criminalisation for abortion provision. Subsequently, the education and training for medical students need to systematically include abortion – regardless of the location or institution of their training (Higgins, Murphy and Eogan 2022).

The second set of recommendations are also informed by my longer engagement with abortion in Ireland for the past 6 years. The connections between

social aspects of care, medical settings and politics need to be strengthened to enhance the social and cultural processes around abortion care. A holistic and empathetic perspective on reproduction, of which abortion is one among many, needs to be the guiding principle in further transformative governance work. Abortion as a common experience approached through empathy, respect and autonomy for pregnant people needs to be at the centre of governance and care. Politicians and policymakers need to take accountability for the direct consequences of governance on the lived engagements with abortion care. It would be helpful for medical practitioners if connections and networks with international care providers are expanded on and utilised more: there is so much to learn from other places and collaboration. Abortion activists have long been focused on international solidarity and collaboration, but it needs to be employed on a structural scale and as part of medical education. The knowledges and experiences that are already in place can also be drawn out more, such as that of midwifery students who have been on placements abroad and have experienced an entirely different approach to abortion. Nonetheless, autonomy and agency for pregnant people should include considerations to move away from legal, political, and medical frameworks and control – after all, the law and the clinic are still sites of discipline and regulation, as Foucault has so importantly conceptualised.

Yet crafting effective discursive and framing strategies for issues like abortion rights requires a deep understanding of the sociocultural context and the nuances of public discourses in a particular location, and perhaps certain strategic choices. Following from Lynn Morgan's (2015) insights into the venularization of abortion rights activism in Argentina, it becomes apparent that tailoring the framing of abortion to align with the specific sociocultural, historical, and legal context is crucial. In Ireland, the framing strategies could leverage the narrative of conscientious care, emphasizing that this applies to the provision of abortion care in a holistic sense, as Donnelly and Murray (2019) so aptly do. Considering Ireland's legal landscape and the influence of European Court of Human Rights cases, the human rights approach potentially remains an effective framing strategy. Highlighting the right to make autonomous decisions about one's body, grounded in international human rights principles, can resonate with policymakers and the broader public.

Future research could contribute to a feminist analysis of the past governance processes that included public submissions, such as the Green Paper on Abortion and the Citizens' Assembly and compare those to the Abortion Review submissions to

further trace the ways in which categories and understandings of gender, sexuality and governance responses to those have (not) changed over time. Additionally, thorough comparative analytical work between the governance process of the Abortion Review and other reviews of recent constitutional changes, such as the Gender Recognition Act 2015, could illuminate how particular dynamics are not specific to abortion only, but cut across wider processes of governance transformations that have taken place in Ireland in recent years.

I see work on education and pedagogies as a crucial contribution to long-term improvements of reproductive justice in Ireland. The research findings will be shared with various stakeholders with whom I have connected throughout the research process, such as the grassroots activists in the Abortion Rights Campaign and Women on Web. I will also disseminate the research findings among a group of scholars working on reproductive justice in the Irish context. Additionally, the innovative methodological approach incorporating ethnographic fiction opens up possibilities for engagement beyond academia. Disseminating the research findings and specifically the ethno-fictional vignettes to non-academic audiences is part of the reproductive justice work that this research sets out to do.

I strongly believe that demonstrating the impact of ethnographic fiction in fostering a deeper understanding of community, care, and lived realities adds weight to abortion rights advocacy. While policymakers may be accustomed to quantitative data, emphasizing the qualitative depth and contextual relevance of ethnographic fiction can make a compelling case for its inclusion in shaping more empathetic policies. Storytelling has a rich and important history and relevance in Ireland and has been especially important in the campaign to repeal the Eighth Amendment, thus it holds a powerful potential in the Irish context, as well as the potential to contribute to more inclusive narratives of abortion care (Mishler, 2021).

The feminist implications of this work will thus be carried forward and shared through the communities of people concerned with reproductive justice and abortion in Ireland. The real transformation, however, has to take place in the very structures of governance and the formations of the abortion regime. To spark this transformative work, voices, experiences, and representations that challenge the regime need to make themselves heard and, more importantly, they need to be listened to. A good starting point would be for the government to commit to the actual accommodation of research findings from people's lived experiences with abortion care and to consult with

participants about what they would consider helpful changes and improvements to abortion policy when they carry out research on abortion services. Why not ask women and pregnant people what their ideal abortion experience would look like?

Epilogue

Responses to the Health Act 2018 Review findings

At the time of writing the final chapters of this thesis, the fifth anniversary of the Repeal referendum (25 May 2023) and the publication of the Review of the Health Act 2018 (26 April 2023) provided an interesting backdrop to formulate the conclusions of this research. The recommendations to the HSE to improve barriers to access and provision of abortion care include a number of legal, clinical, and research suggestions, including mapping the precise number of providers in each county, monitoring non-providing hospitals, and expanding the range of health professionals who may provide abortion services (O'Shea, 2023). When the report of the Abortion Review was finally published in March 2023, the reactions of the Taoiseach, the Minster for Health, and the Tánaiste perfectly illustrate the continuation of the governance mechanisms that are analysed here. To start, the Taoiseach, Leo Varadkar, said that he would be "reluctant and uncomfortable" to make legislative changes, even when the extensive and considerate Review recommends precisely that (Finn, 2023). The Minister for Health, meanwhile, said that it was "totally and utterly unacceptable" that not all Maternity Hospitals are providing abortion care, yet also noted that the recommended legislative changes in the report needed to wait until certain operational issues were taken care of first, consistently failing to acknowledge the proven connections between the law and operational issues (McNally, 2023). Furthermore, the Tánaiste thought it would be fair to follow more processes of deliberation before any changes might be implemented and that the issues in the report deserve similar engagement to how "this issue", abortion, was handled before the referendum (Hurley, 2023).

Regretfully, the reactions of the State representatives confirm the argument of this thesis all too clearly: lasting moral formations in abortion governance hinder further development towards reproductive justice. Their responses sum up a number of the governance mechanisms that this thesis analyses: the reluctance to engage with abortion, the stalling through engaging in processes of political and legal deliberation, the minimising of State responsibility for the regularising of provision across healthcare facilities, and the failure to place women and pregnant people's experiences front and centre.

However, the opposition has shown that a majority of politicians have moved away from the moral governance. In an interesting challenge to the delaying response to the Abortion Review from the Government, Bríd Smith has introduced an Opposition Bill to abolish the 3-day waiting period, to allow for abortion on grounds of fatal foetal abnormality that are likely to lead to the death of the foetus either before or within a year of birth (expanding on the provision for 28 days in the Health Act 2018) and to decriminalise the provision of abortion (Health (Regulation of Termination of Pregnancy) (Amendment) Bill 2023). A 'free vote' was allowed, meaning that members of the Coalition did not need to vote in line with their party's official stance on abortion policy and a majority voted in favour of the Bill. It is hopeful that these initiatives are introduced, and it indicates that there is more space for pro-abortion advocates to work with political mechanisms since abortion has been legalised.

