**Culture, Health & Sexuality**

An International Journal for Research, Intervention and Care

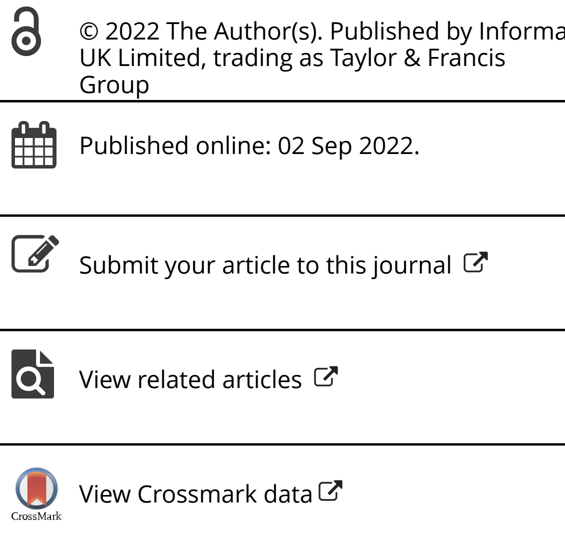
ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tchs20

# ‘To be vigilant to leave no trace’: secrecy, invisibility and abortion travel from the Republic of Ireland

**Joanna Mishtal, Giulia Zanini, Silvia De Zordo, Derek Clougher & Caitlin Gerdts**

**To cite this article:** Joanna Mishtal, Giulia Zanini, Silvia De Zordo, Derek Clougher & Caitlin Gerdts (2022): ‘To be vigilant to leave no trace’: secrecy, invisibility and abortion travel from the Republic of Ireland, Culture, Health & Sexuality, DOI: 10.1080/13691058.2022.2107704

**To link to this article:** https://doi.org/10.1080/13691058.2022.2107704



© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 02 Sep 2022.

Submit your article to this journal

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=tchs20

CULTURE, HEALTH & SEXUALITY
https://doi.org/10.1080/13691058.2022.2107704

OPEN ACCESS

# 'To be vigilant to leave no trace': secrecy, invisibility and abortion travel from the Republic of Ireland

Joanna Mishtal[a], Giulia Zanini[b], Silvia De Zordo[b], Derek Clougher[b] and Caitlin Gerdts[c]

[a]Department of Anthropology, University of Central Florida, Orlando, FL, USA; [b]Department of Anthropology, University of Barcelona, Barcelona, Spain; [c]Ibis Reproductive Health, Oakland, CA, USA

**ABSTRACT**

Until 2018, abortion in the Republic of Ireland was banned in almost all circumstances under one of the most restrictive legal regimes in Europe. The main solution for Irish women and pregnant people seeking abortion services had been to pursue care abroad, typically in clinics in England. In this paper we focus on the hardships of waiting for abortion care experienced by Irish residents leading up to their travel for appointments in England in 2017 and 2018. Based on in-depth interviews with 53 Irish women collected at three British Pregnancy Advisory Services (BPAS) clinics in England we analyse women's experiences as they navigated an 'environment of secrecy' in Ireland. This included making specific secrecy efforts when navigating travel arrangements, conversations, movement, health records, and the travel itself. Despite the expansion of abortion access in Ireland in 2018, the need to travel abroad continues for many women. We argue that the continued need for secrecy when women have to travel abroad for care perpetuates this important phenomenon's invisibility. This argument also applies to other countries where abortion access is restricted, and women are forced to travel for care. We also caution against the presumption that all Irish residents are able to travel internationally for healthcare.

**ARTICLE HISTORY**
Received 25 January 2022
Accepted 26 July 2022

**KEYWORDS**
Abortion; secrecy; cross-border reproductive travel; reproductive rights; Republic of Ireland

## Introduction

In this paper we focus on the hardships of waiting for abortion care experienced by women and pregnant people residing in the Republic of Ireland leading up to their travel for abortion services to England in 2017 and 2018[1]. We investigate the experiences of Irish women as they navigated an 'environment of secrecy' in Ireland after they decided to seek abortion care abroad, including making arrangements and waiting to travel, as well as their experiences until they reached clinics in England. We argue that the continued need for secrecy when women and pregnant people travel from Ireland

**CONTACT** Joanna Mishtal jmishtal@ucf.edu

© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

for abortion care abroad leads to the perpetuation of the invisibility of abortion travel from the Republic of Ireland. This argument may also be valid in other countries where abortion access has been restricted.

Until a 2018 change of the abortion law, abortion was banned in almost all circumstances in Ireland under the 1861 law, and the 1983 Eighth Amendment the Irish Constitution. The 1983 Amendment gave equal status to the life of the woman and to that of the foetus, making Irish legislation among the harshest in Europe (de Londras and Enright 2018; Field 2018). This legal environment contributed to the death of Savita Halappanavar, who died from complications arising from a septic miscarriage due to provider delay (Boylan 2019, 71-86). Following the 2018 national referendum which repealed the Eighth Amendment in a decisive 66.4% vote (Carnegie and Roth 2019) abortion access in Ireland has expanded substantially. The Repeal referendum resulted from years of advocacy led by women's, civil society, and health professionals' advocacy organisations, particularly Doctors' for Choice Ireland (Carnegie and Roth 2019, 110). These campaigns successfully shifted abortion discourse from being 'an abstract moral question' to a 'women's health issue' (Taylor, Spillane, and Arulkumaran 2020). Moreover, studies with the Irish medical community prior to the law change showed that most doctors supported abortion provision in certain situations (Murphy et al. 2012), and their patients' decision to seek abortion (Mishtal 2017). The new legislation implemented in 2018 allows for abortion services on request for up to 12 weeks of gestation; until foetal viability for maternal health issues with significant risk to health or life, including emergency; and at any gestation due to a fatal foetal abnormality (Oireachtas 2018). A 3-day wait between the first appointment (including gestation certification) and the second visit to receive treatment is required. Clinical guidelines dictate that general practitioners (GPs) can provide services up to 9 weeks and 6 days gestation via medical abortion, and obstetricians-gynaecologists can provide abortion on request in hospitals from 10 to 12 weeks, and all cases with medical reasons. The vast majority of abortion services in Ireland are provided by GPs practising in the community (Horgan et al. 2021) using a model of care that has greatly expanded access to early medical abortion in all 26 counties in Ireland (Holland 2022; Mishtal et al. 2022). Beyond the legal parameters, however, abortion remains criminalised with sentences of up to 14 years imprisonment for doctors.

