Access to Safe Abortion – Obstacles and Opportunities in Poland

Master Thesis

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Abstract

Issue/Problem

Polish women are denied their legal right to abortion in their home country, having to overcome various obstacles in order to receive the desired abortion. It is legal to have an abortion in case of a threat to the mother’s health or life, if the fetus suffers from severe genetic malformation or if the pregnancy results from either incest or rape. But Polish women have to resort to underground abortions, which is usually a health risk, or travel to another country in order to have an abortion performed, which is usually connected with high costs.

Proposal

In order to identify what has to change in the situation of restricted access to safe abortion, the present work focused on presenting the obstacles for this restricted access and to present possible solutions for the future for this issue.

Method

For the present work, additional to literature review, two expert interviews were conducted in order to gain deeper insight into this situation and to figure out the solutions these experts see right now for this situation.

Conclusion

In the course of the thesis, three major obstacles were identified. First, the legal documents lead to confusion, as these do not state clearly what is legal and what is illegal. The second obstacle is the huge influence of the Catholic Church on the state and doctors. As a result, the third obstacle occurs when doctors are pressured by the Church to evoke the conscience clause which allows them to deny women the access to abortion.

Concerning possible solutions for this situations, the research concludes with the sad outcome that at the moment there is nothing else to do than to raise awareness about the issue of restricted access and to wait for the next election in 2 ½ years in order to change the government to a more liberal one.
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Abortion has been documented throughout time, but is still treated as a taboo topic and is accompanied by a lot of stigma and ethical problems. With the advancement and modernization of contraception and widespread sexual education, the number of unwanted pregnancies and therefore abortions has decreased in the past decades, but abortions are still carried out daily throughout the world (World Health Organization, 2011).

Just like contraception got modernized, the process of abortion developed from backstreet abortionist to highly advanced surgical or medical abortion. The standards of abortion vary throughout the world, just like with any other surgical procedure, making surgical abortions one of the safest medical interventions in one country but a surgical intervention fraught with risk in another country. Without medical standards in place, some women resort to drastic measures such as shoving coat hangers into their uterus or drinking questionable mixtures of chemicals in order to terminate their pregnancy. And even if medical standards are in place, some women do not have access to these safe procedures due to lack of money, legal restrictions or social stigma (World Health Organization, 2011).

These so-called unsafe abortions, sometimes resulting in death of both mother and fetus, are still present throughout the world and sometimes even common in first world countries, as pregnant women experience restricted access to these safe abortions. The number of unsafe abortions has increased within the last two decades (World Health Organization, 2011), but this may be due to the growing numbers of women in reproductive age. Europe is the only region identified where the total number of unsafe abortion per 100 births decreased, but Eastern and Southern Europe still stand out as the sub-regions with high numbers of unsafe abortion rates.

Abortion laws can be one factor in restricting the access to safe abortion for women. The grounds on which abortions are legal in each country vary throughout the world and also in Europe, with France being a country that has no restrictions on abortion and Malta and the Holy See outlawing abortions completely. Poland is one of the only countries in Europe that has increased its restrictions on abortion over the past
three decades, making it also one of the few Eastern European sub regions where access to safe abortion is restricted by law and safe abortion barriers have increased (Nowicka, 2008).

The situation of abortions in Poland has been the same for 20 years now and even longer, if one does not count the one-year long liberation of laws in 1997, when the government changed and a new, more liberal abortion law was introduced. This law was declared unconstitutional one year later and the stricter abortion law came back into force. Since 1993, after the implementation of the Act on Family Planning, Protection of the Human Fetus and Conditions for Termination of Pregnancy – commonly known as the Polish Anti-Abortion Act, abortions are only legal in three cases: in case of a threat to the mother’s health or life, if the fetus suffers from severe genetic malformation or if the pregnancy results from either incest or rape. And even if a woman would be legally entitled to have an abortion, she cannot be sure if she will actually receive this abortion (Nowicka, 2008).

One of the key components of the WHO Global reproductive health strategies, written in 2004, is to eliminate unsafe abortion (World Health Organizaiton Departement of Reproductive Health & Research, 2004). This strategy is based on the international human rights treaty demanding the highest attainable standard of health. This treaty demands the right for every couple or individual to decide freely and responsibly on the amount, timing and spacing of their children and to have the access to information to be able to do so. Additionally, it claims that every woman should be able to decide for herself concerning her sexuality, including reproductive health. In order for these rights to be realized and also to save women’s lives, legal and policy aspects of the provision of safe abortion need to be adequately addressed. As Poland signed this treaty it is obliged to implement policies in order to complete its demand, but, as will be shown in this thesis, Poland still lacks the implementation of several segments of the treaty, for example that couples can decide freely about the amount and spacing of their children.

The opponents of abortion, above all the Catholic Church, apply pressure not just on the Polish government, but also on the Polish people and therefore also doctors, to not perform abortions (Wellings & Parker, 2006). Due to this pressure the social stigma of abortion increases even more and women, who are entitled to abortions, are afraid to talk about this in public or rather have the abortion performed in an
underground clinic without anybody knowing about their pregnancy in the first place than talking about this issue publicly (Turner, Börjesson, Huber, & Mulligan, 2011).

The official numbers of abortions in Poland mirror the legal restrictions implemented in 1993, as the amount of abortions officially documented has decreased significantly from 59,417 abortions in 1990 to 1,100 in 2015 (United Nations, 2000) (United Nations, 2016). But, as Sedgh et al. (2012) point out in their study, women undergo abortions even if the legal system does not allow them to. And even women who are legally allowed to undergo abortions, as they fulfill the legal requirements, are denied this right and the access to safe and legal abortions in public hospitals. Poland therefore faces a problem of women resorting to the abortion underground in order to get treatment that the law actually allows them to obtain in public hospitals, because they face unnecessary restrictions in order to get access to these safe abortions they are entitled to. A study conducted by Nowicka (2008) in order to get an approximate number of underground abortions came to the conclusion that about 150,000 abortions take place every year in the Polish abortion underground.

