French women's experiences and opinions with in-country versus cross-border abortion travel: a mixed-methods paper

Laura Rahm [1,2] Silvia De Zordo,[3] Joanna Mishtal,[4] Giulia Zanini,[3] Camille Garnsey,[5] Derek Clougher,[3] Caitlin Gerdts [6]

[1]Centre Population et Développement, Paris, France
[2]Central European University, Wien, Austria
[3]Department of Anthropology, University of Barcelona, Barcelona, Spain
[4]Department of Anthropology, University of Central Florida, Orlando, Florida, USA
[5]University of Connecticut, Storrs, Connecticut, USA
[6]Ibis Reproductive Health, Oakland, California, USA

Correspondence to
Dr Laura Rahm; laura.rahm@ceped.org

Received 25 September 2022
Accepted 11 January 2023

To cite: Rahm L, De Zordo S, Mishtal J, *et al*. *BMJ Sex Reprod Health* Published Online First: [please include Day Month Year]. doi:10.1136/bmjsrh-2022-201712

ABSTRACT

Objectives This is the first study contrasting the experience of women residing in France and travelling for abortion services inside and outside their country of residence. We compare travel reasons and costs as well as our study participants' opinions of abortion legislation. The article documents legal and procedural barriers related to accessing local and timely abortions and provides policy recommendations to broaden care options.

Methods The study is based on a mixed-methods research design. Quantitative data were descriptively analysed using Stata and drawn from 100 surveys with in-country abortion seekers collected from 3 Parisian hospitals, and 57 surveys with French residents seeking abortion care in the Netherlands (42), Spain (10) and the UK (5). Qualitative data were thematically analysed using ATLAS.ti and drawn from 36 interviews with French residents (23 in-country abortion seekers and 13 cross-border abortion travellers).

Findings Gestational age (GA) limits were the key reason for cross-border travel, while lack of close-by, timely and good quality abortion care was the main driver for in-country abortion travel. Unlike in-country travellers, cross-border abortion seekers faced significant financial costs and burdens related to such travel. Partners, family members and service providers offered important support structures to both cross-border and in-country travellers.

Conclusions Legal time limits appeared to be the key driver for abortion-related travel of French residents. Having passed or being at risk of exceeding the GA limit caused women to travel outside their country or department of residence for abortion care.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Women frequently travel for abortion care, particularly to those countries with liberal abortion laws.

WHAT THIS STUDY ADDS

⇒ Gestational age (GA) limits and long waiting periods caused French residents to travel for abortion care.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Documenting cross-border and in-country abortion travel is important for evaluating policy impact. Expanding, or eliminating, GA limits and timely, close-by abortion care can help French residents to reduce travel burdens and broaden care options.

INTRODUCTION

Abortion bans force women to travel long distances to receive services outside their country[1] or state[2] of residence. Studies on abortion travel have focused on the context of countries with restrictive abortion laws, such as the USA[3 4] or Ireland,[5–7] and related information barriers,[8] along with the financial and social burdens,[9] and support structures.[10] Less is known about countries with relatively liberal abortion laws.[11–13] France has made particular progress over the past decades to facilitate access to abortions by covering the costs of abortion care, eliminating mandatory waiting periods, expanding service provision to general practitioners and midwives, and increasing the gestational age (GA) limits for medical abortion including via telemedicine up to 9 weeks, and for surgical abortion on request up to 14 weeks.[14–18] Nevertheless, barriers remain, leading women to

travel for care.[19 20] The reasons to undergo such travel are diverse: while GA limits were the primary reason for engaging in cross-border travel before the recent law change,[13] in-country travelling is mainly driven by the lack of close-by, timely and quality abortion care.[17] This mixed-methods study contrasts the experience of French residents travelling inside and outside their country of residence for abortion services. We compare travel reasons, costs, and study participants' opinions of abortion legislation. The study documents legal and procedural barriers related to accessing local and timely abortions and provides policy recommendations to broaden care options.

