

## **Legal and non-legal barriers to abortion in Ireland and the UK**

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### **INTRODUCTION**

This paper compares abortion laws, regulations, and access patterns in the UK and Ireland. We focus in most detail on the Republic of Ireland, Northern Ireland, and England with a shorter discussion of Scotland and Wales. We attend to the laws and legal reforms in each region but also consider the non-legal factors that restrict or facilitate abortion services in each place. In this paper we seek to illustrate the complex relationship between abortion law and abortion access, noting especially how non-legal barriers shape the way an abortion law functions for the people who live under it.

Two of the regions discussed in this paper, Northern Ireland and the Republic of Ireland, have recently undergone seismic shifts in their abortion laws. England has historically been the destination country for abortion travellers from these two regions and continues to receive large numbers of non-resident abortion seekers. It is also in the midst of its own transformation on abortion regulation which has been accelerated by changes to the abortion service during the Covid-19 pandemic. Our analysis accounts for these recent changes, but it also situates these abortion regimes in a longer context of interdependence. We cannot understand the current or former abortion regimes of Ireland or Northern Ireland without understanding their relationship to England's abortion system. Despite their recent reforms, abortion regimes in Ireland and Northern Ireland today continue to be deeply connected to English abortion infrastructure. Scotland and Wales, by contrast, have been less integral to abortion services for people from Ireland and Northern Ireland because their services are not easily accessible for people travelling from abroad.

All of the regions discussed in this paper except Scotland are also united by having been governed – until recently – by the same law that criminalised abortion: the 1861 Offences Against the Person Act (1). This Act made it a criminal offence for a person to have an unlawful abortion or for any other person to carry out an unlawful abortion - even in cases of rape, incest or fatal fetal abnormality - except where there was risk of permanent and serious damage to a woman's life, and held penalties of up to life imprisonment (2: p.10). In England and Wales, reforms in 1967 clarified conditions under which legal abortion may take place, although the 1861 Act still remains in force. Scotland also adopted the 1967 Act, before which common law governed abortion

access. In Northern Ireland, the 1861 Act governed abortion until 2019 when key provisions were removed. In Ireland, the 1861 Act – inherited from UK law upon Irish independence in 1922 – governed abortion until 2013 (1).

In what follows, we offer a brief history of the current abortion law in each region to account for recent changes. We also provide an explanation of the *de facto* patterns of abortion access in each, considering the extra-legal dimensions that expand or restrict abortion access. Ethical approval and informed consent were not required for this article because it did not involve any primary data collection. This article is limited to a brief review of law and practice in the five regions, drawn from secondary scholarship and government documents.

## **LEGAL AND NON-LEGAL BARRIERS TO ABORTION**

The following analysis is rooted in a comparison of the laws in these regions, but we move beyond the legal texts to consider non-legal dimensions that shape the practical availability of abortion. We have written elsewhere about clandestine abortion networks in these regions which have become sophisticated and well developed in the absence of legal reform (3). However, no amount of activist provision for clandestine self-managed abortion can address the needs of all abortion-seekers or offer safe abortion care throughout pregnancy. Restrictive abortion laws are themselves human rights violations and abortion-seekers cannot access self-determination and bodily integrity without the availability of safe, legal and local abortion (4).

Reforming restrictive laws is only the first step. Even in countries with legal frameworks that allow for safe abortion, numerous factors limit people's abilities to obtain these services. Ongoing problems with abortion provision in decriminalised jurisdictions like Canada and some Australian states/ territories provide a case in point (5-6). Non-legal factors that limit the availability of abortion include: non-functioning health systems, lack of trained providers, lack of services in rural areas, poor transportation infrastructure, lack of supplies, lack of knowledge by abortion-seekers about services, high costs of abortion, lack of insurance coverage for abortion, complex referral and reimbursement mechanisms, anti-abortion harassment, administrative barriers like waiting periods, rules limiting who can act as an abortion provider, abortion stigma, lack of privacy/confidentiality, and/ or obstruction by actors in the health service, among others (4). Non-legal barriers are complex and context-specific. They are closely bound up with the legal framework for abortion in a given country, but they are also shaped many other factors. For example, many countries have legal provision for doctors to declare themselves 'conscientious objectors' to abortion, but the professional medical culture and healthcare system structure impact the extent to which conscientious objection disrupts or obstructs abortion access (7-8). By extension, non-legal factors can also facilitate access to abortion: just as professional medical culture can pressure doctors to acts as objectors, it can also foster a culture of conscientious commitment to abortion care (9). Using this framework for understanding legal and non-legal barriers, in what follows we present each of the five regions separately, with sections on historical/ legal context and access in practice.

