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The Changing Landscape of Abortion Care: Embodied Experiences of Structural Stigma in the Republic of Ireland and Northern Ireland

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Abstract

The private use of abortion medication outside of the formal healthcare setting is an international phenomenon. Despite new and expanding pathways to abortion access, we know little about how women's perceptions and experiences of abortion may also be changing. This study examines the embodied experience of 68 women who sought abortion services in Northern Ireland and the Republic of Ireland. Social stigma and restrictive abortion laws were major barriers to care at the time of study, providing the opportunity to explore the ways biological, social, and structural factors shape embodiment. Those who obtained an abortion either traveled abroad for clinical care or self-managed a medication abortion at home. Participant's perceptions of pain, the fetus, the method (medication vs. surgical), and environment in which they sought abortion care (at home vs. in a clinic) were shaped by structural stigma. Women gained greater experiential knowledge through medication self-management, allowing them to relate abortion to other natural bodily processes and redefine their beliefs about pregnancy and the fetus. Preferences and attitudes about the environment of abortion care were informed by stigma and differential perceptions of risk. Those who traveled most often emphasized legal and medical risks of abortion at home, while those who self-managed emphasized social, financial, and emotional risks of pursuing clinical abortion care abroad. Given the increase in reproductive self-care alternatives, these findings situate self-managed abortion in the literature of (de)medicalization and reveal the ways technology and structural factors shape perceptions and beliefs about pain, the fetus, method, and environment. For some, self-managed medication abortion may be a preferred pathway to care. Policies that consider medication self-management as part of a spectrum of legitimate options can improve abortion access for marginalized groups while also offering an improved abortion experience for those who prefer medication abortion and an out-of-clinic environment.

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CRedit author statement

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Keywords

Republic of Ireland; Northern Ireland; Self-managed abortion; embodiment; structural stigma

1. Introduction

Abortion remains a common life experience for women across the world; an estimated one in four pregnancies from 2010–2014 ended in abortion (Fact Sheet: Induced Abortion Worldwide, 2018). Despite widespread need for abortion services, 42% of women of reproductive age live in a country where access to care is highly restricted (Singh et al., 2018a). Legal barriers are just one piece of the broader *structural stigma* encountered by those who seek abortion, characterized by “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized” (Hatzenbuehler and Link, 2014). In response to these constraints, numerous studies from across the world document the use of abortion medications outside of the formal healthcare system (Baxerres et al., n.d.; Guedes, 2000; McReynolds-Pérez, 2017; Singh et al., 2018a, 2018b; Zurbriggen et al., 2018). Although self-managed medication abortion is an international phenomenon, we know little about how women’s perceptions and experiences of abortion may also be changing. Through an analysis of in-depth interviews, I explore the narratives of 68 women who sought abortion services in Northern Ireland and the Republic of Ireland, two countries that had some of the most restrictive abortion laws in the world at the time of study. By analyzing people’s perceptions of abortion across a range of pathways and methods of care, this study contributes to existing literature on (de)medicalization and reveals the ways structural stigma is internalized (and challenged) during the process of abortion-seeking.

1.2 Abortion in Northern Ireland and the Republic of Ireland

The landscape of reproductive rights and healthcare is undergoing significant changes in the Republic of Ireland (hereafter Ireland) and Northern Ireland. For 35 years, the Eighth Amendment to Ireland’s constitution guaranteed fetuses the same right to life as pregnant women; abortion was only permitted to preserve a woman’s life in 2013 (Mills, 2017). In early 2019, after an historic referendum and the repeal of the eighth amendment, Ireland began offering abortion services to patients under twelve weeks’ gestation. Within the same year, abortion in Northern Ireland was decriminalized, effectively ending a “grave and systematic violation of human rights”, as described by a United Nations Report (Aiken and Bloomer, 2019). During the time of study, one of the few options available to those seeking abortion in both countries was to travel abroad for legal access to services (most often to England) (Gilmartin and White, 2011). Qualitative studies describe the significant burdens of travel, to include costs, difficulty finding childcare or taking time off work, feelings of shame and stigma, and managing pain and bleeding on the return home (Aiken et al., 2019, 2018).

In 2006, a group of doctors and activists known as Women on Web (www.womenonweb.org) began offering abortion medication by mail, using a platform known as online telemedicine. After submitting an online consultation and a donation of €90, a person may request a

package that contains mifepristone and misoprostol, the two medicines recommended by the WHO to safely induce a medication abortion (Safe abortion, 2012). Since 2010, more than 5600 women living in Ireland and Northern Ireland have submitted online requests to Women on Web to self-manage their abortion at home (Aiken et al., 2017). Although many chose this route due to the legal and financial challenges of accessing clinical care, the vast majority of those surveyed (98%) felt they had made the right choice and would recommend it to others in a similar situation (ibid.). These findings, alongside data from in-depth interviews, suggest that self-managed medication abortion may sometimes be a preferred pathway of care, rather than simply a last resort in the face of restrictions (Aiken et al., 2019, 2018). The following analysis considers this possibility by exploring the way respondents confront and navigate structural stigma as they seek abortion care.