METHODS

The article draws from data obtained during a 5-year study on barriers to legal abortion in Western Europe (BAR2LEGAB), funded by the European Research Council (ERC). The mixed-methods methodology is summarised below and described elsewhere more extensively.[13] We collected quantitative and qualitative data between 2017 and 2020 at abortion clinics and hospitals of the main destination countries/departments. We chose research sites based on publicly available data about the annual volume of non-resident care seekers: for in-country travel, three Parisian public hospitals were chosen, and for cross-border abortion travel, eight private abortion clinics in the Netherlands, Spain and the UK participated. We recruited eligible participants aged 18 and above in a 2:1 ratio of travellers versus resident care seekers. They were given the option of a tablet or paper-based survey and/or an in-depth semi-structured interview after written and oral informed consent, while awaiting their medical consultation. Participants received €10 (£9) for completing the survey and €25 (£22) for interviews. Survey and interview questions covered participants' sociodemographics, reproductive history, abortion seeking and travel reasons and experiences, related costs, time, delays, abortion stigma, self-administered abortion, and opinions on abortion law. Quantitative data were uploaded into Qualtrics and transferred into Stata for data cleaning and descriptive analysis. Due to the relatively small sample size, we do not present statistical tests to assess differences between in-country versus out of country travellers, and acknowledge the need for larger samples to draw statistically robust conclusions. Qualitative data were recorded, transcribed, anonymised, coded and thematically analysed in ATLAS.ti based on pre-established and newly emerging codes. The qualitative data were used to understand individuals' experiences better and support quantitative findings. A more in-depth treatment of the qualitative findings is out of the scope of the present article. We obtained ethical approvals from the ERC, participating universities, and the French national authorities (N° EudraCT/ID-RCB: 2019-A01048-49).

FINDINGS

Quantitative findings

Drawing on 157 surveys of French residents, a total of 100 participants travelled inside France, leaving their department of residence to come to Paris for abortion care. The remaining 57 participants travelled outside France to the Netherlands, Spain and the UK. We describe the sociodemographics of women travelling in-country versus cross-country, their reproductive history, travel reasons, and costs.

Women travelling in-country were slightly younger, more educated, and more often employed than cross-border travellers (table 1).

Both groups were equally able to cover their basic needs most or all of the time. The share of participants reporting being unemployed and not being able to meet basic needs were similar between in-country and cross-border travellers. Over 50% of all respondents declared being single, separated, or divorced, and one third of respondents reported being married or in a partnership.

Most cross-border travellers had no prior abortion, while this was the case for half of the in-country travellers. About two-thirds of all participants had no children. The starkest difference between in-country and cross-border abortion seekers was in the GA: nearly all in-country travellers were under 14 weeks (99%) since last menstrual period, the legal cut-off limit in France when the study was undertaken, while the majority of cross-country travellers (94%) declared having passed the legal GA (table 2).

Over two-thirds of in-country travellers came directly to Paris, while the same share of cross-border travellers tried first to find services locally. Cross-border travellers reported more often that they would have preferred to obtain an abortion earlier, which can be partly explained by their GA differences.

The main reasons why respondents could not obtain an abortion earlier was delayed pregnancy recognition for both groups. Other common reasons were scheduling issues, decision-making delays, and changed circumstances. While in-country travellers were more frequently delayed by local access to services (25%), women travelling across borders faced delays due to arranging for travel/abortion costs (16%).

Travel reasons differed between the two groups (table 3). While in-country travellers reported (1) referrals by healthcare providers (21%), (2) concerns about the quality of local abortion care (20%), and (3) lack of knowledge and access to local services (14%), the primary reason for cross-border travellers was that they had already exceeded the French limit to abort legally.

One-third of travellers were referred by a healthcare provider or Planning Familial staff. The latter can refer to the French family planning association (https://www.planning-familial.org/fr), or public family planning centres. Cross-border participants frequently