Polish women face restrictions when intending to obtain a legal abortion. It is the aim of this thesis to present in detail the obstacles for this restricted access and to present possible solutions for the future for this issue.
2 Goal and Research Question

As shown in the preceding introduction and problem definition, a clear concept and comprehensive analysis of the legal and ethical background of abortion law in Poland is essential when it comes to why women are denied abortions. In order to find out what can be done to give these women access to abortions they are legally entitled to, the following research question was derived to be answered in the master thesis:

‘What are the reasons that Polish women have restricted access to their vested right of safe abortion services in their home country and what are possible solutions for this issue?’

The goal of this paper is to identify the obstacles that women have to face when wanting access to their vested right of an abortion in Poland and what measures can be taken in the future to enable the women to fulfill their needs. The paper looks at Poland in a European perspective, also considering the women’s right movement and concludes with an outlook to the future, in order to see what possibilities Poland has to tackle the big issue of safe abortion.

The outcome of the thesis are possible solutions seen by the interviewed experts in order to solve the problem of women being denied their vested right to abortion in their home country.
3 Methodology and Research Methods

This paper aims to give an overview of the circumstances regarding abortion in Poland, particularly the denied right to legal abortion and also aims at concluding with possible solutions for the problematic situation. Therefore, the author decided to conduct expert interviews with experts dealing with the topic of restricted abortion in Poland on a regular basis.

When talking about expert interviews, it has to be established first who ranks among the experts. After elaborating on the term of expert, Bogner et al (2009) were able to provide an approximate definition. Concerning a specific field, an expert has process, technical and interpretative knowledge as the expert himself acts in an appropriate way, such as in his own professional area. The expert does not just have knowledge in a systematized and reflexively accessible way on a specific field or subject, but also has knowledge on practice and action, including maxims for action, patterns of social interpretation, his or her own rules of decisions as well as collective orientations. This all means that an expert can become ambitious in his specific field of work, aspiring to have his orientations enforced. By affecting his own practice by his knowledge, the expert also influences other actors in his field.

The experts selected for this thesis are experts rather on the organizational field as well as the women’s rights field. All the experts who were contacted and invited to contribute to this study are directors of organizations dealing with abortion rights in Poland, politicians in Poland or the European Parliament dealing with the topic of abortion, gynecologists in Germany working on the boarder to Poland and authors of articles dealing with the history of abortion or the current problem of access to legal abortion in Poland. These experts all deal with the topic of abortion in Poland on a regular basis and are invested in this issue. But even though numerous experts were contacted in order to receive responses from several viewpoints, only two responses were gathered, as the rest of the contacted experts either were unwilling to contribute to the study, had time scheduling issues, did not feel competent enough to contribute, did not want problems with the Polish government or did not respond at all.

The first respondent is Krystyna Kacpura, who is the executive director of the Federation for Women and Family Planning, a member of the Sexual Rights
Initiative, of the European Society for Contraception and Reproductive Right as well as the Programme Council of the Congress of Polish Women.

The second respondent is Gina Horst, who is a parliamentarian referent at the European Parliament and works for Maria Noichl, a member of the European Parliament. This response was in German and the author of the thesis tried her best to translate this response into English in order to use it for quotes.

After the interviews were conducted, the noticeable and meaningful statements were marked and grouped according to the literature research done previously. These responses can be found in the sections 7.5, 7.6, and 7.8.

It has to be mentioned that in the beginning of the research it was aimed at also interviewing women affected by the restricted access to their vested right. But even after a broad call was conducted to receive answers from these women, assuring them their answers would stay completely anonymous, this call ended in no responses. Therefore, the intention of conducting interviews with affected women was suspended.

It should be noted right away that the author of the thesis identified several potential limitations of the conducted study, which are presented and discussed in the following. The presented thesis includes extensive literature research, which was not done on a systematic approach and also includes expert interviews. It should be noted that this thesis only includes two expert interviews, which can be a limitation. The number of interviews in this case is sufficient for this thesis, as one of the interview partners is a well-known women’s rights activist. On the other hand, the number of interviews should be higher, if specific knowledge on the side of the health sector as well as the governmental side was desired. Furthermore, the questions asked did not follow a specific interview method nor a specific interview guideline, especially as one was conducted via Skype and the other one via E-Mail. The interviews were carried out after conducting the literature research and therefore the questions might have been leading and generated a potential bias.

Furthermore, it has to be noted that regarding the number of interviews the author of the thesis miscalculated the time required to gather more interview partners and many of the potential interview partners either denied giving an interview or there was not enough time to schedule the interview. It should be noted that two potential
interview partners denied giving an interview at all, because they were scared of creating a conflict with the Polish government.

It has to be kept in mind that the interviewed experts have their preexisting viewpoints and their responses are according to these. But as the responses of the experts are consistent with the results from the literature research, this is not a problem. Concerning the literature research, it has to be mentioned that no systematic approach was conducted as the author did not see the need to do so.

As mentioned before, interviews with affected women were planned in order to gather information on the specific problems these women experienced, but no interviews were achieved. This is not a big problem for this thesis, as a sufficient amount of papers and organizations have already dealt with this issue and have produced enough resources to count on. As it was proposed to answer the questions asked via E-Mail, but with the guarantee to treat all responses completely anonymous, this might have scared some women towards not answering these questions at all. For further research and if the viewpoints of the affected women have to be considered, it might be a good idea to gather this information via a questionnaire, guaranteeing complete anonymity for the women.