1.2 Conceptual framework

Similar to pregnancy and childbirth, the experience of abortion is influenced by forces across various analytical levels—to include biological, individual, social, and structural. Despite these theoretical similarities, researchers often investigate pregnancy and childbirth at lower analytical levels of the body and individual identity, while abortion and contraception are more often analyzed within higher-level social and political processes (Almeling, 2015). Given the immense stigma associated with abortion in Ireland and Northern Ireland, the following analysis responds to the need for “an integrated understanding of the relationship between the biological and the social” (Bendelow, 2000). The concept of structural stigma is particularly useful for understanding this relationship. Previous studies suggest that structural stigma associated with HIV, mental illness, and minority sexual orientation contributes to lasting health inequalities for members of these status groups (Hatzenbuehler, 2014; Hatzenbuehler et al., 2013). I further contribute to this literature by examining the ways structural stigma impacts women’s embodied experiences of abortion, accounting for their perceptions of pain and method, the fetus, and the environment in which they obtain care.

This analysis also situates self-managed medication abortion as a distinctive case which lies at the crossroads of (de)medicalization. Medicalization has multiple dimensions and should be analyzed as a continuum rather than a category or state (Halfmann, 2012). Medication self-management can be considered a form of *medicalization* since individuals rely on medical technologies (misoprostol and mifepristone) to end their own pregnancies rather than more crude methods that may have been used in the past. On the other hand, the use of pills outside of the formal healthcare system weakens the influence and social control of medical institutions, representing a *demedicalization* of abortion (Conrad, 1992; Halfmann, 2012). The (de)medicalization of abortion care likely has important implications for structural stigma. While medicalization may serve to weaken stigma associated with certain health problems such as drug addiction, depression, and post-traumatic stress (Conrad, 1992), the demedicalization of abortion through medication self-management presents new physical and environmental experiences, providing the opportunity to explore and redefine the meaning of pregnancy, pain, the fetal body, and abortion.

In the following pages, I describe the ways structural stigma influences women's embodied experience of abortion at three levels of analysis. First, I consider women's narratives of their bodily experience, that is, what they see and feel during their abortion, and how the method they use shapes this experience. Second, women's descriptions of the embryo or fetus also represent an important aspect of their embodied experience. A large amount of research examines popular discourse on the nature of the fetus, which is often restricted to binary categorizations of either 'a life' or 'not-yet a life' (Hopkins et al., 2005; Luker, 1984; Petchesky, 1984). Few studies investigate perceptions of the fetus among women who have terminated a pregnancy, particularly among those using new technologies and pathways of access. Finally, I analyze women's descriptions of place and space of healthcare, which reveal the influence of social and structural factors on embodiment. While previous studies describe women's experiences of abortion within the clinic setting (Beckman and Harvey, 1997; Ganatra et al., 2010; Lafaurie et al., 2005; McLemore et al., 2014), relatively little is known about the experience of abortion at home. In the context of growing legal restrictions on abortion in places such as the United States, evidence from Ireland and Northern Ireland describe why people choose self-managed care and how these behaviors may shape experiential knowledge and beliefs about abortion.

2. Materials and Methods

2.1 Recruitment, Data Collection, and Sample

Interview data for this analysis were collected by a team of four researchers, including the author, between March 2017 and February 2018. Our team conducted semi-structured, in-depth interviews with 68 women from Ireland and Northern Ireland who recently sought an abortion. Many people in our sample who self-managed a medication abortion at home had no contact with the formal healthcare system in their home country, making this population traditionally very difficult to find and research. To find participants who self-managed a medication abortion at home, we partnered with Women on Web, who invited people to participate in an interview if they had recently requested medications by mail. We also recruited participants with the support of three reproductive rights organizations that provided information about our study via mailing lists and social media. These organizations include the Abortion Support Network (ASN), which assists women who travel abroad to access abortion care, 'For Reproductive Rights against Oppression, Sexism and Austerity' (ROSA), which provides information about online access to abortion medication, and Alliance for Choice, which provides information and support to those who travel or use online telemedicine.

Individuals recruited through any channel were invited to contact the research team in order to participate in an anonymous phone interview and offered £80/€90 in appreciation for their time. Interviews were conducted in English and ranged from 35 to 75 minutes. Participants were eligible if they were 18 years or older and sought an abortion in the last 8 years (the period in which services from Women on Web were available in Ireland and Northern Ireland). All women provided their informed consent to participate in an audio-recorded interview. We wished to minimize both legal and social risks to participants by allowing a space of anonymity to share their experience. Therefore, all interviews were conducted over

the phone and the interview guide contained limited demographic questions. The research team did not retain any personally identifying information and gave all participants pseudonyms for anonymity and record-keeping purposes. The study was approved by the Institutional Review Board at The University of Texas at Austin.