Table 1 Sociodemographic characteristics of survey participants

	In-country travellers (n=100)	Cross-country travellers (n=57)	Total (n=157)
Age (years)			
18–24	48 (48%)	23 (40%)	71 (45%)
25–34	36 (36%)	26 (46%)	62 (40%)
35 or above	16 (16%)	8 (14%)	24 (15%)
Highest level of education completed			
Secondary school or below	15 (15%)	22 (39%)	37 (23%)
Some university	21 (21%)	7 (12%)	28 (18%)
University or graduate school	41 (41%)	14 (25%)	55 (35%)
Postgraduate	19 (19%)	7 (12%)	26 (16%)
Prefer not to answer/no response	4 (4%)	7 (12%)	11 (8%)
Employment*			
Employed full-time	45 (45%)	18 (32%)	63 (40%)
Employed part-time	15 (15%)	4 (7%)	19 (12%)
Self-employed	6 (6%)	3 (5%)	9 (5%)
Unemployed	16 (16%)	12 (21%)	28 (17%)
Student	20 (20%)	12 (21%)	32 (20%)
Other	3 (3%)	2 (4%)	5 (3%)
Prefer not to answer/no response	--	6 (11%)	6 (4%)
Ability to meet basic needs			
All or most of the time	62 (62%)	35 (61%)	97 (62%)
Some of the time	16 (16%)	6 (11%)	22 (14%)
Never or rarely	15 (15%)	7 (12%)	22 (14%)
Prefer not to answer/no response	7 (7%)	9 (16%)	16 (10%)
Marital status			
Married or in a civil partnership	33 (33%)	17 (30%)	50 (32%)
Single, separated, or divorced	61 (61%)	32 (56%)	93 (59%)
Other	4 (4%)	2 (3%)	6 (4%)
Prefer not to answer/no response	2 (2%)	6 (11%)	8 (5%)
Religious affiliation			
Atheist/agnostic/no religion	32 (32%)	19 (33%)	51 (32%)
Catholic	26 (26%)	19 (33%)	45 (29%)
Muslim	19 (19%)	5 (9%)	24 (15%)
Protestant	3 (3%)	1 (2%)	4 (3%)
Jewish	--	1 (2%)	1 (1%)
Other	8 (8%)	1 (2%)	9 (5%)
Prefer not to answer/no response	12 (12%)	11 (19%)	23 (15%)

Source: data collected and compiled by authors.
*More than one answer was possible, percentages may exceed 100%.

mentioned the association.[21] Other reasons were the good reputation of the hospital/clinic, easy access and referral by a friend or family member.

The majority of the in-country travellers recruited in Paris originated from Île-de France (n=94). Their travel was easy and cheap (table 4), as most took place via public transport (74%), in contrast to 35% of cross-country travel. One in four participants who crossed the borders (23%) took an aeroplane.

In-country travellers were more often accompanied than cross-border travellers, probably due to travel costs. While in-country transport costs were low (85% spent less than €10), 48% of cross-border travellers paid between €100–299, and 7% even above €500 for transportation.

Cross-border travellers paid out of pocket for their abortion—62% of them indicated costs were above €800—and 39% needed up to a week to raise the

Table 2 Reproductive history and abortion care-seeking

	In-country travellers (n=100)	Cross-country travellers (n=57)	Total (n=157)
Number of children			
0	66 (66%)	35 (61%)	101 (64%)
1–2	23 (23%)	14 (25%)	37 (24%)
3+	--	8 (14%)	8 (5%)
Prefer not to answer/no response	11 (11%)	--	11 (7%)
Prior abortion			
Yes	34 (34%)	16 (28%)	50 (32%)
No	55 (55%)	40 (85%)	95 (60%)
Prefer not to answer/no response	11 (11%)	1 (2%)	12 (8%)
Weeks of gestation when presenting for services			
<14 weeks	99 (99%)	1 (2%)	100 (64%)
14–20 weeks	--	39 (68%)	39 (25%)
>20 weeks	--	15 (26%)	15 (9%)
Prefer not to answer/no response	1 (1%)	2 (4%)	3 (2%)
Mean weeks of gestation when presenting for services	6.7	18.4	12.5
Sought abortion elsewhere before presenting for care in hospital			
Yes	31 (31%)	40 (70%)	71 (45%)
No	69 (69%)	10 (18%)	79 (50%)
Prefer not to answer/no response	--	7 (12%)	7 (5%)
Preferred to obtain abortion earlier			
Yes	73 (73%)	52 (91%)	125 (80%)
No	24 (24%)	2 (4%)	26 (16%)
Prefer not to answer/no response	3 (3%)	3 (5%)	6 (4%)
Reasons for not being able to obtain an abortion as early as wanted *			
No delays/obtained abortion when wanted	24 (24%)	2 (4%)	26 (16%)
Delayed pregnancy recognition	32 (32%)	37 (65%)	69 (44%)
Issues with scheduling (both personal and getting an appointment at the clinic)	27 (27%)	12 (21%)	39 (25%)
Delays related to decision-making	22 (22%)	14 (25%)	36 (23%)
Delays related to local access to abortion services	25 (25%)	4 (7%)	29 (18%)
Procedural barriers including waiting periods, need for multiple approvals, or attending multiple appointments	21 (21%)	3 (5%)	24 (15%)
Delays related to a change in the situation (financial, relationship, decision-making)	13 (13%)	10 (17%)	23 (15%)
Difficulties arranging money for abortion	1 (1%)	9 (16%)	10 (6%)
Religious/moral concerns	--	8 (14%)	8 (5%)
Issues arranging travel	1 (1%)	4 (7%)	5 (3%)
Needed time to talk with partner	--	3 (5%)	3 (2%)
Others	4 (4%)	1 (2%)	5 (3%)