Before the abortion law changed, thousands of women travelled from Ireland to England and Wales for first and second trimester abortion (Best 2005; Bloomer and O'Dowd 2014; Rossiter 2009). Since the law change, travel has declined considerably, however Irish residents continue to seek care in these alternative settings. In 2019, 375 women travelled from the Irish Republic to England and Wales, a further 194 travelled in 2020 despite the COVID-19 pandemic travel restrictions, and 206 travelled in 2021 (UK DoH 2020, 2021, 2022).

There are two main reasons why Irish women continue to find it necessary to travel abroad for care. First, the 'on request' Section 12 of the new legislation restricts the abortion availability to only 12 weeks plus zero days gestation as compared to 24 weeks in the UK and the Netherlands. Exceeding the legal gestational limit has been shown through multi-country research in Europe to fuel cross-border abortion travel (De Zordo et al. 2020a, 2020b), therefore it is reasonable to expect that women

in Ireland will continue to travel for this reason. Exceeding gestational limit may also occur due to the mandatory 3-day wait. Second, Section 11 of the new law allows abortions in cases of fatal foetal abnormalities where the foetus is likely to die within 28 days of birth (Oireachtas 2018). Women whose pregnancies are diagnosed with foetal abnormalities, but not deemed fatal according to the healthcare providers' judgement, will continue to seek care abroad. In fact, the proportion of Irish women travelling to England and Wales for foetal abnormalities grew between January 2019, when services commenced in Ireland, and December 2021 despite the expansion of Irish law (UK DoH 2020, 2021, 2022). The UK statistics represent only one part of the picture as Irish residents also travel for abortion care to the Netherlands (Zanini et al. 2021).

The data in our study capture experiences of Irish women who travelled for abortion care in the two years before the expansion of lawful abortion services in Ireland. This paper focuses on the environment of secrecy that women had to navigate while waiting and making their travel arrangements. The notion of secrecy became clear in data and reflects Carol Sanger's (2017, 61) distinction of secrecy as a necessary and 'more desperate' strategy to defend against potential harassment or harm, as compared with privacy whereby an individual autonomously controls information disclosure without the need to protect against harm. Secrecy after having obtained an abortion has been shown to be one of the effects of abortion stigma, however few studies examine the ways in which women experience and manage secrecy leading up to obtaining abortion care (Hanschmidt et al. 2016).[2] Silence around abortion is linked to the enduring sociocultural, religious and historical factors contributing to morality politics in Ireland and other countries with a strong presence of the Catholic church (Inglis 1998; Mishtal 2015). Scholars have argued that the church's moral monopoly maintains silence that prevents many from speaking overtly about reproductive rights in general, and abortion specifically (McDonnell and Allison 2006). This 'moral conservatism' has also been one of the main barriers that stood in the way of abortion legislation reform in Ireland (Bloomer and O'Dowd 2014). We explore how these long-entrenched pressures that perpetuate the need for secrecy are evident and/or are expected by women in our research in their familial, employment, and social milieus.

This paper further builds on what scholars have identified in the context of Ireland as 'semantic subterfuge' (Oaks 1999) – a discursive dynamic characterised by the need to circumvent open discourse about abortion, leading to creative, if also challenging, ways of manoeuvring the period of time between learning about the pregnancy in Ireland and receiving abortion care in England. We therefore examined the ways in which women manoeuvre the process of seeking abortion care abroad, and focus on the process of waiting, the visibility and invisibility of one's experiences, and the effects that secrecy of abortion and secrecy of travel have on women's experience of abortion-seeking overall.

## Methods

This paper draws on data collected from 53 women who were Irish residents and who travelled from the Republic of Ireland to England for abortion services in 2017 and

2018. We recruited research participants during two consecutive research projects. The first was a study conducted by the first author between January to June, 2017, with data collection from 25 Irish women. The second, larger study was conducted between 2016 and 2021 by a research team that included all the co-authors, with data collection completed with 28 Irish women over the course of 16 months between July 2017 and November 2018. Although the two studies were designed as independent projects, both focused on the experiences of women who travelled to England for abortion care and used the same data collection methods at the same clinics. The first project focused on women from the Republic of Ireland, while the second, larger project focused on women from several European countries, including Ireland, who travelled to England for abortion care.