The interview guide was designed to study the experiences and decision-making processes of people seeking abortion. Our team conducted four pilot interviews and made slight modifications to the interview guide to discuss topics relevant to the participant's country of residence. The order in which we asked questions was determined by the flow and direction of the participant to make the conversation feel less formal and allow for new topics to arise spontaneously. We asked women about both their physical and emotional experiences of pregnancy and abortion and the social support or resistance they encountered while seeking information and care. Women also discussed reasons they sought abortion services, methods and pathways they considered or used, and their attitudes regarding the current legal context of abortion.

Although we limited our collection of demographic characteristics to participants' age, country of residence, and employment status, our sample nevertheless reflects an economically and socially diverse population within the context of Ireland and Northern Ireland. Participants ranged in age from 18–44 years old, 27 were mothers, and they reported a range of socioeconomic backgrounds and family household structures. On average, participants from Ireland were slightly older, more likely to be employed, and a larger proportion were already mothers. However, among mothers, women in Northern Ireland had more children on average. Figure 1 presents the various pathways to care women obtained according to their country of origin. Given the legal restrictions on abortion in both countries at the time of study, the vast majority of participants either accessed abortion services in a clinic abroad (n=20) or requested abortion medications from an online telemedicine service to end their pregnancies at home (n=46). One woman received approval to have an abortion at a hospital in Northern Ireland due to health concerns associated with her pregnancy, and another woman who obtained medications using online telemedicine ultimately decided to continue her pregnancy.

2.2 Analysis

At the end of each interview, interviewers recorded detailed field notes, which were discussed by the research team to collectively develop a coding guide for analysis. Any potentially identifying information was removed from the audio files and all interviews were transcribed prior to analysis. We analyzed transcripts according to the principles of grounded theory, which involved open coding, a line-by-line analysis of the data in order to identify major categories and concepts arising from the data (Grbich, 2013; Strauss and Corbin, 1997). These categories were carefully refined through subsequent analysis until we reached thematic saturation. Each interview was then coded separately by two members of the research team, who met to discuss codes and resolve discrepancies. We used Dedoose 7.6.21 software to code and organize transcript data and Stata 15.0 to perform descriptive statistics.

Once open codes were developed, I separately employed axial coding to identify subcategories related to the core category of embodied experience (Grbich, 2013). This

included all discourse related to physical and emotional experiences throughout the participant's narrative. Discourse analysis was a particularly useful method for exploring the paradoxes and contradictions present in these narratives. In some instances, participants made a point of demonstrating their disagreement with narratives that would provide support for their decision to end their pregnancy. Such contradictions "are powerful tools for highlighting the emotionally charged—what is emotionally difficult to claim, where anxiety lies, and what sort of cultural problems people face for which they need to reach for such contradictory explanations" (Pugh, 2013). These paradoxes revealed the embodied tensions of abortion-seeking in a highly restrictive and stigmatizing context.

I also coded any discussion of abortion methods, the fetus, and descriptions of physical space and environment while seeking or completing an abortion. Although participants who obtained a surgical procedure may have had a vacuum aspiration or Dilation and Evacuation (D&E) procedure, they most often used the terms 'surgical abortion' or 'the procedure' to describe these methods. Similarly, the majority of participants in our sample terminated a pregnancy that would be classified as an 'embryo' due to a gestational age of less than 11 weeks, however, they more often used the term 'fetus' to describe the contents of their pregnancy, so I employ this term throughout my analysis.

2.3 Positionality and reflexivity

Given the divisive nature of the abortion debate in Ireland and Northern Ireland, as well as the illegal nature of many participant's activities, our identity as researchers and our commitment to confidentiality were crucial for ensuring trust in the interview. Abortion discourse is highly sensitive to particular words, such as 'baby', 'fetus', 'life', and 'choice'; these words are often used to determine which side of the debate the speaker falls (for an example, see Camosy, 2019). We therefore attempted to mirror the terms and phrases used by our participants. Nevertheless, our language was likely perceived as supportive of abortion access and reproductive autonomy. When participants asked the purpose of our research, we shared that "we hope to gain a better understanding of women's experiences seeking abortion so that we may provide evidence about access and the quality of care women receive in Ireland/Northern Ireland." We also relied on specific gatekeepers for recruitment. Interview referrals by telemedicine organizations and abortion support groups may have led participants to view interviewers as potential allies and advocates. Consequently, our interview data likely reflect our position as perceived 'insiders' in the abortion debate.