Source: data collected and compiled by authors.
*More than one answer was possible, percentages may exceed 100%.

necessary funds. Meanwhile, abortion procedures performed in France were free of charge, thus most in-country travellers did not need to raise funds.

Half of the respondents took time off work for the abortion consultation, with fewer in-country than cross-border travellers. Lost wages and childcare arrangements were more frequently reported among cross-border than in-country travellers.

Qualitative findings

Complementing the quantitative results, we conducted 36 qualitative in-depth interviews with French abortion travellers (23 in-country and 13 cross-border).

Exceeding the GA limit

All 13 cross-border participants confirmed that the primary travel reason was because the GA limit in

Table 3 Reasons for travelling for abortion care

	In-country travellers (n=100)	Cross-country travellers (n=57)	Total (n=157)
Primary reason for travelling			
I could not obtain an abortion at my gestational age in my department/country	3 (3%)	46 (81%)	49 (31%)
Abortion illegal in my country	--	5 (9%)	5 (3%)
Could not obtain abortion for diagnosed fetal malformation	--	1 (2%)	1 (1%)
A health provider referred me	21 (21%)	--	21 (13%)
I was concerned about the quality of abortion in my department/country	20 (20%)	--	20 (13%)
I did not know where to get an abortion/no abortion services close by	14 (14%)	--	14 (9%)
Reputation/prior knowledge of the hospital	10 (10%)	--	10 (6%)
I was worried about people seeing me/finding out	8 (8%)	--	8 (5%)
The hospital had the earliest available appointment	6 (6%)	--	6 (4%)
It is difficult to find a physician who is willing to provide care	5 (5%)	--	5 (3%)
Close proximity	4 (4%)	--	4 (2%)
Preferred abortion procedure was not available	4 (4%)	--	4 (2%)
I was worried about healthcare provider's judgement/refusal	3 (3%)	--	3 (2%)
A friend or family member referred me	2 (2%)	--	2 (1%)
Prefer not to answer/no response	--	5 (9%)	5 (3%)
Reasons for travelling to specific hospital/clinic*			
I was referred by a healthcare provider/planning familial	33 (33%)	20 (35%)	53 (34%)
It has a good reputation	31 (31%)	21 (37%)	52 (33%)
It was the easiest to get to	26 (27%)	12 (21%)	38 (24%)
I was referred by someone else (doctor, friend, family)	13 (13%)	9 (16%)	22 (14%)
It was the easiest to find online	7 (7%)	5 (9%)	12 (8%)
It was the closest one which provides abortion at my gestational age	4 (4%)	5 (9%)	9 (6%)
The cost of travelling to this hospital was the cheapest or the abortion was the cheapest	3 (3%)	5 (9%)	8 (5%)
The hospital had the earliest available appointment	4 (4%)	--	4 (2%)
Other	1 (1%)	1 (2%)	2 (1%)

Source: data collected and compiled by authors.
*More than one answer was possible, percentages may exceed 100%.

