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Regulation and provision of abortion compared (abridged version)

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Expertise **Working Paper** Documentation Report



Observatory for Sociopolitical Developments in Europe

Regulation and provision of abortion compared

Germany, France, the Netherlands, Sweden, and Spain

Sarah Molter, Julia Lux, Katrin Lange, Friederike Sprang

December 2023

Abstract

Being able to terminate a pregnancy is a prerequisite for bodily self-determination and thus fundamental to gender equality.

This Working Paper compares regulations, coverage of costs, and provision as well as data on abortions in Germany, France, the Netherlands, Sweden, and Spain. It contrasts existing regulations and practices with the recommendations of the World Health Organisation, human rights standards of reproductive and sexual rights, and the concept of reproductive justice.

All five EU Member States should improve their regulation and provision of abortions, to effectively guarantee the rights and health of pregnant persons.

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Glossary

Term	Explanation
Abortion on request	Also named voluntary abortion or voluntary termination. The pregnant person does not have to give any reason for the abortion.
Abortion or termination of pregnancy	The deliberately induced premature termination of a pregnancy. In this paper, we use abortion and termination of pregnancy interchangeably albeit being aware of the mixed associations that the term abortion brings with it.
Conscientious objection or refusal	Medical staff may refuse to perform an abortion due to their values or religious beliefs.
Dilatation and (sharp) Curettage	A surgical termination procedure in which an instrument is inserted into the uterus to manually remove internal tissue.
Embryo	Developmental stage up to the ninth week p. c. (Artal-Mittelmark 2022)
Foetus	Developmental stage from the ninth week p. c. (ibid.)
Gestational age	The gestational age can be calculated differently, either as the time since the first day of the last menstrual period (**post menstruationem, p. m.**) or since the presumed time of conception (**post conceptionem, p. c.**) – i. e. about two weeks after the start of the last menstrual period. This paper uses the calculation method p. c. Where information or sources indicate that the stated gestational age was calculated from the first day of the last menstrual period, two weeks were deducted: For instance, the 14th week p. m. corresponds to the 12th week p. c.
Grounds-based approach to abortion provision	It must be officially established that there is an important reason for the abortion, for example that the pregnant person's health is at risk (**medical grounds**), the foetus is seriously impaired (**embryopathic grounds**), the pregnancy is the result of a criminal offence (**criminological grounds**) or the pregnant person is in a social emergency situation (**social grounds**).

LGBTIQ*	LGBTIQ* is an abbreviation for the terms lesbian, gay, bisexual, trans*, inter*, and queer; and thus an abbreviation for diverse sexual orientations[1] and gender identities[2]. Trans* refers to persons whose gender identity does not or not exclusively correspond to the gender they were assigned at birth. Inter* refers to persons with variations in sexual characteristics. Queer is a collective term for all non-heteronormative[3] and non-cisgender lifestyles and identities.[4] The asterisk * represents the diversity of gender and sexual identities that are not represented by the acronym, as well as the "performativity and incompleteness of gender orientation and positioning[5]".[6]
Medical abortion	Two drugs (mifepristone, misoprostol) are taken one to three days apart, causing the embryo or foetus to be aborted. According to the World Health Organisation (2022), medical abortions are possible up to the 10th week p.c. In many countries, the method is only applied up to the 7th week p.c.
People of Colour	People of Colour is a self-designation to express solidarity of people who share experiences of racism (Ha 2009). When the term People of Colour is used in this working paper, it refers to all people who experience(d) structural, institutional, and interpersonal power inequalities; and therefore discrimination of a racist nature vis-a-vis the majority of society.
Pregnant person	Persons who are not considered binary female can also be pregnant, for example non-binary and trans* persons (see glossary on LGBTIQ*). If the term woman/women is used in this paper, this has been adopted from the original source and is used depending on the respective context. This is for instance the case with figures on abortion rates, where national statistics exclusively refer to women.
Reproductive justice	Reproductive justice is an activist-scientific concept that is based on three basic principles: 1) the right to have a child under conditions of one's own

[1] **Sexual orientation** refers to "each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender" (International Panel of Experts on in International Human Rights Law and on Sexual and Reproductive Health 2007: 8).

[2] **Gender identity** refers to "each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth […]" (ibid.).

[3] **Heteronormativity** refers to "[...] the norms of heterosexuality and binary sexuality and understands them as a social power relationship [...]. Cisnormativity is part of this heteronormative power relationship and refers to the norm of locating oneself within the gender/sex assigned at birth" [own translation] (Dionisius 2020: 78).

[4] "**Cis**" (Latin) means "on this side" and, in the context of the term "cisgender", refers to persons whose gender orientation corresponds to the gender/sex they were assigned at birth" [own translation] (Dionisius 2020: 80).

[5] For example, for **non-binary persons**: "Non-binary is [...] an umbrella term for all genders that are not purely male or purely female. [...] However, only one's own perception is decisive for the identification as non-binary." [own translation] (Queerulant_in e.V. 2019: 37).

[6] Fütty 2019: 17 quoted in Dionisius 2020: 8078.

	choosing; 2) the right to not have a child, be it by means of contraception, abortion or abstinence; and (3) the right to parent children in safe and healthy environments, free of individual or state violence (Ross 2017). The concept thus combines reproductive health issues with the principle of social justice.
Sexual and reproductive health and rights	"Sexual and reproductive health means a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not just the absence of disease, dysfunction or impairments/disability. [...] Every individual has the right to make decisions about their own body and to access services that support this right" (Guttmacher-Lancet Commission 2018).
Uterus	Organ in which the development of an embryo / foetus takes place during pregnancy.

Source: Author's illustration

1 Introduction

Access to and the general right to legal, safe and free abortion is a highly contested issue in Europe: supporters of a right to abortion demand that every pregnant person should be able to decide about their own body and thus about the termination of a pregnancy themself. Opponents in turn want to limit or outright ban access to abortions and thus place the rights of the foetus or embryo above the rights of the pregnant person.

It is a fact that bans and restrictive regulations do not prevent abortions, but rather lead to more unsafe abortions (Ganatra et al. 2017). These may have health consequences or even lead to the death of the pregnant person. Under international law, restrictions on access to or criminalisation of abortion are violations of human rights. They are a form of gender-based discrimination and violence.