On the contrary, although interviewers were all women of reproductive age, most were cultural and national "outsiders"; only one (the principal investigator) is from Northern Ireland and three are from the United States. Since all interviews were conducted over the phone, interviewers with American accents were likely considered to be 'outsiders' in reference to discussions of culture, healthcare, politics, and the law. As is often the case in qualitative research, outsider status may sometimes constrain research but also may present opportunities for the co-production of rich data. In an effort to 'teach' outsider-interviewers about the social and legal context of abortion-seeking in their respective countries, participants often provided detailed descriptions of cultural attitudes towards childbearing

and abortion and interactions with government officials and healthcare providers. Regardless of nationality, all interviewers sought to assume the position of ‘outsider’ when it came to the participant’s personal narrative of abortion; only the participant was deemed the expert of her own perceptions, preferences, and needs.

3. Findings

3.1.1 The Meaning of Pain and Process

Participants discussed their expectations of both physical and emotional pain before the abortion and the ways their expectations were met or challenged. Women who self-managed a medication abortion provided much greater detail of the process, suggesting that the experience of medication abortion is more visceral than the surgical procedure since the woman herself is in control of initiating the abortion, choosing the environment, and monitoring her own body for symptoms or signs of complication. Women who traveled to clinics in England rarely used abortion medications since the protocol included taking the pills and then managing the abortion after leaving the clinic, usually on the journey home. In contrast, participants who had surgical procedures at a clinic were often sedated or anesthetized. These participants were less likely to talk about physical pain and rarely mentioned seeing the products of conception. Bess for example, 27 years old, had a surgical abortion in England and was grateful that she did not remember most of the procedure:

I’m really glad I went under general anesthesia—that I was asleep for it. It’s not something I want to have flashbacks of, you know. I know some people can do it, and it’s fine. I think if it [abortion] was more normalised here, it would just be like any other procedure. But that wasn’t the case. I wanted to sort of protect my memory.

By describing abortion as distinct and not just like “any other procedure”, Bess draws attention to the way abortion stigma impacted her own perception of the surgical procedure as well as her preference for general anesthesia. Compared to using pills, this method allowed her to minimize her exposure to some of the more visceral aspects of abortion, additionally protecting herself from the stigma of a medical procedure that is not “normalised” in society.

Women’s perceptions of medication abortion were also influenced by structural stigma in various ways. A significant majority of the sample, 57 participants, explicitly stated that they would prefer medication abortion over a surgical procedure. They described the process of medication abortion as “less stressful and traumatic... more like a heavy period”, “not really an abortion”, “like the morning after [pill]”, and compared it to “inducing a miscarriage.” One woman, Carmel, 40-years old, wanted to use pills but could not obtain them, so she ended up travelling abroad for a surgical procedure. She described her perception of medication abortion in contrast to the procedure she underwent:

Taking a pill isn’t as invasive as having the procedure. I found the [surgical] procedure quite painful... it was just a bit invasive and a bit clinical... I didn’t like the feeling of it at all. If you could take a pill, you know you’re going to have a very heavy bleed, you know you’re going to pass something, you’re prepared for it

... I would have much preferred that.... I've had miscarriages myself over the years and not realized what they were until I'm right in the middle of it. So, most women at some stage will have had a very heavy bleed. It's not shocking.

Like Carmel, other women in this group emphasized menstruation and miscarriage as natural bodily processes. The use of abortion medications (as opposed to surgical abortion) led them to perceive a more natural experience. Mairead, a 32-year-old woman who self-managed at home, normalized the abortion by relating it to common and already-familiar processes. She believed miscarriage to be "a pretty natural thing, like even an induced miscarriage, you know? It still feels like it was a natural thing. If I told somebody I've had a miscarriage, I don't feel like I was lying or anything. I'm leaving out a detail." Despite her own perceived similarities between medication abortion and miscarriage, her need to "leave out a detail" demonstrates her awareness of the moral line some parts of society draw between the two experiences. By blurring these lines within her own narrative and situating medication abortion alongside processes less likely to incur moral blame (i.e. menstruation and miscarriage), she was able to avoid and diminish this external stigma. Others related their experience to common biological processes to rationalize their emotional response to their abortion. Danielle, 27 years old, described her physical and emotional response after using pills:

When I expelled the pregnancy, I actually thought I was going to die, I was in so much pain. I was sweating, I was vomiting, I had hot and cold flushes, I had pain in my stomach, I was trying to lay down—it wasn't helping... I was expecting to be a little bit more all over the place [emotionally]. There was maybe one or two days that stupid things upset me... but it was nothing more than what's normal for me monthly because I do get fairly emotional every month. So, for me it was kind of normal in that aspect.

Although the physical pain was severe, Danielle managed to normalize her emotional response as being similar to the ups and downs she experienced during her monthly cycle. She further explained, "Once I started feeling the pains, I had a fair idea it was going to be effective and I literally saw what came out—so from then on I knew that it was finished." While pain is often understood as something to avoid, for Danielle, the pain and physical experience of abortion, like the pain of childbirth, signified the arrival of a desired outcome (i.e. the end of her pregnancy). Scholars have previously documented the way certain kinds of pain can create a separation between the body, which rejects and seeks to avoid pain, and the mind, which understands pain to be necessary (Bendelow, 2000; Bendelow and Williams, 1995). This dualism is evident in the feelings of relief and reassurance some felt at the onset of painful side effects such as cramping and bleeding. Danielle's bodily experience and the visual evidence of the abortion were key components of her experience, providing reassurance that she was no longer pregnant.