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Appendix 1: Data overview

1. Legal documents	Health Termination of Pregnancy Act 2018 Health (Regulation of Termination of Pregnancy) (Foetal Pain Relief) Bill 2021 Safe Access to Termination of Pregnancy Services Bill 2021
2. Policy documents	2019 Notifications in Accordance with Section 20 of the Health Act 2018 2020 Notifications in Accordance with Section 20 of the Health Act 2018 2021 Notification in Accordance with Section 20 of the Health Act 2018 Creating a Better Future Together: National Maternity Strategy 2016-2026 All-Ireland Nursing and Midwifery Digital Health Capability Framework Contract for the Provision of a Termination of Pregnancy Service Pursuant to the Health Act 2018 First Report and Recommendations of the Citizens' Assembly the Eighth Amendment of the Constitution (2017) Report of the Joint Committee on the Eighth Amendment of the Constitution (2017) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018: Public Consultation (2021) Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018 Public Consultation Form (2021)
3. Medical guidelines	Covid-19 Infection Guide for Maternity Services (2021) Interim clinical guidance for ToP under 12 weeks (2018)

	Pathway for management of fatal fetal anomalies and/or life-limiting conditions diagnosed during pregnancy perinatal palliative care (2019) Perinatal Management of Extreme Preterm Birth at the Threshold of Viability (2019) Interim Clinical Guidance Risk to Life or Health of a Pregnant Women in relation to Termination of Pregnancy (2019)
4. Political debates	Seanad Eireann Debate Safe Access to Termination of Pregnancy Services Bill 2021: First Stage Seanad Eireann Debate Safe Access to Termination of Pregnancy Services Bill 2021: Second Stage Seanad Eireann Debate Safe Access to Termination of Pregnancy Services Bill 2021: Committee Stage Dail Eireann Health (Termination of Pregnancy) (Foetal Pain Relief) Bill 2021: First Stage Dail Eireann Health (Termination of Pregnancy) (Foetal Pain Relief) Bill 2021: Second Stage Joint Committee on Health Debate Review of Scope and Structure of Health (Regulation of Termination of Pregnancy) Act: Engagement with Minister for Health
5. Research reports	**Accessing Abortion in Ireland: Meeting the Needs of Every Woman - National Women's Council Ireland (2021)** **Too Many Barriers: Experiences of Abortion in Ireland after Repeal - Abortion Rights Campaign and Dr Lorraine Grimes (2021)** **Sligo Action for Reproductive Rights Access 2018-2021 Repeal Review Report part 1 (2021)** **Scoping Study to Inform a Survey of Knowledge, Attitudes and Behaviours on Sexual Health and Wellbeing and Crisis Pregnancy among the General Population in Ireland - Sexual Health & Crisis Pregnancy Programme, HSE Health & Wellbeing (2021)**

	Researching the Experiences of Muslim Women in Irish Maternity Settings - A Mother is Born too - Amal Women's Association (2021) **Improving the health outcomes and experiences of the healthcare system for marginalised women - National Women's Council Ireland (2021)** **Sexual Health Services in Ireland: A Survey of General Practice - Irish College of General Practitioners and the Health Service Executive (2018)** **Evaluation of the HSE's Foundation Programme in Sexual Health Promotion Training for Professionals 2016-2018 - HSE Sexual Health & Crisis Pregnancy Programme and Core Research (2019)** **Late-Term Abortion and Foetal Pain Proposing a Humane Response - All-Party Oireachtas Life and Dignity Group (2021)**
6. Press releases	Department of Health, 'Minister for Health welcomes appointment of HSE Clinical Lead for Termination of Pregnancy Services', 31 December 2019 Department of Health, 'Statement by the Minister for Health Stephen Donnelly on exclusion zones around healthcare facilities', 7 August 2021 National Women's Council, 'Abortion Working Group calls on Minister for Health to take immediate action on Abortion Review', 18 November 2021 Department of Health, 'Minister for Health commences Phase one of the Review of the Health (Regulation of Termination of Pregnancy) Act 2018', 8 December 2021
7. Resources for service users	Your Guide to Medical Abortion (2019) Statement of Informed Consent Medical Abortion (2019) Your Guide to Surgical Abortion (2019) Statement of Informed Consent Surgical Abortion (2019) Unplanned Pregnancy Poster (2019) Unplanned Pregnancy Leaflet (2019)

	Telemedicine, Phone and Video Consultations, A Guide for Patients (2020) Your Contraceptive Choices (no date)
8. Online resources and information on abortion	HSE MyOptions website Irish Family Planning Association website + medical abortion information leaflet Abortion Rights Campaign website Sexual Health Centre website Dublin Well Woman Centre website Women on Web website + medical abortion information video
9. Peer-reviewed research (specific to post-Repeal Ireland)	Chakravarty, D. *et al.* (2023) Restrictive points of entry into abortion care in Ireland: a qualitative study of expectations and experiences with the service. *Sexual and Reproductive Health Matters*, **31**(1), pp.2215567. Grimes, L. *et al.* (2023) '"Still travelling": Access to abortion post-12 weeks gestation in Ireland', *Women's Studies International Forum*, 98, p. 102709. Available at: https://doi.org/10.1016/j.wsif.2023.102709. Stifani, B.M. *et al.* (2022) 'Abortion policy implementation in Ireland: successes and challenges in the establishment of hospital-based services', *SSM - Qualitative Research in Health*, 2, p. 100090. Available at: https://doi.org/10.1016/j.ssmqr.2022.100090. Mishtal, J. *et al.* (2022) 'Abortion policy implementation in Ireland: Lessons from the community model of care', *PLOS ONE*, 17(5), p. e0264494. Available at: https://doi.org/10.1371/journal.pone.0264494. Mishtal, J. *et al.* (2022) '"To be vigilant to leave no trace": secrecy, invisibility and abortion travel from the Republic of Ireland', *Culture, Health & Sexuality*, pp. 1–15. Available at: https://doi.org/10.1080/13691058.2022.2107704.

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Grimes, L., O'Shaughnessy, A., Roth, R., Carnegie, A. and Duffy, D., 2021. Evaluating MyOptions: Experiences of Ireland's Abortion Information and Support Service. Available at SSRN 3981052.

Calkin, S. and Berny, E., 2021. Legal and non-legal barriers to abortion in Ireland and the United Kingdom. Medicine Access@ Point of Care, 5, p.23992026211040023.

