



“The first difficulty is time”: The impact of gestational age limits on reproductive health and justice in the context of cross-border travel for abortion care in Europe

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ABSTRACT

Drawing on qualitative and quantitative data collected during a 5-year multi-disciplinary European research project, in this article we show how restrictions on access to legal abortion, and particularly gestational age (GA) limits at the end of the first trimester of pregnancy, negatively affect women and pregnant people living in European countries where abortion is legal on request or on broad grounds. First, we examine why most European legislations establish GA limits, and illustrate how abortion is framed in national laws and in the current national and international legal and political debates on abortion rights. We then show, based on research data we collected during our 5-year project and contextualized with existing data and statistics, how these restrictions force thousands of people to travel across borders from European countries where abortion is legal, delaying access to care, and increasing pregnant people's health risks. Finally, we explore, from an anthropological perspective, how pregnant people who travel across borders for abortion care conceptualize abortion access, and the relationship between the right to abortion care and the GA restrictions that limit this right. Our study participants criticize the time restrictions established by the laws in their countries of residence as failing to meet pregnant people's needs, highlight the crucial importance of easy, timely access to abortion care even beyond the first trimester of pregnancy, and suggest a more relational approach to the right to access safe, legal abortion. Abortion travel is also a matter of reproductive justice because access to care depends on specific resources including finances, information, support, citizenship status, and social networks. Our work contributes to scholarly and public debates about reproductive governance and justice, by shifting the locus of attention to GA limits and its impact on women and pregnant people, particularly in geopolitical settings where abortion laws are deemed liberal.

1. Introduction

In February 2018, we met Karine, a 23-year-old French woman in an abortion clinic in the Netherlands. She had traveled there with her partner to terminate her pregnancy at 22 weeks, something she was denied in France because legal gestational age (GA) limits to access abortion were established at 12 weeks of pregnancy (after the recent law change in March 2022 they were extended to 14 weeks). Some days after her procedure, she explained: “I was in a special case because I, in fact,

discovered the pregnancy when I was already at 22 weeks, I was at 21 weeks and five days” (February 2018). When Karine suspected that she was pregnant, her gynecologist recommended a blood test and then told her, based on the results, that her pregnancy was still below the legal time limit: “the blood test, in fact, said that I was at seven weeks”, recalled Karine. “It makes a curve”, she explained, “yes, it makes a curve, you know (...) *Voilà*, the hormone beta Hcg is ... the same as this week, and apparently, yeah, it was the same at about 21 weeks”. So Karine and her partner took some time to think about what they wanted to do, and

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when they decided they could not keep it, they went to the Planning Familial and there Karine had an ultrasound that showed that it was a much more advanced pregnancy. The Planning Familial personnel explained the legal time limits in France and provided her and her partner with addresses in Spain, the Netherlands, and also the United States, where it is possible to obtain an abortion for an unintended pregnancy beyond the first trimester.

This was a very stressful and difficult situation for Karine, who commented: “So in fact I didn’t really have a choice, uh, [but] to go abroad to terminate this pregnancy (...) We weren’t sure of being taken as a patient because when I arrived there, I was 22 weeks and three days, according to the ultrasound (...) So I was also a little lucky to be taken as a patient here, and without that, we don’t really know what we could have done”. Karine and her partner are medical students, and had discussed other options, if no clinic would accept to provide an abortion: “we also had a bit of an idea”, she explained, “... if we had no option, well, to take medication, to do it ourselves. But we also knew that it was very dangerous, so we very much hoped that the clinic would accept it.”

Karine is one of many pregnant people who cross borders in Europe to seek abortion care because of refusals of care in their country of residence when pregnancy exceeds legislative GA limits. According to publicly available data, over 3800 non-Dutch and non-British residents from countries where abortion is legal on request or on broad grounds sought abortion care in the Netherlands and England between 2017 and 2018, when we started data collection (Ministerie van Volksgezondheid Welzijn en Sport, 2019; UK, Department of Health and Social Care 2019). Drawing on qualitative and quantitative data collected during a 6-year mixed-methods, multi-disciplinary European research project (ERC Stg 680004 BAR2LEGAB), in this article we show how restrictions on access to legal abortion, and particularly GA limits at the end of the first trimester of pregnancy, negatively affect women and pregnant people living in European countries with relatively liberal abortion legislations, leading them to seek abortion across borders or seek other alternatives.

As we show elsewhere (De Zordo et al., 2020), only a minority of our study respondents from countries where abortion is legal (204) confirmed their pregnancy (6%) and considered an abortion (8%) beyond 20 weeks. In this sense, Karine’s case is “special”, as she highlighted. However, in her case as well as in the case of most of our study participants, the GA limits established by most European legislations for abortion on broad grounds or request are the main reason why they had to travel abroad for abortion care, which represented a serious challenge and economic burden for many, and delayed their access to abortion care by several weeks, increasing pregnant people’s health risks (World Health Organization, 2022). Karine did not have to consider other options to terminate her pregnancy in the end, but, as we shall see, a minority of our survey respondents actually tried to terminate their pregnancy by themselves before traveling. Additionally, we do not know what other women and pregnant people who do not manage to access the information and resources that they need to travel abroad do, whether they carry out unwanted pregnancies to term, or try to self-manage abortion with the support of tele-health services providing access to safe abortion care, or by themselves.