In contrast to Danielle, who diminished her emotional response following the abortion, other participants vividly described the shame and stigma they felt. Previous studies indicate that people's core beliefs about pain, which include self-blame and beliefs about the mysteriousness and duration of pain, are predictive of behavioral manifestations such as subjective pain intensity, poor self-esteem, and psychological distress (Williams and Thorn,

1989). Jo's account aptly demonstrates the relationship between her own shame and her physical experience of the abortion. At the time she discovered she was pregnant, she was a 28-year-old British citizen who had been living and working in Ireland. Since she was able to stay overnight with family in England, she was one of the few participants that received abortion medications from a clinic. The clinic staff, concerned about the side effects of bleeding and pain, instructed her to avoid public transit and take a taxi straight home:

I walked out of the clinic with the pill between my gums. And I was just like, Oh, I'm sure it'll be fine, I kind of don't deserve a taxi, like, I don't deserve to look after myself, in a way. Because I'd already said to my boyfriend, "No, I don't need you looking after me, it's fine, you can go to work." I was in such a way that I just... I had very low self-esteem and I didn't deserve any of these things to make it a little bit easier on yourself. So, I took the tube [subway] home. And I just literally got in the front door, and then the nausea started... I had diarrhea and vomiting and was just really sick for 4 hours. Very, very, very painful cramps. There was nothing to do except keep going to the bathroom and wait it out. And eventually, I felt that the thing had passed. I noticed that moment, which is quite interesting, and then at that point, I was like, oh, I feel like it's over, it's such a pure relief, you know.

Jo's internalized stigma clearly affected her attitude towards her own body and self-care during her abortion. Already suffering from depression before the pregnancy, she described the way the pregnancy compounded her problems: she couldn't tell her family, had to travel alone to England and pay over £500 for the medications, and went through immense physical pain. For Jo, this social and structural stigma of abortion led her to accept the pain and process of abortion as a form of penance.

3.1.3 Perceptions of the fetal body

Qualitative studies often reveal the power of reproductive technologies to shape beliefs and perceptions of the fetus (Casper, 1998; Gerber, 2002; Petchesky, 1984). The medicalization of pregnancy and childbirth, as well as technological advancements in amniocentesis and fetal surgery, have led some providers to view the fetus as patient (Casper, 1998). Several studies have also explored the role of ultrasound images in shaping both individual and public perceptions of the fetus, often before women are even able to feel evidence of its existence (Halfmann and Young, 2010; Hopkins et al., 2005; Palmer, 2009; Petchesky, 1984). Less research has explored how the demedicalization of abortion through medication self-management may shape women's beliefs and perceptions of the fetus. One exception is found among patients and providers of medication abortion in France, who often refer to the products of conception simply 'an egg' rather than a 'fetus', 'embryo', or 'baby' (Gerber, 2002). This language highlights the concept of a reproductive continuum in which women emphasize the small size of 'the egg' and the early gestational timing of their abortions (ibid). Given legal access and greater social acceptability of abortion in France, the highly restrictive contexts of abortion in Ireland and Northern Ireland provide the opportunity to compare the ways social and structural stigma may influence perceptions of the fetus.

Whereas ultrasound technology "dissolves women's bodily boundaries, undermines their experiential knowledge, and represents the fetus as an autonomous, conscious agent"

(Mitchell and Georges, 1997), self-managed medication abortion allowed participants to see and interact with the contents of their pregnancies, gaining new experiential knowledge. Lucia, 33 years old, vividly described her experience researching information about medication abortion online and self-managing at home:

I couldn't imagine that it could be that easy... I went onto YouTube—there's a lot of fake media—people saying 'it's a horrible thing and it's so painful, there's so much blood', you know. So, you have the idea that an abortion is something really terrible, but it isn't... When I felt like I was going to the peak of the contraction, I just went and sat on the toilet, and then I passed a bit of blood and then I passed it [the fetus], and then I stayed a few more minutes. My friend came, and she put her hands in the water to get it out...she's a midwife, so she was very interested in it and curious. She'd never been in a situation like this, so it was an experience for her, as well. So, we investigated—we couldn't see anything significant in size, you know, it's tiny. You couldn't see nothing really, it was just more like looking at a clot.

Similar to the women described in France, those who had medication abortions, like Lucia, were typically not disturbed by seeing the contents of the pregnancy. After using pills in Northern Ireland, Etna, 29 years old, compared her expectations to her actual experience: "I read people talking about fetuses and things like that. That did scare me, but it was really just—it wasn't anything like that." Laura, 21 years old, tried to prepare herself for what she would see by looking up images online. These images prepared her for the worst, but after completing her abortion she said: "I'll be honest, I didn't see any of those images. All I saw was what looked like a big blood clot, probably the size of the palm of your hand, you know? I didn't see any fetuses that were disemboweled or anything from the vacuum suction style abortion, the surgical one."