Taylor, M., Spillane, A. and Arulkumaran, S., 2020. The Irish Journey: Removing the shackles of abortion restrictions in Ireland. *Best Practice &*

	Research Clinical Obstetrics & Gynaecology, 62, pp.36-48. Duffy, D.N., Pierson, C. and Best, P., 2019. A formative evaluation of online information to support abortion access in England, Northern Ireland and the Republic of Ireland. *BMJ sexual & reproductive health*, 45(1), pp.32-37.
10. News articles	From Nexis searches for "abortion AND Ireland" in The Irish Times, Irish Independent, Irish Examiner, RTE News and The Irish Medical Times, including: • Newspaper articles • Newspaper opinion letters • Online news articles Searches were done for the dates of key political moments as identified in the timeline and 3 days before and after each of those dates. The results yielded a total number of 175 articles for the key political moments in abortion politics from 29 December 2018 (three days before the start of abortion provision on 1 January 2019) to 31 December 2021.
11. Reflective engagement	Rebels for Choice Reactivate Repeal 1, 22 June 2021 (online) Rebels for Choice Reactivate Repeal 2, 1 July 2021 (online) Rebels for Choice Reactivate Repeal 3, 21 July 2021 (online) Together for Safety, 23 June 2021 (online) Together for Safety, 1 October 2021 (online) ROSA Assembly for International Women's Day, 5 February 2022 (online) NWCI + USI Webinar on Abortion Review, 24 February 2022 (online) NWCI, International Women's Day, 5 March 2022 (Dublin) ARC 2022 International Women's Day Reproductive Justice webinar, 8 March 2022 (online)

	NWCI Abortion Review Quick Guide Lunchtime seminar, 16 March 2022 (online) NWCI My Body My Choice, 18 October 2022 (online) Savita Halappanavar vigil, 28 October 2022 (Cork) Maynooth University, Reproductive Justice in Ireland: Looking back, looking forward, 29 November 2021 (online)
12. Informal conversations	Providing general practitioner, 19 October 2021 Providing consultant, 21 September 2022 Crisis pregnancy counsellor, 4 May 2022; 16 May 2022

Appendix 2: Carolan's (2016) Chronology of the evolution of law since the Eighth Amendment

APPENDIX B: OUTLINE CHRONOLOGY OF EVOLUTION OF LAW SINCE THE EIGHTH AMENDMENT

Year	
1983	Eighth Amendment of the Constitution: inclusion of Article 40.3.3° (right to life of the unborn with due regard to the equal right to life of the mother).
1992	Decision of Supreme Court in *Attorney General v. X* [1992] I.R. 1.
1992	Proposed Twelfth Amendment of the Constitution to deal with right to life of the unborn rejected.
1992	Thirteenth Amendment of the Constitution provided that Article 4.3.3° would not limit freedom to travel between Ireland and another state (right to travel).
1992	Fourteenth Amendment of the Constitution provided that Article 40.3.3° would not limit freedom to obtain or make available information in relation to services lawfully available in another state (right to information).
1995	Enactment of Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995.

1996	Report of the Constitution Review Group under the chairmanship of Dr. T.K. Whitaker, including, *inter alia*, commentary on Article 40.3.3°, published.
1999	Green Paper on Abortion published.
2000	Fifth Progress Report (Abortion) of the All-Party Oireachtas Committee on the Constitution under the chairmanship of the late Brian Lenihan, T.D. published.
2002	Proposed Twenty Fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) rejected.
2010	Judgment of the European Court of Human Rights in *A,B & C v. Ireland*.
2012	Report of Expert Group on the judgment in *A,B & C v. Ireland* under the chairmanship of Mr. Justice Sean Ryan published in November 2012.
2013	Report of Oireachtas Joint Committee on Health and Children under the chairmanship of Jerry Buttimer, T.D. on implementation of the Government decision following the publication of the Expert Group Report published.

2013	Protection of Life during Pregnancy Act 2013 enacted.
2014	"Implementation of the Protection of Life during Pregnancy Act 2013 – Guidance Document for Health Professionals" published by the Department of Health.
2015	Thirty First Amendment of the Constitution provided for an Article expressly relating to children (Article 42A).
2016	Opinion of the Human Rights Committee on the United Nations International Covenant on Civil and Political Rights in *Mellet v. Ireland* (CCPR/C/116/D/2324/2013).

Appendix 3: HSE Response to a request from NWCI about the provision of abortion by GPs

Following a request from NWC, the HSE provided the below response and data

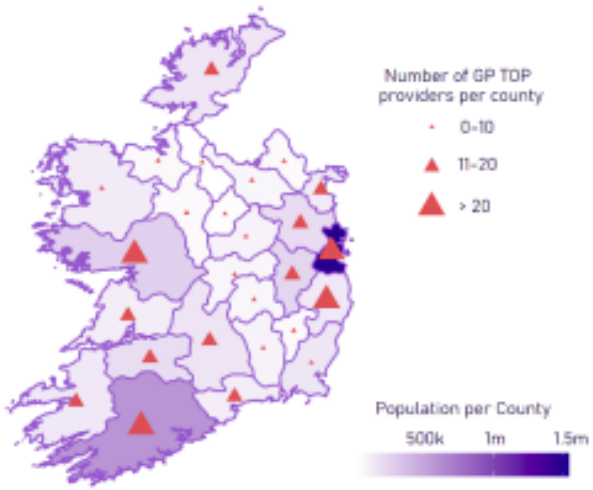
HSE response 1 March 2022: *Some 408 General Practitioners have signed the contract to provide a termination of pregnancy service. The HSE is satisfied that there is a good geographic spread of GPs taking part, enough to meet the needs of people who may need to access the service, with GP's providing services in each county. In consultation with GPs, a decision was made to make participating GP details available by calling the 'My Options' helpline, rather than publishing a list of GPs. Due to GP availability and capacity to take additional patients, not all 408 GPs are on the 'My Options' list at any one time.*

The table below sets out the range of GP providers in each county.

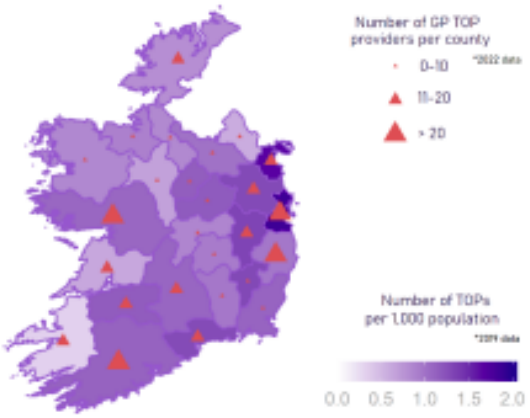
County breakdown	Number of GPs contracted to provide ToP services by range 0-10, 10-20 or 20+
Cavan	0-10
Cork	20+
Donegal	10-20
Dublin	20+
Galway	20+
Kerry	10-20
Kilkenny	0-10
Laois	0-10
Limerick	10-20
Longford	0-10
Louth	10-20
Mayo	0-10
Meath	10-20
Monaghan	0-10
Tipperary	10-20
Waterford	10-20
Westmeath	0-10
Wexford	0-10
Wicklow	20+
Sligo	0-10
Leitrim	0-10
Roscommon	0-10
Carlow	0-10
Clare	10-20
Kildare	10-20
Offaly	0-10

Map showing population density and number of GP providers

Maps below developed by the ICGP



Map showing ordinary county of residence for termination versus number of providers (TOP/1000 population is 2019 and TOP provider info is from 2022).