Access to abortion is linked to the right to decide freely whether and by what means a person wants to have children. Reproductive rights are enshrined in human rights law; and are a basic prerequisite for gender equality. This includes the right to information, resources, and services on sexuality, family planning, and contraception that enable such a decision, free from any coercion and discrimination.

The decision for or against a pregnancy is not only individual and self-determined, but embedded in social and institutional relationships; and significantly dependent on the legal, operational, and infrastructural framework conditions. The scientific-activist concept of Reproductive Justice emphasises the fact that the right to abortion alone is not enough to achieve social justice for vulnerable groups. It emphasises the intersectional nature of the demand for social justice in the area of sexual and reproductive rights and health. This includes the most important recommendations of the World Health Organisation.

This abridged version (Molter et al. 2023) begins with an overview of the most important terminology in Chapter 2 (Glossary) and then provides a brief introduction to the human rights and international anchoring of the issue of abortion and reproductive justice in Chapter 3. Chapter 4.1 then briefly outlines the regulations and current care conditions of providing pregnancy terminations in the Member States of the European Union, followed by a comparative analysis of the situation in GERMANY, FRANCE, the NETHERLANDS, SWEDEN, and SPAIN in Chapter 4.2. Finally, Chapter 5 discusses existing statistical data on social attitudes on abortion, particularly with regard to stigmatisation and the number of unreported cases. Chapter 6 (Conclusion) summarises the results of the country comparison and formulates recommendations for countries that want to ensure good access to abortion in order to protect the human rights of pregnant persons.

2 Human rights situation and vision

2.1 International level

The human rights dimension of access to abortion is internationally recognised; and its criminalisation and prohibition are considered incompatible with international human rights standards (UN HRC 2016, 2019: par. 8). However, despite the interpretations of various human rights treaties by the UN treaty bodies and the corresponding recommendations of the World Health Organisation[7], the right to unrestricted access to abortion is not yet enshrined in a binding manner.

There is also no explicit right to abortion at the European level. However, the European Convention on Human Rights, in force since 1953 (ECHR 2021), can be considered a legally binding instrument at the Council of Europe level. In addition to the general ban on discrimination (Art. 14), Article 3 contains a prohibition of torture and inhumane or degrading punishment and treatment, and Article 8 contains a right to respect for private and family life. According to the interpretation of the European Court of Human Rights, the latter also includes the decision to have or not have children (ECHR 2010).

Within the European Union, abortion is considered a branch of public health policy and therefore a competence of the individual Member States, thus limiting the legislative power of the EU institutions. The European Union cannot fundamentally guarantee pregnant people within the Union the right to a safe and legal abortion; sexual and reproductive rights are not explicitly enshrined in the EU Treaties. However, the European Parliament is calling for an EU-wide right to abortion (EU Parl 2022b, 2022a, 2021).

Human rights and vulnerable groups

Not all people can equally claim and benefit from the existing human rights standards in the field of reproductive and sexual rights. Vulnerable groups whose rights are particularly restricted include, according to the World Health Organisation's recommendations on abortion: persons in rural areas, people in financial hardship, minors, people with disabilities, persons affected by gender-based violence, trans* or non-binary persons, people with low levels of formal education, people with HIV, persons from ethnic or religious minorities, People of Colour, and displaced persons/refugees (WHO 2022: 12f., 21).

2.2 Reproductive justice

The concept of reproductive justice takes the situation of vulnerable groups and the protection of human rights particularly seriously; and is based on three basic principles: 1) the right to have a child under conditions of one's own choosing; 2) the right to not have a child, be it by

[7] See, for instance: "Preventing unintended pregnancies and unsafe abortions requires states to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health" (UN CESCR 2016: par. 28).

means of contraception, abortion or abstinence; and 3) the right to parent children in safe and healthy environments, free of individual or state violence.

Its principle 1 refers to access to sexuality education, contraception, and abortion. Principle 2 emphasises and strengthens the perspective of people whose parenthood is considered socially undesirable (Ross 2017). A feminist view of reproduction must also take into account other social and economic factors, such as population/demographic policy, gender images, birth conditions, and reproductive technologies. Principle 3 refers to structural obstacles to self-determined parenthood and childhood. These can be patriarchal structures – for example, when domestic violence and abuse dominate the family environment – but also capitalist contexts that determine income (in)security, the time available to parents, or the care and education of children (Gärtner et al. 2020; Haller 2021). Analyses of reproductive justice also focus on other power relations like racist, LGBTIQ*-hostile, adultist (LeFrançois 2016), and ableist (Eisenmenger 2019) inequalities.

2.3 Human rights-based recommendations of the World Health Organisation on abortion

The World Health Organisation's (2022) recommendations on abortion care are based on scientific evidence of the detrimental effects of certain kinds of abortion regulation and provision, as well as embedded in the human rights framework.

- Full decriminalisation of abortion
- No prohibition of abortion based on gestational age limits
- No restrictions of abortion by grounds, i.e. always allow for abortion on request
- No mandatory counselling
- No mandatory waiting period
- No third party consent
- Protect the provision of abortion against the effects of conscientious objection/refusal
- Provide scientifically accurate, easily accessible and understandable information that respects the right to privacy and confidentiality
- Communicate information through a variety of health professions
- Cover the costs of abortions
- No restrictions on who can provide abortions if they comply with World Health Organisation guidelines
- Enable self-administration of medical abortion
- Offer telemedicine services for abortion
- Provide interactive, individualised, open and voluntary counselling by a trained person, including post-abortion contraceptive counselling if desired.

3 Country comparison of regulations and provision of services

3.1 Member States of the European Union

All EU Member States regulate abortion in their legislation[8]. In some countries, abortions are possible with particularly few restrictions for the pregnant person, such as in Denmark, Finland, FRANCE, the NETHERLANDS, and SWEDEN (Marques-Pereira 2023).

The regulations in SWEDEN are considered the most liberal in Europe and come closest to a right to abortion (ibid.). In the Netherlands, too, pregnant persons have had comparatively easy access to abortion since the 1980s, although abortion is still regulated by criminal law.