As we discuss in another paper (in preparation), most of the cross-border travelers whom we recruited considered self-managed medication abortion potentially dangerous, as Karine did. At the time of data collection on cross-border travel for abortion care (2017–2019), this method, which is common in countries with restrictive laws, was not provided nor allowed in European countries where abortion is legal. In some European countries, such as Britain, Republic of Ireland, and France, it started to be provided via telehealth during the pandemic in the first trimester and it was recently classified as safe by the World Health Organization (2022), including if provided by non-clinical persons. However, we completed data collection before these important changes occurred.

In the next two sections, first we illustrate how access to abortion is

currently framed within the human right framework, which continues to resonate for European and Latin American abortion rights advocates, despite being criticized by anthropologists, and considered inadequate by reproductive justice advocates (Ross and Solinger, 2017) in other contexts, as we discuss in the third section. We then analyze the abortion legislations in the main origin countries for cross-border travel for abortion care and the political and legal debates around abortion access, rights, and GA limits in these countries. As we illustrate in the second section, legal time limits vary and are defined by legislators and interpreted by abortion providers differently in different countries, because they are built upon medical measurements of pregnancy and fetal development as well as on definitions of fetal viability, which have changed over time, and because they are the result of local political debates on the morality of abortion and fetal “life” and “rights”.

Theoretically, we contribute to the medical anthropology scholarship by approaching abortion legislations and the political debates and discourses on women’s rights to access abortion as crucial apparatuses (*dispositives*), to use a key Foucauldian concept (Foucault, 1976), through which “reproductive governance” (Morgan and Roberts, 2012, 243) is deployed and enacted. In our research project, we explore how these apparatuses shape people’s experiences with abortion seeking, barriers to access and cross-border travel for abortion care, and their relationship with the State.

In the following section of research findings, we begin with survey results and illustrate how GA limits impact pregnant people living in European countries where abortion is legal, forcing them to travel abroad. In the next section, we present our interviewees’ perspectives on abortion laws in their home countries of France, Italy and Germany, and we explain how they conceptualize abortion access, and the relationship between the right to abortion care and the GA restrictions that limit this right. Our analysis considers the reproductive justice framework (Ross and Solinger, 2017) as a way to conceptualize access to healthcare “as collective and interdependent” instead of “individualized and independent,” and address structural disparities evident in human rights’ violations which affect social categories, not only individuals (Zavella, 2017, 511). As we shall see, our interviewees criticize the time restrictions established by these laws as failing to meet pregnant people’s needs, highlight the crucial importance of easy, timely access to abortion care even beyond the first trimester of pregnancy, and suggest a more relational approach to the right to access safe, legal abortion. Based on our study results, we argue that access to abortion beyond the first trimester of pregnancy is primarily a matter of reproductive justice.

1.1. Reproductive rights and access to safe abortion in Europe

In most European countries, where abortion has been legal since the 1960s–70s on a woman’s request or for socio-economic reasons and/or women’s distress (Lavelanet et al., 2018; Levels et al., 2014), unsafe abortion is rare, and maternal mortality and morbidity rates are low even in the few European countries with restrictive abortion laws (Singh et al., 2017); therefore, concerns about maternal mortality do not resonate in Europe (Zampas, 2016). In this context, the main advocacy organizations defend abortion as a woman’s right to health and self-determination and a fundamental sexual and reproductive right (De Zordo, Mishtal and Anton, 2016). In the current political debates on women’s right to access safe, legal abortion at the EU level, however, the arguments on “bodily autonomy and equality and non-discrimination”, which have been widely used by European feminist movements, “have not had the traction they need to keep restrictions on abortion at bay in Europe” (Zampas, 2016: 24). In fact, abortion remains contentious in political and legal debates in countries with ostensibly liberal abortion laws, which is our main focus in this article.

The Programme of Action of the International Conference on Population and Development in Cairo in 1994 and the United Nations Conference on Women in Beijing in 1995 first recognized reproductive rights as “human rights.” Member states also recognized that

reproductive health includes abortion as “a matter of social justice” (Zampas, 2016, 26), which deserves protection via international human rights treaties and national laws. In 1999, the UN Convention on the Elimination of Discrimination against Women (UN Committee on the Elimination of Discrimination against Women, 1999) highlighted “the inextricable link between women’s right to health during pregnancy and childbirth and their other human rights” (Berro Pizzarossa, 2019, 59). The Vatican and other conservative forces, however, imposed the use of the term maternal health (instead of reproductive health) in the Millennium Development Goals, preventing the adoption of a comprehensive human rights framework. Consequently, it became difficult to shift the abortion rights debate away from its focus on women’s rights to life and health (Berro Pizzarossa, 2019).

In Europe, official positions on abortion are equally ambiguous. The 2015 Tarabella Report adopted by the European Parliament, Committee on Women’s Rights and Gender Equality (2015) recognized women’s sexual and reproductive rights, including abortion rights, as fundamental, while simultaneously re-affirming member States’ autonomy to legislate on this issue. On the previous year, the Committee of Social Rights ruled on the issue of conscientious refusal of abortion in Italy, where abortion is legal, but objection rates are very high. The Committee called on States to organize their health systems to ensure access to lawful health services to which citizens are entitled to (notably abortion care), which should not be jeopardized by health professionals’ exercise of freedom of conscience (Council of Europe Committee of Social Rights, 2014). These reports and legal decisions highlighted that access to abortion must be ensured to EU citizens in the name of their human right to health and of their reproductive rights.