The maternity hospitals providing abortion services in Ireland are: • National Maternity Hospital, Holles Street, Dublin • Rotunda Hospital, Dublin • Coombe Women & Infants University Hospital, Dublin • Midland Regional Hospital Mullingar, Co. Westmeath • Our Lady of Lourdes Hospital Drogheda, Co. Louth • University Hospital Galway, Galway • Mayo University Hospital, Castlebar, Co Mayo • University Maternity Hospital Limerick, Limerick • Cork University Maternity Hospital, Cork • University Hospital Waterford • Sligo University Hospital

The full list of maternity hospitals is available here: https://www.hse.ie/eng/services/list/3/maternity/

About NWC

The National Women's Council (NWC) is the leading national representative organisation for women and women's groups in Ireland, founded in 1973. We have over 190 member groups and a large and growing community of individual supporters. The ambition of the National Women's Council is an Ireland where every woman enjoys true equality and no woman is left behind. This ambition shapes and informs our work, and, with our living values, how we work.

We are a movement-building organisation rooted in our membership, working on the whole island of Ireland. We are also part of the international movement to protect and advance women's and girls' rights. Our purpose is to lead action for the achievement of women's and girls' equality through mobilising, influencing, and building solidarity. More information is available on www.nwci.ie

Table 12c: Legal abortions, country of residence by age, gestation group (weeks), previous abortions and marital status, 2019

							numbers and percentages
		Scotland		Northern Ireland		Irish Republic	
		no.	%	no.	%	no.	%
All		**179**	***100***	**1,014**	***100***	**375**	***100***
Age1							
	Under 16	3	*2*	13	*1*	2	*1*
	16 - 17	9	*5*	25	*2*	7	*2*
	18 - 19	20	*11*	69	*7*	16	*4*
	20 - 24	58	*32*	262	*26*	67	*18*
	25 - 29	34	*19*	264	*26*	62	*17*
	30 - 34	26	*15*	203	*20*	74	*20*
	35 - 39	21	*12*	120	*12*	91	*24*
	40 & over	8	*4*	58	*6*	56	*15*
Gestation weeks							
	3 - 9	78	*44*	748	*74*	65	*17*

	10 - 12	8	*4*	132	*13*	33	*9*
	13 - 19	12	*7*	104	*10*	198	*53*
	20 and over	81	*45*	30	*3*	79	*21*
Number of previous abortions							
	0	141	*79*	836	*82*	310	*83*
	1+	38	*21*	178	*18*	65	*17*
Marital status2							
	Single no partner	43	*24*	272	*31*	71	*20*
	Single with partner	102	*58*	451	*51*	145	*41*
	Single not stated	7	*4*	19	*2*	9	*3*
	Married/civil partnership	21	*12*	114	*13*	120	*34*
	Separated/widowed/divorced	4	*2*	31	*3*	5	*1*
	Not known & not stated	2	.	127	.	25	.

1 Records where age was not stated have been included in age group 20-24.
2 percentages exclude not known and not stated
Note: percentages are rounded and may not add up to 100

Table 12d: Legal abortions: residents of Irish Republic by county, 2019

Irish Republic residents		numbers and percentages
	Total	% 1
County of residence	**375**	
Carlow	3	*0.8*
Cavan	6	*1.7*
Clare	13	*3.6*
Cork	36	*9.9*
Donegal	11	*3.0*
Dublin	141	*39.0*
Galway	23	*6.4*
Kerry	3	*0.8*
Kildare	18	*5.0*
Kilkenny	7	*1.9*
Laois	2	*0.6*
Leitrim	2	*0.6*
Limerick	17	*4.7*

Longford	5	*1.4*
Louth	7	*1.9*
Mayo	6	*1.7*
Meath	7	*1.9*
Monaghan	1	*0.3*
Offaly	2	*0.6*
Roscommon	1	*0.3*
Sligo	5	*1.4*
Tipperary	13	*3.6*
Waterford	7	*1.9*
Westmeath	6	*1.7*
Wexford	12	*3.3*
Wicklow	8	*2.2*
County not stated	13	.

1 percentages exclude not known and not stated county of Ireland
Note: percentages are rounded and may not add to 100

Table 12e: Legal abortions: by i) age, ii) statutory grounds, iii) gestation (weeks), iv) marital status, v) ethnicity, vi) purchaser, vii) procedure, viii) complications, ix) previous live stillbirths, x) previous miscarriages, and xi) previous abortions, residents of Irish Republic, 2019

Irish Republic residents					numbers and percentages
All legal abortions occuring in England or Wales				Total	*%*
				375	***100***
i) Age 1					
	Under 16			2	*0.5*
	16 - 17			7	*1.9*
	18 - 19			16	*4.3*
	20 - 24			67	*17.9*
	25 - 29			62	*16.5*
	30 - 34			74	*19.7*
	35 - 39			91	*24.3*
	40 & over			56	*14.9*
ii) Grounds					
	A (alone or with B, C or D)			0	*0.0*
	B (alone)			0	*0.0*
	B (with C or D)			0	*0.0*

	C (alone)			311	*82.9*
	D (alone or with C)			0	*0.0*
	E (alone or with A, B, C or D)			64	*17.1*
	F or G			0	*0.0*
(iii) Gestation weeks					
	3 - 9			65	*17.3*
	10 - 12			33	*8.8*
	13 - 19			198	*52.8*
	20 and over			79	*21.1*
(iv) Marital status 2					
	Single no partner			71	*20.3*
	Single with partner			145	*41.4*
	Single not stated			9	*2.6*
	Married/civil partnership			120	*34.3*
	Separated/widowed/divorced			5	*1.4*
	Not known & not stated			25	
(v) Ethnicity 2					
	White - British			12	*3.3*
	White - Irish			285	*77.2*
	White - Any other White background			36	*9.8*
	Mixed - White and Black Caribbean			0	*0.0*

	Mixed - White and Black African			0	*0.0*
	Mixed - White and Asian			1	*0.3*
	Mixed - Any Other			3	*0.8*
	Asian or Asian British - Indian			3	*0.8*
	Asian or Asian British - Pakistani			1	*0.3*
	Asian or Asian British - Bangladeshi			0	*0.0*
	Asian - Any other Asian background			3	*0.8*
	Black or Black British - Caribbean			1	*0.3*
	Black or Black British - African			9	*2.4*
	Black or Black British - Any other			2	*0.5*
	Chinese			10	*2.7*
	Any other ethnic group			3	*0.8*
	Not known/not stated			6	
(vi) Purchaser					
	NHS Funded			0	*0.0*
	NHS Independent Funded			0	*0.0*
	Privately Funded			375	*100.0*
(vii) Procedure					
	Surgical			**308**	
		Gestation weeks			
			3 - 9	35	*11.4*
			10 - 12	32	*10.4*

			13 - 19	194	*63.0*
			20 and over	47	*15.3*
	Medical			**67**	
		Gestation weeks			
			3 - 9	30	*44.8*
			10 - 12	1	*1.5*
			13 - 19	4	*6.0*
			20 and over	32	*47.8*
(viii)	**Complications 3**				
		Total complications		2	.
(ix) Number of previous pregnancies resulting in live or stillbirth					
	0			191	*50.9*
	1+			184	*49.1*
(x) Number of previous pregnancies resulting in spontaneous miscarriage and ectopic pregnancies					
	0			300	*80.0*
	1+			75	*20.0*

(xi) Number of previous pregnancies resulting in abortion under the Act					
	0			310	*82.7*
	1+			65	*17.3*

