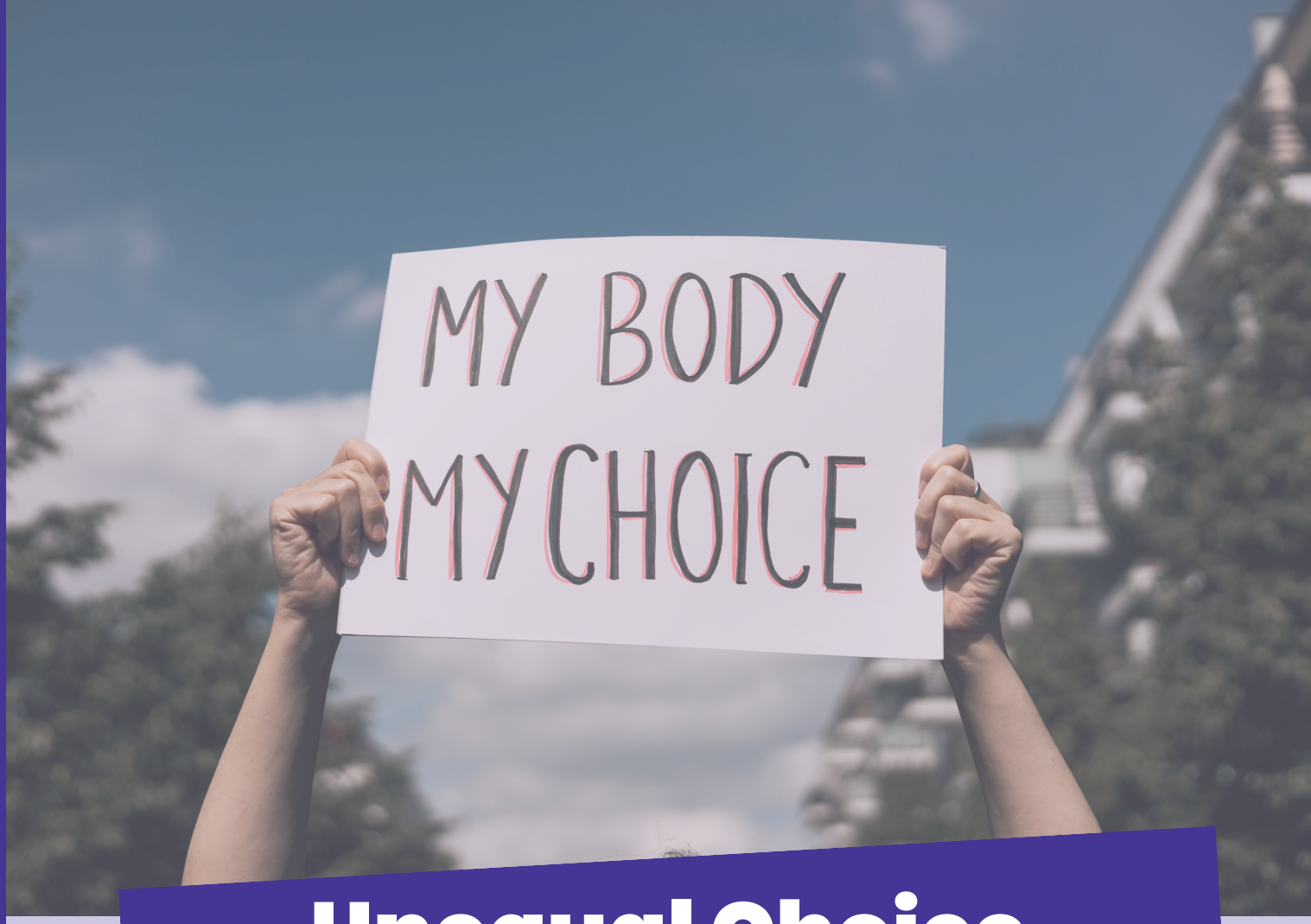


# Unequal Choice

## Abortion Access and Women's Autonomy Across Europe

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**Unequal Choice: Abortion Access and Women's Autonomy Across Europe**

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# Table of Contents

# 1. Introduction



The World Health Organization (WHO) defines reproductive health as a condition of complete physical, mental and social well-being - not simply the absence of disease or infirmity - in all matters related to the reproductive system, its functions and processes.[1] Free enjoyment of Reproductive rights is how women exercise their human rights, without experiencing coercion, pressure or violence. At its core, reproductive autonomy is built on three essential elements: the authority to make decisions about sexual relations, pregnancy, and childbirth; freedom from reproductive coercion or forced choices; and the ability to express and communicate decisions openly without restriction or fear.[2] Including whether to have children, how many to have and the spacing between births. These rights encompass access to comprehensive reproductive healthcare services, such as prenatal care, safe childbirth, and contraception.[3] They also extend to the availability of legal and safe abortion services, ensuring that reproductive choices can be exercised in practice rather than merely recognized in principle.[4]

Today, in 2026, abortion and women's autonomy over their own bodies still remain subjects of continuous political and legal debate. Despite decades of legal development, women in many parts of Europe continuously face limitations in making independent decisions regarding their reproductive health. In practice, they remain subject to legal frameworks and regulatory structures that often restrict rather than facilitate full bodily autonomy.[5]

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9930478/No Madam and damaged my god
[2] Thakar R, Ghandi M, Reproductive Autonomy: Women's Health and Rights, https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.18124.
[3] https://www.hrw.org/topic/womens-rights/reproductive-rights
[4] Ibid.
[5] Later discussed state interference under the title 'Privacy and bodily autonomy (No unnecessary state interference)'.

# 1 Introduction

Legal abortion remains a highly sensitive issue. There is no consensus among EU Member States and the regulation of abortion falls primarily within national competence. As a result, states rely on their margin of appreciation to define their own legal standards, procedures and conditions. These approaches vary significantly across the European Union. Consequently, women's access to abortion largely depends on their nationality and place of residence - in some Member States, women can access legal abortion services relatively easily, while in others, they face substantial legal, procedural, financial, or geographic barriers, limiting the effective exercise of their right to private life and personal autonomy.

This report examines what constitutes abortion in legal and medical terms, under what conditions it is permitted within EU Member States and whether legal recognition translates into tangible and effective access to safe abortion services in practice. It will further analyse selected case studies from specific countries in order to illustrate the implementation gap between law and practice. Based on these findings, the report proposes policy recommendations that aim to strengthen effective access and ensure a more consistent protection of reproductive rights across the European Union.