Concerning scientific criteria of this research, validity is granted as the research question was valid for the desired outcome and the methodology chosen was appropriate for the research question to be answered, and the results and conclusion are valid for the context. Reliability is given as the process of the research as well as the results are replicable and the method of research is documented. Lastly, it can be argued whether generalizability is given as only two expert interviews were conducted. But as both experts in essence state the same thing and the theoretical research came to the same conclusions as well, generalizability is given.
4 Abortion, Possible Consequences and the Ethical Dilemma

Abortion itself is defined as the termination of a pregnancy before the fetus is viable. It has to be distinguished between abortion and miscarriage, as abortion, frequently used as a synonym for the term induced abortion, refers to the term of a deliberate discontinuation of the pregnancy, whereas miscarriage is considered a natural or spontaneous loss of the fetus (Miller, 2006).

Induced abortion can be found in documents throughout history (Paul et al., 2009), but with the advancement of technology and medical devices, abortions have become more safe and the burden on the women's health has decreased immensely. And even though unsafe abortions and related deaths were almost eliminated, an estimated amount of 22 million abortions continue to be unsafe each year, leading to the death of an estimated 47,000 women (World Health Organization, 2011).

Up until the sixteenth century, the quantity and therefore also the quality of information about the uterus and mechanism of delivery where scarce. By gaining insight in anatomy, the knowledge of the external appearance of a fetus also increased. In 1774 Giambattista Bianchi published his work about the history of the fetal development, followed by William Hunter who came to the conclusion that a fetus can be identified with a baby in miniature. The Catholic Church debated about the moment of animation of the fetus, and Pope Sixtus V predicted excommunication for anyone who acquired an abortion, but this opinion was not expressed and followed the majority of theologians. Pope Innocent XI then affirmed in his pontifical bull that once conceived a fetus is a person from the beginning (Galeotti, 2003).

What also played a crucial role in the development of abortion rights was the formation of states as nations and the rise of these in the process of shaping abortion politics. One change in this development was that motherhood emerged as a duty, women should accomplish as citizens and the fetus turned into a potential civilian. The other change was the gender shift in the roles of caregiver pre- and post-natal. For centuries women had been the ones taking care of the rituals, processes and care connected with pregnancy and delivery. But with the
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development of medicine, and as it was exclusively practiced by men, women lost their traditional role of midwives and obstetricians (Galeotti, 2003). France, the first state interested in regulating abortion, punished everyone who assisted in an abortion – excluding and excusing the pregnant women themselves (Beauvoir, 1974).

It is also interesting to look at the policies adopted by the European countries between the two world wars. In the Soviet Union, abortion laws and induced pregnancy termination on demand were liberalized, Nazi Germany made laws according to races, legalizing and encouraging abortion for women of inferior races. This behavior was also experienced later on by African American women in the United States, for whom it was easier to obtain an abortion and who even felt encouraged to do so. Italy, on the other hand, outlawed the assistance to abortion and punished it with a two to five-year imprisonment. Following the end of the second world war was a new wind in women’s politics rights which was also encouraged by the development of the world’s first contraceptive pill, Envoid, allowing the separation of procreation and sexuality and enabling women to make a choice about maternity, to an extent never before possible (Galeotti, 2003).

Reproductive rights were now one of the main factors of women’s liberation and equality. In the second half of the nineteenth century the U.S. had outlawed abortion, if not performed on the ground of therapeutic reasons defined by physicians. In the second half of the twentieth century however, it became easier for women to receive an abortion, as illegal abortionists and psychiatrists indicating false premise for legal termination of pregnancy became relatively easy to access. Many women traveled to Japan, which was very expensive but safe, or to Mexico, which most of the times was no way to a safe abortion. However, many women receiving a legal abortion in the U.S. were sterilized even without their consent. After a collective of women had formed a service and offered safe and cheap abortions to women in need and performed more than 11,000 abortions, the group was forced to quit their actions after the Supreme Court’s ruling in Roe v. Wade (and Doe v. Bolton) in 1973 (Solinger, 1998). Following this decision, abortion was legalized in the United States in the first trimester (Szczuka, 2004).

Influenced by the American feminist movement and the introduction of the Pill, a radical shift went through most European countries and women and reproductive rights were reintroduced into legislation, resulting in the fact that by 1975 most
European countries allowed abortion (Wolf, 1991). The Catholic Church stood unmoved though; a panel was formed discussing the Church’s position on the Pill, concluding in the permission to use such contraceptive measures. The panel was ignored in the Second Vatican Council, identifying abortion as killing and also by the Pope who forbade contraception and abortion in total. Pope John Paul II did not change the take of the church on abortion and contraceptives either, he was known to be an opponent of all these measures. He even stated that from the moment of conception the fetus was a human being (Zubik, 1997). Poland was specially affected by this, as this was their fellow countryman.

Unsafe abortion is defined by the WHO as the process for discontinuing an unintended pregnancy, with this process being carried out persons without the necessary skills or in circumstances that do not comply with medical standards or both (World Health Organization, 2011). As the term of safe abortion is not defined by the WHO or by any other major health organization, this paper will consider it the opposite of the term unsafe abortion defined by the WHO. Therefore, safe abortion will describe the process of terminating an unintended pregnancy by persons with the necessary skills and in circumstances with the appropriate medical standards.