The recruitments sites were three BPAS clinics in England. We selected these clinics based the results of a pilot study (Gerdts et al. 2016) which showed that the highest proportion of non-resident clients seeking abortion care at these locations came from the Republic of Ireland. We collected data via in-depth interviews (IDIs) using semi-structured interview guides. The interview guides explored the challenges faced by women travelling to England for abortion care, including in terms of resources, whether or not they told people in their lives about their travel plans, the effects of travel on work, family, and social life; the ways in which women navigated any challenges associated with travel; and the nature of any delays in receiving abortion care. We present demographic information, including age, education, employment, weeks of gestation, and whether women travelled alone or were accompanied, for 52 of 53 participants. We collected the data from all 25 participants during interviews in the first project, and from 27 of 28 participants (one declined) via a separate survey as part of the second project. The researchers carrying out the IDIs were experienced in qualitative data collection and held degrees in anthropology or sociology.

Participants had the opportunity to review a study information sheet that explained the study objectives and confidentiality safeguards, and their rights as voluntary participants. They also had the chance to ask questions before consenting to participate. We received consent from each participant prior to starting the interview. The consent process highlighted how participants could choose to have their interview on another day. We conducted the IDIs either face-to-face in a private room at the clinic or remotely via telephone or Zoom after the clinic visit in the ensuing days. Four participants did not agree to be audio recorded, while 49 of 53 participants did so. The researchers (JM, GZ, and a paid research assistant) took detailed, including verbatim, interview notes when recording was not possible. We made minor refinements to the interview guides following the initial interviews. No participants withdrew from the study. Overall, women were keen to discuss their experiences seeking abortion in England.

Interviews were transcribed, the transcripts were coded using Atlas.TI and NVivo software. We generated and refined thematic codes and subcodes through an iterative process, wherein we identified themes as common explanations expressed by multiple participants, and we further identified subthemes within the larger themes using the same analytic process. We used a grounded theory approach in coding, which allowed both predetermined *a priori* codes to be explored, as well as inductive, not previously

considered factors and/or explanations (Strauss and Corbin 1998). We assigned identification numbers to all participants (e.g. P1, P2, etc) and pseudonyms when using quotes. For confidentiality reasons, we provide locations only for participants who came from urban areas, and in the case of smaller, rural locations we provide only general regions of the country. We obtained ethical approvals for our research from the University of Central Florida, the European Research Council, the University of Barcelona, and BPAS.

## Findings

The sample characteristics were: age range 19 to 52 years, with the majority of participants being between 25-34; gestational age of the pregnancy was reported to be between 5 weeks and 19 weeks plus 5 days, with majority of participants under 13 weeks; educational level ranged from secondary school to master's level education completed; the majority of women had no children, and about one third had 1-2 children. Of the 53 participants, 41 travelled with a companion: primarily a partner/boyfriend/husband (26), less often with a friend (8) or a family member (7). Twelve women travelled alone.

### *An environment of secrecy*

The interview narratives reveal that the most significant hardship lay in having to wait for their travel in an Irish 'environment of secrecy' (P1) which made it necessary for women to lie or create semi-fictitious stories to cover their tracks. Although, this secrecy was often a given – 'obviously, you need to lie' (Sinéad, P4) – this did not diminish the hardship of having to manoeuvre interactions with people around them. As Shelley, a 31-year-old nurse from County Dublin who had to wait three and a half weeks before her travel summarised at the start of her interview, she was 'not distressed about the abortion, it's about the stress of travel and concealing it all' (P17). Ciara's (P7) account below is emblematic of the complexities and constant risk of being uncovered. She was 26 years old, worked as a spa manager in the west of Ireland, and attended an English clinic at 7 weeks gestation. She explained:

> The hardest, obstacle-wise, I suppose just lying. I mean nobody else knows apart from my boyfriend. I have been sick. I'm afraid if I'm out near [my] mother, because mothers know. I'm only about half an hour away from her so I have no real excuse not to be calling over, whereas I've been avoiding her like the plague the last few weeks because they just pick up on these things. She was questioning my boyfriend at the weekend, 'Is she all right? She's very cranky, you know, just out of sorts' and that kind of thing, I can't stand that so. They don't know I'm here [in England]. I put my phone on airplane mode because if my dad happens to ring, which he already has this morning, it's a foreign dial tone. So I'm a nervous wreck, d'ya know. So yesterday when I was driving up I needed my phone on because I needed the Google maps to get to the hotel. But it just so happened that my boyfriend rang as I just crossed the border and I said what was that dial tone and he's like 'Yeah it sounds like you're out of the country' so I had to turn it off straight away. So, like that, I had to ring my parents first - it's just so stupid like - I had to ring dad first because I knew he'd be ringing. And he's like 'Oh I'll ring you back in two minutes.' 'Okay' - I had to turn it on airplane mode again because he's going to

> ring back. So I said, 'Oh sorry, somebody else rang.' It's just the lies. God forbid anything would happen. If someone dropped dead. If I had a crash. If this storm. If anything happened, they don't know where I am. As far as they know, I'm at work.

Ciara explained she had 'to cover' her 'tracks all the time' and maintain secrecy about her journey which started after work. She drove to Belfast and stayed there overnight in a hotel so she could take a cheaper flight to England where she arrived in the morning. Ciara spent the day at the clinic and then flew back to Belfast in the evening. She then drove to the west of Ireland the same night. She remarked on the need to be vigilant about details such as the dial tone and the currency change: 'it's mad … the minute I crossed that border to Northern Ireland - [snaps fingers] everything changes, you're in the UK.' Women also explained that Facebook, Snapchat and other social media must be turned off when travelling abroad because these programmes track one's whereabouts, however it was hard to not use their phones as they needed to check directions and other information during the journey.