Restrictive regulations

In the majority of EU Member States, a range of regulations complicates access to abortions: Even if abortions are not fundamentally prohibited, there are restrictions due to mandatory counselling and waiting periods, and comparatively short time limits for abortion, such as in Austria, GERMANY, Italy, and Portugal. Many countries generally criminalise abortions, making them not punishable by law only under very specific circumstances.

In Italy, abortion can be performed after counselling and a one-week reflection period. However, doctors can refuse to perform a termination on the basis of conscience – and the vast majority of doctors in the country make use of this option (Minerva 2015).

Liberalising tendencies

In recent years, some countries have further liberalised their laws, making abortion more accessible, such as the Cyprus, Republic of Ireland, FRANCE, Luxembourg, and SPAIN.

The Republic of Ireland had one of the strictest laws in Europe: It was abolished after a referendum in 2018 demanded change – as a result of a very successful campaign by feminist activists in favour of abortion access (The National Women's Council of Ireland 2019). A pregnancy can now legally be terminated during the first ten weeks p.c. without giving reasons for the termination. Abortions under these circumstances also sit outside criminal law, thus making the Northern Irish approach more progressive than many other countries' with longer standing accessibility of abortions.

FRANCE liberalised its regulations with major reforms in 2016 and 2022; and could be the first state in Europe to give constitutional status to having an abortion. SPAIN also has considerably more liberal regulations in place since 2023.

[8] For an index and comparative ranking, see IPPF EN (2021).

Nevertheless: A highly contested issue

In Lithuania (Denkovski et al. 2021), Croatia (Brave Sisters Croatia n. y.; Women's Network Croatia 2021) or Slovakia (Mesochoritisová 2023), political plans to further criminalise abortion or even ban it altogether have so far been prevented by strong civil society movements and feminist resistance.

In other states, in particular in Poland (Lange 2023) and Hungary (Strzyżyńska 2022), the freedom of pregnant people to have a safe and legal abortion has been severely restricted, despite the protest of feminist movements.

Malta is the EU Member State with the most restrictive legislation. Its abortion law dates back to 1850. Abortions are generally prohibited. In June 2023, legislation was minimally relaxed (Taylor/Stuart Leeson 2023).

3.2 Focus on Germany, France, the Netherlands, Sweden, and Spain

According to an index by the International Planned Parenthood Federation on access to abortion (IPPF EN 2021), SWEDEN and the NETHERLANDS are considered to provide very good access (SWEDEN 94 %, NETHERLANDS 85 %). FRANCE and SPAIN have simplified access in recent years; the corresponding figures in future editions of the index could therefore be higher (latest figures: FRANCE 84 %, SPAIN 71 %). These countries can therefore be instructive for identifying ways to enable abortions in ways that safeguard human rights. In European comparison, GERMANY's regulations are currently rather restrictive (62.5 %).

3.2.1 Laws and regulation

The World Health Organisation (2022) recommends the full decriminalisation of abortion. This would mean that abortions are not (or no longer) mentioned in criminal law and that no penalties are imposed on the pregnant person or the supporting (medical) staff in the wake of a termination procedure.

Criminalisation of abortions

There are major differences in the legal regulations in the five countries analysed here: In GERMANY and the NETHERLANDS, the conditions for abortion are regulated by criminal law. However, the DUTCH law only defines abortion as a criminal offence after the foetus is viable outside the uterus, whereas in GERMANY all abortions on request are considered unlawful and therefore a criminal offence (Wetboek van Strafrecht (WvSr) Articles 82, 82a). Abortions remain exempt from prosecution under GERMAN criminal law if compulsory counselling and the waiting period are observed and gestational age limits or grounds adhered to (Strafgesetzbuch (StGB) §§ 218, 219). Nonetheless, in addition to the symbolic effect of abortion regulations being placed besides paragraphs on murder and manslaughter, the prevailing legal status also results in restrictions on the coverage of costs and medical care for abortions.

SPAIN (Ley Orgánica (LO) 1/2023) and SWEDEN (Abortlag 1974:595) regulate abortion in a separate law and not in their respective penal code or criminal law. However, references to criminal law still exist. In practice, this means that abortions taking place outside the legal

regulations can still be criminalised. However, in SWEDEN, a pregnant person cannot make themself liable to prosecution in the event of an abortion (WHO 2021). The same applies to the NETHERLANDS (Visser et al. 2005) (regardless of the regulations being enshrined in criminal law) and FRANCE (Code de la santé public (C. santé publ.) L2222-2 to L2446-3).

In 2016, FRANCE moved regulations on abortion from criminal law to health law (C. santé publ. L2111-1 to L2446-3) and is thus the only country that does not refer to criminal law for abortion regulations. In the near future, FRANCE could also become the first country in Europe to amend its constitution in favour of reproductive self-determination and enshrine the "freedom of women to have an abortion" (BMFTV 2023).

Gestational age limits

There are also major differences between the countries in terms of the gestational age limits set for termination procedures. With 12 weeks p. c., GERMANY (StGB §218a, para. 4) and SPAIN (LO 1/2923: Article 14) set the shortest periods. Since a reform in 2022, a period of 14 weeks p. c. applies in FRANCE (C. santé publ. L2212-1). SWEDEN, with 16 weeks p. c. (Abortlag 1974:595 § 1), and the NETHERLANDS, with reference to the viability of the foetus outside the uterus at approximately 22 weeks p. c., have the longest gestational age limits (Government of the Netherlands n. y.).

In FRANCE in particular (Cordier 2022), where the limit was only recently extended, but also in the NETHERLANDS (e*vibes 2020) and GERMANY, it became clear that not all providers in fact offer abortions up to the legal gestational age limit.

The World Health Organisation (2022) recommends avoiding fixed gestational age limits altogether, as this results in more unsafe self-performed abortions or in people continuing unwanted pregnancies.