France had been exceeded.[8] For example, Shaira explained: 'In France, we have the right to terminate a pregnancy… up to fourteen weeks.' Then she added: 'When I discovered it (the pregnancy) I was at 15, and suddenly, time to make an appointment and all that, I was at 17 (weeks GA)' (Shaira, 18 years, 19 weeks GA, Netherlands, December 2018). Irregular periods and/or lack of clear pregnancy signs were the main reasons why most cross-border travellers, like Shaira, who experienced 2 days of bleeding, which was normal for her, exceeded the GA limits.

Two participants, however, could have obtained an abortion within the time limits, but travelled abroad. Elissia, a married woman and mother of two, reported: 'My doctor told me 13 weeks, talking about amenorrhoea… when I told him I was out of time, he told me 'yes', when in fact I think it's a misunderstanding between us. In any event, I would have had a hard time finding an appointment in France within the deadline, so … I went abroad' (Elissia, 33 years, 14 weeks GA, June 2018). The other interviewee, Florence (22 years, 23 weeks+ GA, UK, December 2018), experienced delays and lack of access to timely abortion care: she was at 13 plus two and could only get an appointment 1 week later, so she decided to travel abroad.

Referral

Healthcare providers and the Planning Familial frequently referred women to specific clinics abroad. Karine, for example, a medical student who travelled to the Netherlands, said: 'It was the Planning Familial that explained to us that with the delays in France it was impossible (to obtain an abortion), and they also helped us to take necessary steps' (Karine, 23 years, 22 weeks GA, Netherlands, February 2018). Referral also played an important role in in-country travel, as 19 of 23 women interviewed were referred to travel to Paris, mainly by Planning Familial staff, medical

Table 4 Travel experiences and cost

	In-country travellers (n=100)	Cross-country travellers (n=57)	Total (n=157)
Mode of transportation for travel*			
Public transport (train, bus, RER)	74 (74%)	20 (35%)	94 (60%)
Personal car	31 (31%)	23 (40%)	54 (34%)
Aeroplane	1 (1%)	13 (23%)	14 (9%)
Other (taxi, motorcycle, bike)	4 (4%)	--	4 (2%)
Prefer not to answer/no response	--	1 (2%)	1 (%)
Travelled alone			
Yes	69 (69%)	9 (16%)	78 (50%)
No	31 (31%)	45 (79%)	76 (48%)
Prefer not to answer/no response	--	3 (5%)	3 (2%)
Transport cost			
€0	36 (36%)	--	36 (23%)
€1–10	49 (49%)	--	49 (31%)
€10–49	10 (10%)	--	10 (6%)
€50–99	5 (5%)	8 (14%)	13 (8%)
€100–199	--	13 (23%)	13 (8%)
€200–299	--	14 (25%)	14 (9%)
€300–399	--	3 (5%)	3 (2%)
€400–499	--	3 (5%)	3 (2%)
>€499	--	4 (7%)	4 (3%)
Prefer not to answer/no response	--	12 (21%)	12 (8%)
Abortion cost			
€0	100 (100%)	--	100 (64%)
€500–699	--	1 (2%)	1 (1%)
€700–799	--	3 (5%)	3 (2%)
€800–899	--	25 (44%)	25 (16%)
€900–999	--	1 (2%)	1 (1%)
>€999	--	9 (16%)	9 (6%)
Prefer not to answer/no response	--	18 (32%)	18 (11%)
Time needed to cover the cost of travelling and abortion procedure			
<1 week	6 (6%)	22 (39%)	28 (18%)
1–4 weeks	--	6 (11%)	6 (4%)
4+ weeks	--	3 (5%)	3 (2%)
I didn't have to raise money	86 (86%)	10 (18%)	96 (61%)
Prefer not to answer/no response	8 (8%)	16 (38%)	24 (15%)
Difficulty covering travel costs			
Very or somewhat easy	86 (86%)	21 (37%)	107 (68%)
Very or somewhat difficult	7 (7%)	30 (53%)	37 (24%)
Prefer not to answer/no response	7 (7%)	6 (11%)	13 (8%)
Difficulty covering abortion costs			
Costs covered by French social security	100 (100%)	--	100 (64%)
Very or somewhat easy	--	13 (%)	13 (8%)
Very or somewhat difficult	--	38 (%)	38 (24%)
Prefer not to answer/no response	--	6 (11%)	6 (4%)
Overall difficulty of travelling			
Very or somewhat easy	83 (83%)	31 (54%)	114 (73%)