Concealing one's plans from their family of origin was a common concern for participants. Sinéad (P4), for example, a 26-year-old with a degree in English and Irish, who was unemployed and therefore lived with her parents and siblings in the south of Ireland, explained how she managed the interactions:

> I have 4 brothers and 1 sister, so 5. Obviously, you need to lie to them, say that you're not going to be around, you know, for 2 days. They questioned it, 'Where are you going mid-week for two days?' I live with all of them at home. I just said I was basically going on a shopping trip with my girlfriend, obviously, so. I just said we had got cheap flights and were gonna have a get-away.

Nobody in Sinéad's family probed the issue any further, therefore she felt she could manage the situation. In another woman's (P25) case, the cover-up consisted of a Legoland trip. When Molly, a 39-year-old healthcare assistant in County Dublin and 14 weeks pregnant, realised the earliest available appointment in an English clinic was on one of her sons' birthdays, her husband suggested 'look we'll bring the kids and we'll say we're taking them over for their birthday.' The Legoland (located outside of London) holiday gave her a way to ease her mother's growing suspicions about Molly's frequent napping. It was a relief for her and her husband not to have to keep the secret because 'everyone knows I'm here' in England. She added, 'it's the best cover-up of all cover-ups.'

Linked to the need for vigilance were concerns about keeping the pregnancy off the Irish medical records. For example, Alison (P23), a 23-year-old nurse in the Dublin area, who was eager to share her story but did not want to be audio-recorded for fear of creating a record, explained:

> The worst worry for me is to be vigilant to leave no trace. I didn't want to see any healthcare provider in Ireland because I don't want this on record. I'm paying cash for everything so that nothing can be traced. The stigma in Ireland is too much. Politicians say 'It's no big deal, women can travel to England,' but in fact it's a hassle and trouble to go through all the arrangements and sorting of everything. … But it's hard to wait for the appointment day and keep it a secret. Hard to organise travel and keep it a secret.

Another woman, Imogen, a 25-year-old student with a part-time job in the south of Ireland (P26) described a similar concern:

> I just think that I'd rather not tell them in Ireland what I'm doing. Because it goes on my record as well then. Even though it is on my record that I'm pregnant right now because I found out at the [Irish] doctor's that I was pregnant. So, regardless, I'm going to *have to* falsely say I've had a miscarriage when I go back. Which is sad, you know, what you *have to* do. It's sad even the circumstances, but the choices are your own, aren't they. [emphasis ours]

While Imogen's concern about her records may appear to be a desire for privacy, her main concern was about having to report a false outcome of her pregnancy, something which she found 'sad' but a 'must'; she did not feel she has a choice on the matter. She simultaneously felt forced to maintain secrecy in her social circles.

When seeking abortion information, Irish women generally prefer to do so online so as to avoid healthcare providers (Zanini et al. 2021). Concerns about what goes on one's medical record and the fear of loss of confidentiality has been observed by doctors even following the abortion law reform, noting that 'some women in Ireland may prefer not to attend their local GP, but to travel to nearby town or city' (Boylan 2019, 234). Our data reveal that some women chose to see a different GP than their own for reasons of privacy and confidentiality. While Irish patients have a legal right to medical records' confidentiality[3], health providers' adherence to this law is of the utmost importance in a context where the need for social and familial secrecy about abortion is highly significant.

### *Delays that intensified and prolonged the need for secrecy*

Women whose travel was delayed encountered more situations in which their pregnancy could be discovered, thus extra challenges in keeping an advancing pregnancy a secret. Travel delays typically arose due to lack of availability of appointments in England, but also included the need to find money to pay for travel and treatment, and delays due to misleading information in the local healthcare system, a failed abortion pill attempt, or a failed attempt to self-manage an abortion through other means. Regardless of the cause of the delay, women found it hard to manoeuvre the extra wait and the need to fabricate a story if the pregnancy was becoming visible. Imogen (P26), for example, who was 13 weeks gestation when she arrived in the clinic, recruited a friend to help her conceal how her pregnancy disappeared, 'my friend has already covered for me to my other friend to say that basically there's been complications with the pregnancy. That I've been rushed to Dublin, rather than saying that I'm in England.' Bridget (P30), a 26-year-old unemployed participant who temporarily lived with her sister in rural Ireland and presented at a clinic in England at 22 weeks gestation after an initial delay involving a child custody battle, recounted her experience,

> They couldn't give me an appointment for 3 whole weeks. … and I found that really hard because obviously, I have a daughter, I've been pregnant before. You know, you're continuing on with your pregnancy. You're starting to feel movements and you're getting heavier and you're noticeably pregnant. So, then it was having to tell people afterwards I lost the baby or I had a miscarriage or whatever. … Yeah, it was the waiting that I found the hardest.

Bridget's delays were significant and distressing. She attempted to buy abortion pills online but they never arrived, necessitating a long journey to a clinic in England. She

said, 'I was travelling for about 5 h before I even hopped on a flight' to Heathrow; 'by the time I got to England I was crying. I was tired …. Everything that went wrong could have gone wrong.'

For some, the need to organise payment caused the delay, which created its own challenges around secrecy. Madeleine (P3), a 25-year-old bank teller from the rural west of Ireland explained that,

> 'we knew it would take about 4 weeks to get the money, so we arranged for about a month's time and then she [clinic receptionist] gave [me] the 15th and it was perfect, 'cause we said Valentine's day, so it was an excuse. I would have took an earlier appointment if I had the money.'

While Madeleine and her boyfriend were able to use Valentine's day as a credible travel excuse, others were grateful when they did not have to explain their journey, but some still had to fabricate reasons for borrowing money. Amy (P20), a 35-year-old unemployed chef in the Midlands, who was delayed by three weeks and arrived at the clinic at 14 weeks gestation explained,

> 'I borrowed €200. I pawned my engagement ring and I got €200 for that, and borrowed from two friends - I said that it's children's allowance next week and I just need it for food shopping. Thank God I didn't have to explain. So, thank God I didn't have to get into a story, because I didn't want anyone to know.'