Other important documents at the EU level have highlighted the entanglement of abortion rights, women’s human rights and gender equality, including the report adopted in June 2021 by the EU Parliament, which stated that the right to health, in particular sexual and reproductive health rights (SRHR), is a fundamental pillar of women’s rights and gender equality. MEPs stressed that restrictive laws force women to carry unwanted pregnancies to term or seek clandestine abortions, which is a violation of their human rights. However, legal restrictions to accessing abortion care, such as GA limits at the end of the first trimester of pregnancy, have never been the object of a serious debate at the EU level, and each State continues to legislate on abortion and organize abortion provision independently. The consequent fragmented legal landscape (De Zordo et al., 2016) thus creates serious disparities in access to abortion care that became evident during the pandemic (Mishtal et al., 2020). The adoption of a human rights framework at the EU level therefore has serious limitation and does not necessarily ensure access to abortion care, as we discuss in the following section.

1.2. Rights or exceptions? Restrictions to legal abortion and gestational age limits in Europe

Beginning in the 1960s, in most Western European countries abortion was legalized mainly to protect the woman’s life or health, and not women’s autonomy and body ownership, and all abortion legislations established specific GA limits. GA limits for abortion on broad grounds vary in Europe from 10 to 14 weeks (calculated since conception or the last menstrual period - LMP), with only a few countries allowing abortion up to 24 weeks by law, like the UK (providers accept to treat only women whose GA is calculated up to 23 weeks and 5 days). The Dutch interpret the legal limit of fetal viability as 22 weeks, while in Spain abortion is allowed up to 22 weeks if risks to the woman’s physical or psychological health exist. For this reason, Spain, the Netherlands, and Britain are, as we have seen, the main destinations for cross-border abortion travel.

The significant variability in GA limits highlights that these are not based on clinical evidence (Lavelanet et al., 2018, 9). Restrictions to legal abortion, like GA limits, clearly show that in the pre-Cairo era

abortion legislations were conceived as paternalistic concessions of patriarchal benevolent states to assert the social importance of motherhood (Passerini, 1994). We argue that these restrictions are based on stereotyped notions of women’s presumed maternal role. As Cusack and Cook (2009) and Berro Pizzarossa (2019) have shown, stereotypes depicting motherhood as central in women’s lives and women as “irrational” and “weak” are embedded in legal discourses on abortion, including in relatively liberal legislations. These stereotypes justify the need that external authorities – states, doctors – monitor their sexual/reproductive behavior and decisions by scrutinizing their reasons, and imposing restrictions to access that woman must respect to avoid legal punishment. Abortion laws are, as several scholars have shown, “the prime example of so-called ‘morality polices’: the policies reflecting high-order moral principles” (Levels et al., 2014, 100) and “moral governance” is meant to boost the authority of the church-state machinery (Mishtal, 2015). From the perspective of the Catholic Church—a historically important actor opposing abortion, in Europe as well as elsewhere—women’s primary social role is maternal, therefore abortion is stigmatized even in countries where it is legal (Kumar et al., 2009). Abortion is considered immoral and cast as a sin in most world religions (Christianity, Islam, Hinduism). However, religious practices and the influence of religion on politics vary from one context/country to another and across time. Furthermore, social and political forces such as feminist movements contest religious norms regulating sexuality and reproduction, which explains why some countries have more liberal laws than others (Unnithan et al., 2023 in press), including regarding GA limits.

Time restrictions can harm pregnant people, as they can delay access to safe abortion care or make it very difficult. Consequently, pregnant people may be forced to either seek an abortion illegally where they live, or in another country with less restrictive legislation, which is what our findings show, or continue an unwanted pregnancy.

According to the UN Convention on the Elimination of All Forms of Discrimination Against Women, states have the obligation “to eradicate gender stereotypes from domestic laws” (Berro Pizzarossa, 2019, 257), including abortion laws, while most abortion legislations in Europe remain unmodified for decades. As Berro Pizzarossa notes, despite being promising, this new approach fails to consider an intersectional perspective, by focusing only on gender, and excluding other forms of discrimination/inequalities such as social, or racial/ethnic marginalization. As we shall see in the “Findings,” our study clearly shows that not only gender, but also social inequalities are deepened by restrictions to access legal abortion.

We argue that European abortion legislations, in spite of being ostensibly liberal, not only reproduce gender stereotypes and deepen gender and social inequalities, but also manifest the legislators’ concern for the embryo/fetus, which abortion laws from the pre-Cairo era sometimes refer to as “human life.” The French and Italian abortion laws mention in their first articles the “protection” or “respect” of “human life since its beginning” (France, 1975; Italia, 1978). These laws’ language evokes the existence of a conflict between women’s freedom (to terminate their pregnancy) and the respect of “human life,” a term which refers to the embryo/fetus, or “the conceived” in the Italian law (Italia, 1978). The French law states that the law “grants the respect of all human being since the beginning of life” (France, 1975). These legislations originally established respectively 90 days and 12 weeks as GA limits. GA limits at the end of the first trimester are legally unjustifiable (Carayon, 2018, 39), unless women’s freedom and rights are opposed to the “abstract interest of embryos.” In Germany, the law also establishes not only GA limits, but also a mandatory waiting period, like in Italy, and mandatory pre-abortion counseling.

These legislations depict abortion as transgressive, with motherhood as the norm, and imply that the embryo/fetus, constructed as a social being needing protection, progressively acquires rights throughout pregnancy.