## REPUBLIC OF IRELAND

Until 2019, legal and safe abortion was almost entirely unavailable in Ireland. Abortion had been illegal since the state's establishment in 1922, when it inherited in the UK's 1861 Offences Against the Person Act. Although abortion was already outlawed, in 1983 Ireland held a referendum which added the 8th amendment to its constitution. The 8<sup>th</sup> amendment committed the state to "vindicate the right to life of the unborn" and accorded equal status to the fetus and pregnant person. The referendum to institute a constitutional ban on abortion was driven by anti-abortion groups in Ireland who feared that legal abortion might be introduced through the courts (10). Subsequent referendums in 1992 refined the scope of the *de facto* abortion ban, including by establishing the constitutionality of seeking abortion abroad, but no legislation was passed to give clarity to the 8th amendment until 2013 (11). At that point, a highly restrictive law came into force that clarified the circumstances under which life-saving abortion could be accessed in Ireland (12). This marked the first piece of legislation that outlined legal grounds for abortion in the region (13). Meanwhile, the high-profile death of Savita Halappanavar and European court judgments (14) against Ireland had mobilised a pro-choice movement which grew in power from 2012 onwards. Abortion travel abroad also continued: during 2001-2016, between nine and eighteen people left Ireland each day to access abortion abroad; an unknown number obtained abortion pills through clandestine networks (15). By 2016, the unsustainability of the 8th amendment regime became an unavoidable issue for the political elites who had been reluctant to grapple with it (16).

After holding a Citizens Assembly and joint parliamentary committee on the issue, the Irish government voted to hold a referendum in May 2018. The referendum asked Irish voters whether they wanted to remove the 8th amendment from the constitution and replace it with a provision to enable the legislature to regulate abortion (17). The referendum campaign was largely led by civil society campaigns on both sides, though many Irish politicians took prominent pro-repeal positions, including the Taoiseach (Prime Minister) and Health Minister (18). Clergy took a backseat in the campaign, while doctors, lawyers and politicians were the most prominent public representatives for both campaigns (15). The referendum on the 8th amendment was held on 25 May, 2018 when a two-thirds majority voted to strike down the abortion ban. Despite speculation that a strong urban-rural divide would become evident in the referendum result, 25 out of 26 counties in Ireland voted for reform (19).

After the repeal vote, the government set about legislating for abortion. The Health (Regulation of Termination of Pregnancy) Act was passed in December 2018. This law allows for abortion on request up to 12 weeks and for abortion at a later gestation in the case of risk to health/life or severe fetal anomaly (20). The abortion service for termination before 12 weeks is led by GPs and sexual health providers, with additional provision in hospitals. The new law maintains criminal penalties for anyone - doctor, parent, spouse, etc. - who helps a person to obtain an abortion outside of the terms of the new law, although it no longer criminalises the person who obtains the abortion. Abortion services launched in Ireland in January 2019.

## ABORTION SERVICES IN PRACTICE

In the first annual report on its abortion service, the Irish Department of Health reported that 6,666 abortions had been carried out in 2019, 98% of which took place within the twelve-week ‘on request’ period (21). During that same period, the UK Department of Health reported 375 abortions that were carried out for patients who travelled from Ireland, totalling 7,041 recorded abortions amongst Irish residents (22). This is a much higher figure compared with the previous year when abortions weren’t available in Ireland: in 2018, the UK Department of Health recorded only 2,879 abortions amongst Irish residents (23). The substantial increase to 6,666 likely reflects the true extent of demand for abortion that was masked by the semi-clandestine nature of abortion under the 8th amendment, where possibilities for abortion included travelling abroad or attempting to self-manage abortion with medication ordered online. However, the true extent of self-managed abortion in Ireland before 2019 is difficult to estimate because it was criminalised and clandestine (3).