# 2. Conceptual Framework

## a. Defining Abortion and the Limits of Formal Legal Recognition



In order to understand what abortion means, it is necessary to provide a clear legal and medical definition. Comprehensive abortion care has been recognised by the World Health Organization (WHO) as an essential component of healthcare services since 2020 and therefore, abortion is considered a safe and effective medical procedure that can be provided by trained healthcare professionals through either medication or minor surgical methods.[6] During the first 12 weeks of pregnancy, medical abortion may also be safely self-managed outside a clinical setting, including at home, either fully or partially.[7] This, however, requires access to reliable information, quality-assured medication, and the availability of professional medical support should the woman require or choose to seek assistance during the process.[8] International law generally frames abortion rights in terms of access to "safe and legal abortion."[9] Abortion rights discourse has traditionally focused on the legal grounds under which abortion is permitted and the extent to which individuals can access services within those legal frameworks.[10]

However, even where abortion is legally guaranteed by the state, this does not necessarily mean that it is effectively accessible in practice. In such circumstances, states have positive obligations to create the conditions necessary for the provision of abortion services - this includes establishing adequately equipped clinics, training physicians and healthcare professionals, adopting appropriate licensing frameworks,

[6] https://www.who.int/news-room/fact-sheets/detail/abortion
[7] ibid
[8] ibid
[9] https://pmc.ncbi.nlm.nih.gov/articles/PMC9760240/#ref7
[10] Erdman JN, Cook RJ. Decriminalization of abortion – A human rights imperative. Best practice and research. [September 10th 2022];Clinical Obstetrics and Gynaecology. 2020 62:11–24. doi: 10.1016/j.bpobgyn.2019.05.004. [DOI] [PubMed] [Google Scholar]

and ensuring the availability of essential medicines and medical equipment.[11] The critical issue is whether the law is effectively implemented in practice and whether individuals are able to exercise their abortion rights in a tangible and meaningful way.

## b. When Legal Rights Do Not Translate into Effective Access



On paper, abortion is broadly accessible across much of Europe; however, notable exceptions remain.[12] Over the past decade, significant progress has been made in advancing abortion rights across Europe, as several countries have reformed their laws - albeit gradually - to better align with international human rights standards, thereby expanding access to abortion care for millions of women, girls and people who can become pregnant.[13]

Notably, significant progress has been made in several European countries. (Ireland has repealed its near-total abortion ban, marking a major shift in its constitutional framework, while France has recently enshrined abortion as a guaranteed freedom in its constitution. These reforms reflect a broader recognition of reproductive autonomy as a fundamental right and an essential component of healthcare across parts of Europe.)[14] However, legal reforms alone do not fully capture the reality of abortion access, which remains uneven and often restricted in practice.[15] Access to such care is increasingly constrained by a range of structural, legal and institutional barriers.[16] Government-imposed restrictions at various levels, limitations on insurance coverage, funding constraints affecting medical training and policies adopted by hospitals and healthcare systems all contribute to narrowing the availability of abortion services: these restrictions are further compounded by social stigma, acts of intimidation or violence against healthcare providers and the resulting decline in the

[11] Erdman , J. N Access to information on safe abortion: A harm reduction and human rights approach. Harvard Journal of Law and Gender. 2011;34(2):413–462.
[12] Amnesty International
[13] When rights are not real for all-Amnesty international, pg 3
[14] ibid
[15] ibid
[16] https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion

number of professionals willing or able to offer abortion care.[17] Such legislative restrictions significantly disrupt the patient–provider relationship and undermine the delivery of timely medical care.[18]

When timely and safe abortion services are unavailable, women and girls are often driven to seek unsafe alternatives. An unsafe abortion occurs when a pregnancy is terminated by someone lacking the necessary skills or in an environment that does not meet minimum medical standards — or both. Globally, a significant proportion of abortions are unsafe, contributing substantially to preventable maternal deaths each year. Restricting access does not eliminate abortion; rather, it increases health risks and endangers lives.



## c. Comparative Abortion Regimes in the EU and Their Human Rights Implications

In the EU context, access to abortion can broadly be categorised into four regulatory models. First, and most common among European countries, abortion is allowed on request within defined gestational limits. Under this model, the pregnant person is not required to justify the decision to terminate the pregnancy, provided the procedure takes place within the legally established timeframe. In Europe, most countries allow abortion on request during early pregnancy, with legal limits typically falling somewhere between 10 and 14 weeks of pregnancy. Some countries' time limits run from the last menstrual period (LMP) whereas others start at conception (Denmark, Norway and Sweden permit abortion on request up to 18 weeks, Iceland up to 22 weeks, and the Netherlands between 22 and 24 weeks).[19]

Secondly, in some countries abortion is permitted on broader social or economic grounds. Countries such as Great Britain, Italy, Hungary, the Netherlands, and

[17] https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion
[18] ibid
[19]Center for Reproductive rights, Europe Abortion Laws 2025, at https://reproductiverights.org/wp-content/uploads/2025/10/Europe-Abortion-Laws-2025-1.pdf.

Switzerland follow this approach, whereby abortion is legally accessible but requires justification based on social or economic circumstances. A useful illustration of this model can be found in Great Britain under the Abortion Act 1967,[20] which permits abortion up to 24 weeks where two registered doctors agree that continuing the pregnancy would pose a greater risk to the physical or mental health of the woman or her existing children than termination. In practice, this allows for a broad interpretation of risk, encompassing factors such as financial hardship, unstable living conditions, or disruption to education or employment.

This interpretation was established in R v Smith (John)[21] where the court confirmed that doctors may take into account a woman's social and economic circumstances when assessing risks, provided they act in good faith. The continuing authority of this principle can be seen in R (on the application of BPAS) v Secretary of State for Health,[22] where the courts adopted a purposive interpretation of the Abortion Act and reaffirmed the central role of clinical judgment. Together, these cases demonstrate how social and economic considerations remain embedded within the legal framework while maintaining formal medical oversight.

In contrast, highly restrictive abortion regimes persist in several European jurisdictions, where termination of pregnancy is permitted only under narrowly defined grounds, such as risk to life or serious health impairment. Such frameworks remain in countries including Liechtenstein, Faroe Islands, Malta, Monaco, and Poland. Poland in particular illustrates the gap that can emerge between formal legal exceptions and their practical implementation.

Although Polish law permits abortion where a woman's life or health is at risk, the restrictive legal climate has repeatedly resulted in delayed or denied care. The case of Lela, a Georgian woman hospitalized in Olsztyn at 15 weeks' pregnancy, exemplifies

[20] The Abortion Act 1967 (1967 c. 87).
[21] R v Smith (John)[1974] QB 354.
[22] R (on the application of BPAS) v Secretary of State for Health 2011; [2011] EWHC 235.

this dynamic. Suffering from type 1 diabetes and multiple serious complications exacerbated by pregnancy, including vomiting blood, physical deterioration, and inability to eat, she repeatedly requested a medically indicated abortion.[23] Despite documented health risks and her clear, consistent refusal to continue the pregnancy, care was delayed for weeks. Her situation underscores how restrictive legal frameworks, even when they contain health exceptions, still are not fulfilled leading to institutional hesitation that places women's lives at risk.