Some post-Cairo legislations, like the Spanish 2010 law, appropriate

the human rights framework and allow abortion on women's request in the name of "women's fundamental rights" to "physical and moral integrity, intimacy, ideological liberty and non-discrimination" (España, 2010). But framing of abortion legislation as a right may not guarantee access for migrants due to financial and bureaucratic obstacles and insufficient information access (Ostrach, 2017). Moreover, the Spanish law and the more recent Irish legislation still establish GA limits for abortion on women's request.

Among the European countries where abortion has been legal for decades, France is an exception. Under the pressure of abortion rights groups and providers, the government eliminated the mandatory waiting period, and made abortion more accessible by allowing midwives (not only gynecologists and general practitioners) to provide it. Furthermore, France allowed medication abortion provision in the first trimester via telemedicine during the COVID-19 pandemic along with Britain and Ireland (Mishtal et al., 2020). Additionally, GA limits were extended from 10 to 12 weeks in 2001, and to 14 weeks in 2022.

Extension of GA limits has not been on the agenda of any other European country. In Britain, which has one of the most liberal abortion legislations in what concerns time limitations, GA limits for abortion on socio-economic grounds have been restricted from 28 to 24 weeks (Levels et al., 2014), due to political discussions on the "Human Fertilization and Embryology Act" (Guyard-Nedelec, 2018). Such debates center on fetal viability—the capacity of a fetus to survive outside the uterus even if under intensive care. Since the 1990s, progress in the domain of neonatology, assisted reproductive technologies, and new discussions of "rights" as assigned to embryos and fetuses provoked many debates on abortion, but in most cases the law was unaffected.

These debates, however, and the anti-abortion campaigns that have been promoted since 2013 at the EU level and at national levels as well by the Vatican-inspired, professional advocacy network "Agenda Europe" (Datta, 2018), have made discussion on expanding GA limits difficult in Europe.

1.3. From rights to justice: a new analytical framework for GA limits in abortion care

Anthropologists have criticized the human rights discourse for its universalistic, Eurocentric underpinnings (Goodale, 2009), highlighted how they can be mobilized to serve both conservative and progressive political projects (Speed, 2006). Starting from the premise that women's rights as human rights are important, scholars have also investigated how versions of rights discourses can be vernacularized to suit local political and social contexts (Levitt and Merry, 2009). "In a context where the great utopias of the twentieth century seem to have vanished, leaving us in an ideological vacuum," observes anthropologist Julie Billaud (2018, 1), "human rights appear to have become a mere form shaped by bureaucratic procedures instead of a 'real' thing with the potential of achieving the good in the world."

Nevertheless, gender equality and women's rights to life and health are fundamental to human rights, and have been advanced through the key human rights treaty, the Convention for the Elimination of All Forms of Discrimination Against Women (Englehart and Miller, 2014). In the context of contemporary struggles for sexual and reproductive rights, human rights as an advocacy tool has been extremely important as they have facilitated abortion access in different world jurisdictions, including through such mechanisms as the European Court of Human Rights (ECHR) (Chavkin and Chesler, 2005). However, the use of rights discourses to defend abortion is risky, because, as Morgan and Roberts (2012) argue, anti-abortion groups have been using the same human rights rhetoric to oppose abortion through fetal "rights" claims.

In the US, Europe, and elsewhere in the world, abortion rights advocates and scholars are progressively embracing the concept of reproductive justice – a growing concern about the situation of reproductive rights globally (Chrisler, 2012). Originally proposed by US collective Women of African Descent for Reproductive Justice, it critiques the

notion of reproductive rights, as too narrowly centered on the need of white, middle-class women, and solely shaped around abortion and the notions of privacy and autonomy (Ross and Solinger, 2017), therefore marginalizing women's rights to have children and raise them in a safe, healthy environment. The concept of reproductive justice is more about social justice and inclusion, as it supports the reproductive lives and decisions of all, including socially marginalized groups. Moreover, it is focused on access to services and opportunities, not rights alone. This is one of the reasons why we have found this concept pertinent to our results. In the findings sections, we will explore how our study participants, most of whom have traveled abroad because of GA limits, envisage their right to accessing abortion care, and interrogate the extent to which a human rights or a reproductive justice framework better represents the claims they make.

2. Methodology

This article and the next research sections in particular are based on 204 anonymous, self-administered surveys and 30 in-depth interviews (IDIs) with pregnant people who traveled abroad from countries where abortion is legal. Participants were recruited in three clinics in England (North-West and county of London) from July 2017 to March 2019, two clinics in the Netherlands (North) from August 2017 to February 2019, and three clinics in Spain (Catalunya) from March 2018 to April 2019. We selected these clinics based on existing data showing them to be the main destinations for cross-border travel from countries with legal abortion. When patients arrived from their origin countries for their medical appointments, potential participants were shown an information sheet inviting them to participate in the study via a survey and/or an interview by one of the five researchers included in data collection, or by administrative staff.

Our research participants qualified for our study based on being referred to as "women" in our recruitment materials. However, we acknowledge that transgender and gender non-binary people can get pregnant and seek abortion care. In this manuscript, we thus use the gender-inclusive term "pregnant people", or "women and pregnant people" to refer to our study participants and, more broadly, to all people who are capable of pregnancy and/or desiring of abortion, as not all of them identify as "women". We use gender-explicit terms (e.g. "women") when reporting the results of other research studies, where participants identified as such.

Individuals who consented to participate (via an electronic consent for surveys and verbal and written consent for interviews) were offered a self-administered, tablet-based anonymous survey and/or a longer in-depth interview with a researcher at the clinic before their procedure. They could also opt for a remote survey/interview at a later time. Participants received 10 Euro or a 10 Euro gift card for completing the survey, and a 25 Euro gift card for the interview. Translations into English were conducted by the researchers and by a professional translator for German.