1 Records where age was not stated have been included in age group 20-24.
2 Percentages exclude 'not known' and 'not stated'.
3 Total complications include: haemorrhage, uterine perforation and/or sepsis and are those reported up to the time of discharge from the place of termination.
Therefor complications that occur after discharge may not be recorded.
Note: percentages are rounded and may not add to 100

Table 12c: Legal abortions, non residents of England and Wales, country of residence by age, gestation group (weeks), previous abortions and marital status, 2020

							numbers and percentages
		Scotland		Northern Ireland		Irish Republic	
		no.	%	no.	%	no.	%
All		**123**	***100***	**371**	***100***	**194**	***100***
Age1							
	Under 16	0	*0*	2	*1*	0	*0*
	16 - 17	1	*1*	17	*5*	2	*1*
	18 - 19	4	*3*	31	*8*	5	*3*
	20 - 24	21	*17*	100	*27*	26	*13*
	25 - 29	35	*28*	95	*26*	33	*17*
	30 - 34	25	*20*	59	*16*	34	*18*
	35 - 39	30	*24*	48	*13*	60	*31*
	40 & over	7	*6*	19	*5*	34	*18*
Gestation weeks							
	3 - 9	68	*55*	238	*64*	11	*6*

	10 - 12	6	*5*	66	*18*	7	*4*
	13 - 19	11	*9*	55	*15*	134	*69*
	20 and over	38	*31*	12	*3*	42	*22*
Number of previous abortions							
	0	75	*61*	315	*85*	171	*88*
	1+	48	*39*	56	*15*	23	*12*
Marital status2							
	Single no partner	36	*30*	111	*34*	32	*17*
	Single with partner	52	*43*	165	*51*	73	*39*
	Single not stated	3	*2*	13	*4*	6	*3*
	Married/civil partnership	26	*21*	26	*8*	74	*39*
	Separated/widowed/divorced	5	*4*	10	*3*	4	*2*
	Not known & not stated	1	*.*	46	*.*	5	*.*

1 Records where age was not stated have been included in age group 20-24.
2 percentages exclude not known and not stated
Note: percentages are rounded and may not add up to 100

Table 12d: Legal abortions: residents of Irish Republic by county, 2020

Irish Republic residents		numbers and percentages
	Total	% 1
County of residence	**194**	
Carlow	7	*6.4*
Cavan	3	*2.8*
Clare	1	*0.9*
Cork	12	*11.0*
Donegal	1	*0.9*
Dublin	40	*36.7*
Galway	7	*6.4*
Kerry	3	*2.8*
Kildare	5	*4.6*
Kilkenny	2	*1.8*
Laois	7	*6.4*
Leitrim	0	*0.0*
Limerick	3	*2.8*

Longford	0	*0.0*
Louth	2	*1.8*
Mayo	0	*0.0*
Meath	1	*0.9*
Monaghan	0	*0.0*
Offaly	0	*0.0*
Roscommon	2	*1.8*
Sligo	4	*3.7*
Tipperary	4	*3.7*
Waterford	1	*0.9*
Westmeath	0	*0.0*
Wexford	2	*1.8*
Wicklow	2	*1.8*
County not stated	85	.

1 percentages exclude not known and not stated county of Ireland
Note: percentages are rounded and may not add to 100

Table 12e: Legal abortions: by i) age, ii) statutory grounds, iii) gestation (weeks), iv) marital status, v) ethnicity, vi) purchaser, vii) procedure, viii) complications, ix) previous live stillbirths, x) previous miscarriages, and xi) previous abortions, residents of Irish Republic, 2020

Irish Republic residents					numbers and percentages
All legal abortions occuring in England or Wales				Total	%
				194	***100***
i) Age 1					
	Under 16			0	*0.0*
	16 - 17			2	*1.0*
	18 - 19			5	*2.6*
	20 - 24			26	*13.4*
	25 - 29			33	*17.0*
	30 - 34			34	*17.5*
	35 - 39			60	*30.9*
	40 & over			34	*17.5*
ii) Grounds					
	A (alone or with B, C or D)			0	*0.0*
	B (alone)			0	*0.0*
	B (with C or D)			0	*0.0*
	C (alone)			131	*67.5*

	D (alone or with C)			0	*0.0*
	E (alone or with A, B, C or D)			63	*32.5*
	F or G			0	*0.0*
(iii) Gestation weeks					
	3 - 9			11	*5.7*
	10 - 12			7	*3.6*
	13 - 19			134	*69.1*
	20 and over			42	*21.6*
(iv) Marital status 2					
	Single no partner			32	*16.9*
	Single with partner			73	*38.6*
	Single not stated			6	*3.2*
	Married/civil partnership			74	*39.2*
	Separated/widowed/divorced			4	*2.1*
	Not known & not stated			5	.
(v) Ethnicity 2					
	White - British			9	*4.7*
	White - Irish			148	*77.5*
	White - Any other White background			12	*6.3*
	Mixed - White and Black Caribbean			0	*0.0*
	Mixed - White and Black African			2	*1.0*

	Mixed - White and Asian			1	*0.5*
	Mixed - Any Other			2	*1.0*
	Asian or Asian British - Indian			1	*0.5*
	Asian or Asian British - Pakistani			0	*0.0*
	Asian or Asian British - Bangladeshi			0	*0.0*
	Asian - Any other Asian background			2	*1.0*
	Black or Black British - Caribbean			0	*0.0*
	Black or Black British - African			4	*2.1*
	Black or Black British - Any other			2	*1.0*
	Chinese			1	*0.5*
	Any other ethnic group			7	*3.7*
	Not known/not stated			3	.
(vi) Purchaser					
	NHS Funded			0	*0.0*
	NHS Independent Funded			0	*0.0*
	Privately Funded			194	*100.0*
(vii) Procedure					
	Surgical			**179**	
		Gestation weeks			
			3 - 9	9	*5.0*
			10 - 12	7	*3.9*
			13 - 19	131	*73.2*

			20 and over	32	*17.9*
	Medical			**15**	
		Gestation weeks			
			3 - 9	2	*13.3*
			10 - 12	0	*0.0*
			13 - 19	3	*20.0*
			20 and over	10	*66.7*
(viii)	**Complications 3**				
		Total complications		1	.
(ix) Number of previous pregnancies resulting in live or stillbirth					
	0			75	*38.7*
	1+			119	*61.3*
(x) Number of previous pregnancies resulting in spontaneous miscarriage and ectopic pregnancies					
	0			143	*73.7*
	1+			51	*26.3*

(xi) Number of previous pregnancies resulting in abortion under the Act					
	0			171	*88.1*
	1+			23	*11.9*

1 Records where age was not stated have been included in age group 20-24.
2 Percentages exclude 'not known' and 'not stated'.
3 Total complications include: haemorrhage, uterine perforation, sepsis and/or cervical tear and are those reported up to the time of discharge from the place of termination. Therefore complications that occur after discharge may not be recorded.
Note: percentages are rounded and may not add to 100

Table 12c: Legal abortions, non residents of England and Wales, country of residence by age, gestation group (weeks), previous abortions and marital status, numbers, percentages, 2021
This worksheet contains one table.
[Note 1] Records where age was not stated have been included in age group 20 to 24.
[Note 2] Percentages exclude not known and not stated.
[Note 3] Percentages are rounded and may not add up to 100.
[Note 4] [z] denotes where figures are not applicable.