Other women did not specifically discuss their visual encounters, but rather their emotional relationship to the fetus during pregnancy. Jo, the woman who traveled and received pills from a clinic, completed her abortion at the home of a relative in England. She described the moment that she passed the pregnancy: "...at that point, I was like, oh, I feel like it's over. It was just pure relief that it was out of my body because really, it had felt like a foreign object. And obviously, I was exhausted—but I felt much lighter emotionally." In sharp contrast to the relieved detachment that Jo felt, Jackie, 39 years old, described intense sadness after her abortion. Almost every woman we spoke with said that despite a range of feelings and emotions, they believed that abortion was the right decision. Throughout Jackie's interview, however, she emphasized her love for children and expressed strong ambivalence about having another child. When she discovered she was pregnant, she wanted to seek medical advice but was convinced that seeing the ultrasound would cause her to want to continue the pregnancy. After requesting and using the pills at home, Jackie reflected on her experience:

I knew I was very early-on pregnant, and I kind of was under the illusion that taking the abortion pill was going to be like a late period, you know. Like if you google, a lot of them say "Oh it's going to be like a late period." It's very crass and then they're like "Oh it's two weeks late, it's just a lump of blood cells, it's nothing." And that, to be honest, was what I was expecting. That wasn't my

experience of it. It wasn't quite as simple as that, even though I was under 7 weeks... I wanted to see it. That was mine, that was my baby, do you know what I mean? I know what I've done, I've got to live with it forever. But, I wanted to see it. I should have minded her, I shouldn't have done that.

Jackie's narrative differs markedly from others but highlights the ways medical technology may be utilized based on individual needs and values. She rejected ultrasound technology for fear that it would complicate her decision to end her pregnancy, yet she preferred the technology of medication self-management because it gave her the opportunity to see 'her baby'. Other women who self-managed chose to avoid looking for visual evidence of the abortion. The majority of those who did look were surprised to find that the contents of their pregnancy were less shocking than they anticipated. Contrary to images of large, developed fetal bodies that they had seen online or in public spaces from abortion protestors, the use of abortion medication provided visual relief for many women who hoped that the process would be "more like a heavy period" or "not really an abortion". In the same way that ultrasound images are used to suggest 'proof' of fetal personhood, participant's visual descriptions of the physical contents of their abortions (as a "clot", a "sac", or "a foreign object") were used to invalidate notions of fetal personhood. Jackie's experience serves as a reminder that, as with ultrasound technology, the meaning and nature of the fetus when using abortion medication "is not straightforward or given but is a product of the viewing practices through which [it is] consumed" (Hopkins et al., 2005). With increased medicalization of pregnancy and childbirth, new technologies are often used to delineate the beginning or end of a pregnancy, replacing women's own experiential knowledge of this timeline (Layne, 2003). Although the pills themselves originate from medical institutions, self-management represents a demedicalization of abortion by allowing women to interpret and redefine abortion, the fetus, and the reproductive continuum according to their own bodily experiences.

3.2 The space and place of abortion care

In the face of restrictions and high levels of abortion stigma, women's narratives revealed how physical space and location shaped their embodied experience of abortion. Many women who requested medications from online telemedicine organizations did so out of necessity—because abortion was restricted in their country and expensive or difficult to access abroad. Nevertheless, many also highlighted the benefits of telemedicine and claimed that if abortion were legal in their country, they would still prefer to self-manage at home. Tanya, 26 years old, recounted her experience:

I think the safety and security of your own home when you're going through something like that is just preferable... being able to be in my own bed, where my own bathroom was literally a second away, and I could go in and lie down on the couch, it was such a comfort. I couldn't imagine being in a strange place... I could send [my partner] to the shop to get me whatever I wanted anytime, which is around the corner from my house. It was so much nicer being at home.

In contrast, many that traveled abroad for a surgical procedure said they would have preferred to use pills at home, citing advantages such as lower cost, privacy, comfort, and autonomy. These participants portrayed the medical environment as "sterile", "much more

clinical”, “cold”, “scary”, “serious”, and “intrusive”. Kate, 23 years old, was in college in Ireland when she found out she was pregnant. She did not know about telemedicine services at the time, so she travelled to England for a surgical procedure. Reflecting on these experiences, she said:

I could have had my mum there with me or my brother, and I could have had the people that love me around me, and it would have been much nicer to just be at home in my bed... It’s not really private when you go to the clinic over there, you have all these people in the clinic, and I felt uncomfortable in the waiting room.