Abortion access in Ireland since January 2019 is clearly incomparable to what preceded it. The 6,666 legal abortions carried out in 2019 stand in stark contrast to the 32 legal abortions carried out in Ireland one year earlier (24). The move from a near-total ban to free, safe and legal abortion with an on-request period of 12 weeks is a significant advance for reproductive freedom in Ireland.<sup>1</sup> However, in 2020, 194 people from the Irish Republic travelled to England for a termination, highlighting serious problems with abortion access in practice, most of which have been created by flaws in the legislation and can be amended at the upcoming three-year review (25). Below, we outline three obstacles to access.

First, abortion seekers in Ireland are denied care because of the rigidity of the law’s mandatory waiting period and gestational limits. The new law requires a three-day waiting period after the abortion request is made in consultation with a doctor. In practice, doctors interpret this to mean that the waiting period and termination must both be completed by the end of the 12-week gestation window; someone who presents at 11 weeks + 5 days would be denied abortion care under the current practices. No exceptions are made for people who have experienced failed medication abortion within the Irish medical system: if they present past 12 weeks, they are denied care in Ireland and forced to travel abroad (26). Imposing such a waiting period also produces harmful effects because it creates a minimum two-appointment requirement which adds an additional time and travel burden (27). In 2019, the charity Abortion Support Network reported contact from 160 abortion-seekers from Ireland, most of whom only discovered their pregnancy after the 12-week cut off (28). The foreseeable harms of the waiting period requirement were raised during the legislative debate, but the Health Minister rejected amendments that would have allowed this waiting period to be waived or counted from the appointment request, rather than the appointment itself (17).

Second, the legislation imposes unworkable and arbitrary standards for termination after 12 weeks, leaving people who experience fetal anomalies in pregnancy especially vulnerable. To access termination in Ireland, two specialist medical practitioners must agree there is a “condition affecting the fetus that is likely to lead to the death of the fetus either before, or within 28 days of

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<sup>1</sup> The Irish government’s report on abortion services cites only the total number of abortions, not an abortion rate per 1,000 women (21).

birth” (20). In practice, such a requirement has proved difficult to satisfy and there is growing evidence that the law creates a chilling effect around certifications of fatal fetal anomaly. In a 2020 study carried out at University College Cork, doctors described their fear of prosecution and media scandal as a result of a misdiagnosis. Doctors in the study described the law as “too restrictive” and explained that its rigidity meant that people were being forced to travel for conditions that were “not quite fatal enough” according to the law’s terms (29).

Third, abortion services are geographically uneven and some rural areas are still without services. In 2021, the National Women’s Council of Ireland found that only one in ten GPs provide early medical abortions while only half of maternity hospitals provide surgical care (30). This geographical unevenness stems partly from obstructive doctors, for whom the legislation creates wide scope for conscientious objection (26). Anecdotal evidence from reproductive rights groups also suggests low-level obstruction by practitioners who provide inaccurate scans that either delay abortion-seekers or lead them to travel when they should qualify for care in Ireland (28). Geographical unevenness in the service has been temporarily ameliorated by telemedicine abortion services introduced during the Covid-19 pandemic, during which patients have been able to have remote telemedical consultations and collect both medications to use at home, eliminating the need for multiple in-person visits (31).

## **NORTHERN IRELAND**

In 2019, abortion was decriminalised in Northern Ireland, ending 158 years of a near-total abortion ban in the region. Previously, Northern Ireland had been governed by the highly restrictive Offences Against the Person Act of 1861 and subsequent legal precedents that interpreted it (32). Under this law, only a handful of pregnant people could access abortion in local hospitals each year. Some people travelled to other parts of the UK to access abortion services where they paid the same fees as non-residents, whilst others attempted illegal methods of ending their pregnancies, including by buying abortion pills online (33). In 2017, the UK Government established funding to cover the travel and procedure costs for Northern Irish people seeking abortion on the UK mainland. In that same year, just 12 people from Northern Ireland accessed abortion in local facilities while more than 900 travelled to England (34).