Breakdown	Further breakdown	Scotland numbers	Scotland percentages	Northern Ireland numbers	Northern Ireland percentages	Irish Republic numbers	Irish Republic percentages
All legal abortions	**All legal abortions**	**150**	**100**	**161**	**100**	**206**	**100**
Age [Note 1]	Under 16	2	1	2	1	3	1
Age [Note 1]	16 to 17	6	4	9	6	5	2
Age [Note 1]	18 to 19	6	4	13	8	5	2
Age [Note 1]	20 to 24	33	22	38	24	24	12
Age [Note 1]	25 to 29	33	22	34	21	19	9
Age [Note 1]	30 to 34	28	19	29	18	42	20
Age [Note 1]	35 to 39	31	21	27	17	73	35
Age [Note 1]	40 & over	11	7	9	6	35	17
Gestation weeks	2 to 9	98	65	45	28	7	3
Gestation weeks	10 to 12	3	2	35	22	2	1

Gestation weeks	13 to 19	8	5	55	34	137	67
Gestation weeks	20 and over	41	27	26	16	60	29
Number of previous abortions	0	120	80	135	84	184	89
Number of previous abortions	1	26	17	25	16	22	11
Number of previous abortions	2+	4	3	1	1	0	0
Marital status [Note 2]	Single no partner	31	22	48	35	28	14
Marital status [Note 2]	Single with partner	82	58	66	48	64	33
Marital status [Note 2]	Single not stated	6	4	13	9	5	3
Marital status [Note 2]	Married/civil partnership	19	13	11	8	97	50
Marital status [Note 2]	Separated/widowed/divorced	3	2	0	0	0	0
Marital status [Note 2]	Not known & not stated	9	[z]	23	[z]	12	[z]

Table 12d: Legal abortions: residents of Irish Republic by county, numbers, percentages, 2021
This worksheet contains one table.
[Note 1] Percentages exclude not known and not stated county of Ireland.
[Note 2] Percentages are rounded and may not add to 100.
[Note 3] [z] denotes where figures are not applicable.

County of residence	Total numbers occurring in England and Wales	Percentages
All Irish Republic counties	**206**	**100**
Carlow	3	1.5
Cavan	4	2.0
Clare	5	2.5
Cork	27	13.2
Donegal	6	2.9
Dublin	75	36.8
Galway	14	6.9
Kerry	6	2.9
Kildare	11	5.4
Kilkenny	1	0.5
Laois	2	1.0
Leitrim	0	0.0
Limerick	2	1.0
Longford	1	0.5
Louth	0	0.0

Mayo	4	2.0
Meath	11	5.4
Monaghan	0	0.0
Offaly	3	1.5
Roscommon	0	0.0
Sligo	3	1.5
Tipperary	5	2.5
Waterford	6	2.9
Westmeath	5	2.5
Wexford	5	2.5
Wicklow	5	2.5
County not stated	2	[z]

Table 12e: Legal abortions: by i) age, ii) statutory grounds, iii) gestation (weeks), iv) marital status, v) ethnicity, vi) purchaser, vii) procedure, viii) complications, ix) previous live or stillbirths, x) previous miscarriages, and xi) previous abortions, residents of Irish Republic, numbers, percentages, 2021

This woksheet contains one table.

[Note 1] Records where age was not stated have been included in age group 20-24.

[Note 2] Percentages exclude 'not known' and 'not stated'.

[Note 3] Total complications include: haemorrhage, uterine perforation, sepsis and/or cervical tear and are those reported up to the time of discharge. Therefore complications that occur after discharge may not be recorded.

[Note 4] The Department is undertaking a project to review the system of recording abortion complications data.

[Note 5] [z] denotes where figures are not applicable.

Breakdown	Further breakdown	Total numbers	Percentages
All legal abortions occuring in England or Wales	**Irish Republic residents**	**206**	**100**
(i) Age [Note 1]	Under 16	3	1.5
(i) Age [Note 1]	16 to 17	5	2.4
(i) Age [Note 1]	18 to 19	5	2.4
(i) Age [Note 1]	20 to 24	24	11.7
(i) Age [Note 1]	25 to 29	19	9.2
(i) Age [Note 1]	30 to 34	42	20.4
(i) Age [Note 1]	35 to 39	73	35.4
(i) Age [Note 1]	40 & over	35	17.0
(ii) Grounds	A (alone or with B, C or D)	0	0.0
(ii) Grounds	B (alone)	0	0.0
(ii) Grounds	B (with C or D)	0	0.0
(ii) Grounds	C (alone)	103	50.0
(ii) Grounds	D (alone or with C)	0	0.0

(ii) Grounds	E (alone or with A, B, C or D)	103	50.0
(ii) Grounds	F or G	0	0.0
(iii) Gestation weeks	2 to 9	7	3.4
(iii) Gestation weeks	10 to 12	2	1.0
(iii) Gestation weeks	13 to 19	137	66.5
(iii) Gestation weeks	20 and over	60	29.1
(iv) Marital status [Note 2]	Single no partner	28	14.4
(iv) Marital status [Note 2]	Single with partner	64	33.0
(iv) Marital status [Note 2]	Single not stated	5	2.6
(iv) Marital status [Note 2]	Married/civil partnership	97	50.0
(iv) Marital status [Note 2]	Separated/widowed/divorced	0	0.0
(iv) Marital status [Note 2]	Not known & not stated	12	[z]
(v) Ethnicity [Note 2]	White - British	10	5.2
(v) Ethnicity [Note 2]	White - Irish	156	81.3
(v) Ethnicity [Note 2]	White - Any other White background	18	9.4
(v) Ethnicity [Note 2]	Mixed - White and Black Caribbean	0	0.0
(v) Ethnicity [Note 2]	Mixed - White and Black African	0	0.0
(v) Ethnicity [Note 2]	Mixed - White and Asian	0	0.0
(v) Ethnicity [Note 2]	Mixed - Any Other	0	0.0
(v) Ethnicity [Note 2]	Asian or Asian British - Indian	4	2.1
(v) Ethnicity [Note 2]	Asian or Asian British - Pakistani	0	0.0
(v) Ethnicity [Note 2]	Asian or Asian British - Bangladeshi	0	0.0
(v) Ethnicity [Note 2]	Asian - Any other Asian background	0	0.0

