

Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study

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ABSTRACT

Background The Republic of Ireland has one of the world's most restrictive abortion laws, allowing abortion only to preserve a pregnant woman's life. We examined the impact of the law on women's options for accessing abortion, their decision-making regarding which pathway to follow, and their experiences with their chosen approach.

Methods We conducted semi-structured in-depth interviews with 38 women who had either travelled abroad to access abortion in a clinic or had self-managed a medical abortion at home using online telemedicine, between 2010 and 2017. We coded interview transcripts according to an iteratively developed coding guide and performed a thematic analysis to identify key themes.

Results We identified four key themes: (1) self-managing a medical abortion at home using online telemedicine can be a preference over travelling abroad to access abortion services; (2) regardless of the pathway chosen, women experience a lack of pre- and post-abortion support in the Irish healthcare system; (3) feelings of desperation while searching for safe abortion care can lead to considering or attempting dangerous methods; and (4) Irish abortion law and attitudes have impacts beyond physical health considerations, engendering shame and stigma.

Conclusions Despite the country's restrictive abortion law, women in Ireland do obtain abortions, using methods that are legal and safe elsewhere. However, the law negatively impacts women's ability to discuss their options with their healthcare professionals and to seek follow-up care, and can have serious implications for their physical and emotional health. This study's

Key messages

- ▶ Despite highly restrictive abortion laws, women in Ireland do obtain abortions, either by travelling to clinics abroad or by accessing medical abortion through online telemedicine.
- ▶ Travelling abroad can be an emotionally and physically traumatic experience, and self-managing at home using online telemedicine is preferred by some women due to comfort and privacy.
- ▶ Abortion using online telemedicine is against the current law. Women report difficulty seeking support from healthcare professionals in Ireland, as well as experiencing fear and feelings of stigma.

findings provide evidence to inform public and policy discourse on Ireland's abortion laws.

INTRODUCTION

Women in the Republic of Ireland (hereafter Ireland) are subject to some of the world's most restrictive abortion laws.^{1 2} The Eighth Amendment to the Irish Constitution, adopted in 1983, guarantees fetuses the same right to life as pregnant women. In a widely publicised case in 2012, a woman died from an infected inevitable miscarriage for which medical staff would not intervene as the fetal heartbeat was still detectable.³ The Protection of Life During Pregnancy Act 2013 then introduced one exception to the Eighth Amendment: abortion is permitted if a panel of doctors agrees that



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a pregnancy endangers a woman's life and if the procedure is carried out in a designated hospital.^{4,5} Abortions under any other circumstance carry a criminal penalty of up to 14 years' imprisonment.⁶

As a result of these laws, thousands of women travel from Ireland each year to access abortion in England and Wales.^{7,8} Such women are not entitled to abortion care under the UK National Health Service (NHS) and must cover the costs of travel, accommodation and the abortion procedure. Since 2001, the number travelling to England each year has almost halved, from 8250 to 4284.⁹ While some women do travel to other countries to access abortion services, evidence suggests that increasing numbers are self-managing early medical abortions using online telemedicine services. Recent data from one such service, Women on Web (WoW), showed that the number of requests from women in Ireland and Northern Ireland tripled between 2010 and 2016, from 548 to 1748.¹⁰ A study examining the outcomes of online telemedicine in Ireland and Northern Ireland found that 99% of women completed their abortions successfully.¹¹

Ireland's abortion law is currently the subject of intense policy debate. In 2016, 99 Irish citizens known as the Citizens' Assembly examined the current law. They recommended that the Irish Parliament call a referendum to repeal the Eighth Amendment, and to replace it with legislation to allow abortion on request up to 12 weeks' gestation.¹² The Citizens' Assembly Chair, Justice Mary Laffoy, explicitly called for discussion of "the increasing numbers of women who are making contact with online abortion pill providers".¹³ However, very few scientific studies have examined the impact of Ireland's abortion law from the perspectives of women living in Ireland. In light of the need for evidence to inform such important and far-reaching policy decisions, the objectives of this study were: (1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore their experiences in accessing care through each pathway.