4.1 Unsafe Abortion

Even though the definition of unsafe abortion appears only to include the actual process of the abortion itself, it also contains the inappropriate circumstances before and after the abortion. The absence of pre-counseling and advice, the performance of the abortion by an unskilled provider, in unhygienic conditions or by a health practitioner outside adequate or official health facilities are also contained in the definition of unsafe abortion. Additionally, if the abortion is triggered by the insertion of an object into the uterus by either the woman herself or by a traditional practitioner or by violently massaging the abdomen, it is considered an unsafe abortion. Furthermore, a medical abortion occurring due to incorrectly prescribed medication or medication distributed by a pharmacist without the adequate instructions and no follow-up, and a self-induced abortion by ingestion of traditional medication or hazardous substances are all included in the term unsafe abortion (World Health Organization, 2011).
Additional dangerous features of unsafe abortion include the failure of providing post-abortion check-up and care, such as the missing of contraceptive counseling to avoid repeated abortion, the absence of immediate intervention in case of severe bleeding or any other emergency during the procedure, and lastly, the reluctance of the women seeking immediate medical care if complications occur due to legal restrictions, social and cultural stigma linked to induced abortion. It qualifies as an unsafe abortion, not only, if all conditions occur, but also if only a few conditions occur (World Health Organization, 2011).

The consequences of unsafe abortions depend on various reasons and can therefore vary. If all pregnant women received care recommended by World Health Organization (WHO) standards, maternal deaths would decrease from 290,000 to 96,000 by 67%, and the burden of disability connected to pregnancy and delivery experienced by women and newborns would decrease by three-quarters (Singh, Darroch, & Ashford, 2015). The procedures of unsafe abortions include the insertion of an object or substance into the uterus, intake of toxic substances and application of external force. In some occasions the woman’s lower abdomen is beaten in order to end the pregnancy, which might lead to rupturing the uterus and killing the woman. The costs of an unsafe abortion and its occurring complications are contributing to the costs to the health system.

Long term effects include reproductive tract infections which 20–30% of women who have undergone an unsafe abortion suffer from. 20–40% of these can furthermore result in an infection of the upper genital tract (Murray & Lopez, 1998). Furthermore, every fourth woman undergoing an unsafe abortion will most likely require medical care due to a temporary or lifelong disability (Singh, 2006). But as some women do not consider the complication they suffer from as serious enough to seek medical care, or they are afraid of abuse, ill-treatment, legal reprisal or do not have the financial resources, the number of women suffering from complications is not correct (Juarez, Cabigon, Singh, & Hussain, 2005) (Sathar, Singh, Rashida, Shah, & Niazi, 2014).
4.2 Safe Abortion

The WHO recommends one method of surgical abortion to policy makers, program managers and providers of abortion care, which is vacuum aspiration for pregnancies up to 12 to 14 weeks of gestation. It also recommends methods of medical abortion according to the gestational age, pointing out two different medications, from the beginning of the pregnancy up to 14 weeks. After this time period, health care facilities should offer at least one of two options: dilatation and evacuation and medical methods (World Health Organization, 2012).

The WHO also issued recommendations for the care before an induced abortion, which include advice on cervical preparation, ultrasound scanning, prophylactic antibiotics and pain management. Regarding post-abortion care the WHO offers recommendations on contraception, follow-up visits and incomplete abortion cases. Recommendations for the health systems include that safe abortion services at primary-care level with a referral system to required higher-level care should be available and affordable to all women to the full extent of the law. Included is also the recommendation that the act to strengthen services and policies should always be based on the human rights and health needs of women. In addition, abortion providers should have training that ensures good-quality care in line with national standards and guidelines, with supervision, monitoring and evaluation. In the field of finance, the recommendation is that services should be affordable and available to all women who need them. The WHO also points out that bearing the additional costs of safe abortions will only be insignificantly higher compared to the costs of treating complications from unsafe abortions. Lastly, the WHO’s recommendations on regulatory, policy and human rights considerations state that abortion laws and policies should always protect women’s human rights and health, that barriers that hinder access and provision to safe abortion should be removed, and that if women legally can get an abortion performed, they should have access to safe abortion care (World Health Organization, 2012).
4.3 The Ethical Dilemma of Abortion

The topic of abortion is one of wide range, in which personal issues collide with political, social, religious and ethical issues (Ryan, 2012). The attitude toward abortion has varied over time, is different in cultures and places all around the world, ranging from being performed as a common method for birth control to being severely restricted. As for example in Latin America where reproductive issues such as abortion are influenced immensely by the Catholic Church, triggered by the fact that the Church views teaching about abortion as unethical (Harris, 2011).

Even though the labels the two parties in this discussion give themselves might just seem convenient, it is important to take a closer look at both of them. One party identifies themselves as pro-life, implying that the other party is against life entirely. The other side calls itself pro-choice, therefore implying the other side would be against choice completely (Harris, 2011).

The two viewpoints of the two parties were simplified by Jones and Chaloner (2007). The pro-life party argues in the way that the fetus is an innocent human being, and killing an innocent human being is morally wrong, so the conclusion would be that killing a fetus is morally wrong. The pro-choice on the other hand argues that a fetus does not have a moral status, and destroying something without a moral status is not morally wrong. So the conclusion here is that it is not morally wrong to destroy the fetus. However, it has been argued on when this point of time of moral status is actually reached, and therefore the point of time when abortions are ethically and morally wrong. Here the stages of conception, human appearance, the sensitivity to pain and then the viability were proposed as moment of achieving a moral status (Hunt, 1999).