The 2019 decriminalisation of abortion resulted from the confluence of several events. First, a string of high-profile prosecutions relating to abortion during 2015 - 2017 increased public awareness of the treatment of people experiencing crisis pregnancies and helped consolidate the pro-choice campaign narrative in a human rights framework (35: pp.21-3). Second, an inquiry by the United Nations Convention on the Elimination of All Forms of Discrimination Against Women found Northern Ireland’s abortion law in grave and systematic violation of the Convention in 2018 (36: p.18). Subsequently, the majority of judges in a 2018 Supreme Court Case brought forward by the Northern Ireland Human Rights Commission (NIHRC) found the abortion law to be incompatible with human rights law (37). Additionally, the success of the campaign to legalise abortion in the Republic of Ireland in 2018 boosted the visibility and momentum of the campaign to reform the abortion law north of the border. In 2019, with Northern Ireland’s Executive collapsed, campaigners found an opportunity to cement decriminalisation via Westminster in the

Northern Ireland Executive Formation Bill, which was intended to provide for an extension of time for forming an Executive. Activists argued that the abortion issue was not just a health issue (which is a devolved issue governed by the Northern Irish Assembly) but a human rights issue that the UK government at Westminster had the authority to legislate on. Furthermore, they argued that people in Northern Ireland could not wait for the Northern Ireland Assembly for reform given that it had been collapsed since January 2017 (38). Stella Creasy MP tabled an amendment that would decriminalise abortion in Northern Ireland, should there not be a sitting Northern Ireland Assembly by 21 October 2019. On 22 October, with Stormont still not functioning, this law took effect and repealed sections 58 and 59 of the 1861 law.

In repealing these sections and imposing a moratorium on all criminal proceedings relating to an offence under those sections, the new law decriminalised abortion in Northern Ireland. Under regulations in effect from 31 March 2020, abortion is now legal without conditionality up to 12 weeks gestation, and up to 24 weeks gestation where the pregnancy would risk the physical or mental health of the pregnant person greater than the risk of terminating the pregnancy (2). In cases of fetal abnormality and where there is risk to the person's life, there is access to abortion with no gestational time limit. The March 2020 law did, however, re-introduce criminal penalties for "unlawful terminations" (39).

#### *ABORTION SERVICES IN PRACTICE*

Despite its 2019 abortion decriminalisation, and over a year since the new regulations took effect, the Northern Ireland Health Minister is yet to commission abortion services. Until services are commissioned, the task of providing early medical abortion services has fallen to Northern Ireland's five local Health and Social Care Trusts. Most of the Trusts are only providing abortion up to 10 weeks, rather than the 12 weeks that the law permits (40). Under this temporary system of care - which has been led by a group of fewer than a dozen medics - 719 abortions took place in Northern Ireland between 31 March and 14 October 2020 compared with just 8 the previous year (40-41). Whilst this is a significant increase, the lack of additional resourcing coupled with the pressure brought on by the COVID-19 pandemic means that some of the Trusts have had to close or temporarily suspend their abortion services leaving some areas in Northern Ireland without local abortion provision. The lack of cover for abortions across the region has led to what campaigners have termed a "postcode lottery" of abortion provision (42).

In January 2021, the NIHRC responded to the lack of commissioned and funded abortion services in Northern Ireland – which, it says, has caused "a vacuum for many women and girls seeking such services" – by launching legal action against the Secretary of State for Northern Ireland, the Northern Ireland Executive and the Department of Health for Northern Ireland (43). The NIHRC has warned that the failure of the Northern Ireland Executive and Department to agree to fund and commission services breaches the European Convention on Human Rights.

While abortion is now legally accessible in Northern Ireland, it is not yet a healthcare service easily available to those who require it. Abortion has long been a contentious and politicised issue in Northern Ireland (32) and the law reform cannot change that overnight. Polarised and loud pro-

and anti-abortion voices remain, with the Northern Ireland Assembly led by the anti-abortion Democratic Unionist Party and Sinn Féin, which recently reversed its stance on abortion to support the new regulations. Whilst the majority of public opinion favours abortion reform (44), it is not clear how legal reforms will translate into practical access to a healthcare service which, for generations, has been something people have often had to access secretly. Abortion services need to be made available urgently.

## ENGLAND

Abortion in England is still regulated under the criminal code via the 1861 Offences Against the Person Act, but is legally available through the 1967 Abortion Act which established grounds under which abortion could be performed (45). Originally, this law permitted termination up to 28 weeks of pregnancy, but this was reduced to 24 weeks in 1990. Terminations are permitted after 24 weeks in rare circumstances, including on health/life grounds and on the grounds of “severe disability”. In England and Wales, the majority of abortions (74%) take place in the independent sector, in standalone clinics run by BPAS, MSI or NUPAS and 99% of all abortions that take place in England are funded by the National Health Service (22).