METHODS

Between March and December 2017, we conducted in-depth interviews with 38 women who had either travelled to access abortion services in Great Britain or self-managed a medical abortion using online telemedicine. Participants were recruited by email invitation through three organisations: (1) Women on Web (WoW), which sent the invitation to women who had recently used their online telemedicine service; (2) the Abortion Support Network (ASN), which assists women in travelling to access abortion, and which sent the invitation to women on their mailing list; and (3) 'For Reproductive Rights Against Oppression, Sexism and Austerity' (ROSA), which provides information about accessing pills online and which posted the invitation on social media. Women were eligible

to participate if they: (1) were aged over 18 years; (2) had had an abortion within the last 8 years (ie, since both WoW and travel have been available); (3) lived in Ireland at the time of their abortion; and (4) had either travelled abroad to access abortion or used online telemedicine. Potential participants contacted the research team for further details and to set up interviews.

Trained research team members, all of whom are authors of this article, interviewed participants by telephone. All participants gave their informed consent to participate and for the interview to be audio recorded. No potentially identifying information was included on the recordings, which were securely stored on a SSL-protected server, and no records of contact information were retained by the research team. Participants were not asked to share their real names and were instead assigned pseudonyms. Interviews lasted between 35 and 75 min and were all conducted in English. Participants were offered €90 in appreciation for their time.

Interviews were semi-structured and followed an in-depth interview guide developed using prior literature examining Irish abortion laws and the options available to women in Ireland.¹⁻¹⁰ We also allowed scope for participants to discuss whatever they felt was most important about their experiences. Two pilot interviews were conducted to test the interview guide, which was iteratively updated for new content. The interview guide contained questions about participants' circumstances at the time of their pregnancy, their decision-making process when seeking a pathway to abortion, their experience accessing abortion, and their unmet needs. To protect anonymity, we collected very limited demographic information. At the conclusion of each interview, the interviewer recorded detailed field notes, which were discussed by the research team to iteratively develop the coding guide and assess thematic saturation. We transcribed each interview, and each transcript was coded by two research team members, who then met to discuss coding and resolve discrepancies. Coded transcripts were analysed according to the principles of grounded theory to identify key themes.¹⁴ We used Dedoose version 7.6.21 (2017; Los Angeles, CA: SocioCultural Research Consultants, LLC) qualitative analysis software to assist with coding, data organisation and thematic analysis. The University of Texas Institutional Review Board approved the study.

Patient and public involvement

No patients were involved in this study. The in-depth interview guide was developed based on the experiences shared by women in the pilot interviews.

RESULTS

Participants ranged in age from 18 to 42 years and were diverse in terms of employment status and number of children (table 1), rural or urban location

Table 1 Characteristics of study participants who obtained abortion either by travelling abroad or using online telemedicine between 2010 and 2017 (n=38)

Characteristic	Frequency (%)
Age (years)	
18–19	2 (5.3)
20–24	8 (21.0)
25–29	7 (18.4)
30–34	9 (23.7)
35–39	10 (26.3)
40–44	2 (5.3)
Employment status	
Employed	22 (58.0)
Student	12 (31.5)
Not currently working	4 (10.5)
Children (n)	
0	20 (52.6)
1+	18 (47.4)

and socioeconomic status. Eleven participants had travelled abroad to access abortion at a clinic, and 27 had used online telemedicine. Four major themes emerged from our analysis. Each is described below, using illustrative quotations from the interviews.

Self-managed medical abortion as a preferred option

A strong theme among women who chose online telemedicine was that they preferred the idea of self-management over the idea of travelling. Reasons underlying this preference included perceptions of travel as logistically challenging and emotionally traumatic, as well as the advantages of greater privacy when using medications at home. Self-management is against the law in Ireland, but the widespread use of online telemedicine and the negative impact of travel contribute to its perception as a rational choice. Jody (age 40; 5 children) explained:

I didn't consider travelling at all. I don't really get why people travel when the pill is available online. Travel just seemed very invasive and unnecessary and the pill just seems like such a sensible option.