(v) Ethnicity [Note 2]	Black or Black British - Caribbean	0	0.0
(v) Ethnicity [Note 2]	Black or Black British - African	2	1.0
(v) Ethnicity [Note 2]	Black or Black British - Any other	2	1.0
(v) Ethnicity [Note 2]	Chinese	0	0.0
(v) Ethnicity [Note 2]	Any other ethnic group	0	0.0
(v) Ethnicity [Note 2]	Not known/not stated	14	[z]
(vi) Purchaser	NHS Funded	0	0.0
(vi) Purchaser	NHS Independent Funded	0	0.0
(vi) Purchaser	Privately Funded	206	100.0
(vii) Procedure	**Surgical**	**182**	**[z]**
(vii) Procedure by gestation weeks	2 to 9	3	1.6
(vii) Procedure by gestation weeks	10 to 12	2	1.1
(vii) Procedure by gestation weeks	13 to 19	134	73.6
(vii) Procedure by gestation weeks	20 and over	43	23.6
(vii) Procedure	**Medical**	**24**	**[z]**
(vii) Procedure by gestation weeks	2 to 9	4	16.7
(vii) Procedure by gestation weeks	10 to 12	0	0.0
(vii) Procedure by gestation weeks	13 to 19	3	12.5
(vii) Procedure by gestation weeks	20 and over	17	70.8
(viii) Complications [Note 3]	Total complications	2	[z]
(ix) Number of previous pregnancies resulting in live or stillbirth	0	100	65.4
(ix) Number of previous pregnancies	1	53	34.6

resulting in live or stillbirth			
(ix) Number of previous pregnancies resulting in live or stillbirth	2+	53	34.6
(x) Number of previous pregnancies resulting in spontaneous miscarriage and ectopic pregnancies	0	138	77.1
(x) Number of previous pregnancies resulting in spontaneous miscarriage and ectopic pregnancies	1	41	22.9
(x) Number of previous pregnancies resulting in spontaneous miscarriage and ectopic pregnancies	2+	27	15.1
(xi) Number of previous pregnancies resulting in abortion under the Act	0	184	89.3
(xi) Number of previous pregnancies resulting in abortion under the Act	1	22	10.7
(xi) Number of previous pregnancies resulting in abortion under the Act	2+	0	0.0

Appendix 7: Community care pathway

Visit 1: Community Care

- **Consultation/Examination**
- **Urine pregnancy test**
- **FBC/rhesus testing**
- **Provide verbal & written information/contact number for My Options**
- **Advise on contraception**
- **Provide an STI risk assessment, as appropriate**
- **Refer for ultrasound if clinically indicated but dating pregnancy based on LMP in most cases accurate**
- **Certify that the pregnancy is not exceeding 12 weeks**
- **Refer to hospital if person is between 9-12 weeks, or if clinically indicated or according to patient preference**

1 days from certification

Visit 2: Community Care

- **Re-certify person is not exceeding 12 weeks if a different doctor is seeing the person at visit 2**
- **Explain the termination of pregnancy procedure**
- **Obtain informed consent**
- **Administer first medication – mifepristone**
- **Supply second medication & instructions – misoprostol**
- **Advise & provide written information on what to expect/possible complications**
- **Provide prescription for pain relief, as appropriate**
- **Provide information on contraception and provide a prescription for contraception, as appropriate**
- **Provide the person with low sensitivity pregnancy test with instructions**
- **Provide information/contact number for My Options**
- **Refer for anti-D, with the person's consent, between 7-9 weeks when there is a rhesus negative blood group**
- **Notification of record (28 days to submit)**

1-2 days

- **Person takes second medication at home, as instructed**

1 weeks

- **Low sensitivity pregnancy test taken at home, as instructed**



Visit 3 (optional): Community Care

- **Aftercare consultation**
- **Refer to hospital for complications or for ongoing pregnancy, where indicated**
- **Refer to other services e.g. counselling, as required**
- **Provide prescription for contraception, as appropriate**
- **Provide report to the person's primary doctor, if the person consents to it**
- **If the person does not book an aftercare consultation, they should be contacted to confirm the low sensitivity pregnancy test has been taken and that they are no longer pregnant**



Person referred to hospital, where indicated

Appendix 8: Secondary care pathway for medical abortion

Less than 9 weeks 9-12 weeks

Visit 1: Community Care	Visit 1: Community Care
• **Consultation/Examination** • **Urine pregnancy test** • **FBC/rhesus testing** • **Provide verbal & written information/contact number for My Options** • **Advise on contraception** • **Provide an STI risk assessment, as appropriate** • **Refer for ultrasound if clinically indicated but dating pregnancy based on LMP in most cases accurate** • **Certify that the pregnancy is not exceeding 12 weeks** • **Refer to hospital if person is between 9-12 weeks, or if clinically indicated or according to patient preference**	• Consultation/Examination • Urine pregnancy test • FBC/rhesus testing • Provide verbal & written information/contact number for My Options • Advise on contraception • Provide an STI risk assessment, as appropriate • Refer for ultrasound if clinically indicated but dating pregnancy based on LMP in most cases accurate • Certify that the pregnancy is not exceeding 12 weeks • Refer to hospital if person is between 9-12 weeks, or if clinically indicated or according to patient preference

3 days from certification

Visit 2: Secondary Care	Visit 2: Secondary Care
• **Provide ultrasound if clinically indicated** • **Consultation/Examination** • **Re-certify person is not exceeding 12 weeks, if a different doctor sees the person at visit 2**	• Provide ultrasound scan if clinically indicated • Consultation/Examination • Re-certify person is not exceeding 12 weeks, if a different doctor sees the person at visit 2

• **FBC/rhesus testing** • **Obtain informed consent** • **Administer first medication – mifepristone** • **Supply second medication & instructions – misoprostol** • **Advise & provide written information on what to expect/possible complications** • **Provide prescription for pain relief, as appropriate** • **Provide information on contraception and provide a prescription for contraception, as appropriate** • **Provide the person with low sensitivity pregnancy test with instructions** • **Provide information/contact number for My Options** • **Refer for anti-D, with the person's consent, between 7-9 weeks when there is a rhesus negative blood group** • **Notification of record (28 days to submit)**	• FBC/rhesus testing • Obtain informed consent • Administer first medication – mifepristone • Advise & provide written information on what to expect/possible complications/pain medication • Provide information/contact number for My Options

1-2 days

Visit 3 Secondary Care

• **Person takes second medication at home, as instructed**	• Administer second medication – misoprostol • Monitor and re-administer medication, as required (admission for up to 8 hours in the hospital, if required/overnight stay may also be required on rare occasions)

	• Administer anti-D, with the person's consent, when there is a rhesus negative blood group • Confirm completion of TOP prior to discharge • Dispose of fetal remains in accordance with hospital policy • Provide prescription for pain relief, as appropriate • Provide information on contraception and provide a prescription for contraception, as appropriate • Provide the person with low sensitivity pregnancy test with instructions • Provide information/contact number for My Options • Notification of record (28 days to submit)

2 weeks

Visit 3 (optional) Community or Secondary Care	Visit 4 (optional) Community or Secondary Care
• **Aftercare consultation** • **Refer to hospital for complications or for ongoing pregnancy, where indicated** • **Refer to other services e.g. counselling, as required** • **Provide prescription for contraception, as appropriate** • **Provide report to the person's primary doctor, if the person consents to it** • **If the person does not book an aftercare consultation, they should be contacted to confirm the low sensitivity pregnancy test has been taken and that they are no longer pregnant**	• Aftercare consultation • Refer to hospital for complications or for ongoing pregnancy, where indicated • Refer to other services e.g. counselling, as required • Provide prescription for contraception, as appropriate • Provide report to the person's primary doctor, if the person consents to it • If the person does not book an aftercare consultation, they should be contacted to confirm the low sensitivity pregnancy test has been

	taken and that they are no longer pregnant

Person referred to hospital, where indicated

Appendix 9: Secondary care pathway for surgical abortion

Visit 1

Community Care

- **Consultation/Examination**
- **Urine pregnancy test**
- **Provide verbal & written information/contact number for My Options**
- **Advise on contraception**
- **Provide an STI risk assessment, as appropriate**
- **Certify that the pregnancy is not exceeding 12 weeks**
- **Refer to hospital**