Finally, a total ban on abortion exists in Andorra, where abortion is prohibited under all circumstances.[24] A comprehensive cross-border journalistic investigation conducted in 2024 revealed that more than 5,000 pregnant individuals are forced each year to travel abroad to obtain abortion care, as a result of the barriers and restrictions they encounter in accessing services within their own countries.[25]

Laws that criminalise or unduly restrict access to abortion infringe upon a broad spectrum of human rights, including the right to life, the right to the highest attainable standard of physical and mental health - encompassing sexual and reproductive health - the rights to equality and non-discrimination, the right to privacy, equal protection before the law, and the right to be free from torture or other cruel, inhuman, or degrading treatment.[26] Violations of women's sexual and reproductive health and rights, including forced abortion, the criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, and the abuse or mistreatment of women, girls, and other pregnant individuals seeking sexual and reproductive health services, constitute forms of gender-based violence

[23] Case of Georgian woman in Poland at https://sign.myvoice-mychoice.org/forms/solidarity-with-lela-eng
[24] Amnesty International
[25] See "Exporting Abortion", 2025, available at https://exportingabortion.com/ The journalists involved conducted research in 11 countries: Andorra, Czech Republic, France, Germany, Ireland, Malta, Netherlands, Poland, Portugal, Slovakia and Spain. They collected data between 2019 and 2023.

[26] Amnesty International, Amnesty International's Policy on Abortion (Index: POL 30/2846/2020), 28 September 2020, (previously cited) section 2

and,[27] in certain circumstances, may amount to torture or other forms of cruel, inhuman, or degrading treatment.[28]

### d. Privacy and bodily autonomy (no unnecessary state interference)



Privacy and bodily autonomy require that the State refrain from unnecessary interference in decisions concerning reproduction. Equality in reproductive healthcare demands non-discriminatory access to affordable, high-quality services, including contraception and emergency contraception. Achieving substantive equality may require acknowledging biological differences and responding appropriately to women's specific health needs.[29]

State interference in reproductive healthcare can have profound consequences. For example, in M.L. v. Poland, the Polish Constitutional Court's 2020 ruling effectively introduced a near-total ban on abortion. The applicant, who was legally entitled to an abortion on the basis of fetal abnormalities, was prevented from accessing the procedure in Poland and had to travel abroad for care. She alleged violations of her rights under Articles 8, 3, and 6 of the European Convention on Human Rights, including interference with her private life, psychological suffering, and lack of fair legal safeguards. On 14 December 2023, the European Court of Human Rights found a violation of Article 8, emphasising that irregularities in the appointment of judges undermined the legitimacy of the Constitutional Court and deprived the applicant of proper safeguards against arbitrariness. While the Court did not find a violation of

[27] CEDAW, General Recommendation 35 on gender-based violence against women, updating General Recommendation 19, UN Doc. CEDAW/C/GC/35 (2017). See also CEDAW, Inquiry concerning Poland under article 8 of the Optional Protocol to the Convention
on the Elimination of All Forms of Discrimination against Women, Report of the Committee, UN Doc. CEDAW/C/POL/IR/1 (2024)
[28] CEDAW, General Recommendation 35 (on gender-based violence), UN Doc. CEDAW/C/GC/35, 2017, para. 18; CAT, Concluding Observations: Poland, 29 August 2019, U.N.Doc. CAT/C/POL/CO/7, paras. 33(d), 34(e); CAT, Concluding Observations: United Kingdom of Great Britain and Northern Ireland, 7 June 2019, UN Doc. CAT/C/GBR/CO/6 paras. 46 and 47
[29] Ibid.

Article 3, the ruling reinforced that abortion restrictions must comply with rule of law standards and respect privacy, dignity, and access to healthcare.[30]

Comparative constitutional developments further illustrate how protections of privacy and liberty shape reproductive autonomy. In Dobbs v. Jackson Women's Health Organization, the Supreme Court of the United States overturned nearly five decades of precedent established by Roe v. Wade, holding that the U.S. Constitution does not confer a right to abortion. Earlier jurisprudence had grounded reproductive decision-making in constitutional protections of privacy and liberty under the Fourteenth Amendment, recognising decisions about childbearing as central to personal autonomy. The reversal of this precedent has generated significant debate about the scope of constitutional guarantees against state interference, particularly the protections of liberty and equal protection under the Fourteenth Amendment. Critics argue that removing constitutional protection for abortion risks deepening sex, race, and economic inequalities and undermines bodily autonomy and equal citizenship.



These developments highlight that reproductive autonomy is not merely a question of healthcare regulation, but one of constitutional principle, equality, and the limits of state power. Legal frameworks must therefore ensure that restrictions meet standards of legality, proportionality, and non-discrimination, and that courts remain effective guardians of privacy, dignity, and equal protection, particularly where state interference restricts access to essential reproductive healthcare.[31]

[30]European Network of National Human Rights Insitutions detailing violataions at https://ennhri.org/news-and-blog/european-court-of-human-rights-issues-landmark-judgment-on-access-to-abortion-and-rule-of-law-in-poland/.
[31]The Constitutional Right to Reproductive Autonomy: Realizing the Promise of the 14th Amendment, https://reproductiverights.org/resources/the-constitutional-right-to-reproductive-autonomy-realizing-the-promise-of-the-14th-amendment/.

## e. EU-Level Competences and Democratic Action in Reproductive Rights



At the core of the European Union's constitutional framework is the principle of conferral, enshrined in Article 5 of the Treaty on European Union (TEU), this principle establishes that the Union may exercise only those competences explicitly granted to it by the Treaties, with all remaining powers reserved to the Member States.[32] By limiting the Union's competences in this manner, the principle of conferral preserves national sovereignty and prevents the EU from developing into a federal entity with autonomous authority.

This tension is particularly evident in the field of reproductive rights, where differing national legal frameworks intersect - and at times conflict - with the European Union's broader commitment to the protection of fundamental rights.[33] As already discussed in this report, EU Member States remain highly divided in their approaches to abortion law, making it difficult for the Union to establish a binding framework or adopt directives that explicitly require Member States to implement specific rules on abortion. This limitation was reflected early in SPUC v Grogan,[34] where the Court of Justice recognised that while abortion could constitute a "service" within the meaning of EU law, the regulation of its provision ultimately remains within the competence of Member States.

As demonstrated, such harmonisation is politically and legally unlikely. However, the EU nevertheless possesses legal and policy instruments through which it can promote the full enjoyment of reproductive rights and strengthen women's effective access to abortion within the scope of its competences, particularly through its supporting role in public health under Article 168 TFEU,[35] its equality mandate, and the operation of internal market principles as developed in the Court's case law. In particular, cases

[32] Treaty on European Union, Art. 5
[33] https://reproductiverights.org/regions/europe/
[34] Case C-159/90, Society for the Protection of Unborn Children Ireland Ltd v Stephen Grogan and others.
[35]

such as Kohll v Union des Caisses de Maladie[36] confirm that medical services fall within the scope of free movement, enabling individuals to travel across borders to access healthcare, including abortion services, in jurisdictions where it is legally available. In this way, EU law does not harmonise abortion rules but facilitates practical access across Member States.