Continued

Table 4 Continued

	In-country travellers (n=100)	Cross-country travellers (n=57)	Total (n=157)
Very or somewhat difficult	12 (12%)	20 (35%)	32 (20%)
Prefer not to answer/no response	5 (5%)	6 (11%)	11 (7%)
Time taken off work			
Yes	44 (44%)	31 (54%)	75 (48%)
No	55 (55%)	20 (35%)	75 (48%)
Prefer not to answer/no response	1 (1%)	6 (11%)	7 (4%)
Lost wages (if time taken off work, n=75)			
Yes	15 (34%)	13 (42%)	28 (37%)
No	27 (61%)	16 (51%)	43 (57%)
Prefer not to answer/no response	2 (5%)	2 (6%)	4 (5%)
Childcare arrangements			
Yes	8 (8%)	14 (25%)	22 (14%)
No	42 (42%)	28 (49%)	70 (45%)
Prefer not to answer/no response	50 (50%)	15 (26%)	65 (41%)

Source: data collected and compiled by authors.
€1=£0.9/$1.1.
*More than one answer was possible, percentages may exceed 100%.
RER, Rapid transit system, subway.

professionals, or sometimes friends and family. Women came to Parisian hospitals to avoid long waiting periods at their local hospitals, which may lead to exceeding the legal GA limit. 'The (next available) appointments were too late. I would have surely exceeded the date, so I preferred to do it as soon as possible and here [in Paris]' (Marie, 39 years, French, 4 weeks GA, Paris, January 2020). Hence, procedural and legal barriers were the primary reasons for travel for in-country and cross-border care-seekers, respectively. The Planning Familial or medical professionals played a crucial role, by providing both groups with necessary travel information.

Costs and burdens

The major differences between the experiences of in-country versus cross-border travellers relate to the burdens and costs of the travel and the procedure. Abortion is covered by social security within France, therefore in-country travel was reported as easy and cheap. Melanie explained: 'We are next to Paris, it costs me the price of the metro ticket to come … it didn't cost me any time or money…' (Melanie, 40 years, 6 weeks GA, Paris, March 2020). Meanwhile, cross-border travel involved significant costs,[19 20] which many travellers like Jade found difficult to cover: 'It's difficult, because we had to collect the money for the operation and for the trip, and we didn't even know that we had to stay there for 3 days' (Jade, 28 years, 21 weeks GA, Spain, April 2018).

Jade, a single mother of four, unemployed, could count on friends for childcare, and on the financial support of the Planning Familial. Cross-border travellers frequently relied on the support of friends, relatives, and partners to overcome financial and logistical barriers. Karine reported: 'it was all at my expense. (The cost) of travel, or hospitalisation and medication.' Luckily, Karine could count on her partner. However, both being university students, it was difficult for them to raise the money. They finally opted for car sharing and a youth hostel because of economic constraints.

Opinions about the law

More cross-border than in-country travellers supported extending the French GA limit, and many took as a model their destination country's law. Chantal, who travelled to the Netherlands, stated, 'The law should be like… in Holland, they should extend the dates, to 22 weeks' (Chantal, 20 years, 18 weeks GA, Netherlands, May 2018). One interviewee recruited in Spain was in favour of the total elimination of GA limits. In-country travellers had mixed opinions: many agreed with the abortion law in France, but some acknowledged they might think differently when being at a more advanced pregnancy stage. 'I didn't have any problems because I did it on time, but… the question could arise if I were at 14 weeks or more' (Marie, 39 years, 4 weeks GA, Paris, January 2020). Other in-country travellers favoured prolonging the GA limit to the law as in Holland or Spain: 'I think we should also, like in Spain, allow abortion after 3 months' (Brune, 23 years, 7 weeks GA, Paris, March 2020). Overall, the interviewees considered timely and easy access to abortion a fundamental woman's right and acknowledged the need for legislation to safeguard this right.