Mandatory counselling and waiting periods

In addition to a gestational age limit, some countries stipulate further conditions before a termination procedure may be carried out. GERMANY has by far the strictest regulations in this regard, with mandatory counselling (StGB § 219) and a subsequent waiting period of three days before an abortion can be performed (StGB § 218a para 1.1). SWEDEN, FRANCE, and SPAIN do not require any counselling or waiting period. In SPAIN, both were abolished with the latest legal reform in February 2023. In the NETHERLANDS, counselling is mandatory, but unlike in GERMANY, this can be provided by the same person carrying out the abortion (Wet van 16 januari 2023 tot wijziging van de Wet afbreking zwangerschap alsmede enkele andere wetten in verband met de legale medicamenteuze afbreking van de zwangerschap via de huisarts Article 5). In January 2023, the previous waiting period of five days was abolished, and the pregnant person themself in consultation with the doctor now determines the length of the waiting period. This period can range from zero to ten days (Fiom n. y.).

The World Health Organisation (2022) recommends against both mandatory counselling and a mandatory waiting period, partly because both increase costs for pregnant persons, for example due to absence from work or in the form of travel costs.

Grounds-based approaches to abortion

Under certain circumstances, abortions can also be performed later in pregnancy in all countries. Grounds for such terminations include threats to the health of the pregnant person and impairment or non-viability of the foetus. Only in GERMANY do the latter embryopathic grounds in fact fall under medical grounds (StGB §218a para. 2), as it is argued that the pregnant person is under psychological strain due to the foetus's impairment. A social indication and thus a personal emergency of the pregnant person is only mentioned as a ground for an abortion after the set gestational age limit in SWEDEN (RFSU 2020: 6). Pregnancy resulting from a criminal offence (criminological grounds) is regulated in GERMANY (StGB §218a para. 3) and SWEDEN (IPPF EN 2019: 34). In GERMANY, unlike in SWEDEN, however, this is not accompanied by a longer gestational age limit; only the mandatory counselling and the costs are waived. Since the gestational age limit stays the same, it can be assumed that most affected people in GERMANY will not take on the psychological burden of disclosing the violence they have experienced to the respective doctor.

The procedures for determining grounds and indications vary from country to country, in some cases requiring the judgement of other doctors. In FRANCE, this includes multidisciplinary consultations (C. santé publ. L2213-1) where the pregnant person themself can appoint a member of the medical committee. In SWEDEN, the National Board of Health and Welfare is responsible for the decision (Abortlag 1974:595 § 6).

The World Health Organisation points out that time-consuming procedures for determining indications delay abortions, which can, for instance, have negative consequences for the health of the pregnant person. In turn, fast-track procedures could also lead to problems if they result in legal uncertainties for the healthcare staff providing the procedure. In the NETHERLANDS, for example, it is problematic that an evaluation committee only decides retrospectively whether an abortion was lawful based on embryopathic grounds (Aanwijzing vervolgingsbeslissing inzake late zwangerschapsafbreking en levensbeëindiging bij pasgeborenen). This leads to legal uncertainty for the medical staff, which is why people usually decide to have such abortions performed in Belgium, where a committee decides on the legality *before* the termination takes place.

Third party consent

In SWEDEN and FRANCE, the consent of a person with parental authority does not have to be provided, but in FRANCE the minor must be accompanied by an adult for the abortion (C. santé publ. L2212-7). In GERMANY (Bürgerliches Gesetzbuch (BGB) § 630d para 1.1; pro familia n. y.) and the NETHERLANDS (Fiom n. y.*), the physician assesses whether the minor is capable of giving consent or whether consent must be provided up to the age of 18 or 16, respectively. In SPAIN, consent is required up to the age of 16.

Conscientious objection or refusal by health workers to provide abortion services

In most European countries, medical staff can refuse to terminate a pregnancy on grounds of conscience. However, this does not apply if the pregnant person's health is in danger. In its recommendations, the World Health Organisation (2022) recommends to protect the provision of abortion services against the negative effects of conscientious objection. SWEDEN does not

grant service providers the right to refuse performing an abortion on grounds of conscience. GERMANY (Schwangerschaftskonfliktgesetz (SchKG) §§ 1, 2), FRANCE (C. santé publ. L2212-8), the NETHERLANDS (Wet afbreking zwangerschap (Wafz) Article 20 para. 1) and SPAIN (LO 1/2023 Article 19 para. 1.1, 1.2), in contrast, continue to have conscientious objection clauses in place.

In order to ensure access to abortion despite a conscientious clause, it is necessary to clarify exactly what this clause covers: Who (whole clinics or just individuals) can object to which aspects of care services (abortion at what gestational age, post abortion care, etc.)? In addition, rejected patients must be referred to doctors performing abortions. The NETHERLANDS and FRANCE already oblige doctors to do so. In SPAIN, a register is to be set up (LO 1/2023 article 19 ter) to make transparent who refuses to perform terminations. This register is intended to improve care planning, but it will not be publicly accessible.

Provision of evidence-based information

Providing adequate information is crucial when people want to have an abortion and are looking for appropriate options. This is also emphasised by the World Health Organisation. It includes information on the legal framework, but also information on where persons can have an abortion and with which methods. After GERMANY abolished the ban on "advertisements for abortions" in June 2022 (Oltermann 2022), information is freely accessible by law in all analysed countries. FRANCE has a law in place that prohibits deterrence efforts by disseminating claims that are intentionally misleading regarding the characteristics or medical consequences of an abortion (C. santé publ. L2223-2; Marques-Pereira 2023: 26). This includes, in particular, misinformation on the internet and anti-abortion campaigners harassing pregnant persons or medical staff in front of abortion or counselling facilities.

3.2.2 Coverage of costs

In all countries except GERMANY, the costs of an abortion for residents are covered by the state. In the NETHERLANDS, either health insurance or basic long-term care insurance for residents covers the costs (Abortusklinikien Amsterdam & Haarlem n. y.). In SPAIN, terminations are covered by the national healthcare system (LO 1/2023.: Article 18). In SWEDEN, a small contribution must be paid by the pregnant person themself, as is usual for any other doctor's visits as well. The SWEDISH (RFSU 2020: 5) and FRENCH (DREES 2022: 4f.) systems further cover abortions for people without a valid residence permit.

Only in GERMANY does the distinction between voluntary abortions on request and terminations on the basis of an indication have consequences for the coverage of costs. Costs are only reimbursed for grounds-based abortions (BMFSFJ 2023). In the case of abortion on request, the costs are only covered for persons with low incomes – and even in these cases, not all entitled people take advantage of this cost coverage[9].