## 2 Conceptual Framework

Although the EU does not possess direct competence to harmonise reproductive rights across Member States, its institutions - including the European Parliament, the Court of Justice, and the European Commission - are increasingly shaping the field through indirect yet influential mechanisms.[37] Through parliamentary resolutions, judicial interpretation, and policy initiatives such as the European Commission's Roadmap for Women's Rights (March 2025), which integrates sexual and reproductive health and rights into its long-term gender equality agenda, these bodies are gradually expanding the Union's normative and political engagement in reproductive matters.[38] Rather than establishing a fixed regulatory framework, this development reflects the emergence of a dynamic process of institutional evolution, in which legal interpretation, policy innovation, and contestation with organised counter-movements progressively reshape the practical boundaries of EU involvement in reproductive rights.[39]

[36] Kohll v Union des Caisses de Maladie (Case C-158/96).
[37] https://www.humanrightsresearch.org/post/autonomous-integration-and-reproductive-rights-in-the-european-union
[38] ibid
[39] ibid

# 3. Public Health Consequences of Restricted Access

## Illegal Abortion: Outcomes and Prevention



In many countries, restrictive policies either significantly limit or effectively obstruct access to appropriate abortion services[40]. There is little evidence to indicate that countries or jurisdictions with abortion bans or highly restrictive laws experience lower abortion rates.[41] On the contrary, modelling studies examining pregnancy intentions and abortion trends from the 1990s to 2019 suggest that the proportion of unintended pregnancies ending in abortion remains broadly similar regardless of the legal status of abortion, while unintended pregnancy rates tend to be higher in countries with more restrictive abortion laws.[42]

Abortion is generally recognised as a low-risk medical procedure. However, abortion-related deaths predominantly occur in contexts where unsafe practices are used and are estimated to account for approximately 8% (95% uncertainty interval: 4.7–13.2%) of maternal deaths worldwide, [43] placing them among the leading direct causes of maternal mortality alongside haemorrhage, hypertension, and sepsis.[44] Such abortions are frequently carried out by individuals lacking appropriate medical training or involve unsafe and potentially harmful methods.[45] Consequently, in countries with restrictive abortion laws, a significant proportion of abortions are

[40] Center for Reproductive Rights. The World's Abortion Laws [Internet]. New York (NY): Center for Reproductive Rights; c1992–2022. [cited June 30, 2022]. Available from: https://reproductiverights.org/maps/worlds-abortion-laws/[Google Scholar]
[41] https://pmc.ncbi.nlm.nih.gov/articles/PMC9321431/#pmed.1004075.ref005
[42] Bearak J, Popinchalk A, Ganatra B, Moller A, Tuncalp O, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. Lancet Glob Health. 2020;10(8): E1152–1161. doi: 10.1016/S2214-109X(20)30315-6
[43] Say L, Chou D, Gemmill A, Tuncalp O, Moller A, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health. 2014;2(6): E323–333. doi: 10.1016/S2214-109X(14)70227-X [DOI] [PubMed] [Google Scholar]
[44] https://pmc.ncbi.nlm.nih.gov/articles/PMC9321431/#pmed.1004075.ref004
[45] ibid

classified as unsafe, which may contribute to increased maternal morbidity and mortality.[46]

3

Public Health Consequences of Restricted Access

The human rights implications of such restrictions have been repeatedly recognised in international jurisprudence. In A, B and C v Ireland, the European Court of Human Rights held that restrictive abortion frameworks must not create barriers that effectively deny women access to lawful services, particularly where their health is at risk. Similarly, in Tysiąc v Poland, the Court found that the failure to provide effective procedures for accessing a lawful abortion constituted a violation of the applicant's rights, highlighting how legal restrictions combined with procedural barriers can endanger women's health. These cases demonstrate that the absence of effective access mechanisms can transform formal legal rights into illusory protections.

A study covering 162 countries found that maternal mortality rates tend to be lower in jurisdictions with more liberal abortion laws, [47] indicating that restrictive changes to abortion policies may have serious implications for maternal health outcomes. This reinforces the legal findings that denial or delay of access to safe abortion services can have life-threatening consequences.

As previously mentioned, the World Health Organization (WHO)'s right-based reproductive health programs include guidelines that give the whole picture of abortion care. It is emphasized that ensuring universal access to comprehensive abortion care requires coordinated action at the legal, healthcare system, and community levels. [48] The social and institutional environment in which a person lives strongly affects both their ability to obtain care and their overall health outcomes.

[46] Ganatra B, Gerdts C, Rossier C, Johnson B, Tuncalp O, Assifi A, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. Lancet. 2017;390(10110): 2372–2381. doi: 10.1016/S0140-6736(17)31794-4 [DOI] [PMC free article] [PubMed] [Google Scholar]
[47] Latt S, Milner A, and Kavanagh A. Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries. BMC Womens Health. 2019;19(1). doi: 10.1186/s12905-018-0705-y [DOI] [PMC free article] [PubMed] [Google Scholar]
[48] Abortion care guidelines, WHO, 2022

Creating an enabling environment is therefore essential for delivering high-quality abortion services.[49] Such an environment is built upon three key pillars:

1. Respect for human rights supported by appropriate laws and policies,
2. Accessible and reliable information, and
3. A supportive, affordable, inclusive, and well-functioning healthcare system that is available to everyone.[50]

3

Public Health Consequences of Restricted Access

Access to information is a critical component of this framework. In Open Door and Dublin Well Woman v Ireland,[51] The European Court of Human Rights held that restrictions on providing information about abortion services abroad violated the right to freedom of expression. The case illustrates how limiting access to information can directly obstruct individuals from obtaining safe and lawful abortion care, thereby exacerbating health risks associated with unsafe procedures.

To meet these standards, two types of abortion-related information should be provided: first, general information intended for the public, and second, individualized information tailored to the specific needs of a person seeking abortion care, which forms the basis for free and informed consent. [52] States parties are required to guarantee that all individuals have the right to access accurate, impartial, and evidence-based information on sexual and reproductive health (SRH) in connection with their obligation to reduce maternal mortality and morbidity, states must also provide comprehensive, non-discriminatory, scientifically reliable, and age-appropriate education on sexuality and reproduction, including information related to abortion, both within formal education systems and in broader community settings and Furthermore, states must ensure that comprehensive sexuality education (CSE) is accessible to minors without requiring parental or guardian consent.[53] Within an

[49] ibid
[50] ibid
[51] Well Woman v Ireland 1992.
[52] Abortion care guidelines, WHO, 2022
[53] Ibid.

enabling environment, individuals should be equipped with all necessary information to make informed decisions regarding contraception and reproductive health, including guidance on where and how to obtain abortion or contraceptive services, the associated costs, and the applicable legal framework.

# 3

## Public Health Consequences of Restricted Access

# 4. Policy and Governance Solutions: Two Sides of One Coin

## 1. Reproductive Autonomy (Right to Decide)



International human rights bodies have increasingly emphasized that states should allow women to terminate a pregnancy upon request, particularly during the early stages of pregnancy, such as the first trimester.[54] There have also been strong calls for the decriminalization of abortion and the repeal of restrictive laws that prioritize societal or state interests over a woman's life, health, and fundamental rights. Criminal penalties imposed on women or medical service providers for terminating a pregnancy undermine protections recognized under instruments such as the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights.