Other participants chose to self-manage their abortion for the privacy and protection from stigma that it offered. Those who traveled and received clinical care often described public shame brought on by their interactions with protestors, taxi drivers, and even healthcare providers. Shannon, 29 years old, expressed apprehension at “the thought of having to go to a clinic and speak to a nurse.” She said:

For me, there’s something appealing about the online process, and being at home... I didn’t really want anybody helping me, or comforting me, particularly someone I didn’t know. The idea of actually being able to be on your own and just get it done was appealing to me.

Similarly, Imelda, 29 years old, found that telemedicine offered support and information while simultaneously protecting her from judgement and social stigma:

I liked the way they [WoW] were supportive, that you could talk to them, you could send them an email whenever you wanted. And you’re not physically talking to some person face to face, so they don’t know what you look like or who you are, you don’t feel judged the way that you do when it’s face to face.

A few women in our sample had abortions both in the clinic and at home and were able to compare their own experiences directly. Frankie traveled to a clinic at age 18, and then later self-managed using medications at age 26. Although she managed to obtain legal access to abortion the first time, Frankie said that traveling “cost a lot of money and drained your energy” and made you “paranoid...because you feel like people can know by looking at you what you’re doing.” To avoid traveling again and the associated shame and stigma, she requested abortion medications from Women on Web when she discovered she was pregnant at the age of 26.

Bernadette was just 18 years old when she had an abortion, and she saw telemedicine as her only option due to the high costs of traveling and her need to keep the pregnancy a secret from her parents. She told her boyfriend, requested the medications, and they went away for a weekend together to end the pregnancy. Reflecting on this experience, she said:

I’d much prefer to go to a clinic... I imagine I’d have better care, and if there were a complication, I’d be looked after really quickly. It wouldn’t be as scary, I don’t think, and from what I’ve read about people going to clinics, you have nurses and staff that stay with you and tell you that whatever is happening is normal, but when you’re on your own, you don’t know if it is [normal].

Like Bernadette, Leona, 37 years old, also expressed a preference for clinical care. Although she was personally “involved in a lot of activism around the pills” and supported the right to self-manage, she felt physically and emotionally conflicted after taking medications. She explained that she was familiar with the discourse of autonomy and “women taking things into their own hands”, but her own experience departed from this:

I just did not feel empowered at all. I felt really vulnerable... just feeling so sick, and like I can't go to the doctor... I just felt like I shouldn't have to be here lying in this bed writhing in pain, you know? I just felt sort of, like, abandoned by society.

Almost all who self-managed were grateful for the option to request medications online and emphasized the privacy, lower cost, and convenience that self-managed medication abortion offered. Unfortunately, the benefits of self-management at home were often not fully realized in a context where restrictions, social stigma, and legal prosecution loomed overhead. A comparison of these narratives effectively demonstrates the impact of structural stigma on participants' perceptions of the location and setting where they accessed abortion. For people like Tanya, Kate, and Imelda, the clinic setting evoked fears of discomfort, financial costs, and judgement. For those who stated a preference for the clinic, the thought of self-managing at home was associated with fears of medical complications, limited information and resources, and fear of legal repercussions. The list of needs and preferences described by these women call for a range of patient-centered models of care that provide options for prioritizing specific concerns and minimizing risk.

4. Discussion

Alongside the rapid increase in the availability of abortion medication outside of the formal healthcare system, some have claimed that “medical abortion pills have the potential to change everything for the better for women who need an abortion” (Berer and Hoggart, 2018). These claims suggest that greater access will allow women to terminate their pregnancies at earlier gestations and lead to greater bodily autonomy in abortion care. The narratives of women in our sample suggest that these claims may be true, but that the benefits of self-managed abortion will be more difficult to attain in contexts of high legal restrictions and social stigma. Although participants expressed gratitude that telemedicine services were available, self-managed abortion at home sometimes resulted in feelings of isolation and anger towards the government. Any consideration of new healthcare delivery systems must account for the impact of the law and stigma on women's experiences. Decriminalization of self-managed abortion would represent a significant step towards reducing this stigma.

Ireland and Northern Ireland are currently in a place to develop new models of care. Through an historic referendum in 2018, citizens in the Republic of Ireland voted to repeal the 8th amendment, and the country began providing clinical abortion care on January 1, 2019 (Cullen, 2018). Just 10 months later, abortion was decriminalized in Northern Ireland, and abortion services are expected to become available in March of 2020 (Aiken and Bloomer 2019). Despite evidence showing the use of telemedicine in Ireland and Northern Ireland to be both safe and effective (Aiken et al., 2017), popular discourse continues to portray self-managed medication abortion as dangerous. Rather than considering how these

new pathways of access might be incorporated into existing healthcare models, some have stressed the need to “provide a safe alternative to—and eliminate the risks that arise from—the use of online abortion pills outside the law...” (“Latest,” 2018). The spread of misinformation regarding the safety of self-managed medication abortion deters patients from choosing a model that they may prefer. It also fails to consider the wide range of reasons that people may choose self-management, which extend beyond concerns of medical safety. In some cases, self-managed medication abortion may mitigate what are often perceived to be larger concerns, such as the need for secrecy or the financial difficulties of travel and clinical care, which can have serious consequences in a person’s life.