[9] According to estimates by gynecologists and counselling centres, around one in three people who want to have an abortion are entitled to have the costs covered, but only around 60-70 % of these people make use of this option (Maeffert/Tennhardt 2023).

In addition to direct costs, indirect costs such as absence from work, childcare, transport, or accommodation are incurred depending on accessibility and time (particularly in the case of compulsory counselling as in GERMANY and/or if the distance to the facility is long).

3.2.3 Access

The legal situation alone says little about the factual access and the situation for pregnant persons in the respective countries. Access can only be assessed to a limited extent in the context of a general research and in the context of this paper, as there are few figures or studies available. There is also no guideline as to how many facilities would be deemed necessary for good care. However, it can be shown that the legal situation has a direct influence on the provision of care at facility level.

Regional differences in access to abortion

The care situation in SWEDEN and the NETHERLANDS (Marques-Pereira 2023, IGJ 2021; Ploem et al. 2020) is rated as very good. Having a longstanding commitment to providing abortion care, disallowing conscientious refusal of care in SWEDEN, and being a fairly small country geographically with a good health infrastructure as the NETHERLANDS supports this.

In contrast, there is insufficient access to abortion facilities in GERMANY (Bruhn 2017; Maeffert/Tennhardt 2023)[10], FRANCE (Batistel/Muschotti 2020: 30ff.), and SPAIN (Rivas Barrera 2018), though this varies depending on the respective region. Care is particularly poor in rural and conservative regions, where abortions are only performed earlier in pregnancy and there is no free choice of termination method. In addition to the right of medical staff to refuse abortions, health economic aspects also play a role: in GERMANY, abortion on request is not a public health service and therefore does not have to be taken into account in hospital planning by the federal states. This is in conflict with the mandate of the GERMAN federal states[11] to ensure adequate abortion care.

Availability of different termination procedures / methods

While there are hardly any medical abortions offered in GERMANY (Tennhardt 2022), some surgical abortions are not offered in FRANCE, as they are not economically lucrative for the facilities (Batistel/Muschotti 2020: 45). This can lead to access problems. Home abortion using the medication method is officially possible in all countries except GERMANY. However, even

[10] There is no systematic overview of the provision of abortions available (Escamilla Loredo / Hollederer 2023). However, there is reference to the poor supply situation in many areas, particularly in newspaper articles and other media reports. See, for instance, the ARD broadcast “Kontraste”, citing a calculation by the Federal Statistical Office from 23 August 2018, according to which in some regions of Germany, such as Trier or Hamm, there is no longer a single facility that performs abortions (quoted after Klein/Wapler 2019: 25). For Lower Saxony, see Engelhardt (2022).

[11] Neither the SchKG nor the respective implementation act (AG SchKG) defines what is to be understood as “sufficient supply”. According to a statement by the federal government in 2018, it is up to the respective German state to assess the extent to which the number of facilities is sufficient (Bündnis 90/Die Grünen 2018: 2).

in GERMANY, the existing regulations are interpreted differently and abortions at home are in fact taking place[12].

Personnel performing abortions

In SWEDEN (Abortlag 1974:595 § 5), FRANCE (Administration française 2022), and the NETHERLANDS (Wafz article 2), several healthcare professionals can perform abortions: For instance, midwives can perform a medical abortion in SWEDEN and FRANCE, while in the NETHERLANDS, not only specialists but also general practitioners can perform a medical termination (Wet van 16 januari 2023). In GERMANY (BMFSFJ 2023) and SPAIN (LO 2/2010: article 13a), only specialists are authorised to administer abortions. The World Health Organisation (2022) recommends expanding the range of providers.

Availability of and access to information

In some cases, there is a lack of easily and quickly available information for pregnant persons on where they can go for an abortion. This can lead to the termination only being carried out at a later point in the pregnancy or the gestational age limit being exceeded. In GERMANY, the former ban on “advertising” still has an impact. The available lists of facilities and practices that offer abortions are not complete and it is not clear whether all facilities on the list do in fact perform abortions[13]. In comparison, FRANCE is highlighted as a positive example regarding the provision of information due to detailed information on abortion provided online by the state as well as a hotline (Zanini et al. 2021: 6f.). The World Health Organisation (2022) recommends making complete, accurate and evidence-based information on abortion freely available.

Training of health staff

The lack of training and further education opportunities for doctors and healthcare staff is problematic in some countries. Efforts are being made to improve training in this regard, for example in GERMANY and in SPAIN[14].

Voluntary counselling offers

In all countries studied, there are (voluntary) counselling services offered by various providers.

The option of a digital service could simplify access. FRANCE already has a hotline in place (Zanini et al. 2021: 6f.); SPAIN plans to set up one as well (LO 1/2023 Article 18 through to c).

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[12] In December 2020, Doctors for Choice Germany (n.y.) started the project “Abortion at home”, which offers pregnant persons in poorly serviced areas the opportunity to have an abortion at home using medication (this is generally prohibited, but possible as part of the project) accompanied by telemedical support.

[13] Down from 2,050 so-called reporting centres in 2003 to 1,097 in the 2nd quarter of 2022. Reporting centres are facilities in which abortions are generally performed. However, some of these facilities may not currently offer terminations (Destatis 2023). Since 2019, the German Medical Association publishes a list of organisations that voluntarily report that they perform abortions (Bundesärztekammer n. y.). In December 2022, 375 centres were registered. Following the abolition of the "advertising ban" under Section 219a StGB, it is to be hoped that more doctors will register in future. It is also known that due to the generational change in the gynaecological field, many doctors with the expertise and political will to perform abortions are retiring. This cohort will be followed by fewer doctors who are qualified and willing to perform abortions (Czilwik 2018).

[14] To this end, sexual and reproductive health is included in the curricula (LO 1/2023 article 8(1)(a)), professionals are trained in voluntary abortion (LO 1/2023 article 8(1)(b)), continuing education programmes on sexual and reproductive health are offered (LO 1/2023 article 8(1)(c)) and the needs of the most vulnerable groups or social sectors, such as people with disabilities, are included in the medical training (LO 1/2023 article 8(1)(d)).