DISCUSSION

Travelling for abortion care is a reality for many women living in France who lack access to local care because they exceed the legal GA limit or cannot access timely quality services close-by. Often they are referred by health providers to travel outside their department/country of residence. The costs of cross-border travel are much greater than in-country travel, and lead to delays that can increase health risk and costs. Delays in the second trimester are particularly problematic, because they may prevent women from obtaining an abortion even in countries with less restrictive legislations.[22]

This article expands on an understudied topic in the literature—abortion mobility or the need to travel for an abortion in settings where abortion is legal, but time-sensitive.[13] It explores the factors leading women to travel within or outside France, offering evidence for guiding legal frameworks and delivery of care in France and beyond.[23] The unevenness of abortion legislation across the EU leads women, who have the necessary information and financial means, to seek abortion in countries with more liberal abortion legislation.[24] This has discriminatory effects due to unequal access to abortion care and raises questions about the role of GA limits. The WHO takes a clear stand against laws and regulations that prohibit abortion based on GA limits because these limits may force women to resort to unsafe abortion.[22] A stronger European response in safeguarding abortion as a fundamental right is necessary, considering the recent backsliding in abortion rights in the USA and parts of Europe. To reduce travel-related burdens, which deepen existing social and gender inequalities, states should eliminate or expand GA limits, to allow women to access abortion care in their country of residence, free of charge and without delays. The recent GA extension to 14 weeks for abortions on request and efforts to enshrine abortion in the French constitution are steps in this direction. French residents forced to travel abroad should also be able to apply for cost coverage for their procedures performed in the EU. Moreover, decentralising abortion services within France, especially in Île-de-France, would improve access to timely and local care, reducing the need to come to Paris for services.

This research has limitations. While most data were collected before the COVID-19 outbreak, the pandemic forced us to pause data collection for 3 months. Fewer patients travelled for care due to COVID-19-related restrictions and the promotion of telemedicine abortion in France during the pandemic.[25] The study took place in some of the major travel destinations—private clinics abroad, and public hospitals in Paris. Future studies should further explore the differences between private and public service provision in and outside of women's countries of residence. We acknowledge that the situation in Île-de-France, where travel costs and distance are minimal, is not representative of all of France. By recruiting at travel destination sites, participants from more vulnerable socioeconomic backgrounds, for example, who could not afford to travel for abortion care, were underrepresented in the study. In particular, our findings are not generalisable to rural France, where access and referral to hospitals may be more limited.

Acknowledgements We are extremely grateful to our study participants, and the organisations and clinics that partnered with us in the development of the study, including the British Pregnancy Advisory Service (England), CASA Kliniek, Beahuis & Bloemenhove Kliniek and Rutgers (Netherlands), Clínica d'Ara, Clínica Sants and Clínica Aragon in Catalunya (Spain), and Hôpital Port Royal, Hôpital Les Bluets and Hôpital Armand-Trousseau (France). We also thank Ann-Kahtrin Ziegler, who was in charge of data collection and analysis in the Netherlands, Lieta Vivaldi, who contributed to qualitative data collection in the UK, and Allie Wollum, Camille Garnsey and Margot Cohen for their assistance during quantitative analysis.

Contributors SDZ, JM and C Garnsey planned the study, developed the methodology, and validated the findings. LR and GZ collected the data. DC, C Garnsey, and C Gerdts curated the quantitative data. LR analysed the qualitative data and wrote the original draft. SDZ and JM reviewed and edited the paper.SDZ was principal investigator and guarantor of the study.

Funding This study was funded by the European Research Council (ERC) via a Starting Grant awarded to Dr De Zordo (BAR2LEGAB, 680004), and hosted by the University of Barcelona. It was supported by the Spanish Ministerio de Economía, Industria y Competitividad through grant RYC-2015-19206.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and we obtained ethical approvals from the ERC, participating universities, and the French national authorities (N° EudraCT / ID-RCB: 2019-A01048-49). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

ORCID iDs
Laura Rahm http://orcid.org/0000-0001-9211-8919
Caitlin Gerdts http://orcid.org/0000-0002-2488-5072

REFERENCES

1 Hussein J, Cottingham J, Nowicka W, *et al*. Abortion in Poland: politics, progression and regression. *Reprod Health Matters* 2018;26:1467361.
2 Fuentes L, Lebenkoff S, White K, *et al*. Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas. *Contraception* 2016;93:292–7.
3 Barr-Walker J, Jayaweera RT, Ramirez AM, *et al*. Experiences of women who travel for abortion: a mixed methods systematic review. *PLoS ONE* 2019;14:e0209991.