The dilemma of abortion starts at the question whether the pregnant woman has the right to do with her body what she wants. As the fetus ‘lives’ in the woman’s body, one could argue that she can do as she pleases with the fetus as well, therefore also defending herself from any harm or threats in conjunction with the fetus (Thomson, 1976). The US Supreme court ruled in the case Roe vs. Wade in 1973 that it was unconstitutional to have a law that would prevent an abortion in the first trimester, as in this time period the mother would have a right to privacy and determination of what happened to her body. After this period though, the mother’s priorities were put behind the ones of the fetus (Ellis & Hartley, 2012).
The question from when the fetus is entitled to live has to be considered as well. As already mentioned, the Roman Catholic Church is known for the opinion that from the moment of conception the fetus should be considered a human being (Harris, 2011). Here the time from which a fetus is able to survive plays an important role to others. But this point of time has changed in the recent years and with the advancement of medical technology. Furthermore, the rights of the father have become a increasingly discussed topic as well, some claiming that the prospective father should have the same say in the abortion decision as the mother.
5 Abortion Laws and Incidence of Abortion

Nearly all developed countries offer safe abortions legally upon request or also under social and economic grounds (United Nations, Department of Economic and Social Affairs, & Population Division, 2014). Nonetheless, the probability of a woman undergoing an abortion is about the same in countries where it is legally restricted compared to the countries where it is not (Sedgh et al., 2012). Legal restrictions lead to women seeking abortion in another country, from an unqualified provider or under unhygienic conditions, leading to a significant risk of death or disability. Additionally, to legal restrictions the inability to pay, the lack of social support, the poor quality of service and the providers’ negative attitudes can be other barriers to safe abortion.

5.1 Comparison of Laws and Major Changes in the Past Years

An extensive report about abortion policies all over the world done by the United Nations in 2013 shows the grounds on which an abortion is legal in each country. In at least 71 countries it is legal to perform an abortion to preserve a woman’s physical or mental health. In addition to that, 50 countries allow an abortion to be carried out to save the woman’s life. In contrast to that, there is only 70 countries allowing abortions due to economic or social reasons or on request (United Nations, Department of Economic and Social Affairs, & Population Division, 2013). According to a study conducted by Boland and Katzive in 2008, 56 countries, embodying almost 40% of the citizens of the world, have laws permitting abortions without any restrictions, including China, France and India (Boland & Katzive, 2008).

Overall there is only six countries that have outlawed abortion under all conditions. In Europe Malta and the Holy See do not permit abortions, in Latin America and the Caribbean, there is four countries, Dominican Republic, El Salvador, Chile and Nicaragua. While restrictions have declined in a few African, European and Asian countries, Latin America is the continent in which the restrictions have increased the most between 2005 and 2013 (United Nations et al., 2013). El Salvador changed its law in 1998, eliminating all legal possibilities for abortions, restricting the previously allowed case of saving a woman’s life and in the case of fetal impairment or rape (United Nations et al., 2014). In Nicaragua the law was changed in 2006 from previously permitting women to undergo an abortion in the case of a therapeutic
Abortion approved by three physicians, in addition to the consent of the woman’s spouse or nearest relative, as opposed to now where abortion is prohibited in all cases (Boland & Katzive, 2008). Even though some countries in Latin America did not expand the grounds for legal abortion, they put practices in place making abortion safer, such as Uruguay in 2004, where patients will now be provided with information in order for them to make an informed decision, including consultations with gynecologists, mental health services and post abortion care (S. Wood, Abracinskas, Correa, & Pecheny, 2016).

Taking a closer look at Asia, Nepal is the country, where restrictions have changed the most. In 2002 a law was amended which gave the right to women to receive an abortion without restrictions in the first 12 weeks of gestation, unless the abortion is carried out for the purposes of sex selection (Samandari, Wolf, Basnett, Hyman, & Andersen, 2012).

In the middle eastern region, one country which has changed its abortion laws drastically is Iran; in 2005 a law was issued legalizing an abortion in the first four month of pregnancy in case of fetal impairment and if the mother’s life is in danger. This change is especially significant as it is the first change of the penal code based on Islamic law since the Revolution of 1989, outlawing abortions altogether (Boland & Katzive, 2008).

The region of Sub-Saharan Africa has seen a lot of changes after a series of meetings, bringing together government officials and other interested parties. They issued a model law helping legislators to address reproductive health issues. This resulted in several countries changing their abortion laws, including Benin, Guinea and Togo. These countries legalized abortions in case the fetus is marked by a serious condition, if the pregnancy is a threat to the woman’s health or life or if it is resulting from rape or incest. Niger and Chad now allow an abortion if the woman’s health is in danger, but excluding the grounds of rape and incest, compared to the previous law of only allowing an abortion to save the mother’s life (Boland & Katzive, 2008).

Focusing on Europe in particular, it stands out, that the countries in Eastern Europe have less restrictive laws than in the other parts of Europe where at least one country has quite restrictive laws. Andorra, Ireland and San Marino, for example, only allow the women to receive an abortion if their life is in mortal danger. Specifically Ireland in the past 20 years has voted five times on its abortion laws.
The last vote cast continues to allow women abortions on the ground of suicide (Republic of Ireland, 2013), a gap in the law that especially the government and the Catholic Church wanted closed. More than 3,000 women legally choose to travel to the UK for a termination of pregnancy (Department of Health, 2015). Other countries, such as Switzerland and Portugal, have changed their abortion policies considerably in favor of women seeking abortions. Portugal for example voted in 2007 in favor of making abortions available on all grounds up until 10 weeks of pregnancy. Switzerland changed its abortion laws in 2002 from only allowing abortions on health grounds to making abortions legal up to 12 weeks of pregnancy without any restrictions. On the other hand, there are some countries which have put up more restrictions for women to undergo an abortion. Latvia is one of these countries, as the country approved new regulations in 2003 which now require the woman to undergo counseling, making her aware of the medical complications of an abortion, the possibility of preserving the life of the unborn child and of the moral aspects of an abortion. A three-day waiting period is imposed on the women in which they have to be informed again about the complications of the abortion. In addition to the counseling, the woman, in case she is a minor, has to be accompanied by a parent or guardian when undergoing the abortion (Boland & Katzive, 2008).