The World Health Organisation (2022) recommends interactive, open, and voluntary counselling tailored to the individual and provided by trained staff.

Harassment and intimidation in front of facilities

To prevent anti-abortion activists from threatening pregnant persons or healthcare staff or preventing them from accessing facilities, FRANCE (C. santé publ.: L2223-2) and SPAIN (LO 4/2022 Article 172 quater) have criminalised harassment by anti-abortion activists in front of facilities. In the NETHERLANDS, there are protection/buffer zones around facilities in some large cities despite anti-abortion activists' struggles against them (ANP 2022). In GERMANY, a respective law has been drafted.

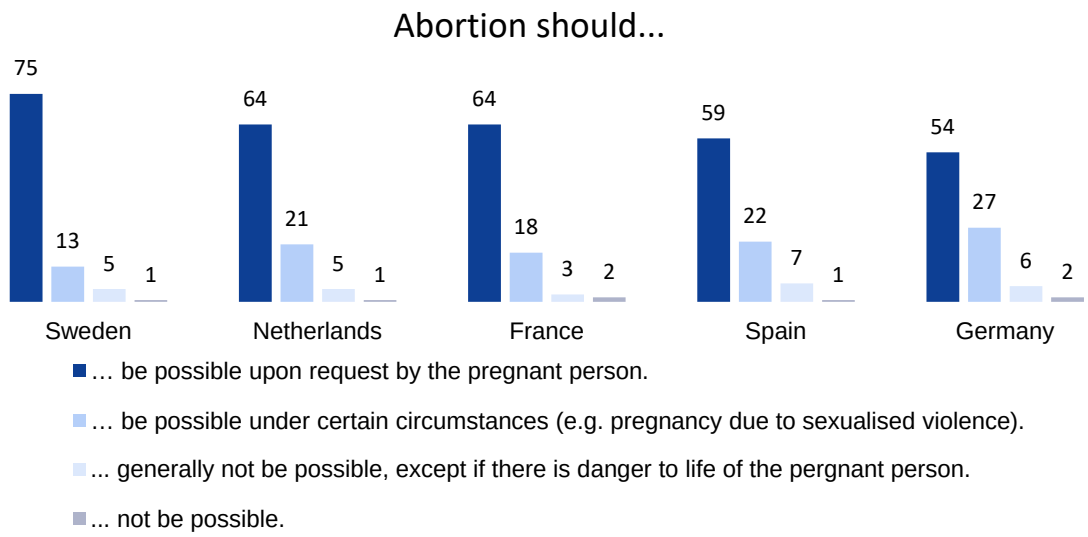
4 Data and unreported cases

Abortions, and thus people who have abortions or perform them, are stigmatised in many ways. Stigmatisation marginalises people on the basis of certain experiences or attributes. This marginalisation can cause feelings of shame and guilt in the pregnant person concerned (Kumar et al. 2009; Marques-Pereira 2023; Busch 2020), and sometimes prevents pregnant persons from having an abortion or drives them into illegality.

Societal attitudes

According to a survey by Ipsos Public Affairs (2021) (see Figure 1), three quarters of SWEDES are in favour of pregnant persons being able to have a termination performed if they wish so. In the NETHERLANDS, FRANCE, and SPAIN, the figure is around two thirds of society, and in GERMANY just over half (54 %). The survey results also show that outright opponents of abortion are a very small minority in all countries.

Figure 1: Attitudes on abortion[15]



Source: Ipsos Public Affairs 2021, authors' illustration

[15] Answer "I do not know" is not depicted.

Reproductive justice and unwelcome parenthood

The concept of reproductive justice emphasises that reproduction of/for certain groups can be politically and socially considered undesirable (Schultz 2021). These groups experience multiple forms of discrimination (intersectional discrimination) when they want to exercise their reproductive rights. Forms of discrimination include racism, adultism (i.e. discrimination against children) (LeFrançois 2016), ableism (i. e. hostility towards disabled people) (Eisenmenger 2019) or hostility towards queer people. These take place in the context of existing power structures.

The right to freely decide on parenthood is particularly restricted for People of Colour. The reasons for this are socio-economic (low financial resources and precarisation), institutional (such as discrimination in the healthcare system which is reflected, for instance, in the higher mortality rate of People of Colour giving birth (for example in FRANCE and the NETHERLANDS (Diguisto et al. 2022) or the estimation of so-called “migrant birth rates” (Schultz 2021) and discursive (for instance through a discourse focusing on allegedly “excessive migrant fertility” (ibid.)).

Adolescent pregnancy and parenthood is often considered undesirable by the state and society (Cadena et al. 2016; Ellis-Sloan 2014), as young people are deemed to lack decision-making ability, maturity, and foresight. An empirical study from SWEDEN shows that the social environment of pregnant adolescents often exerted great pressure on the pregnant person, so that a personal decision in favour of parenthood could hardly take place (Ekstrand et al. 2009). From a reproductive justice perspective, it is important to provide young people with reliable information about the potential risks of early pregnancy (as part of an inclusive and shame-free sexuality education) as well as non-discriminatory access to contraceptive methods for all age groups (Depping/Osterkamp 2022), whilst decisions in favour of parenthood should be respected.

People with disabilities are often denied the ability to become parents and their parenthood is unwelcome (Zinsmeister 2017). In addition, the potential transmission of disabilities is perceived as undesirable. Forced sterilisations and abortions represent the most severe infringements of the human rights of people with disabilities. However, the administration of long-term contraceptives – such as three-month injections, which are used by a disproportionate number of people living in care facilities for people with disabilities – also presents further challenges with regard to reproductive justice for people with disabilities due to their long-term side effects (ibid.).

Reproductive healthcare services are rarely queer-sensitive. This means that LGBTIQ* people are often confronted with non-inclusive language and discrimination (Depping/Osterkamp 2022; National LGBTIQ Taskforce 2017; Queermed n. y.). Their right to decide freely whether and when to have children of their own, as well as their rights to information (and education), to equal treatment and non-discrimination, and to privacy are restricted. This circumstance is all the more serious when previous human rights violations have not yet been addressed and processed, such as the aforementioned forced sterilisations of trans* people. The (both historical and current) exclusion of LGBTIQ* people and couples from access to assisted

reproduction, adoptions and the recognition of parenthood reveal further dimensions of discrimination against these groups (Lange 2022).