The cost of abortion travel including financial cost, childcare and lost wages, makes travel challenging or potentially impossible for some women who need to access the service abroad. Some women reported borrowing from friends or relatives, or taking out bank loans, typically around €800 to €1000 but as much as €5000. Several participants sought help from the Abortion Support Network (ASN), a UK-based charity, as their main source of financial and logistical support. The charity can help with approximately 50% of these costs, but while substantial, this help may not be sufficient for all people in need of abortion travel (Ely, Hales, and Jackson 2018). The ASN also helps visitors to their website understand how to 'cover their tracks' when they are making arrangements for abortion care abroad.[4]

Rather than travel abroad, some Irish women ordered abortion pills online, a practice that is growing in use, particularly among residents of countries with restrictive abortion laws (Aiken, Gomperts, and Trussell 2017). Such practices were common in Ireland before the law reform, and continue after the reform, albeit on a much smaller scale (Greene et al. 2021). Self-managed abortion option is key to expanding access and has been established as safe and effective (Ganatra et al. 2017). However, some scholars caution that ordering pills, which is illegal in Ireland, may perpetuate abortion stigma, create anxiety and have an alienating effect, and is therefore not a 'panacea' for a deficient health system that fails to meet the needs of the population (Sheldon 2016, 95).

At the time of our study, abortion pills could only be ordered through online services and delivered by post to the Republic of Ireland or Northern Ireland. Our data show that in some cases a failed attempt to self-manage an abortion using pills contributed to a delay in accessing abortion care in England. Aileen, a 26-year-old part-time worker in Dublin who presented at an English clinic at 20 weeks gestation, recounted that after she ordered pills online she had to travel to Belfast to pick them

up. Three weeks later she learned she was still pregnant. She was then further delayed by having to arrange the money for an appointment in England. She explained she 'was dealing with a feeling of anxiety just by getting my appointment taking so long.' Aileen worried about people discovering her advancing pregnancy, 'in particular my mother who is very Catholic and it's just a conversation that I wouldn't have been comfortable having with her. It would just be easier for her not to know …. I was starting to shower with my clothes [on] and stuff, so I was really anxious about that.' Aileen's and other's stories exemplify how a variety of delays, combined with the need for concealment, intensify the hardships women encounter before they are able to receive abortion care.

### *A culture of probing for personal information as acceptable or expected*

Interview narratives also reveal that secrecy is made harder in Ireland by a culture of probing for personal information that may reveal pregnancy and travel plans. Having to continue to work or attend school while waiting for travel can be particularly difficult as some women may experience sickness, weight gain or other signs of pregnancy, which may invite probing questions from co-workers and peers. In addition, when women say they need time off work or plan to travel, supervisors and co-workers often feel free to probe where they are going and why. For example, Clare (P22), a 26-year-old chef in the south of Ireland, who was at 16 weeks gestation when she attended the clinic in England, found the enquiries from her college peers 'horrible':

> I've had a couple of people in college turn around to me and comment about my stomach 'cause obviously I got bigger, and ask me if I was pregnant. I suppose they just seen me getting a little bit heavier, so then they just asked me if I'm pregnant, and I would just say, 'No, no, no, I'm just putting on some weight.' So, it is quite upfront to be fair, I found that it was kind of cheeky of them, but at the same time, they're curious. Oh, yeah, it's horrible.

A similar experience was reported by Lorraine (P18), a 29-year-old creamery worker residing in rural middle Ireland, who was 9 weeks and 6 days pregnant when interviewed:

> I think they [co-workers] kind of noticed I was puttin' on a bit of weight', and I was staying away from certain foods, and I wasn't really drinkin'. One of the girls is kind of copping on a bit, I think. She's like, 'Oh you're pregnant, you're with baby' and all this. I was like 'No, no, just trying to take care of myself' even though I was getting heavier and putting on weight. So, she's kinda like 'Right … .'. She's the only one who really copped on, I think the lads just they didn't really clock it too much.

Likewise, neighbours may be inquisitive in ways that participants had to have to manoeuvre. Nora (P41), a 35-year-old who lived in Dublin, attended a clinic in England at 16 weeks gestation, after having to wait for a month for an appointment. Nora explained that while she had to reveal the reason for her travel abroad to her employer because she needed time off work, she wanted to otherwise conceal the plan. When asked if she was afraid that somebody else would find out she replied,

> Yeah, you know, the neighbours. We're all nosy neighbours. So, they can see how you come and go …. And there was bad snow and we had to try and get out of the snow. They helped us get out of the snow, but we had to make up a story about why we need to suddenly go somewhere.

The finding that people so readily ask about pregnancy - in line with normative assumptions about the desirability and expectation of motherhood - while abortion remains a topic shrouded in silence, has been reported by Allison (2013) in her ethnographic research on motherhood and infertility in Ireland (2013). She argues that despite changing social values, women in Ireland are 'constantly questioned about having children' with the assumption of there being 'a natural progression between marriage and motherhood' (2013, 33–34). An awareness of these normative expectations can be the very reason for concealing one's pregnancy and plans to seek an abortion, as is reflected by Dana, a 36-year-old from the south of Ireland, who explained she would prefer her immediate family did not know her plans:

> Just from knowing them I think that they'd feel differently, and also because like I have a fiancé. I'm getting married. They think well, your life is set up you can just go through with it. That doesn't mean I should have to.