This position has been reinforced in international jurisprudence. In Mellet v Ireland,[55] The UN Human Rights Committee found that Ireland's restrictive abortion laws subjected a woman to cruel, inhuman, and degrading treatment when she was forced to travel abroad to terminate a non-viable pregnancy. Similarly, in Whelan v Ireland,[56] The Committee reiterated that denial of access to abortion services in cases of fatal fetal abnormality violated fundamental rights, including dignity and freedom from inhuman treatment. These cases highlight that criminalisation and restrictive legal frameworks are not merely policy choices but can constitute serious human rights violations.

When timely and safe abortion services are unavailable, women and girls are often driven to seek unsafe alternatives. An unsafe abortion occurs when a pregnancy is terminated by someone lacking the necessary skills or in an environment that does

[54] Written Contribution to the Human Rights Committee, Draft General Comment 36 on Article 6 (Right to Life) – Call for Comments.
[55] Mellet v Ireland 2016.
[56] Whelan v Ireland 2017.

not meet minimum medical standards or both. Globally, a significant proportion of abortions are unsafe, contributing substantially to preventable maternal deaths each year. Restricting access does not eliminate abortion; rather, it increases health risks and endangers lives.

4

Policy and Governance Solutions

## 2. Support for Parenthood (Rights to Continue Pregnancy)

Ensuring reproductive autonomy also requires that services be financially accessible. Non-discriminatory health insurance coverage and affordable healthcare provision are essential components of equality in reproductive health. Socio-economic conditions play a decisive role in shaping access to services. Women from lower-income backgrounds often face structural obstacles, including lack of insurance, financial insecurity, inadequate transportation, lower levels of education, and limited access to reliable health information.[57] These factors can delay or prevent access to abortion and contraception services.

The importance of effective and accessible healthcare systems has been recognised in cases such as Tysiąc v Poland,[58] where the European Court of Human Rights held that the absence of accessible procedures to obtain a lawful abortion violated the applicant's rights. The Court emphasised that legal entitlements must be supported by practical and effective access mechanisms, including affordability and timely care.

Economic inequality deepens existing health disparities. Women in disadvantaged communities are more likely to experience unintended pregnancies and less likely to receive timely, high-quality care.[59] Financial constraints frequently make it difficult to attend medical appointments, afford prescribed methods, or travel to clinics, particularly where services are geographically centralized or limited.

[57] Guttmacher, Pregnancy Trends in the United States at, https://www.guttmacher.org/fact-sheet/pregnancy-trends-united-states.
[58] Tysiąc v Poland 2007.
[59] Guttmacher, Pregnancy Trends in the United States at, https://www.guttmacher.org/fact-sheet/pregnancy-trends-united-states.

# 5. Structural Inequality Effects - Legal and Systemic Barriers to Abortion Access



## 1. Migrants

Another important and problematic aspect is that access to abortion may differ even among women themselves. Migrants, low-income individuals, and minors may face significantly higher barriers simply because they belong to marginalized groups. Abortion access should not be a privilege; however, in many cases, this unfortunately remains the reality.

Migrant and refugee women often avoid seeking prenatal and maternal health services due to fear of being reported to immigration authorities, unclear entitlement rules, and complex administrative procedures. Similarly, socioeconomically vulnerable native women may refrain from accessing care due to fear of state intervention in their personal or family life. Additional barriers include limited knowledge of the healthcare system, language and communication difficulties, financial constraints (including user fees), and insufficient cultural competence within health services. Social stigma and cultural pressures further discourage women from engaging with formal care systems, leading many to rely on self-care or emergency services instead of preventive and continuous maternal care.

The Hirsi Jamaa and Others v. Italy case provides a striking analogue: the European Court of Human Rights found that irregular migrants intercepted at sea were unlawfully returned to Libya without individual assessment, violating Articles 3, 4, and 13 of the ECHR. Crucially, the Court emphasised that the risk of ill-treatment and lack

of procedural safeguards alone was sufficient to constitute a rights violation, regardless of whether physical harm occurred. Similarly, the fear of immigration enforcement or punitive state measures can act as a deterrent to accessing reproductive and maternal healthcare, effectively limiting autonomy and creating inequities in care access. Just as Hirsi highlighted the importance of accessible remedies and safeguards to protect vulnerable populations, ensuring clear entitlements, procedural transparency, and protection from state interference is critical to guarantee that all women can exercise their reproductive rights safely and without fear.[60]

## 2. Minors

Another significant barrier is the importance of third-party authorization requirements. Mandatory parental consent or notification are associated with significant delays and can expose minors to interpersonal violence, reproductive coercion, or family disharmony.

Evidence indicates that adolescents and women often attempt to circumvent parental or spousal authorization requirements in order to avoid anticipated consequences such as violence, reproductive coercion, or family conflict. [61] Several studies used the terms "parental notification" or "parental involvement" rather than "parental authorization"; however, these concepts frequently include requirements that mandate disclosure of a minor's intention to seek an abortion, thereby creating opportunities for parental refusal or veto. Collectively, the findings reinforce a clear association between mandated parental involvement, including authorization policies, and increased barriers to abortion access, such as delays in obtaining care, continuation of unwanted pregnancies, fear of interpersonal violence or exploitation,

[60] Strasbourg Observer: Interception-at-sea : Illegal as currently practiced- Hirsi and Others V Italy at https://strasbourgobservers.com/2012/03/01/interception-at-sea-illegal-as-currently-practiced-hirsi-and-others-v-italy/#:~:text=Hirsi%20Jamaa%20and%20Others%20v,migration%20policy%20to%20be%20revised.
[61] Abortion care guidelines, WHO, 2022

experiences of reproductive coercion, family disharmony, and a greater likelihood of resorting to unsafe abortion methods.[62]

The importance of respecting minors' autonomy and confidentiality in healthcare decision-making has been emphasised in Gillick v West Norfolk and Wisbech Area Health Authority,[63] where the court recognised that minors may possess sufficient maturity to make decisions regarding their own medical treatment. This principle has been applied in the context of abortion access, highlighting that mandatory parental involvement may undermine minors' ability to obtain timely, safe, and confidential care. Furthermore, the UN Committee on the Rights of the Child has consistently recommended that states remove barriers that require parental authorization for sexual and reproductive health services, emphasising that adolescents have the right to access information and healthcare free from coercion or undue interference.



Integrating these findings and legal principles underscores that third-party authorization requirements can create serious risks for minors' health, autonomy, and safety. Policies that mandate parental consent or notification should therefore be carefully reconsidered to ensure that minors can exercise their reproductive rights without fear, delay, or harm.

## 3. Low- income

Women with limited financial resources face distinct barriers to abortion access. Costs associated with the procedure, travel, and childcare can make timely access impossible, particularly for those already balancing employment and caregiving responsibilities. Mandatory waiting periods and multiple clinic visits disproportionately affect low-income women, sometimes forcing them to continue unwanted pregnancies or seek unsafe alternatives. Limited knowledge of healthcare systems and insufficient local services further compound these challenges.