Some, like Mairead (age 32) described the advantage of being in her home environment:

A big advantage [of self-management] was feeling like you're in a safe environment, that you can just go about your day normally, and be in your own bed. I definitely felt much more comfort from being able to do it in the home environment than in a medical environment.

For others, the decision about which pathway to choose involved a nuanced combination of factors, including barriers to travel as well as preferences for privacy and autonomy. Shannon (age 29) who self-managed,

described the combination of financial and personal factors that played into her decision:

It costs a thousand Euros to go to England, and that's a staggering amount, particularly if you feel that you can't tell your family, and you can't look for support elsewhere. Privacy was a factor as well, because there's this notion of shame in Ireland, of the thought of having to go to a clinic and speak to a nurse. I didn't feel like I wanted anybody helping me, or comforting me, particularly someone I didn't know. The idea of actually being able to be on your own was appealing to me.

Most women who travelled to access abortion services abroad did not know about the option of online telemedicine when making their decision. A strong theme among those who travelled was that the travel experience was physically and emotionally traumatic, and that they would strongly consider self-management rather than repeat it. Emma (age 24) explained:

I was interested in the online [option] because I didn't want to travel again. It's horrific. The actual travelling last time was the most traumatic bit of the entire thing. The worst part was when I got to the airport and had to wait 5 hours to get a plane home when I really needed be in bed and resting. I was sitting there bleeding and it was really tough. I felt like a criminal. But even when I got home the real sense of shame doesn't leave. I had problems looking people in the eye because an experience like that basically says: we don't care about you enough in this country, you should leave.

Constraints on accessing local care

Under current Irish law, healthcare professionals in Ireland can provide post-abortion follow-up care to anyone who has had an abortion¹⁵ and may provide information about obtaining abortion services outside the country.¹⁶ In practice, such information is usually limited to providing clinic contact numbers.¹⁷ However, regardless of whether they travelled or self-managed, participants expressed reluctance to consult with local healthcare providers before or after their abortion. A key factor underlying this reluctance included fears about judgement. Jamie (age 22) who travelled, explained:

I was of course scared. I definitely knew that I couldn't keep the pregnancy, but I couldn't go to the doctor and openly discuss it because abortion is illegal. So, I was scared that if I even mentioned I was considering abortion, it would have a very negative impact on the relationship with my doctor.

Others actually experienced judgmental and unhelpful reactions, which not only left them without support from a healthcare professional, but also risked causing

harm through shame and stigma. As Maisie (age 21) who self-managed described:

I went to the GP and said 'I think I'm pregnant, can we do a check-up?' And he gave me the pregnancy test and it was positive. He smiled at me and I couldn't just smile back. And I said, 'Look, this was not planned at all, I would love to have children one day, but I can't at the moment'. And then the doctor started crying. I was really shocked to see him crying, and he said 'I have a baby, I was young, I was in college', and he started sharing his story. But he wouldn't help me. He said 'Okay, you can go if you're thinking you want to do abortion. You don't need to come to my clinic'. And I had to leave because he didn't want to treat me.

Others felt that doctors in Ireland would be unable to help because the information they can lawfully provide is so limited. Maureen (age 33) who travelled to England for an abortion due to fetal anomaly discovered at 20 weeks, experienced this issue:

The doctor said 'I wish it was different but we are unable to provide you with any more information'. And I could see from her demeanour that she felt bad. I'd say it's a very wearing thing to have to deliver bad news to so many women every year and then to say 'we can do nothing for you'.