## Conclusions

Cross-border travel for those who cannot access abortion care suitable to their needs in Ireland largely remains a hidden phenomenon and is shrouded in secrecy. Our findings highlight the hardship of waiting for abortion care in an environment of secrecy ahead of travel to England.

The deployment of secrecy may be understood as a form of agency and power in response to oppressive reproductive governance experienced in the family and society (Smart 2011). In the Irish context, this governance has been driven by powerful role of the Catholic church (similar to Poland and Malta, where reproductive rights are limited) and decades of legislative restriction on abortion specifically, and family planning in general (Inglis 1998). Irish church and state governance has also relied on a gendered politics of shame by forcing Irish women seeking abortion to travel abroad, thereby rendering their unsanctioned reproductive choices invisible (Fischer 2019). Although shame did not arise in the women's narratives, the ostracising aspect of Irish reproductive governance is an integral part of the context in which women seek to maintain secrecy.

The extent to which secrecy may be interpreted as a form of power should also be contextualised within debates about the importance of privacy. These debates, particularly about self-managed abortion, include the observation that home use of abortion pills allows for the circumvention of repressive laws, and greater reproductive self-determination and privacy. However, scholars caution that when 'privacy collapses into secrecy' and results in pervasive non-disclosure during the abortion-seeking experiences, this may 'obscure the harm done by punitive criminal laws' (Sanger 2017; Sheldon 2018, 825). Our findings show that sustaining secrecy by carefully navigating conversations, movements, health records and clothing during abortion-seeking (and not only non-disclosure in the public realm) can lead to a more difficult access to care, delays and harm. Keeping abortion a secret is especially difficult in a context of normative pregnancy expectations. These points are significant for the importance of our findings in the current context of the new abortion regulation.

Specifically, while the expansion of the Irish abortion law and the commencement of services in 2019 ushered a new era of greater availability of care, this is confined to 12 weeks gestation beyond which abortion on request continues to be criminalised, unless there exist medical reasons for treatment, which may still be deemed insufficient by medical judgement (de Londras 2020). Therefore, for those who exceed this limit or do not present with acceptable medical reasons, the need to travel remains. Their travel continues to be recorded by the UK Department of Health and Social Care (2020, 2021, 2022). In addition to the individual hardships illustrated in this paper which are emotionally and financially taxing, the relative invisibility of those who continue to travel abroad for abortion and those who are unable to travel when contrasted against the expansion of abortion care for the majority of Irish women who can receive it locally since 2019, risks generating complacency in the political decision-making sphere based on the perception that Irish women's needs are now being met.

Our findings also raise questions about the presumption of international mobility of individuals who need care abroad. As the travel restrictions experienced during the COVID-19 pandemic demonstrate, international mobility cannot be the assumed and accepted avenue for abortion care (De Zordo et al. 2020b). Notably, the Irish government enacted timely modifications to permit telemedicine and ease abortion access during the pandemic (Mishtal et al. 2020). This modification was vital for women seeking lawful abortion care in the first trimester. However, it was not sufficient to accommodate all Irish women seeing abortion when their circumstances fell outside of the legislation (e.g. with a foetal anomaly deemed not fatal, or beyond the 12-week limit).

Other on-going mobility restrictions exist that are not related to the pandemic. Before Brexit, EU citizens could travel freely between Ireland and Britain if they could afford to do so, but people of non-EU nationalities resident in Ireland had to obtain a UK visa and seek re-entry into Ireland if they needed to travel abroad for abortion care. In addition, Irish nationals who do not have a passport cannot fly to England but must make the eight-hour journey on a boat. These mobility restrictions create numerous pressures for disclosure, delay abortion care and may jeopardise secrecy.

Additionally, migrants and refugees who may have an undocumented status in Ireland cannot travel internationally, nor can those who lack the financial or logistical means to do so. Abortion secrecy adds another layer of hardship to their already difficult 'secret' presence in the country. These groups on the margins therefore cannot exercise the same rights to mobility that are presumed to be available to legal Irish residents seeking abortion care abroad. Consequently, in the Irish context there is both the 'enforced mobility' for those who fall outside of the legislation, and 'restricted mobility' or 'fixity' for those who cannot avail of the possibility of travel (Gilmartin and Kennedy 2019, 130-131; Side 2020). When looking forward, the needs of all women and pregnant people must be understood from the perspective of a social justice that promotes equitable access to abortion care.

In sum, the implications of current abortion legislation in Ireland suggests that the need for secrecy may not disappear with the new law, since abortion on request beyond 12 weeks gestation is not normalised. Therefore, continued scholarly and advocacy attention is necessary to highlight the hardships that women and pregnant people experience as a result of navigating an environment of secrecy about reproductive

health decision making. We hope new studies will follow to examine issues of secrecy around abortion travel since the expansion of abortion services in Ireland. Future research, some of which is now emerging (ARC and Grimes and ARC – Abortion Rights Campaign 2021; Mishtal et al. 2022), may shed light on the extent to which the normalisation of abortion on request is taking place following the new law. Likewise, there is a continued need for women and pregnant people to air their experiences of cross-border travel to bring more visibility to this phenomenon, and a need for continued advocacy to improve abortion legislation as a matter of right to healthcare and gender equity.