[62] Ibid
[63] Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112; [1985] 3 All ER 402.

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Structural Inequality Effects

The European Court of Human Rights has increasingly recognised that socio-economic barriers can undermine the effective enjoyment of healthcare rights. In Sentges v Netherlands,[64] The Court acknowledged that while states retain discretion in allocating healthcare resources, they must ensure that access to essential medical services is not rendered ineffective in practice. Although not an abortion case, its reasoning is directly applicable: where financial or structural barriers make access to lawful medical services unattainable, rights risk becoming purely theoretical.

Beyond direct financial barriers, systemic factors such as conscientious objection by providers, weak regulatory oversight, and unclear legal frameworks disproportionately affect low-income women, especially in rural or underserved areas where health alternatives are scarce. These structural inequities demonstrate that income, rather than medical need, too often determines whether a woman can access reproductive care. Addressing these disparities requires both financial support and systemic reforms to ensure equitable access for all.

## 4. Systemic Barriers Affecting All Groups

In some cases, healthcare providers invoke conscientious objection to refuse abortion services within the public health sector while simultaneously offering the same services for payment in private practice, thereby creating inequitable access to care.[65] Research shows that the impact of conscientious objection is especially pronounced in rural and underserved areas, where even limited refusal can significantly restrict or eliminate access to services.[66] These barriers are further intensified in settings where abortion laws have recently changed and there is insufficient clarity regarding the scope of permissible objections, where regulatory oversight is weak, or where objecting providers refuse to offer referrals, provide biased counselling, or disseminate inaccurate legal or medical information. In such contexts, conscientious

[64] Sentges v Netherlands 2003
[65] Abortion care guidelines, WHO, 2022.
[66] ibid

objection functions not only as an individual ethical stance but also as a systemic barrier that disproportionately affects populations with fewer healthcare alternatives.

The need for effective regulatory frameworks has been emphasised in R.R. v Poland,[67] where the European Court of Human Rights held that denial of timely and accurate medical services, compounded by systemic failures and lack of clear procedures, violated the applicant's rights. The case demonstrates that states must not only permit access in law but must also organise their healthcare systems in a way that ensures services are genuinely available in practice. This principle is particularly relevant in the context of conscientious objection, where inadequate regulation can result in de facto denial of care.

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Structural Inequality Effects

The available evidence indicates that mandatory waiting periods imposed prior to abortion procedures significantly increase both the financial and logistical costs associated with accessing abortion services, and in some cases may render abortion effectively unattainable. The importance of timely access to medical care has also been recognised in P. and S. v Poland,[68] where the Court found that delays, misinformation, and administrative obstacles imposed on a minor seeking a lawful abortion constituted a violation of her rights. The case highlights how procedural requirements, such as delays or multiple steps can operate as substantive barriers to access.

These requirements can result in the continuation of pregnancy against the expressed wishes of the individual seeking care, with particularly disproportionate impacts on individuals with limited economic resources, adolescents and younger women, members of racial or ethnic minority groups, and those required to travel long distances to reach abortion providers. Research consistently demonstrates that

[67] R.R. v Poland 2011
[68] P. and S. v Poland 2012

mandatory waiting periods are widely perceived not as protective measures, but as barriers that restrict timely and equitable access to legally available health services.

For many individuals, the practical burdens created by such requirements—including the need to take time away from employment or education, arrange transportation for multiple clinical visits, or secure childcare—are substantial. These pressures may also compel involuntary disclosure of pregnancy to employers, family members, or others, thereby undermining the principles of privacy, autonomy, and confidentiality that underpin international human rights standards in sexual and reproductive healthcare.

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Structural Inequality Effects

These systemic gaps create conditions in which reproductive decision-making is shaped not by genuine choice, but by structural constraints, potentially resulting in hardship, insecurity, or coercive pressure to continue a pregnancy. Ensuring meaningful support for parenthood therefore requires more than the formal recognition of rights; it demands comprehensive structural measures that guarantee access to sexual and reproductive healthcare, including family planning, antenatal and postnatal services, and early detection and treatment of pregnancy-related health conditions.

# 6. Financial Security and Reproductive Choice



Socio-economic inequalities demonstrate how financial insecurity can influence reproductive decisions. Income protection during pregnancy and after birth is essential to ensure that women are not pressured by economic hardship when choosing whether to continue a pregnancy.

## 6. Income Protection and Economic Security

Income protection during pregnancy and after childbirth varies significantly across countries, reflecting differing political priorities, economic capacities, and social attitudes toward parenthood. In many European countries, maternity and parental leave are treated as social rights, funded through national insurance or social security systems and offering extended paid leave with strong job protection. Countries such as Estonia, Bulgaria, Hungary, Sweden, and Norway provide lengthy paid leave periods, often with high wage-replacement rates funded by the state. These models promote maternal health, financial stability, and workforce retention, while reducing the risk that women are forced to choose between income and childbirth.

By contrast, countries without comprehensive national paid leave schemes place greater reliance on employers or unpaid leave frameworks. For example, in the United States, there is no federally mandated paid maternity leave; eligible workers may access up to 12 weeks of unpaid leave under the Family and Medical Leave Act. While some states and employers provide partial wage replacement, access remains uneven and often dependent on employment status, employer size, or geographic location. Similar gaps exist in several smaller states where maternity leave protections are minimal or absent.

Positive aspects of strong income protection systems include:

- Reduced financial stress during pregnancy and early parenthood
- Improved maternal and infant health outcomes
- Higher rates of workforce retention and gender equality
- Greater social cohesion through universal access to benefits



Overall, robust income protection during pregnancy and after birth plays a critical role in ensuring that choosing to continue a pregnancy does not result in economic hardship. However, disparities in design, funding, and accessibility continue to shape unequal outcomes across jurisdictions.[69]

## 7. Childcare, Parental Leave and Supporting Reproductive Autonomy

Affordable and accessible childcare is essential to ensuring that childbirth does not lead to exclusion from education, training, or employment opportunities. When childcare is expensive, unavailable, or of low quality, the burden of caregiving disproportionately falls on women, reinforcing existing gender inequalities in the labour market, income, and career progression. For example, Sweden provides subsidised, high-quality childcare for all children from early ages, supporting high maternal labour participation, while France offers comprehensive public crèches and family support systems that facilitate parents' return to work. By contrast, countries with limited childcare provision often experience much lower take-up of formal care and weaker workforce engagement among mothers: in some EU countries, enrolment of children under three in early childhood education and care ranges from as low as 5% to over 78%, reflecting vast disparities in availability and accessibility that correspond with lower female employment rates and greater caregiving burdens for families.[70] Children at risk of poverty or social exclusion are significantly less likely to

[69] Clare Ath, Human Coalition : How does childcare affect a woman abortion decision at https://www.humancoalition.org/impact/blog/how-does-childcare-affect-a-womans-abortion-decision/.
[70]Eurostat,https://www.google.com/url?q=https://ec.europa.eu/eurostat/web/products-eurostat-news/w/ddn-20250930-

participate in formal childcare, compounding socio-economic inequalities. Internationally, the European Pillar of Social Rights (Principle 11) recognises the right to affordable and high-quality childcare as a means of promoting gender equality and inclusive labour markets.