A deeper understanding of structural stigma experienced by those in need of abortion care motivates the development of greater structural competency among healthcare providers (Metzl and Hansen, 2014). The findings of this study provide the basis for several possible interventions: First, participants who preferred medication to surgical procedures often associated a medication abortion with natural bodily processes such as menstruation or miscarriage. This framing was helpful for normalizing and de-stigmatizing abortion in the minds of participants. For reasons of contraindications and gestational age, some patients will not have the option to use medication, so the introduction of new language for surgical abortions could also be useful (for proposed improvements to language pertaining to first trimester abortion methods, see Weitz et al. 2004). For example, informational videos from Planned Parenthood use the term ‘in-clinic’ abortions for all surgical procedures and they describe vacuum aspiration as using “gentle suction to empty your uterus” (“In-Clinic Abortion Procedure | Abortion Methods,” Planned Parenthood). The use of less-medicalized language may improve understanding of these procedures and allow women to normalize their experiences. Second, women who used medication were concerned about what they would see and feel during the abortion. To alleviate these concerns, the provision of abortion medication should be accompanied by detailed instructions of use and information on what a patient can expect to see and feel depending on gestational age, acknowledging that this may be an emotionally distressing experience for some people. Finally, although some participants preferred to access abortion in a clinic setting, few had positive things to say about their experience of the clinic environment. This was likely a result of the immense barriers they faced to accessing care, which included factors outside of clinic control, such as the difficulty of travel and the presence of protestors outside of clinics. Given these challenges, efforts to improve the physical space of the clinic, reduce waiting periods, and foster positive interaction with clinic staff could greatly improve patient experience.

The narratives of participants who sought abortion care during this period suggest that the legalization of abortion, although a major step forward, will not necessarily eliminate the need or preference for self-managed care. Full decriminalization of self-managed abortion would reduce structural barriers by allowing individuals to seek their preferred pathway of care and safeguard the most vulnerable groups who seek informal pathways to care due to other constraints.

This study illuminates how structural stigma influences the embodied experience of abortion in various ways, to include perceptions of pain and method, the fetal body, and the physical environment of abortion care. Numerous studies confirm that internalized structural stigma

may lead to long-term health outcomes, particularly among those with stigmatized identities that can be concealed (Berg et al., 2013; Hatzenbuehler, 2014; Hatzenbuehler et al., 2013; Link and Phelan, 2001). The elimination of unnecessary barriers to abortion care is a major step towards reducing structural stigma. Some countries have taken small steps to reduce these burdens and improve access. For example, until clinic-based care is established within Northern Ireland, people will be able to receive funding for travel and accommodation under the Northern Ireland Executive Formation (NIEF) Act 2019 for abortion services in England (Northern Ireland Office, 2019). While helpful for reducing cost, this does not alleviate the burdens of travel, stigma, childcare, and time away from work that so many describe (Aiken et al., 2018). In England, any individual obtaining a medication abortion was previously required to come to the clinic twice in order to take mifepristone and then misoprostol within a 24–48 hour timeframe. In December 2018, the country announced that patients would be allowed to take the second drug, misoprostol, at home, relieving them of the need to travel or return for a second appointment (Murphy, 2018).

Studies from the United States show that telemedicine improves access for women living in remote areas and reduces the number of abortions at later gestations (Grossman et al., 2013). Unfortunately, access to mifepristone in the United States is limited by a set of restrictions imposed by the FDA known as Risk Evaluation and Mitigation Strategy (REMS). REMS programs prohibit the sale of certain drugs at retail pharmacies and require providers to be certified in order to dispense them. Given the established safety and effectiveness of mifepristone, healthcare providers and researchers have called for the removal of the outdated REMS to improve both supply and access (Mifeprex REMS Study Group et al., 2017).

The options described above move beyond the clinic setting to increase access and autonomy for those who prefer or need medication self-management. By highlighting women's experiences and narratives of abortion-seeking, this study reveals the broader influence of structural stigma on embodiment and paves the way for service models that expand access and prioritize patient experience.

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Highlights:

- Structural stigma greatly impacted perceptions of the abortion process
- Pain, the fetus, and environment were important aspects of embodiment
- De-medicalization of abortion may attenuate or intensify structural stigma
- Self-managed medication abortion can be a preferred pathway to care
- Support for medication self-management as a viable option can reduce stigma

Figure 1: Reproductive outcomes and pathways to care among women seeking abortion care in Ireland and Northern Ireland

*Four women requested pills from either a telemedicine organization or feminist network but did not end up completing an abortion with these pills. Among this group, 1 woman qualified for abortion care in a clinic in Northern Ireland, so did not use the pills she acquired; 2 women reported that the pills they used did not work and they both traveled abroad and had a surgical abortion; 1 woman received pills but ultimately decided not to use them because she was concerned about how effective they would be.