Not all women had wanted to talk through their choices or decision-making with a healthcare professional. But those who did express this wish were often unable to have the conversation. Janine (age 32; 2 children) explained:

Doctors in the Republic of Ireland do not help. They don't want to speak about it. I know it's not completely their fault, but eight phone numbers on a sheet is not enough. Whenever I said 'I can't have this baby', it was like a barrier went up. It was just like we don't want to talk about that situation, we don't want to hear about your abortion plan.

Seeking post-abortion follow-up care was particularly fraught among women who used online telemedicine, mainly due to fear of being reported to the authorities. Stacey (age 37; 2 children) explained:

I felt completely unsupported by my country and by my health system. I was having to think 'In what way will I lie if I need medical assistance?' I shouldn't have to lie if I need medical assistance. I should be able to go to my doctor and tell them what's wrong with me and have them help me. At the most vulnerable stage, I shouldn't be having to wonder 'In what way will I lie?'.

Desperation and unsafe methods

Although all of our participants were eventually able to access a safe and effective abortion, they often considered or tried ineffective or dangerous methods while searching for a feasible pathway to care. Women

in these situations often lacked social support and anticipated extremely negative consequences if they continued their pregnancies. Frankie (age 35) had to take out a loan to afford travel and abortion care in England. She also felt her community would judge and ostracise her if she revealed her decision to have an abortion:

If you're feeling desperate and your support system is non-existent, you do very desperate things. There was this forum online talking about having a hot bath and drinking a bottle of vodka, or going in there with a long, sharp instrument. I tried the hot bath. And there's a fitness class that's on a mini trampoline, and people told me that if you go on that within the first 6 to 8 weeks, you miscarry. So, I tried that religiously for 2 weeks, but it didn't help. It was just pure desperation.

Rebecca (age 39; 2 children) experienced severe postpartum depression after each of her births and described the isolation she felt before finding online telemedicine:

I was devastated when I found out [about the pregnancy]. I could already feel the depression coming down on me. But this is Ireland, so you can't just pick up the phone and talk to someone. I couldn't have another baby. I tried Vitamin C and parsley tea. I walked 20km every day, I did sit-ups, I did squats. I did anything I could possibly do to end the pregnancy. I was actually reading pregnancy sites and everything they were warning you not to do was exactly what I was doing: roasting hot baths to the point that I almost scalded myself. And I'm an educated woman. It's just so sad.

Stigma engendered by the law

Beyond making the process of obtaining abortion services burdensome and unsupported, Irish abortion laws have wider social impacts. Brittany (age 29) echoed the observations of many others when she described the impact of the law on perceptions of abortion in Ireland, and how these perceptions have become socially ingrained:

The whole way people think about abortion in Ireland stems back to it being illegal. Abortion is illegal, so it's automatically bad. My parents are not even that religious. But they're from Ireland, they're going on 60 and that's the world that they've grown up in.

Others described the fear and stigma engendered by the law. Bernadette (age 19) who self-managed explains the close intertwining of illegality and social censure: *I had to illegally have an abortion in my own country, and it's not right that I had to do that at*

19 on my own without telling anyone out of fear of either being arrested or even just being judged. I don't think I will ever tell anyone about it because of the stigma around it.

DISCUSSION

Our findings demonstrate that while women in Ireland do obtain abortions despite restrictive laws, the pathways available to them involve significant burdens. Travel is costly and emotionally challenging, and self-managed medical abortion carries legal risk. Moreover, current law prohibits either option from integrating seamlessly into a continuous care pathway. Women feel unable to rely on healthcare professionals in Ireland for pre- or post-abortion care for fear of negative reactions or being reported to the authorities, and because the information that healthcare professionals can provide is so limited. The law also perpetuates shame and stigma, isolating women at a time when many need support. Those with few sources of support may consider ineffective or dangerous options while looking for a feasible care pathway.