## Notes

1. Although reproductive experiences may be distinct for transgender and gender nonbinary people, we acknowledge they may also seek abortion care. Therefore, in the remainder of the article, when referring to women, we have an inclusive intent to denote women and pregnant people. The terms Irish and Ireland as used in this paper denote the Republic of Ireland.
2. While abortion stigma comprises a significant body of scholarship (e.g. Carnegie and Roth 2019; Cullen and Korolczuk 2019; Kumar, Hessini, and Mitchell 2009; Lakhani and Horgan 2015), this article does not fully engage with this literature because of its focus on the topic of secrecy.
3. See Health Service Executive patient confidentiality information. Available at: https://www2.hse.ie/conditions/abortion/how-to-get/where-to-go/
4. See ASN, 'Need to cover your tracks?' Available at: https://www.asn.org.uk/get-help-ireland/#need-to-cover-your-tracks

## Acknowledgements

We are grateful to research participants who generously shared their perspectives and experiences with us, and the BPAS clinics which supported our study. We thank Lieta Vivaldi and Ann-Kathrin Ziegler for their contribution to data collection and other aspects of the study.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Funding

The work conducted in the first study was supported by a University of Central Florida faculty sabbatical during which the first author was a visiting fellow in the School of Law at the University of Kent, UK. The second study, which involved all authors, was funded by the European Research Council via a Starting Grant awarded to Silvia De Zordo (BAR2LEGAB, 680004) and hosted by the University of Barcelona. The work also received support from the Spanish Ministerio de Economía, Industria y Competitividad (Grant RYC-2015-19206).

## ORCID

Silvia De Zordo http://orcid.org/0000-0002-8956-6566
Caitlin Gerdts http://orcid.org/0000-0002-2488-5072

## References

Aiken, A., R. Gomperts, and J. Trussell. 2017. "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: An International Journal of Obstetrics & Gynaecology* 124 (8):1208–1215.

Allison, J. 2013. *Motherhood and Infertility in Ireland: Understanding the Presence of Absence*. Cork: Cork University Press.

ARC – Abortion Rights Campaign, and L. Grimes. 2021. "Too Many Barriers: Experiences of Abortion in Ireland after Repeal." https://www.abortionrightscampaign.ie/wp-content/uploads/2021/09/Too-Many-Barriers-Report_ARC1.pdf

Best, A. 2005. "Abortion Rights along the Irish-English Border and the Liminality of Women's Experiences." *Dialectical Anthropology* 29 (3–4):423–437.

Bloomer, F., and K. O'Dowd. 2014. "Restricted Access to Abortion in the Republic of Ireland and Northern Ireland: Exploring Abortion Tourism and Barriers to Legal Reform." *Culture, Health & Sexuality* 16 (4):366–380.

Boylan, P. 2019. *In the Shadow of the Eighth: My Forty Years Working for Women's Health in Ireland*. Dublin: Penguin Ireland.

Carnegie, A., and R. Roth. 2019. "From the Grassroots to the Oireachtas: Abortion Law Reform in the Republic of Ireland." *Health and Human Rights Journal* 21 (2):109–120.

Cullen, P., and E. Korolczuk. 2019. "Challenging Abortion Stigma: Framing Abortion in Ireland and Poland." *Sexual and Reproductive Health Matters* 27 (3):6–19.

de Londras, F. 2020. "A Hope Raised and Then Defeated'? The Continuing Harms of Irish Abortion Law." *Feminist Review* 124 (1):33–50.

de Londras, F., and M. Enright. 2018. *Repealing the 8th: Reforming Irish Abortion Law*. Bristol: Bristol University Press.

De Zordo, S., J. Mishtal, G. Zanini, and C. Gerdts. 2020b. "Consequences of Gestational Age Limits for People Needing Abortion Care during the COVID-19 Pandemic." *Sexual and Reproductive Health Matters* 28 (1):1818377.

De Zordo, S., G. Zanini, J. Mishtal, C. Garnsey, A. K. Ziegler, and C. Gerdts. 2020a. "Gestational Age Limits for Abortion: Failed Laws and Cross-Border Reproductive Care." *BJOG : An International Journal of Obstetrics and Gynaecology* 128 (5):838–845.

Ely, G. E., T. W. Hales, and D. L. Jackson. 2018. "A Cross-Cultural Exploration of Abortion Fund Patients in the USA and the Republic of Ireland, Northern Ireland, and the Isle of Man." *Culture, Health & Sexuality* 20 (5):560–573.

Field, L. 2018. "The Abortion Referendum of 2018 and a Timeline of Abortion Politics in Ireland to Date." *Irish Political Studies* 33 (4):608–628.

Fischer, C. 2019. "Abortion and Reproduction in Ireland: Shame, Nation-Building and the Affective Politics of Place." *Feminist Review* 122 (1):32–48.

Ganatra, B., C. Gerdts, C. Rossier, B. R. Johnson, Jr, Ö. Tunçalp, A. Assifi, G. Sedgh, S. Singh, A. Bankole, A. Popinchalk, et al. 2017. "Global, Regional, and Subregional Classification of Abortions by Safety, 2010-14: Estimates from a Bayesian Hierarchical Model." *The Lancet* 390 (10110):2372–2381.

Gerdts, C., S. De Zordo, J. Mishtal, J. Barr-Walker, and P. Lohr. 2016. "Experiences of Women Who Travel to England for Abortions: An Exploratory Pilot Study." *The European Journal of Contraception & Reproductive Health Care* 21 (5):401–407.

Gilmartin, M., and S. Kennedy. 2019. "A Double Movement: The Politics of Reproductive Mobility in Ireland." In *Abortion across Borders: Transnational Travel and Access to Abortion Services*, edited by C. Sethna, and G. Davis. Baltimore, MD: Johns Hopkins University Press.