Taking an even closer look on Eastern Europe, it is interesting that in Hungary for example abortion was legal on socio-economic grounds during the Communist period. After Communism ended, the parliament amended a law permitting abortion on request in the first twelve weeks of the pregnancy, but stressed the respect for life. The Czech Republic has a regulation in place that abortion is a private matter between a woman and her gynecologist, and it did not revise the abortion law after the fall of Communism, but kept the law it amended in 1986 (United Nations et al., 2014).
5.2 Incidence of Abortion Throughout the World

It is estimated that every year 208 million women become pregnant worldwide. Out of these, 59% planned the pregnancy and leading to either a birth, a miscarriage or a stillbirth (Singh, 2016). This leads to the remaining 41% being unintended pregnancies.

The number of pregnancies worldwide has fallen, as in 2008 there were 134 pregnancies per 1,000 women aged 15–44, compared to 160 pregnancies per 1,000 women in 1995 (Singh, 2016), which can be due to the increased use of contraceptives. Taking a closer look at the unintended pregnancies, the number has decreased as well, from 69 per 1,000 women aged 15–44 in 1995 to 55 per 1,000 women aged 15–44 years in 2008. The rate of induced abortions has fallen from 35 per 1,000 women aged 15–44 years in 1995 to 26 per 1,000 women aged 15–44 years in 2008. Even though the numbers of pregnancies and also the numbers of induced safe abortions have fallen, the rate of unsafe abortions remains constant since 2000 at 14 per 1,000 women aged 15–44 years. The absolute number of unsafe abortions is estimated to have increased by 2 million from 20 million in 2003 to 2008 (Sedgh et al., 2012).

Sedgh et al. (2016) also took a look at the abortion rates throughout the world and grouped these into geographic regions, illustrated in Table 1. It is estimated that there were 35 abortions per 1,000 women of reproductive age worldwide every year in the timeframe of 2010–2014, representing a non-significant decline from 40 abortions per 1,000 women in 1990–1994. In the developing world this decline was not significant, as it only dropped from 39 abortions per 1,000 in 1990–1994 to 37 abortions in 2010–2014. In the developed world, on the other hand, the decline was significant, as the rate dropped from 46 abortions per 1,000 women in 1990–1994 to 27 in 2010–2014. The largest decline can be found in eastern Europe. Here, the rate fell from 88 abortions per 1,000 women in 1990–1994 to 42 abortions in 2010–2014. Interestingly, the rate of abortions in western Europe increased significantly by 5 points to 18 abortions per 1,000 women in 2010–2014 from before 13 abortions in 1990–1994 (Sedgh et al., 2016).

It is estimated that there were 35 abortions per 1,000 women of reproductive age worldwide every year in the timeframe of 2010–2014. Due to the population growth
the total number of abortions rose to 56 million induced abortions worldwide. The
decline of this number was not significant in the developing world, but significant in
the developed world, leaving the rates at 37 per 1,000 women in the developing
world and 27 per 1,000 women in the developed world. Even though the annual
number of abortions dropped from 12 million abortions to seven million in the period
of 2010–2014 in the developed regions, in the same timeframe the number grew
from 39 million to 50 million in developing regions. An explanation for this can be the
population growth in the reproductive age at that pace (Sedgh et al., 2016).

The Caribbean had the highest annual rate of abortions in the period of 2010–2014
with an estimated number of 65 per 1,000 women of reproductive age. The second
highest number occurred in South America, with 47. On the contrast, North America
had the lowest rate with 17, followed by Western and Northern Europe, both ending
at 18 abortions per 1,000 women of reproductive age. Interestingly, even though
Eastern Europe has experienced the biggest drop of the rate, from 88 in 1990–1994
to 42 in 2010–2014, this rate is still significantly higher than the rate of Western
Europe. On the other hand, Western Europe actually experienced a rise from 13 to
18 abortions per 1,000 women. Contrary to common beliefs, Africa had an abortion
rate of only 34 per 1,000 women in 2010–2014, ranging from 31 in Western Africa to
38 in Northern Africa, with little change in abortion rates since 1990–1994. In Latin
America, with abortion rates ranging from 33 in Central America to 47 in South
America, the rates have increased slightly since 1990–1994. Also no significant
change occurred in Asia, where the rate of abortion per 1,000 women comes to 36
(Sedgh et al., 2016).
Abortion Laws and Incidence of Abortion

Table 1: Estimated abortion rates per 1,000 women 15–44 years old, by geographic region and time period