The main strength of our study is to provide an in-depth analysis of a topic that represents a significant gap in the scientific literature. Pathways to abortion care in Ireland are challenging to study given the sensitivity and secrecy surrounding abortion. Study limitations include the fact that our sample is necessarily self-selected, which limits our ability to generalise our findings to all women in Ireland who have had abortions. Additionally, women in Ireland may obtain abortions by other routes not represented in our sample, including by purchasing medications from online pharmacy sites, or travelling to clinics in mainland Europe.

Online telemedicine is commonly perceived by the public as a last resort, and is often reported in the media as a desperate option used only by those who cannot afford to travel.¹⁸ However, we found that the ability to self-manage medical abortion in the privacy and comfort of home was often viewed as preferable to taking on the financial and emotional burdens of travelling abroad. This insight is consistent with findings from the USA and Great Britain showing that women who travel long distances to obtain abortion care encounter many of the same logistical and emotional challenges that the women in our study were anxious to avoid.^{19 20} Moreover, studies examining home use of mifepristone and misoprostol in varied settings worldwide have demonstrated consistently high acceptability among women.^{21–23}

Although abortion is a fact in Ireland, the difficulties these women experienced seeking care from local healthcare professionals before and after their abortions demonstrate clearly that it is not adequately supported. The small number of doctors in Ireland who do provide pre- and post-abortion care feel that the

current legal framework is out of step with best clinical practice.²⁴ Others have argued that the discrepancy between the widespread use of abortion telemedicine and the underground nature of this practice presents a strong case for decriminalisation, as well as for allowing accurate and objective information on these medications to be offered by local doctors.²⁵ Notably, the spectre of unsafe abortion methods is not confined to history.²⁶ Our findings show that these methods are still sometimes pursued by women before they find the option of medication self-management. Since medical abortion is currently recommended only up to 10 weeks' gestation,²⁷ there also remains an unmet need in Ireland for legally available clinical abortion services. The limited existing literature on Irish healthcare professionals' attitudes towards abortion suggests that the majority do support a change in the law to allow abortion up to various gestational age limits.²⁸

Finally, our findings suggest that the discourse on abortion in Ireland is unduly influenced by religious beliefs and moral conservatism. These observations reflect prior work examining how religious and moral norms have shaped the legal frameworks governing current abortion policy in Ireland, despite significant social and cultural shifts.²⁹ Moreover, our findings show that the stigma engendered by the illegal status of abortion shapes every aspect of women's experiences of unwanted pregnancy. As both policymakers and the public consider reforming Ireland's abortion law, our findings provide important evidence of the extremely negative impact of the current law on the quality and safety of women's healthcare and on the social experience of abortion in Ireland.