## 6 Financial Security and Reproductive Choice

The importance of legal protection for family and professional life is also reflected in binding European frameworks. The EU Charter of Fundamental Rights recognises the right to protection of family and professional life, including paid maternity and parental leave, as essential to reconciling work and family responsibilities and advancing gender equality.[71]

Paid and expanded parental leave policies are critical to promoting shared caregiving responsibilities and mitigating the disproportionate economic and professional impact of childbirth on women. Policies that allow both mothers and fathers to take leave help redistribute caregiving duties, challenge traditional gender roles, and support early childhood bonding. For instance, Germany offers up to 14 months of paid parental leave, with at least two months reserved exclusively for fathers, encouraging paternal participation,[72] while Iceland provides non-transferable leave for each parent under a three-part system, promoting equality in caregiving.[73] However, the scope of parental leave varies dramatically across countries: some, such as the United States, Ireland, Switzerland, Greece, and Cyprus, provide very limited or unpaid parental leave, leaving parents—particularly women—with minimal support during early childcare.[74] Conversely, countries like Sweden, Estonia, and Portugal offer extended, well-compensated leave.[75] These disparities highlight that access to parental leave is far from universal and can reinforce inequalities when women are

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[71] Article 33, Family and professional life, European Agency for Fundamental Rights at https://fra.europa.eu/en/eu-charter/article/33-family-and-professional-life?

[72] OECD,Germany statistics at https://www.oecd.org/en/publications/paid-leave-for-fathers_07442bed-en/full-report.html.

[73] Ibid.

[74] Ibid.

[75] Ibid.

forced to balance work and caregiving with minimal support. Research shows that comprehensive leave policies reduce long-term career penalties for women, increase paternal involvement, and contribute to more equitable labour market outcomes.



The impact of childcare and parental leave has been reinforced by recent case law. In *C-129/20* (XI v Caisse pour l'avenir des enfants), the Court of Justice of the European Union affirmed that the right to parental leave under the revised Framework Agreement is a fundamental EU social right closely tied to gender equality (reflecting Charter provisions on equality between women and men and family life), and must not be interpreted restrictively.[76] This judgement underscores that Member States must ensure parental leave rights are effectively available and not undermined by restrictive national conditions. Equally important are rulings addressing discrimination linked to pregnancy and childbirth. In **C-438/99 (Maria Luisa Jiménez Melgar v Ayuntamiento de Los Barrios)**, the CJEU held that the dismissal of a worker because of her pregnancy, including non-renewal of a fixed-term contract, constitutes direct sex discrimination under EU law and is prohibited.[77] Most recently, in *C-284/23* (Haus Jacobus), the CJEU clarified procedural protections for pregnant workers, ruling that national time limits for challenging dismissal must not render protection "excessively difficult" in practice. Where a pregnant worker becomes aware of her pregnancy after a statutory deadline has passed, requiring a very short additional window to seek leave to bring proceedings may be incompatible with the directive protecting pregnant workers if it undermines effective access to justice. This reinforces the principle that legal protections must be practical and not merely theoretical.[78]

Despite these legal frameworks, the impact of childcare and parental leave deficits becomes even more pronounced where abortion is restricted or banned. Women forced to carry pregnancies to term without sufficient social, financial, or institutional support face a double burden: compulsory childbirth coupled with limited access to

[76] CJEY Case C-129/20 at https://fra.europa.eu/en/caselaw-reference/cjeu-case-c-12920-judgment?
[77] https://curia.europa.eu/site/jcms/qua1_5959/en/gender-equality-at-work?
[78] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A62023CJ0284&utm

affordable childcare, parental leave, or workplace accommodations. This situation disproportionately affects women who are already socio-economically vulnerable, reducing workforce participation, increasing poverty, and exacerbating gender inequalities. In some jurisdictions, advocacy and litigation against discriminatory treatment related to parental leave and childcare rights have illustrated the intersection between reproductive autonomy and broader equality obligations; for example, in cases where differential parental leave entitlements based solely on the primary carer's sex have been challenged as discriminatory and contrary to non-discrimination principles embedded in European law.[79]

Restrictive reproductive laws combined with weak social support effectively punish women for circumstances beyond their control, undermining autonomy, economic security, and equality. Ensuring comprehensive parental support, including accessible childcare, paid parental leave, and policies that respect reproductive rights, is therefore essential to protect women's health, dignity, and full participation in society.

[79] Gender Equality ECHR at https://www.echr.coe.int/documents/d/echr/fs_gender_equality_eng?

# 7. Civil society and mobilisation

## a. Public Advocacy Campaigns



Public advocacy campaigns can generate political momentum for reform and strengthen democratic accountability mechanisms. The European Citizens' Initiative My Voice, My Choice illustrates how structured civic mobilisation can translate public demand into formal institutional engagement at EU level. By gathering 1,124,513 signatures across all 27 Member States, the initiative surpassed the legal threshold required to trigger examination under the European Citizens' Initiative framework. This activated procedural accountability mechanisms, compelling the European Commission to formally respond, assess the proposal, and publicly clarify its position.[80] The campaign called for the creation of an EU solidarity mechanism to guarantee safe and affordable access to abortion for women unable to obtain care in their home countries.

Although the Commission did not introduce new legislation or establish a dedicated funding instrument, it acknowledged that Member States may voluntarily use existing resources under the European Social Fund Plus (ESF+) to facilitate access to safe and legal abortion care.[81] This includes support for cross-border travel, assistance for women in remote areas, and financial aid for those without sufficient means. The clarification marked a significant institutional recognition that EU funding tools can be mobilised to address disparities in access.

The campaign also generated political momentum within the European Parliament, which adopted a non-binding resolution calling for a financing mechanism to assist women lacking access to safe abortion services. Members of Parliament further increased pressure through direct engagement with Commission President Ursula von

[80] Ibid.
[81] Ibid.

der Leyen, reinforcing the democratic signal conveyed by over one million signatories.[82]

This mobilisation is particularly significant in light of persistent disparities across the Union. Abortion remains highly restricted in Malta, where a near-total ban applies, and in Poland, where access is limited to narrowly defined circumstances. Even in Member States with more liberal legal frameworks, barriers related to cost, geography, administrative procedures, or misinformation continue to undermine effective access. While the initiative did not result in new EU legislation, it demonstrates the accountability function of participatory democracy tools. By obliging institutional response, increasing transparency around funding competencies, and sustaining public scrutiny, campaigns such as "My Voice, My Choice" show how civil society can shape policy discourse and reinforce democratic oversight in areas where Member State practice remains uneven.[83]



## b. NGO Support and Accountability

Non-governmental organizations (NGOs) play a vital governance role in advancing reproductive rights through information provision, service facilitation, and accountability monitoring. By disseminating accurate, rights-based information about contraception, abortion access, and maternal healthcare, NGOs strengthen legal literacy and enable individuals to make informed decisions about their reproductive lives. They frequently bridge gaps in public health systems by operating clinics, coordinating referrals, assisting with logistical and financial barriers, and supporting marginalized populations disproportionately affected by restrictive laws.