<table>
<thead>
<tr>
<th></th>
<th>1990-1994 (90% UI)</th>
<th>2010-2014 (90% UI)</th>
<th>Difference (90% UI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>40 (36 to 48)</td>
<td>35 (33 to 44)</td>
<td>-5.0 (-11 to 0)</td>
</tr>
<tr>
<td>Developed countries</td>
<td>46 (41 to 59)</td>
<td>27 (24 to 37)</td>
<td>-19.0 (26 to -14)</td>
</tr>
<tr>
<td>Developing countries</td>
<td>39 (37 to 47)</td>
<td>37 (34 to 46)</td>
<td>-2.0 (-9 to 4)</td>
</tr>
<tr>
<td>Africa</td>
<td>33 (28 to 51)</td>
<td>34 (31 to 47)</td>
<td>1.0 (-8 to 8)</td>
</tr>
<tr>
<td>Eastern Africa</td>
<td>32 (26 to 47)</td>
<td>34 (31 to 41)</td>
<td>2.0 (-10 to 9)</td>
</tr>
<tr>
<td>Middle Africa</td>
<td>32 (21 to 65)</td>
<td>35 (24 to 66)</td>
<td>3.0 (-11 to 15)</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>40 (25 to 94)</td>
<td>38 (22 to 60)</td>
<td>-2.0 (-25 to 13)</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>32 (17 to 68)</td>
<td>35 (20 to 70)</td>
<td>3.0 (-14 to 22)</td>
</tr>
<tr>
<td>Western Africa</td>
<td>28 (23 to 41)</td>
<td>31 (28 to 39)</td>
<td>3.0 (-6 to 10)</td>
</tr>
<tr>
<td>Asia</td>
<td>41 (38 to 51)</td>
<td>36 (31 to 48)</td>
<td>-5.0 (-14 to 4)</td>
</tr>
<tr>
<td>Eastern Asia</td>
<td>44 (38 to 66)</td>
<td>36 (26 to 55)</td>
<td>-8.0 (-22 to 8)</td>
</tr>
<tr>
<td>South and Central Asia</td>
<td>36 (28 to 48)</td>
<td>37 (30 to 51)</td>
<td>1.0 (-12 to 16)</td>
</tr>
<tr>
<td>Southeastern Asia</td>
<td>46 (35 to 76)</td>
<td>35 (30 to 64)</td>
<td>-11.0 (-26 to 2)</td>
</tr>
<tr>
<td>Western Asia</td>
<td>46 (36 to 70)</td>
<td>35 (26 to 61)</td>
<td>-11.0 (-23 to 2)</td>
</tr>
<tr>
<td>Latin America region</td>
<td>40 (37 to 47)</td>
<td>44 (36 to 62)</td>
<td>4.0 (-6 to 20)</td>
</tr>
<tr>
<td>Caribbean</td>
<td>50 (46 to 97)</td>
<td>65 (46 to 107)</td>
<td>5.0 (-14 to 25)</td>
</tr>
<tr>
<td>Central America</td>
<td>27 (24 to 34)</td>
<td>33 (25 to 46)</td>
<td>6.0 (-4 to 17)</td>
</tr>
<tr>
<td>South America</td>
<td>43 (36 to 52)</td>
<td>47 (35 to 72)</td>
<td>4.0 (-10 to 27)</td>
</tr>
<tr>
<td>Northern America</td>
<td>25 (24 to 26)</td>
<td>17 (16 to 18)</td>
<td>-7.0 (-9 to -6)</td>
</tr>
<tr>
<td>Europe</td>
<td>52 (46 to 64)</td>
<td>30 (27 to 38)</td>
<td>-22.0 (29 to -17)</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>88 (80 to 107)</td>
<td>42 (38 to 51)</td>
<td>-46.0 (-60 to -38)</td>
</tr>
<tr>
<td>Northern Europe</td>
<td>22 (20 to 25)</td>
<td>18 (17 to 20)</td>
<td>-4.0 (-7 to -3)</td>
</tr>
<tr>
<td>Southern Europe</td>
<td>38 (27 to 76)</td>
<td>26 (18 to 57)</td>
<td>-12.0 (-31 to 1)</td>
</tr>
<tr>
<td>Western Europe</td>
<td>13 (10 to 23)</td>
<td>18 (14 to 31)</td>
<td>5.0 (1 to 11)</td>
</tr>
<tr>
<td>Oceania</td>
<td>20 (18 to 28)</td>
<td>19 (15 to 29)</td>
<td>-1.0 (-5 to 3)</td>
</tr>
</tbody>
</table>

UI= uncertainty interval. *Based on comparison of 2010-2014 with 1990-1994

Data source: Sedgh et al., 2016, author’s own presentation

Sedgh et al. (2016) also grouped the countries according to the grounds on which abortion was legal in each state, which is illustrated in Table 2, but they did not find any association between the abortion rates of 2010–2014 and the legal status of abortion. In countries where abortion was prohibited or only allowed to save a woman’s life the rate was 37 abortions per 1,000 women, compared to a rate of 34 abortions per 1,000 women in countries where abortion is available on request. This shows that women undergo abortion even if the legal system does not allow them to (Sedgh et al., 2012).
Table 2: Abortion rate per 1,000 women aged 15–44, by grounds under which abortion is legally allowed, 2010–2014*

<table>
<thead>
<tr>
<th>Grounds</th>
<th>Average number of countries per year</th>
<th>Abortion rate (90% UI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prohibited altogether or to save a woman's life†</td>
<td>58</td>
<td>37 (34-51)</td>
</tr>
<tr>
<td>Physical health</td>
<td>34</td>
<td>43 (40-53)</td>
</tr>
<tr>
<td>Woman’s mental health</td>
<td>19</td>
<td>33 (27-49)</td>
</tr>
<tr>
<td>Socioeconomic health</td>
<td>10</td>
<td>31 (23-47)</td>
</tr>
<tr>
<td>On request</td>
<td>63</td>
<td>34 (29-46)</td>
</tr>
</tbody>
</table>

UI=uncertainty interval. *Gestational limits, authorisation requirements, waiting periods, and other conditions for legal abortions vary across countries in all categories. †Includes countries where abortion is also allowed in cases of rape or incest.

Data Source: Sedgh et al., 2016, author’s own presentation

5.3 Incidence of Unsafe Abortion

When talking about unsafe abortion it has to be mentioned that the number of unsafe abortions cannot be assessed precisely, as women can always resort to measures not recorded by the health systems or other organizations. But the WHO (2011) estimated that the number of unsafe abortions in 2008 were between 21 million and 22 million, increasing the number by about two million from the estimated for 2003. And as worldwide 210 million pregnancies were reported, this means that every tenth pregnancy ends in an unsafe abortion. But as the rate of unsafe abortion per 1,000 women aged 15–44 stays unchanged at 14, this means that the increase of numbers of abortions is mainly due to the increase of women in reproductive age worldwide. These estimates can be found in Table 3.