Greene, J., É. Butler, C. Conlon, K. Antosik-Parsons, and R. Gomperts. 2021. "Seeking Online Telemedicine Abortion Outside the Jurisdiction from Ireland Following Implementation of Telemedicine Provision Locally." *BMJ Sexual & Reproductive Health*. Online First: 25 October. doi:10.1136/bmjsrh-2021-201205

Hanschmidt, F., K. Linde, A. Hilbert, S. G. Riedel-Heller, and A. Kersting. 2016. "Abortion Stigma: A Systematic Review." *Perspectives on Sexual and Reproductive Health* 48 (4):169–177.
Holland, S. 2022. "GPs and Hospital Now Providing Abortion Services in Sligo." *Independent.ie*, May 9. https://www.independent.ie/regionals/sligochampion/news/gps-and-hospital-now-providing-abortion-services-in-sligo-41621131.html
Horgan, P., M. Thompson, K. Harte, and R. Gee. 2021. "Termination of Pregnancy Services in Irish General Practice from January 2019 to June 2019." *Contraception* 104 (5):502–505.
Inglis, T. 1998. *Moral Monopoly: The Rise and Fall of the Catholic Church in Modern Ireland*. Dublin: University College Press.
Kumar, A., L. Hessini, and E. M. H. Mitchell. 2009. "Conceptualising Abortion Stigma." *Culture, Health & Sexuality* 11 (6):625–639.
Lakhani, N., and G. Horgan. 2015. "Pregnant, in Danger and Scared to Speak: Abortion Laws and Social Stigma in El Salvador and Ireland." *Index on Censorship* 44 (4):29–33.
McDonnell, O., and J. Allison. 2006. "From Biopolitics to Bioethics: Church, State, Medicine and Assisted Reproductive Technology in Ireland." *Sociology of Health & Illness* 28 (6):817–837.
Mishtal, J. 2015. *Politics of Morality: The Church, the State, and Reproductive Rights in Postsocialist Poland*. Athens: Ohio University Press.
Mishtal, J. 2017. "Quiet Contestations of Irish Abortion Law: Reproductive Health Politics in Flux." In *Transcending Borders: Abortion in the Past and Present*, edited by S. Stettner, K. Ackerman, K. Burnett, and T. Hay, 187–202. New York: Palgrave Macmillan.
Mishtal, J., K. Reeves, D. Chakravarty, L. Grimes, B. Stifani, W. Chavkin, D. Duffy, M. Favier, P. Horgan, M. Murphy, et al. 2022. "Abortion Policy Implementation in Ireland: Lessons from the Community Model of Care." *PloS One* 17 (5):e0264494.
Mishtal, J., S. De Zordo, I. Capelli, A. Martino, L. Rahm, and G. Zanini. 2020. "Political (In)action in Abortion Governance during COVID-19 in Europe: A Call for a Harmonized EU Response During Public Health Crises." *Medical Anthropology Quarterly*, June. https://medanthroquarterly.org/rapid-response/2020/06/political-inaction-in-abortion-governance-during-covid-19-in-europe/
Murphy, M., A. Vellinga, S. Walkin, and M. MacDermott. 2012. "Termination of Pregnancy: Attitudes and Clinical Experiences of Irish GPs and GPs-in-training." *The European Journal of General Practice* 18 (3):136–142.
Oaks, L. 1999. "Irishness, Eurocitizens, and Defining Abortion." In *Reproducing Reproduction: Kinship, Power, and Technological Innovation*, edited by S. Franklin and H. Ragoné, 132–155. Philadelphia: University of Pennsylvania Press.
Oireachtas. 2018. Health (Regulation of Termination of Pregnancy) Act 2018. Contract No.: 31.
Rossiter, A. 2009. *Ireland's Hidden Diaspora: The 'Abortion Trail' and Making of a London-Irish Underground, 1980–2000*. London: IASC Publishing.
Sanger, C. 2017. *About Abortion: Terminating Pregnancy in Twenty-First-Century America*. Cambridge, MA: Belknap Press of Harvard University Press.
Sheldon, S. 2016. "How Can a State Control Swallowing? The Home Use of Abortion Pills in Ireland." *Reproductive Health Matters* 24 (48):90–101.
Sheldon, S. 2018. "Empowerment and Privacy? Home Use of Abortion Pills in the Republic of Ireland." *Signs: Journal of Women in Culture and Society* 43 (4):823–849.
Side, K. 2020. "Abortion Im/mobility: Spatial Consequences in the Republic of Ireland." *Feminist Review* 124 (1):15–31.
Smart, C. 2011. "Families, Secrets and Memories." *Sociology* 45 (4):539–553.
Strauss, A., and J. Corbin. 1998. *Basics in Qualitative Research: Techniques and Procedures in Developing Grounded Theory*. London: SAGE.
Taylor, M., A. Spillane, and S. Arulkumaran. 2020. "The Irish Journey: Removing the Shackles of Abortion Restrictions in Ireland." *Best Practice & Research. Clinical Obstetrics & Gynaecology* 62: 36–48. doi:10.1016/j.bpobgyn.2019.05.011
UK Department of Health and Social Care. 2021. Abortion Statistics, England and Wales 2020, July 12. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020

UK Department of Health and Social Care. 2022. Abortion Statistics, England and Wales 2021, July 21. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021

UK DoH – United Kingdom Department of Health and Social Care. 2020. Abortion Statistics, England and Wales 2019, June 11. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf

Zanini, G., J. Mishtal, S. De Zordo, A. K. Ziegler, and C. Gerdts. 2021. "Abortion Information Governance and Women's Travels across European Borders." *Women's Studies International Forum* 87:1–8.