4 Baum SE, White K, Hopkins K, *et al*. Women's experience obtaining abortion care in Texas after implementation of restrictive abortion laws: a qualitative study. *PLoS ONE* 2016;11:e0165048.
5 Bloomer F, O'Dowd K. Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform. *Cult Health Sex* 2014;16:366–80.
6 Ely GE, Hales TW, Jackson DL. A cross-cultural exploration of abortion fund patients in the USA and the Republic of Ireland, Northern Ireland and the Isle of Man. *Cult Health Sex* 2018;20:560–73.
7 Gilmartin M, Kennedy S. *Abortion across borders: transnational travel and access to abortion services*. Baltimore, Maryland: Johns Hopkins University Press, 2019: 123–43.
8 Kavanaugh ML, Jerman J, Frohwirth L. "It's not something you talk about really": information barriers encountered by women who travel long distances for abortion care. *Contraception* 2019;100:79–84.
9 Addante AN, Paul R, Dorsey M, *et al*. Differences in financial and social burdens experienced by patients traveling for abortion care. *Womens Health Issues* 2021;31:426–31.
10 Kimport K. Reducing the burdens of forced abortion travel: referrals, financial and emotional support, and opportunities for positive experiences in traveling for third-trimester abortion care. *Soc Sci Med* 2022;293:114667.
11 Sethna C, Doull M. Spatial disparities and travel to freestanding abortion clinics in Canada. *Women's Studies International Forum* 2013;38:52–62.
12 Gerdts C, DeZordo S, Mishtal J, *et al*. Experiences of women who travel to England for abortions: an exploratory pilot study. *Eur J Contracept Reprod Health Care* 2016;21:401–7.
13 De Zordo S, Zanini G, Mishtal J, *et al*. Gestational age limits for abortion and cross-border reproductive care in Europe: a mixed-methods study. *BJOG* 2021;128:838–45.
14 Faucher P. *Une sur trois*. Paris: Robert Laffont, 2021.
15 DGOS. *Accès à l'IVG*. Paris: Ministère des Solidarités et de la Santé, 2019.
16 HCEFH. *Rapport relatif à l'accès à l'IVG. volet 2:accès à l'IVG dans les territoires*. Paris: Haut Conseil à l'égalité entre les femmes et les hommes, 2013.
17 Roman D, Rixain M-P, Sehier V, *et al*. Parachever la loi veil 46 ANS après. *Journal Du Droit de La Santé et de l'Assurance - Maladie (JDSAM)* 2021;N° 28:38–45.
18 French Government. *LOI n° 2022-295 du 2 mars 2022 visant à renforcer le droit à l'avortement (1)*. 2022.
19 Garnsey C, Zanini G, De Zordo S, *et al*. Cross-country abortion travel to England and Wales: results from a cross-sectional survey exploring people's experiences crossing borders to obtain care. *Reprod Health* 2021;18:103.
20 Wollum A, De Zordo S, Zanini G, *et al*. n.d. Systemic barriers and delays in access to abortion care: a cross-sectional study of travel to obtain care in England and the Netherlands from European countries where abortion is legal on broad grounds. *Perspect Sex Reprod Health*
21 Zanini G, Mishtal J, De Zordo S, *et al*. Abortion information governance and women's travels across European borders. *Women's Studies International Forum* 2021;87:102496.
22 WHO. *Abortion care guideline*. Geneva: World Health Organization, 2022.
23 Rahm L, De Zordo S, Mishtal J, *et al*. Inter-departmental abortion travels in metropolitan France: a mixed-methods analysis of women's experiences, access, and barriers to abortion care. *PLoS ONE* 2022;17:e0273190.
24 De Zordo S, Mishtal J, Anton L, eds. *A fragmented landscape: abortion governance and protest logics in Europe*. New York: Berghahn, 2017.
25 Moreau C, Shankar M, Glasier A, *et al*. Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses. *BMJ Sex Reprod Health* 2021;47:e14.