The survey included questions on socio-demographic characteristics, reproductive history, gestational age, abortion-seeking experiences (both in country of origin and abroad), experiences traveling abroad for abortion (focusing particularly on time and cost), abortion stigma and disclosure, and experience with self-administered abortion. In-depth interviews focused mainly on our participants' experiences with barriers to abortion care in their country of origin and abortion-related travel abroad.

We assigned identification numbers to participants and pseudonyms are used when quoting interviewees, with interview dates indicated. We conducted quantitative analyses using STATA statistical software package: Release 12. We calculated simple counts and percentages for most variables. We coded the IDIs using Atlas. TI. The coding process was inductive and was informed by qualitative content analysis approaches and by the Grounded Theory, which we followed as a way to conduct a careful thematic analysis of participants' standpoints, more

than as a method to generate a theory (Strauss and Corbin, 1998). These approaches allow for both predetermined, a priori codes to be explored, as well as the emergence of inductive, not previously considered factors or explanations. [Researchers' initials] conducted the interviews and coded them, using both pre-determined codes, which were created based on the main interview guide themes, and new codes emerging from the interviews. For instance, while the code group 'delays' (with regard to access to care) was a predetermined topic of inquiry and was associated with predetermined codes such as lack of access to services, mandatory waiting periods/counseling, and conscientious refusal of care, other emergent explanations were also identified (e.g. finding out/confirming the pregnancy "late", according to the GA limits established in the country of origin), thus new codes were created and included in the analysis. We used constant comparison of codes and data, and an inductive approach, to generate findings. The qualitative team discussed all new codes, which were then adopted by the entire team, as well as any eventual discrepancies and disagreements. For this article, we focused particularly on the codes: reasons for traveling, GA limits, abortion information seeking, delays, self-induced abortion, opinions on GA limits and abortion law, abortion definition, and human rights.

For the purposes of this analysis, countries were characterized as having relatively liberal abortion laws if, during the period of data collection, abortion was available upon request or on broad grounds within legally specified GA limits.

This study was approved by the ERC Ethics Committee on March 4, 2016 (ERCEA/BT/ercea. b.1 (2016)1090019). Ethical approvals for this study were also granted by the University of Barcelona (Spain) on February 13, 2017, the University of Central Florida (US) on February 21, 2017 (SBE-17-12964), the University of Tillburg (Netherlands) on March 23, 2017 (EC-2017.22), and the British Pregnancy Advisory Services Research and Ethics Committee (UK) on May 8, 2017 (REC, 2017/02/SDZ).

3. Findings

3.1. Consequences of gestational age limits and cross-border travel: attempts to self-manage abortion and delays

Our survey participants traveled from eight countries (Austria, Belgium, Bulgaria, Denmark, France, Germany, Italy, and Luxemburg). The majority traveled from Germany (56%), followed by France (23%). Most of our interviewees were from France (13), followed by Italy (11), Germany (5), and Austria (1). We also interviewed several experts, mainly abortion providers and sexual and reproductive rights advocates, whose perspectives have helped us reconstruct the genealogy of abortion legislations in Europe and the origins of GA limits.

In our surveys, pregnant people traveling from countries where abortion is legal overwhelmingly reported having exceeded gestational legal limit as the primary reason for traveling to the Netherlands or England. Over half (56%) learned they were pregnant at 14 weeks or later, when they were already beyond GA limits in their country of residence. Interview narratives reveal that experiencing irregular periods, sometimes combined with stressful life circumstances, lack of clear pregnancy signs and/or misinformation by doctors about contraception and pregnancy signs underpinned the delayed recognition of pregnancy. Some were also delayed by decision-making challenges and changing life circumstances, such as the end of their partnership or the sudden illness of a close relative (De Zordo et al., 2020).

Most of our survey respondents would have preferred to obtain abortion care earlier. In the few cases where women reported that their GA had been miscalculated, it is unclear if the doctor did not explain the matter clearly, or was not willing to provide an abortion close to the GA limit. Many abortion providers in Italy and France whom we talked to highlighted that the difficulties to find abortion providers able and willing to provide care close to GA limits.

Less than half (38%) of our survey respondents confirmed their pregnancy before the limit, and 33% considered abortion before 14 weeks (De Zordo et al., 2020), when legal abortion in Germany and France is still lawful, in principle. In Italy, instead, abortion is allowed up to "90 days of pregnancy," usually interpreted by Italian providers as 12 weeks and 6 days (LMP). Some study participants, as Alina, an Italian 37-year-old woman, mother of one, recruited in Spain, were entitled to a legal abortion, but did not manage to obtain it. Alina explained: "at 10 weeks I decided to terminate ... [Eventually] I was late [exceeded GA limits] because I have gone to the family planning center ... it was closed. I had to go only at certain times, but as I was working I did not ever manage to go. Nobody answered the phone. I had to do thousands of calls, then they re-directed me to the provincial services, then to the regional ones ... they are open only for a few hours and I could not reconcile my obligations and time passed by" (May 2018). Consequently, Alina was only able to secure an abortion abroad at 14 weeks. Unlike in France and in the UK, in Italy there is no governmental website providing easily accessible abortion information. A mandatory seven days waiting period is also enforced before a physician performs the procedure. Finally, another barrier some interviewees faced is refusal of care.