Abortion data

In 2021, FRANCE recorded the highest absolute number of abortions at 208,200, GERMANY reported 94,596 abortions, SPAIN 90,189, SWEDEN 33,578, and the NETHERLANDS 30,934.

Due to the different population sizes, it is more appropriate to compare the abortion rate, which shows the number of terminations per 1,000 women aged 15 to 44 or 49 years within a year. Comparative difficulties still arise from the differently set age groups. In 2021, SWEDEN had an abortion rate of 18 per 1,000 women aged 15-49, FRANCE 14.9 (same age range), SPAIN 10.7 (age range 15-44 years), the NETHERLANDS 8.7 (15-45 years), and GERMANY 5.6 (15-49 years).

Unreported cases

Given the proportionally low number of abortions recorded in GERMANY, it can be assumed that the existing reporting practice harbours potential for improvement. Owners of medical practices and managers of hospitals in which abortions are performed are obliged to report performed terminations (Destatis 2022). The Federal Statistical Office of GERMANY states that "despite intensive research by the specialist department, errors caused by an incorrect or incomplete basis for recording cannot be completely ruled out" (ibid.: 5). The Austrian abortion expert and gynaecologist Christian Fiala criticised in 2017 that the reports are not cross-checked with other data like cost coverage by health insurance companies and federal states (Mengersen 2017).

In addition, the criminalisation of abortions and the resulting heightened stigmatisation impacts on the reporting practices of doctors who perform abortions. Surveys among medical staff indeed highlight taboo and voicelessness (Baier et al. 2019). The majority of surveyed doctors stated that they found the topic "emotionally charged, sometimes stressful and conflict-laden on a personal as well as societal level" (ibid.).

Circumventing the law by travelling to another country or region where laws are less restrictive further leads to an underreporting of the need for abortions in one country. One of the most common reasons given is that the time limits in their own country have passed, partly because the search for an abortion facility or other restrictions have taken up too much time (Zordo et al. 2021).

In the NETHERLANDS, 9.51 percent of all reported abortions are performed on pregnant persons from abroad, while this proportion is significantly lower in SPAIN (1.45 %), GERMANY (0.6 %), and FRANCE (0.06 %). SWEDEN does not collect these data. Around a third of reported abortions on foreigners in the NETHERLANDS are performed on GERMANS (IGJ 2022), who are therefore not included in the GERMAN statistics.[16] In a qualitative study on pregnant persons in several European countries who have travelled abroad for an abortion, participants from

[16] According to IGJ (2022), a total of 1,011 German persons had an abortion performed in the Netherlands in 2021.

GERMANY (among others) report a particularly poor information situation and restrictive legal regulations regarding access to abortions in their own country (Zanini et al. 2021).

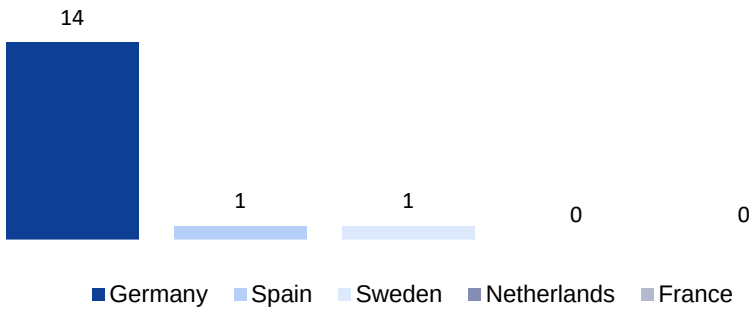
The number of illegal abortions is difficult to record. First and foremost, it is unclear to what extent agencies enforce the laws and to what extent illegal abortions are reported at all. While abortion rates are modelled in studies using various indicators for countries in which abortions are completely prohibited (Sedgh/Keogh 2019), no such modelling is usually undertaken for countries in which official figures are available. However, the fact that pregnant persons from GERMANY and FRANCE are travelling abroad (Zanini et al. 2021; Batistel/Muschotti 2020) shows that not all people who want or need an abortion actually receive it as part of the regular healthcare systems in their respective countries of residence.

In addition, the Canadian organisation Women on Web, which offers medical abortions outside the regular healthcare system, has collected its own data on why pregnant persons in GERMANY, the NETHERLANDS, and FRANCE use the offer of telemedically assisted abortion pills sent by post (Atay et al. 2021; Killinger et al. 2022; Holten et al. 2021). Abortions outside the national healthcare system are illegalised, as they do not take place under the conditions stipulated in the respective legislation (e.g. in certain facilities, performed by formally trained staff). Studies show that there is a need for "discreet" abortions outside the national healthcare system. The pregnant persons concerned describe situations of domestic violence, difficult access due to being uninsured (because of precarious residence permits), taboo and stigma, or living far away from practising clinics (ibid.).

Termination procedures

The bar chart below (see Figure 2) shows that GERMANY has a significantly higher proportion of unsafe abortions compared to the other countries. This is due to the fact that the curettage method is still used. According to the World Health Organisation (2012: 41), this termination method is less safe and significantly more painful.

Figure 2: Share of unsafe abortions among total abortion figures (in %)



Source: Ganatra et al. 2017, authors' illustration

Medical abortions, on the other hand, are favourable with regard to the rights to health and physical integrity as well as to privacy and the utilisation of scientific progress.

5 Conclusion

The country comparison between GERMANY, FRANCE, the NETHERLANDS, SWEDEN, and SPAIN delivers the following findings:

Regulation of abortions outside criminal law / ending criminalisation of terminations

Abortions are no longer regulated by criminal law in SWEDEN (since 1974) and FRANCE (since 2016), but by health and social law. Pregnant persons are not liable to prosecution if they violate the legal regulations on abortion. In the NETHERLANDS, abortions are still regulated by criminal law, but deadlines are not set until the foetus is viable outside the uterus of the pregnant person (22 weeks p. c.). Here too, the law stipulates that pregnant persons who violate these legal regulations on abortion are not liable to prosecution.