Beyond service delivery, NGOs function as accountability actors within domestic and international human rights systems. For example, they submit shadow reports and

[82] Euronews.com, https://www.euronews.com/my-europe/2026/02/26/eu-says-member-states-can-use-social-fund-for-cross-border-abortion-access.
[83] https://today.rtl.lu/news/world/eu-says-member-states-can-use-blocs-funds-for-safe-abortion-access-1398117712.

evidence to treaty-monitoring bodies such as the Committee on the Elimination of Discrimination Against Women under the Convention on the Elimination of All Forms of Discrimination Against Women and engage with mechanisms overseen by the Office of the United Nations High Commissioner for Human Rights.[84] Through documentation, strategic litigation support, and policy advocacy, NGOs help ensure that states comply with their obligations to respect, protect, and fulfill reproductive rights as matters of equality, dignity, and constitutional governance.



[84] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women and https://www.ohchr.org.

# 8. Conclusion: Abortion Access as Democratic Infrastructure

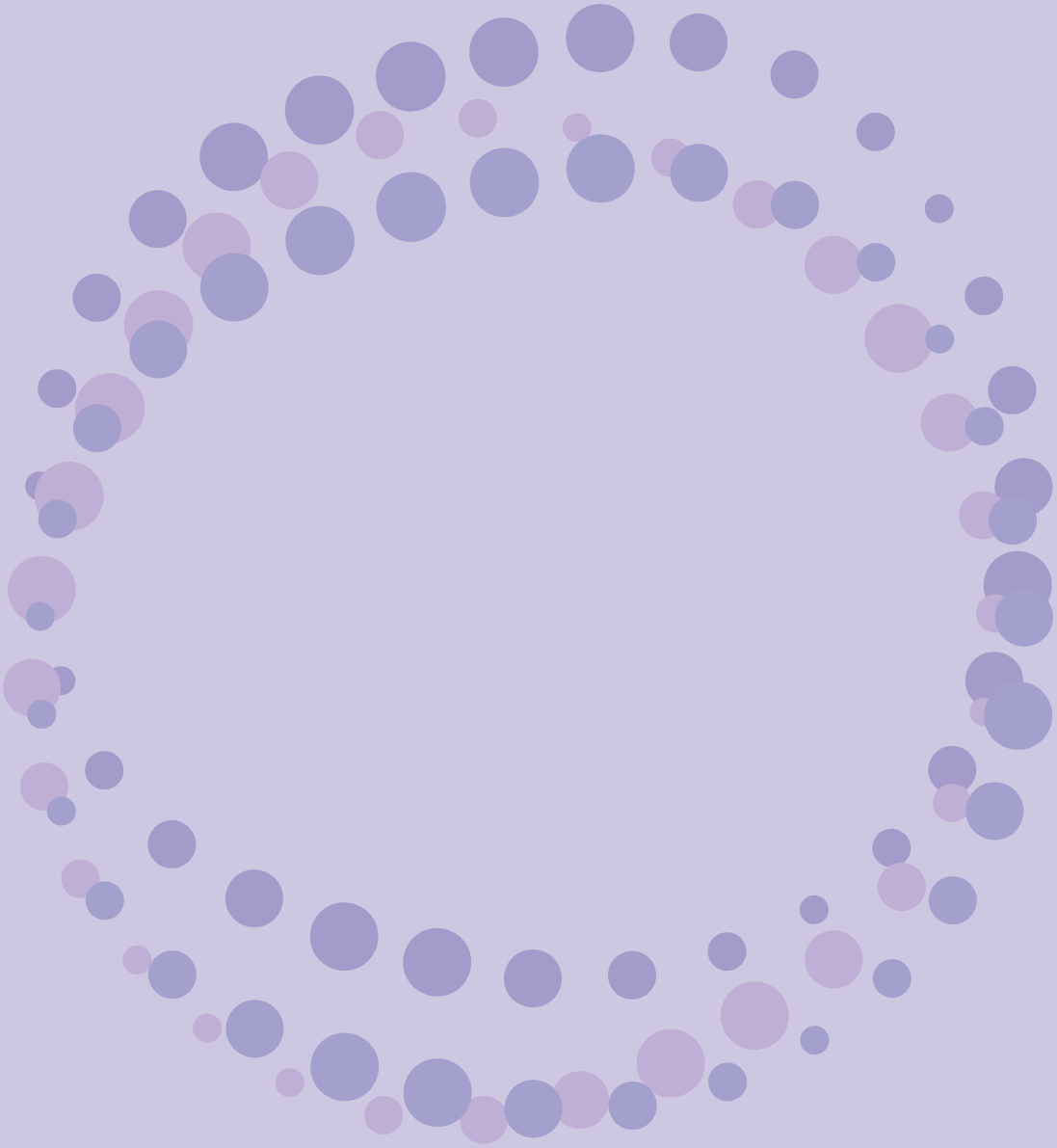
8
Conclusion

The foregoing analysis demonstrates that reproductive autonomy is shaped not only by formal legal recognition but by the structural, socio-economic, and institutional conditions that determine whether rights can be exercised in practice. Barriers such as parental involvement requirements, mandatory waiting periods, expansive conscientious objection, and administrative opacity do not operate neutrally; they disproportionately burden migrants, low-income women, minors, and those living in rural or underserved areas. In this sense, inequality is not incidental to abortion access but embedded within its regulation. Where fear of state intervention, financial insecurity, or procedural complexity deters individuals from seeking care, autonomy becomes conditional and unevenly distributed.

At the same time, the availability of income protection, paid parental leave, and affordable childcare reveals that reproductive choice extends beyond the decision to terminate a pregnancy. Meaningful freedom requires that continuing a pregnancy does not entail economic hardship, exclusion from employment, or long-term marginalisation. Comparative models demonstrate that robust social protection systems reduce coercive pressures and support gender equality, whereas weak welfare frameworks—particularly when combined with restrictive abortion laws—compound disadvantage and entrench structural inequality. Reproductive justice therefore demands both accessible abortion services and comprehensive support for parenthood.

# 8 Conclusion

Encouragingly, progress is visible. Civil society mobilisation, NGO engagement, judicial oversight, and participatory democratic tools have generated institutional responses, policy clarification, and increased transparency. International monitoring mechanisms and regional initiatives reflect growing recognition that reproductive rights are inseparable from equality and human dignity. Yet these advances remain uneven, and significant disparities persist across jurisdictions. Legal reform, social policy design, healthcare governance, and public advocacy must therefore operate in concert. Governments, courts, civil society, healthcare providers, and supranational institutions share responsibility for dismantling structural barriers and closing the gap between formal rights and lived reality.



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