Most participants who traveled abroad from countries where abortion is legal, like Alina, were 18–34 years old (44% were 18–24, 42% between 25 and 34, and 14% were older), had not had a prior abortion (76%) and had not given birth (61%). Approximately half (43%) were married or in a civil partnership or cohabiting and a similar proportion (42%) were single, separated or divorced. The majority had some university education, while 34% had a secondary school degree or below. Most were employed full-time or part-time, but 25% were students and 10% were unemployed. The majority reported that they had sufficient economic resources to meet their basic needs all (39%) or most (27%) of the time. However, 18% indicated that they experienced moderate to severe financial insecurity (De Zordo et al., 2020).

All of our study participants, both from restrictive and relatively liberal legal contexts, faced serious challenges not only when they sought abortion care in their own country, but also when organizing their travel and traveling abroad, especially highlighting inequalities of resources. First, they needed money for travel, accommodations, and procedure.

About two-thirds of the respondents to the surveys from countries where abortion is legal, which we analyzed to investigate the abortion/travel related costs (164 surveys – see Wollum et al. unpublished, under review), and especially single, divorced, or separated participants (compared to being married) experienced some difficulty covering the cost of the abortion procedure and/or the travel. They also had to take time off work/studies and those who had children had to make childcare arrangements. This explains why, on average, approximately 4.2 weeks elapsed between when our survey respondents first considered abortion and when they were recruited at the destination clinic. Longer delays were reported by those with the lowest means. Most of our interviewees felt lucky to be able to afford the costs of an abortion abroad, even if this meant asking others for help or using their savings. Many of them also highlighted that not all women can afford these expenses.

Our findings confirm what the WHO has highlighted in its most recent guidelines on abortion (World Health Organization, 2012; 2022). Abortion travel delays care, increasing pregnant people's health risks, which is a serious concern from a public health perspective. A few study participants considered alternatives. Six percent of our survey respondents who traveled to the Netherlands tried to abort on their own, and all came from countries with legal abortion (6 from Germany, 4 from France, 1 from Luxemburg). Most did not try to use abortion pills. They rather used other methods, including hitting their abdomen.

These findings show that cross-border travel is a potential public health problem and a matter of reproductive justice. In fact, pregnant people seeking abortion care beyond the legal gestational age limit in their country of residence depend on different kinds of resources they

may or may not have access to. These restrictions thus deepen existing gender and social inequalities and make access to abortion very difficult for the most vulnerable pregnant people.

Our study does not account for those pregnant people who could not travel and sought to obtain the service illegally, or were forced to carry unwanted pregnancies to term. It does, nevertheless, illustrate, as we shall better see in the next section, how current abortion policies fail to respond to an expressed need, by prohibiting access to abortion care beyond GA limits. It also illustrates reproductive injustice, as not all people can afford to travel abroad for abortion services.

In the following section, we explore the perspectives of our interviewees from countries where abortion is legal on the restrictions established by the abortion laws of their countries of origin, in particular GA limits, which forced them to travel abroad, and we interrogate the extent to which a reproductive justice framework can help us understand them.

3.2. Laws and rights versus Women's health needs: A difficult balance

An important line of inquiry during our interviews sought to understand what our study participants thought of the abortion law of their country of residence, whether and how they believed it could be modified, and if they thought that a law on abortion was necessary altogether. The topic of GA limits was spontaneously mentioned by many when we asked about the laws.

Most interviewees stressed that the most important aspect of abortion care is an easy access and the availability of the range of existing techniques, regardless of abortion's legal definition, thus suggesting that what pregnant people look for is not necessarily, or not only, the entitlement to an abortion, but mostly that care is granted, irrespective of gestational age. Magda, a 22-year-old Polish student resident in Italy and recruited in the UK, commented: "it's like a tricky thing. There's human rights and no one respects them, so, you know. I feel like it's not even necessary to define it as a human right. I feel like to define it as a woman's choice is a better way to say it" (December 2018). Magda was 7 weeks pregnant when she got her termination, but she had difficulties in getting medical appointments at local family planning centers in Italy, so she feared she may exceed GA limits, and therefore decided to travel abroad.

The majority of the interviewees believed that a specific law on abortion was necessary. However, most highlighted that the main objective of abortion laws should be to protect and help women, by ensuring easy and timely access to services (otherwise physicians would refuse to provide it, three Italian and one French women highlighted) as well as to women's preferred techniques. The gap between what the abortion law established and its actual application was highlighted by several participants from Italy, including Magda, and Sveva, a 47-year-old Italian woman, mother of one, separated from her partner. Sveva faced several difficulties which prevented her from accessing abortion care, including a doctor's refusal, and therefore traveled to the Netherlands. While discussing the Italian abortion law, she commented: "The law must be there to regulate, to provide indications to protect health, not to punish or prohibit" (April 2018).

Abortion services' actual accessibility was the main concern for our interviewees, prompting us to argue that a reproductive justice framework, one which focuses on abortion access instead of abortion rights, represents the claims they made in a more comprehensive way.