3 days from certification

Visit 2

Secondary Care

- **Provide ultrasound scan if clinically indicated**
- **Consultation/Examination**
- **Re-certify person is not exceeding 12 weeks, if a different doctor sees the person at visit 2**
- **FBC/rhesus testing**
- **Explain the termination of pregnancy procedure**
- **Obtain informed consent**
- **Advise & provide written information on what to expect/possible complications/pain medication**
- **Access elective surgical care pathway (according to local hospital policy) if general anaesthesia is required**
- **Surgical TOP as fay case**
- **Administer anti-D, with the person's consent, when there is a rhesus negative blood group**
- **Confirm completion of TOP prior to discharge**
- **Dispose of foetal remains in accordance with hospital policy**
- **Provide prescription for pain relief, as appropriate**

- **Provide information on contraception and provide a prescription for contraception, as appropriate**
- **Provide the person with low sensitivity pregnancy test with instructions**
- **Provide information/contact number for 'My Options'**
- **Notification of record (28 days to submit)**

2 weeks

- **Low sensitivity pregnancy test taken at home, as instructed**



Visit 3 (optional)

Community or Secondary Care

- **Aftercare consultation**
- **Refer to hospital for complications or for ongoing pregnancy, where indicated**
- **Refer to other services e.g. counselling, as required**
- **Provide prescription for contraception, as appropriate**
- **Provide report to the person's primary doctor, if the person consents to it**
- **If the person does not book an aftercare consultation, they should be contacted to confirm the low sensitivity pregnancy test has been taken and that they are no longer pregnant**



Person referred to hospital, where indicated

Appendix 10: Interview questions as part research plan in September 2020



Please note that the interviews will be semi-structured. The questions serve as guidelines for the researcher to address certain topics, but there is space to expand on some of the questions or to deviate from these if the participant wishes to discuss matters not directly addressed with the questions below. The questions here are an indication of the topics which will be discussed during the interview.

Women who accessed abortion care

General, factors which might influence experiences with abortion access

How old are you?

Where are you from? Where do you live? What is your current living situation? What do you do? Do you work or study?

Abortion care/details

When did you have an abortion?

Where did you have an abortion?

How many weeks pregnant were you?

Experiences of pregnancy and abortion

Would you consider the pregnancy a crisis pregnancy from the moment you knew about it? At which gestational age did you get confirmation of the pregnancy?

What was the process like on deciding how to proceed with the pregnancy or with an abortion?

Did you draw on other people into the decision making – were partners, friends, or family involved? Who did you tell about your pregnancy and who did you consult about how to proceed?

Contact with medical professionals

How and where did you have first contact with a medical professional about (the possibility of) an abortion procedure? Was this a doctor, midwife or nurse? Did you speak to a counsellor or any other type of professional first?

If yes, how did that go?

How did you feel about this process?

Accessing information on abortion

How did you access information about abortion?

Where did you access this information?

Did you go through this by yourself or did anyone help you?

To what extent did you notice that the legislation on abortion was part of the information?

Experiences of the abortion process

Did you have any support throughout this entire experience?

If yes, from whom and in what ways?

If no, did that influence how you experienced the process around the abortion?

What did you experience as positive or helpful about the process around the procedure or the procedure itself?

What did you experience as difficult about the process around the procedure or the procedure itself?

Gestational date of procedure

If the abortion took place before 12 weeks of pregnancy: what was the process like to determine which abortion procedure would be used?

Did you have a choice in this?

How did the medical staff go about this?

If the abortion took place when the pregnancy exceeded 12 weeks: what was the process like to determine the need for an abortion? And how was the type of abortion procedure decided?

Did you have a choice in this?

How did the medical staff go about this?

Barriers related to specific issues that are under discussion more generally

Did you experience any difficulties during the entire process of abortion care and, if so, how did they have any direct consequences for the procedure?

How did they influence your experience with the procedure?

How did you experience the three day waiting period?

Do you feel comfortable telling people you have had an abortion?

Closing questions

Have you experienced any emotional or physical (or other) consequences?

Would you like to add anything else? If another woman who was thinking about an abortion came to you for advice, what would you tell her?

Medical staff who provide abortion care

General, factors which might influence experience with abortion provision

How old are you?

Where are you from? Where do you live?

What is your professional position and for how long have you been working in that position? Could you tell me about your career and studies that led you to your current position?

Transition to abortion care services in the workplace

Since when have you been providing abortion care?

Did you have experience with this before the legalisation in Ireland?

When, how and where have you been trained to provide abortion care?

What was the transition like after legalisation in Ireland for you? How did it affect you and your work?

How did you feel about the legislation being introduced? Did you have a choice in being involved in this?

How was the transition process organised at your workplace?

How is abortion care training organised at your workplace? Who provides the

training? How is abortion care organised alongside other procedures?

Have other aspects of reproductive healthcare been influenced since the legalisation of abortion?

Abortion care and medical processes generally

How much of the legislation influences the everyday work for medical staff

around abortion?

How do medical staff work with the different sections under The Health (Regulation of Termination of Pregnancy) Act, namely:

- section 9, where there is a serious risk to the life of, or of serious harm to the health of, a pregnant woman, after examination by two medical practitioners;
- section 10, in cases of emergency, where there is an immediate serious risk to the life of, or of serious harm to the health of a pregnant woman, after an examination by one medical practitioner;
- section 11, where two medical practitioners are of the opinion formed in good faith that that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth; and
- section 12, where there has been a certification that the pregnancy has not exceeded 12 weeks, and after a period of three days after this certification.

How are those different cases determined?

What is it like for the medical staff to work with those parameters?
Have you been directly involved in having to determine the need for an abortion under section 9, 10 or 11?

How, do you think, the relevant legal sections under which an abortion is carried out, affect the provision of abortion care?

<u>Personal and professional barriers on specific issues that are currently under discussion</u>

Do you experience any barriers in providing abortion care?
If yes, could you identify the barriers and explain how they affect your work?

What do you think about conscientious objection?
How does conscientious objection influence abortion care provision in your work location?

What do you think about the mandatory three day waiting period?
How does this affect your work?

Do you feel that it is more difficult for some women to avail of the service?

Do you speak openly to your family and friends about your work in providing abortion care? If not, why?

Does this influence how you do your work?

Do you experience abortion care provision differently than other aspects of your work?

Closing questions

Have you experienced any emotional or physical (or other) consequences from providing abortion care?

Would you like to add anything else? If another medical professional who would be considering providing abortion care came to you for advice, what would you tell them?