England’s abortion law is complex and poorly understood, in part because it is generally interpreted in a liberal way by English doctors. The 1967 Abortion Act establishes limited circumstances (‘grounds’) under which abortion is not a crime: namely, when the request for abortion is approved by two doctors. English law does not actually contain any provision for abortion on request or without regard to reason. In practice, English doctors broadly interpret ground C - “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” - to allow abortion on request (46). In 2019, 98% of abortions were performed under ground C. Of these, 99.9% were carried out due to a risk to the person’s mental health (22). Thus, English abortion providers interpret the law liberally, although they work in a context that maintains abortion criminalisation.<sup>2</sup>

The 1967 Abortion Act was passed in a political context of concern over inequality in abortion access: the wealthy could pay for a private, safe abortion, while the poor were subjected to less safe abortions and the spectre of criminalisation (35, 46). The 1967 Act emphasised the importance of place in its framework for legal abortion, making licensed clinical and medical spaces the only “approved place” in which a legal abortion could be carried out. When pills were introduced for early medical abortion in the 1990s, the “approved place” part of the 1967 Abortion Act was interpreted as requiring patients to take both the pills required for a medical abortion -

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<sup>2</sup> The recent referendum to legalise abortion in Gibraltar adopts a similar model: abortion will become legal to twelve weeks, based on a doctor’s certification that continuing the pregnancy presents greater risks to mental and physical health than ending it. In England, the overwhelming number of abortions performed on this ground signal a particular interpretation of the balance of risks test among English abortion providers; whether doctors in Gibraltar, where abortion has been wholly banned until 2021, will adopt a similar approach to the balance of risk test is yet to be seen.

mifepristone and misoprostol - in the abortion clinic (47). In December 2018, the regulation was changed so that people in England could take the misoprostol at home (authorities in Scotland and Wales had already introduced this change in October 2017 and June 2018 respectively) (48-49). In 2020, as a response to the COVID-19 pandemic which made it unsafe to travel, the UK Government amended this restriction, designating the home as an approved place under the 1967 Act and enabling people to take both pills at home (50).

### *ABORTION SERVICES IN PRACTICE*

As the 1967 Abortion Act allows for a broad application of clinical discretion, abortion in England appears relatively accessible before 24 weeks. There are around 200,000 abortions per year in England, Wales and Scotland (51). In 2020, the abortion rate for England and Wales was 18.2 per 1,000 women, the highest number since the Act was introduced. Of these, 85% were induced with medication rather than vacuum aspiration (25).

Whilst there is a lack of data on how many abortions in England are denied, it is clear that despite the liberal interpretation of the law, there remain issues in accessing abortion services. This is largely because abortion remains in the criminal code and is governed by a law set more than fifty years ago, when the medical landscape was very different (52). First, the fact that two doctors need to approve abortions can cause delays and adds a level of stigma that impacts negatively on abortion-seekers - this is especially the case in rural settings where there are fewer doctors available; second, the criminal law framework for abortion can incite fear in some medical practitioners and can deter doctors from choosing to practice in abortion provision; third, the fact that abortion needs to be performed in a clinical setting – a legal condition set at a time when the majority of abortions were performed by surgical methods – adds an unnecessary barrier to medical abortions, which now account for the majority of terminations (52). This regulation requires a pregnant person to take the first abortion pill in a clinical setting, despite it being safe to take both mifepristone and misoprostol at home without having to travel or wait for an appointment. Since the government temporarily<sup>3</sup> lifted this regulation to allow both pills to be taken at home during the COVID-19 pandemic, abortions have taken place at earlier gestations: almost 50% of abortions took place before seven weeks gestation between January and June 2020, compared with almost 40% for the same period the previous year, demonstrating that people were able to access the service sooner and that the legal requirement to take the first pill in a clinic adds a barrier to swift abortion care (53).

However, some abortions need to take place in a hospital, and in these cases access issues come down to location and waiting times. According to BPAS, there is a lack of appropriate services for women and pregnant people with medical complexities who must be cared for in hospital settings (54). With limited services, these people sometimes have to travel far or endure long waiting times for a termination. In some cases, they have no options but to continue with

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<sup>3</sup> On 26 November 2020 the UK Government launched a consultation on whether the temporary measure to allow two abortion pills to be taken at home should be made permanent. At the time of writing, the consultation is still open.



their pregnancy. During 2016 and 2017, BPAS was unable to secure NHS hospital treatment for forty-six people in this category (55).