The main problem with abortion legislations raised by our interviewees regardless of their country of residence was the fact that they did not favor the evaluation of each individual case, and imposed time restrictions, forcing pregnant people to make quick, sometimes difficult decisions. GA limits are even more problematic, if we consider that other barriers can delay access to abortion, making people find themselves eventually requesting access beyond the limits. This is well illustrated by the case of Julia, who defined the German abortion law as "paradoxical" in this sense, because "in the end, it just lets one down (...), I mean if you

read that through, you think, okay, I got a chance and then the next clause comes and then you think, I don't have a chance at all" (November 2018). Julia refers to GA limits in particular, but she also faced other barriers. She learned she was pregnant after week 13, went to a family planning center for the mandatory pre-abortion counseling and then saw her gynecologist, who told her and her partner "some horror stories, how the baby is then dismembered and stuff like that." Her doctor then added that she had very limited time and referred her to a hospital, where they scanned her and told her she was beyond the GA limit. As she had some mental health problems, she may have qualified for an abortion for medical reasons in Germany (allowed up to 22 weeks), but she was afraid of losing more time to get the mandatory medical report.

In her study on the temporalities of pregnancies that end with an abortion in England [Beynon-Jones \(2017\)](#) has shown that the legal and medical construction of "later" abortions as risky (from a medical perspective) and, at the same time, morally questionable, shape the experience of 'time running out' of many pregnant people seeking abortion care, including our study participants. She also illustrates how in women's accounts pregnancy emerges as a process that is disrupted by socio-material relations, whose temporality clashes with the temporality established by medical experts as well as by the law. These disruptions emerge also in our study participants' stories.

In the case of Beatrice, she explained that the Italian abortion law had been "absolutely impeding to what I had to preserve, which was the right of a girl who already exists, who is 7-year-old, and for whom I am fighting for foster care, which is the right for serenity for a mother who, however, has to make a rather difficult decision in itself" (March 2018). Many interview respondents, particularly those in relationships or with children, emphasized the importance of considering the well-being of their families, and particularly their living children as well as their future, eventual children, and the beneficial effect of abortion on them. Alina defined abortion as "a liberating act, for the mother, for eventual children who are already there and for the *nascituro* (child to be born), because if the mother gets to this decision, it means that she cannot provide them with a dignified life, neither from the economic point of view, nor from the moral, cultural etc." Others highlighted the importance of economic or relationship conditions, if women had no access to abortion care. Anna, for instance, said, referring to single women in particular: "... a lot of women already have children they can't take care of, yes, children that already have a horrible childhood. Maybe they are not even loved, because they were never wanted. Well, I think the law should be more personalized and open."

By asserting their desire to act responsibly and the will to act as "good" mothers and citizens, our interviewees stressed the morality of their choice, and aligned themselves with the dominant gender norms, as women seeking abortion care do in other, more conservative contexts, like Mexico ([Amuchástegui and Flores, 2013](#)). Moreover, they depict abortion access as a matter of reproductive justice, one which allows pregnant people to make decisions on the basis of the family and the children they want to care for. As [Hoggart \(2017\)](#) shows in her study on young women's strategies of resistance to internalized abortion stigma in England and Wales, constructing the abortion decision as morally sound and aligning themselves with dominant gender norms can be a way of resisting and contrasting abortion stigma. At the same time, however, most of our interviewees defended their individual choice to terminate their pregnancy, defended women's ability to make a "choice," and stressed that GA limits made this choice very difficult by forcing them to pursue an illegal abortion in their home country. Several highlighted the positive impact of women's individual choice on their wellbeing. Sveva, from Italy, defined abortion as "... a therapeutic thing (...), it must be therapeutic, meaning that it must be able to cure and restore the woman's wellbeing." Anna, from Germany, said: "for a woman that has her reasons not to have it [a child], is a chance to handle her life instead of complicating it" (November 2018). Elissia, from France, defined abortion as "the possibility to choose your life (...), the

number of children that one wants, even if there has been an accident and ... And to me it gave me back my freedom, actually" (June 2018). Similarly, Shaira observed: "It's something that should be more natural. And in my case, for instance, as I never wanted to have a child or so, it has been very natural, it has been, frankly, very natural. I have not suffered." As Shaira, other women underscored that they did not want to have a child and wanted, instead, to be able to focus on their studies and/or work.

Our interviewees framed their decision both as a personal issue of autonomy and self-determination and in moral terms, confirming what Lesley Hoggart argues based on a study carried out in the UK abortion decision-making is "a complex individualized and intertwined relationship between these two processes of reasoning" (Hoggart, 2019, 2). Finally, they called for more liberal, homogeneous laws at the EU level, which should not limit their reproductive freedom, by imposing GA limits, and should grant easy, timely access to abortion care. Several interviewees would have preferred an earlier abortion and close to home – an easier process both logistically and emotionally. Most of our interviewees would modify the law in their country by extending GA limits, and one French woman was in favor of their total elimination. Only three interviewees had no clear opinion on this matter, while one Italian woman favored the status quo. Shaira, a Brazilian student who lived in France and obtained her abortion in the Netherlands, suggested that a more homogeneous EU regulation would be beneficial. She said: "If we could have, for instance, in the European Union, something regular concerning that, let's say, voilà, we have the right until 24 weeks ... it would be cool" (November 2018). This is not possible, however, because EU member States can legislate autonomously regarding sexual and reproductive rights (Mishtal, 2014), and abortion is a highly contentious object of debate in several countries (Matalucci, Mishtal, De Zordo 2018).