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REFERENCES

- Berer M. Abortion law and policy around the world: in search of decriminalization. *Health Hum Rights* 2017;19:13–27.
- Mills S. Brief background to Irish abortion law. *BJOG* 2017;124:1216.
- Berer M. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: an analysis of the death of Savita Halappanavar in Ireland and similar cases. *Reprod Health Matters* 2013;21:9–17.
- Office of the Attorney General. Electronic Irish Statute Book (eISB). Government of Ireland. Number 35 of 2013. Protection of Life During Pregnancy Act 2013. 2013. <http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/pdf> (accessed 24 Jan 2018).
- Murray C. The Protection of Life during Pregnancy Act 2013: suicide, dignity and the Irish discourse on abortion. *Soc Leg Stud* 2016;25:667–98.
- Mulligan A. The right to travel for abortion services: a case study in Irish 'Cross-border Reproductive Care'. *Eur J Health Law* 2015;22:239–66.
- UK Department of Health. Abortion Statistics, England and Wales: 2016. 2017. <https://www.gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2016> (accessed 24 Jan 2018).
- UK Department of Health. Abortion Statistics, England and Wales: 2015. 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/523623/Abortion_Stats_2015.pdf (accessed 24 January 2018).
- UK Department of Health. Abortion Statistics, England and Wales hosted by the National Archives. <http://webarchive.nationalarchives.gov.uk/20130123231223/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm> (accessed 25 Apr 2018).
- Aiken A, Gomperts R, Trussell J. Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis. *BJOG* 2017;124:1208–15.
- Aiken ARA, Digol I, Trussell J, *et al.* Self reported outcomes and adverse events after medical abortion through online telemedicine: population based study in the Republic of Ireland and Northern Ireland. *BMJ* 2017;357:j2011.
- The Citizens' Assembly. The Eighth Amendment of the Constitution. Final Report on the Eighth Amendment of the Constitution. 2017. <https://www.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Final-Report-incl-Appendix-A-D.pdf> (accessed 24 Jan 2018).
- Independent.ie. Citizens' Assembly chairwoman concerned at increasing use of abortion pills. 2017. <https://www.independent.ie/breaking-news/irish-news/citizens-assembly-chairwoman-concerned-at-increasing-use-of-abortion-pills-36152031.html> (accessed 24 Jan 2018).
- Strauss A, Corbin JM. *Basics of qualitative research: grounded theory procedures and techniques*. Sage Publications, Inc, 1990.
- Irish College of General Practitioners Quality in Practice Committee and HSE. Crisis pregnancy programme. Crisis pregnancy: a management guide for general practice. 2014. Reviewed 2017. https://www.icgp.ie/go/library/icgp_publications/quick_reference_guides/E568181D-D1B1-295B-0807F11B316A86F0.html (accessed 24 Jan 2018).
- Office of the Attorney General. Electronic Irish Statute Book (eISB). Government of Ireland. Regulation of Information (Services Outside the State For Termination of Pregnancies) Act, 1995. <http://www.irishstatutebook.ie/eli/1995/act/5/enacted/en/print> (accessed 24 Jan 2018).
- Gilmartin M, White A. Interrogating medical tourism: Ireland, abortion, and mobility rights. *Signs* 2011;36:275–80.
- Sanghani R. Ireland's abortion problem: new report lays bare the horrifying truth. *The Telegraph*. 2015. <http://www.telegraph.co.uk/women/womens-life/11660028/Irelands-abortion-problem-New-report-lays-bare-the-horrifying-truth.html> (accessed 24 Jan 2018).
- Jerman J, Frohwirth L, Kavanaugh ML, *et al.* Barriers to abortion care and their consequences for patients traveling for services: qualitative findings from two states. *Perspect Sex Reprod Health* 2017;49:95–102.
- Aiken ARA, Guthrie KA, Schellekens M, *et al.* Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception* 2018;97:177–83.
- Swica Y, Chong E, Middleton T, *et al.* Acceptability of home use of mifepristone for medical abortion. *Contraception* 2013;88:122–7.
- Ngo TD, Park MH, Shakur H, *et al.* Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review. *Bull World Health Organ* 2011;89:360–70.
- Wainwright M, Colvin CJ, Swartz A, *et al.* Self-management of medical abortion: a qualitative evidence synthesis. *Reprod Health Matters* 2016;24:155–67.
- Murphy M, Vellinga A, Walkin S, *et al.* Termination of pregnancy: attitudes and clinical experiences of Irish GPs and GPs-in-training. *Eur J Gen Pract* 2012;18:136–42.
- Sheldon S. How can a state control swallowing? The home use of abortion pills in Ireland. *Reprod Health Matters* 2016;24:90–101.
- Rossiter A. *Ireland's hidden diaspora – the 'abortion trail' and the making of a London-Irish Underground, 1980-2000*. London: IASC Publishing, 2009.
- Greene MF, Drazen JM. A new label for mifepristone. *N Engl J Med* 2016;374:2281–2.
- Aitken K, Patek P, Murphy ME. The opinions and experiences of Irish obstetric and gynaecology trainee doctors in relation to abortion services in Ireland. *J Med Ethics* 2017;43:778–83.
- Bloomer F, O'Dowd K. Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform. *Cult Health Sex* 2014;16:366–80.