Although there is a liberal application of the abortion law in England, the fact that abortion remains in the criminal code, restrictions around mifepristone/misoprostol, and the lack of NHS hospital services that offer treatment up to 24 weeks on all grounds produces barriers to the accessibility of abortion in terms of speed and therefore safety (54).

## **SCOTLAND AND WALES**

Scotland and Wales, like England, are governed by the 1967 Act. An examination of abortion access patterns in all three jurisdictions can therefore highlight how a law's application is context specific. Whilst in England and Wales the 1967 Act amended the 1861 Offences Against the Person Act, in Scotland it updated a common law framework for abortion provision. Thus, whilst all three regions share an abortion law, abortion remains a common law crime in Scotland and a statutory crime in England and Wales. During the COVID-19 pandemic, the UK Government, Scottish Government and Welsh Government all introduced temporary measures to allow people to take the mifepristone at home, as well as giving approval for telephone, video consultations and remote prescribing (56: pp.4-5). Whereas in England and Wales the gestational limit for a telemedical abortion at home is 10 weeks, in Scotland – where abortion is a devolved issue governed by the Scottish government – there is a 12 week limit (57).

### *ABORTION SERVICES IN PRACTICE*

The NHS provides free abortion care in Scotland, Wales and England. NHS-funded provision can be carried out in hospital settings or in independently-run licensed abortion clinics (BPAS, MSI, NUPAS). There is variation as to the gestational limits, internal capacity and treatment options at each site, so the availability of services varies at a local level, meaning that people living in some – usually more remote – areas have to travel to access abortion care.

In Scotland, there are no independently-run clinics; abortions are only provided in hospital settings, and none of these provide abortion up to 24 weeks. In practice, Scottish abortion services are difficult to access after 18 weeks and generally not available after 20 weeks, well below the 24 week legal limit in UK law (58). Although the reasons for this lack of services are not clear, Purcell et al. suggest that medical providers “distaste” for later abortions and senior management's lack of support for later abortions are important factors (59: p.102).

Rurality and remoteness also create geographical unevenness in abortion access. Many people living in rural or island communities are unable to access services locally. This impacts deprived populations most: in the Islands (Orkney, Shetland, Western Isles), the most deprived residents are the least likely to access abortion services, in contrast to Scotland as a whole, where those who are most deprived are more than twice as likely to access to abortion services (60: p.8). In remote communities, financial costs and other barriers associated with traveling to the mainland

means those facing structural issues of socio-economic disadvantage can be left struggling to access the healthcare (60).

In Wales, there are 14 sites providing abortion services, of which two are independent BPAS clinics (61: p.6). Most of these sites are clustered in the South of Wales to reflect population density, meaning that abortion seekers in the North often have to travel for care. Across Wales, the highest gestational limit for ground C and D abortion provision is 18 weeks (61). As of 2019, there were no surgical options provided in Wales beyond 16 weeks and women across much of Wales had no surgical option beyond 12 weeks. Unlike in Scotland, abortion is not a devolved issue for the Welsh Assembly, meaning it remains under the jurisdiction of Westminster (49).

In comparison, there are more than 100 independent specialist clinics approved to carry out abortions in England, in addition to hospitals (62). People from Scotland and Wales seeking a later surgical abortion often have to travel to England, where currently four stand-alone clinics and three hospitals provide abortions up to 24 weeks. Whilst this impacts access abortion seekers in Scotland and Wales in terms of distance, travel time and associated costs, the reality is that later surgical abortions make up a minority of overall abortions. In 2020, 81% of abortions were performed under nine weeks gestation in Scotland and 97% were carried out medically (63: pp.4-9). This represents the largest percentage of terminations carried out under nine weeks gestation since reporting in Scotland began, likely influenced by the changes due to COVID-19 that allowed a telemedicine home abortion service.