4. Conclusions

In this article we argue that an equitable access to abortion care is impossible for people facing GA limits to services, long enshrined in European countries' laws. Our study thus contributes to anthropological and feminist debates about reproductive health, and reproductive governance and justice, by shifting the locus of attention to GA limits and its impact on pregnant people, as a very relevant phenomenon that is often missed from scrutiny in settings where abortion laws are deemed liberal. These restrictions to legal abortion, which have been established since the 1960s by most legislations, are based on stereotyped notions of women's presumed gender role as mothers and caretakers, and implicitly recognize the embryo/fetus as a person that acquires "rights" during pregnancy. Despite the variation of legal time limits in the abortion legislations that we have analyzed, all have one thing in common: they fail to take into account the actual time of pregnant people's lives – marked, as we have shown, by complex relationships, with their partners, children and families, and by work – and the time of their reproductive bodies, which cannot be easily controlled or trusted. Most of our study participants, as we have seen, did not learn they were pregnant before the GA limits due to lack of symptoms, irregular periods, wrong assessment of gestational age by doctors, and those who were still within the limits were delayed by barriers in accessing abortion services where they lived.

The legal "hierarchy in the acceptability of women's reasons" – life threat, serious risks for the woman's physical or mental health, severe fetal malformations, and rape – clashes with the fact that most women seek abortion for socio-economic, family or marital/relationship status issues (Lavelanet et al., 2018, 8), which is confirmed by our findings. For all these reasons our interviewees called for a more personalized, woman-centered and relational approach to abortion rights that considers the complexity of their lives.

The European abortion laws counter-pose pregnant people not only vis-à-vis the fetus, but also health professionals – the enforcers of GA

limits, and thus, the gatekeepers of their right to access legal abortion. Our study illustrates how legal restrictions to accessing abortion care deepen existing social and gender inequalities and jeopardize pregnant people's health. In fact, delayed access may increase risks to health. Furthermore, not all pregnant people are able to afford or arrange travel abroad, and some may attempt to self-manage an abortion in the second trimester of pregnancy, or feel forced to carry on with an unwanted pregnancy. Abortion travel thus is also a matter of reproductive justice, as people are dependent on access to specific resources including finances, information, support, citizenship status, and social networks. The disparities in accessing these resources pave the way for unequal reproductive opportunities (Zanini et al., 2021), leading to self-arranged reproductive practices and, in some cases, to the open, or silent contestation (via self-arranged travels) of discriminating reproductive policies.

Our findings show that the human rights framework, which has been adopted at the EU level, but is not reflected in the legislations, nor in the organization of abortion provision of all EU countries yet, is not sufficient to grant easy and equal access to abortion care to all EU citizens living in countries with legal abortion, therefore sustaining existing gender inequalities. The influence and persistence of "gender stereotypes" concerning women's maternal role underpins many European pre-Cairo abortion legislations that we have examined in this article, including the French and Italian cases, which establish serious restrictions to abortion access. These laws clearly exemplify "how the conferral and implementation of reproductive rights may work unexpectedly to extend harmful processes of reproductive governance" (El Kotni and Singer, 2019, 120). Laws that restrict abortion access to specific individuals, under specific circumstances, within a precise timeframe established by legislators, and under health professionals' control, fail to recognize pregnant persons' need to avail of abortion as full moral and political subjects and citizens entitled to reproductive rights, while depicting them, instead, as potential criminals and persons unable to make their own moral decisions. These laws are usually considered liberal, while they are, in fact, restrictive.

Women and pregnant people, however, are not passive subjects of the restrictive laws apparatuses, unable to contest them (Deveau, 1994). By seeking illegal abortion or traveling abroad, they challenge the laws and GA limits in their home country, and thus assert their will and their power to make decisions, in spite of legal restrictions. For most of our study participants, who were unfamiliar with how abortion was defined by national laws and transnational treaties, it would be important for abortion to be defined as a woman's right, which most abortion legislations lack, and also as a human right, and that abortion regulation allowed the evaluation of every case as legitimate without establishing rigid limits. Based on their own experience, our participants argue that more homogeneous abortion laws in Europe, with more extended GA limits, would mean that pregnant people are not forced to travel cross-border to meet their reproductive needs. Regardless of its formal definition, however, our participants think they should be entitled to choose whether to carry on a pregnancy or not, in the name of their bodily autonomy and self-determination, to avoid the negative consequences that carrying on an unwanted pregnancy could have for their lives, and for the lives of their families, including potential future children. Abortion access emerges in their accounts mainly as a matter of reproductive justice, allowing pregnant people to make decisions based on the actual or potential children and family they care for.

More research is needed to understand how not only gender, but also other forms of discrimination and inequalities (citizenship status, race/ethnicity, disability, age, educational level, employment, marital/relationship status, etc.) affect the ways in which women and pregnant people envisage and enjoy their reproductive rights, and particularly abortion.

Our findings show that unless abortion laws are based upon pregnant people's needs rather than upon physicians' and medical knowledge and priorities, and conservative groups' concerns for the "life" of the

embryo/fetus, abortion will be a “right that isn’t” (The *Guardian*, 2010), and that abortion should be framed as an issue of reproductive and social justice, and not only as an individual woman’s human right.

Credit author statement

Silvia De Zordo: funding acquisition, project administration, supervision, conceptualization, methodology, investigation (qualitative data collection), (qualitative) data curation, writing original draft, review and editing; **Joanna Mishtal:** supervision, conceptualization, methodology, (qualitative) data curation, contribution to writing original draft, review and editing; **Giulia Zanini:** investigation (qualitative data collection), (qualitative) data curation, contribution to conceptualization and to writing original draft, review and editing; **Caitlin Gerds:** supervision, conceptualization, methodology, (quantitative) data curation, contribution to writing – review and editing.

Data availability

The data that has been used is confidential.

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