In contrast, as long as pregnant persons can be prosecuted for abortions outside of the legally defined rules (GERMANY and SPAIN) – for example, because the gestational age limit has been exceeded – this can cause problems. For instance, if they can no longer obtain an abortion legally, people may resort to illegal and unsafe abortions.

Not only pregnant persons, but also healthcare professionals are liable to prosecution under criminalising and restrictive regulations with narrow and sometimes unclear requirements. This can deter medical staff from performing abortions and thus worsen care provision. This situation is also detrimental to the (often still inadequate) inclusion of termination procedures in medical training.

In addition to this threat of prosecution, regulations in criminal law and the corresponding wording have a stigmatising effect, particularly for the pregnant person themself. When adapting or creating new regulations, it is important not to transfer the language of the previous regulations into a new law, but to give special weight to the self-determination of the pregnant person by using appropriate wording. SPAIN's law on sexual and reproductive health and on voluntary termination of pregnancy can provide guidance – also with regard to the content of medical training, which, according to the text of the law, should include an appreciation of intersectional gender equality and raise awareness of the particular challenges faced by vulnerable groups.

Fewer legal restrictions

Mandatory counselling and waiting periods before abortion were abolished in SPAIN in 2023 and in FRANCE in 2016. Among the countries analysed, such requirements are thus only still in place in GERMANY and to a limited extent in the NETHERLANDS. In the NETHERLANDS (unlike in GERMANY), the mandatory counselling can be carried out by the doctor providing the treatment and, since a recent reform came into force, the waiting period is determined or cancelled altogether in joint consultation between the doctor and the pregnant person.

Compulsory counselling and a waiting period unnecessarily delay the abortion and can put pregnant persons in distress regarding the legal gestational age limits. In addition, it patronises pregnant persons by denying them their decision-making capacity and thus restricting their

self-determination. In countries without mandatory pre-abortion counselling, voluntary counselling is still offered.

The gestational age limits for abortion on request in the countries analysed range from 12 weeks p. c. in GERMANY to 22 weeks p. c. in the NETHERLANDS: SPAIN has a limit of the 12th week p. c. as well (raised from 10 weeks in 2010), FRANCE 14th week p. c. (raised from 12 weeks in 2022), SWEDEN 16th week p. c.

It can be observed that liberal regulations and longer legal time limits are associated with a large number of earlier terminations, which pose a lower health risk for the pregnant person. SWEDEN, which has a comparably long time limit of 16 weeks, many terminations are carried out at an early stage of pregnancy using medication: Almost 94% of abortions in 2021 took place up to the 10th week p. c (Socialstyrelsen 2022). As the gestational age limit for abortion on request is relatively long in the NETHERLANDS and SWEDEN, grounds-based abortions play a much smaller role in these countries than in GERMANY or SPAIN. Determining grounds is time-consuming and ties up more staff capacity as compared to longer access times for abortion on request.

Coverage of costs

With the exception of GERMANY, all the countries compared cover the costs of abortions: in FRANCE, the NETHERLANDS, SWEDEN and SPAIN, the costs of abortions on request (and for indications) are covered by the state for their residents. In FRANCE, abortion is generally free of charge for everyone, including persons without insurance or a valid residence permit. If abortions on request are considered a regular healthcare service, they are taken into account in hospital and healthcare planning, which improves the respective care situation.

Application of rights and regulations in practice

Clear regulations regarding the possibility for medical staff to refuse abortions (conscientious objection) are important to ensure the adequate provision of care. SWEDEN is the only country that does not allow healthcare staff to refuse abortions on the basis of conscience. SPAIN is at least trying to obtain information about who refuses abortions via a register. In FRANCE, doctors are obliged to refer people to other medical practitioners if they themselves refuse to perform a termination. In contexts where a conscientious objection clause exists, it therefore seems sensible to monitor its factual application and to ensure access to abortions for pregnant persons by means of supplementary provisions.

Opponents of abortion try to prevent pregnant persons (and medical staff) from performing abortions by disrupting access to counselling facilities and to abortion clinics. In FRANCE and SPAIN, this kind of harassment is explicitly prohibited. The current federal government in GERMANY also plans to introduce effective legal regulations to counter this specific phenomenon.

Safe termination procedures

In addition to differences in access to abortions, there are differences in the use and availability of abortion methods. In the countries analysed, terminations by means of curettage only take place in GERMANY – and should be avoided due to their health risks. Medical abortions account

for the majority of abortions in SWEDEN (96 %) and FRANCE (76 %). In SWEDEN, FRANCE, and the NETHERLANDS, they can be assisted not only by doctors but also by other healthcare staff. In FRANCE, they can be carried out entirely at home, which meets the desire for confidentiality and privacy of many pregnant persons.

Improving data availability

Liberal regulations on termination result in an improved data situation, as fewer abortions take place illegally, people have to travel abroad less often to have abortions and stigmatisation has a weaker impact. The FRENCH data quality on abortions is rated as particularly good. Here, data from health insurance companies, which cover the costs of all terminations, is compared with hospital statistics and reports from doctors. Valid data collection based on abortions performed as a healthcare service can help reduce the stigmatisation.

Reproductive justice

Finally, in terms of a human rights perspective on the topic, it should be emphasised that a comprehensive understanding of reproductive justice is essential. A special focus should be placed on the needs of vulnerable groups, such as persons in rural areas, people in financial hardship, minors, people with disabilities, persons affected by gender-based violence, trans* or non-binary persons, people with low levels of formal education, people with HIV, persons from ethnic or religious minorities, People of Colour and displaced persons/refugees. Here, too, it is important not to reduce reproductive health and rights to access to abortions, but to base the concept on a broad understanding of sexual and reproductive health and rights. For example, targeted sexuality education, access to contraceptives, abortion counselling and care should be ensured in particular for vulnerable groups. It is also important to include the right to have and safely raise children (Ross 2017).

Current international (especially in the USA) and European (especially in Poland and Hungary) developments show how quickly and drastically rights in the areas of sexual and reproductive health, self-determination, and freedom can be restricted. A just society that wants to achieve gender equality and combat (intersectional) discrimination must in particular protect and guarantee rights in the area of sexuality and reproduction. This includes the right and access to abortion.

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