According to BPAS, the temporary telemedicine provision has meant waiting times for abortion have fallen by more than a week and has opened abortion access to people who previously faced barriers to accessing abortion care due to the requirement to take medication in a clinic, including: domestic abuse survivors; people with disabilities; people from certain religious or cultural backgrounds; people living with socio-economic disadvantage; and people living in remote areas (60). Telemedicine also prevents abortion-seekers feeling intimidated by anti-abortion protests which have risen across the UK in the past few years (64), with groups like 40 Days for Life keeping a tally on their homepage of the number of people they have convinced to not go ahead with an abortion, the number of abortion centres closed and the number of abortion workers they have forced to quit their jobs (65).

Whilst Wales, Scotland and England share the same 1967 legislation in terms of abortion provision, access differs in each region depending on the services commissioned at a local level. The roll out of the temporary telemedicine service has seemingly collapsed this disparity and the barriers that prevented certain populations from accessing abortion. Currently, all three countries are holding consultations to decide whether to make the temporary measure a permanent feature of abortion provision.

## **CONCLUSION**

In this article, we sought to illustrate the complexities that shape how abortion law becomes abortion services (or lack thereof). The United Kingdom and Republic of Ireland are useful contexts to examine these issues, both because they have undergone significant changes in abortion law in recent years, but also because they demonstrate the context-specific legal and non-legal barriers that impact on abortion access at different national and regional scales.

Our analysis has shown that legal abortion does not necessarily equate to accessible abortion services. For more than fifty years, England, governed by the 1967 Abortion Act, had a considerably more liberal legal framework for abortion than Ireland and Northern Ireland. Yet recent reforms in the latter two regions mean England is now the only jurisdiction of the three where abortion is wholly covered by the criminal code and the only jurisdiction without any period of 'on request' access. Abortion-seekers in England must give reasons that comport with the existing legal reasons to end a pregnancy. Although abortion providers in England interpret these limitations in the least restrictive way, the law maintains their gatekeeping role and preserves their power at the expense of autonomy for abortion seekers. In the regional context, these barriers to entry are low relative to the barriers on Irish and Northern Irish abortion seekers, where waiting periods enforce delays, uneven provision generate disparities between postcodes, and the nascent medical culture around abortion-provision remains hamstrung by stigma, uncertainties about interpreting the law, and obstruction from opponents of abortion. Barriers in England are also low relative to Wales and Scotland, where fewer providers and lower gestational limits force many abortion-seekers to leave their home region for care.

Beyond abortion law, we have argued, the availability of abortion access is determined by numerous extra-legal factors. The real accessibility of services depends on cultural acceptance of the law, political will to implement it, medical culture and medical practice to facilitate it. With abortion access, the speed, availability, efficiency and locality of provision are vitally important factors, the absence of any one of which can delay an abortion-seeker and result in them being denied care. The perils of delay and obstruction are particularly acute for people who have multiple barriers to overcome in pursuit of abortion, even in a context where abortion laws are relatively progressive including: non-citizens, undocumented people, people in abusive or controlling relationships, and other marginalised groups face compounding barriers to safe abortion care.

The regions discussed in this article have different levels of autonomy over their abortion laws. Central governments in Dublin and London write abortion laws for their jurisdictions; regional governments in Edinburgh, Cardiff, and Belfast have varying levels of control over their abortion laws and regulations. We have covered these distinctions in fine-grain detail above, but here we conclude with a general comment about the interdependence of the systems for abortion provision in all of the places discussed. National or regional governments with autonomous control over abortion law legislate independently, but shortcomings in their abortion provision systems create spill-over in the form of abortion-seekers who travel to more permissive jurisdictions. In the geographical area we discuss in this article, England remains the destination for abortion-seekers from all regions. For example, Ireland's reticence to allow abortions after 12 weeks in its 2018 abortion law has not ended the demand for post-12 week abortion. Instead, this limitation merely

displaces people whose gestational age exceeds it, many of whom travel to England for abortion, relying on much the same infrastructure of English clinics and NGO support services that served Irish abortion-seekers under the 8th amendment.

As we made final changes to this article, the Northern Irish charity Informing Choices NI announced that its medication abortion services will be withdrawn and its clients forced to travel to England, if government funding is not urgently allocated (66). The geographical proximity of the regions discussed in this article, as well as the substantial differences in abortion services within them, creates a persistent interdependence between abortion-seekers and abortion services. Inadequate services with insurmountable barriers in one jurisdiction will continue to result in heightened demand for clandestine self-managed abortion and abortion travel abroad, despite the provisions set out in the abortions laws of each region.

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