In 2003, the number of unsafe abortion was lower by 2 million in the developing countries than in 2008, with an incidence rate of 16 per 1,000 women of reproductive age. The highest numbers of unsafe abortion occur in Africa and Latin America, but the range of numbers in Africa varies as Middle and Eastern Africa experience the highest incidence rate at 36 per 1,000 women in reproductive age, compared to 9 unsafe abortions per 1,000 women in Southern Africa. In Latin America, the highest number can be found in the Caribbean, if Cuba and several
other islands where abortion is legalized and services are made available are excluded, with a rate of 29 unsafe abortions per 1,000 women ages 15–44 (World Health Organization, 2011).

Asia records an unsafe abortion rate of 19 per 1,000 women in reproductive age, if the Eastern Asia sub-region is excluded due to its high demographics. In India, which legalized abortion in 1971, two thirds of all abortions take place outside authorized health services, therefore contributing to the high number of 17 unsafe abortions per 1,000 aged 15–44 in this sub-region, actually the highest number of unsafe abortions worldwide with an estimated 6.8 million unsafe abortions in 2008, which can be accounted to its high population size. The WHO points out that this number will likely not decrease soon as women tend to be uneducated about their right to abortion and the contraceptive prevalence increases (World Health Organization, 2011).

As not much data is available for Oceania, with the exception of Australia and New Zealand, the rate of 8 unsafe abortions per 1,000 women of reproductive age could be much higher. Europe has recorded the lowest number of unsafe abortion for a long time and the number appears to have decreased even further in some sub-regions. But some Eastern European sub-regions still experience problems with unsafe abortions. The WHO excludes all other European sub-regions from their estimations as the incidence of unsafe abortions here are negligible (World Health Organization, 2011).
Table 3: Global and regional estimates of annual numbers and rates of unsafe abortion, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Unsafe abortion numbers (rounded)</th>
<th>Unsafe abortion rate (per 1000 women aged 15-44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>21,600,000</td>
<td>22</td>
</tr>
<tr>
<td>Developed regions</td>
<td>350,000</td>
<td>6</td>
</tr>
<tr>
<td>Developing regions</td>
<td>21,200,000</td>
<td>23</td>
</tr>
<tr>
<td>Africa</td>
<td>6,190,000</td>
<td>28</td>
</tr>
<tr>
<td>Eastern Africa</td>
<td>2,430,000</td>
<td>35</td>
</tr>
<tr>
<td>Middle Africa</td>
<td>930,000</td>
<td>35</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>900,000</td>
<td>19</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>120,000</td>
<td>9</td>
</tr>
<tr>
<td>Western Africa</td>
<td>1,810,000</td>
<td>28</td>
</tr>
<tr>
<td>Asia</td>
<td>10,780,000</td>
<td>19</td>
</tr>
<tr>
<td>South-Central Asia</td>
<td>6,820,000</td>
<td>17</td>
</tr>
<tr>
<td>South-Eastern Asia</td>
<td>3,130,000</td>
<td>26</td>
</tr>
<tr>
<td>Western Asia</td>
<td>830,000</td>
<td>15</td>
</tr>
<tr>
<td>Europe</td>
<td>380,000</td>
<td>6</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>300,000</td>
<td>6</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>4,230,000</td>
<td>31</td>
</tr>
<tr>
<td>Caribbean</td>
<td>170,000</td>
<td>29</td>
</tr>
<tr>
<td>Central America</td>
<td>1,070,000</td>
<td>29</td>
</tr>
<tr>
<td>South America</td>
<td>2,990,000</td>
<td>32</td>
</tr>
<tr>
<td>Oceania</td>
<td>1,800</td>
<td>8</td>
</tr>
</tbody>
</table>

No estimates are shown for regions where the incidence of unsafe abortion is negligible.

Data Source: World Health Organizations, 2011, author’s own presentation
6 Barriers Hindering Women to Acquire Safe Abortions

Throughout the literature research, several barriers occurred several times, allowing the author to draw the conclusion that these barriers are severe. Turner et al. (2011) gave an overview about these barriers which will be described in the following section into detail.

6.1 Social Barriers

All the barriers included in the social section work in a vicious cycle as the point of gender discrimination can lead to lack of information, which then makes gender-based violence more probable and reinforces the stigma of sexuality. This can then lead to the lack of social support.

- **Gender discrimination** means discrimination based on gender alone. Women might be seen more as a person responsible for the household, leading to less opportunities to access health care. Girls are less likely to attend schools in developing countries. Women are likely to be paid less than men, therefore having less money to pay for health services on their own. In some countries the belief is that unmarried women should not be sexual active, consequently not requiring sexual and reproductive health services. They then will have to hide the use of such services or will be prohibited to access them at all. As a result, they might not be able to prevent pregnancies at all, might have to deny their pregnancy and postpone seeking care as they fear consequences from their partners and families (Davis & Beasley, 2009).

- **Gender-based violence** describes the abuse of power, either physical, sexual or mental, performed on an individual in a submissive position by another person resulting from social beliefs about gender (Bruyn, France, Health & Development Networks, & Ipas, 2001). As in some countries women and girls still have a subordinate status in society, they might experience violence including physical, sexual, psychological and economic abuse. These abuses seem to be legitimized by norms, beliefs and social institutions and are therefore preserved. They are not challenged when they are carried out by men, especially in the family, but would be prosecuted if carried out by an
Barriers Hindering Women to Acquire Safe Abortions

employer or neighbor. Apart from the discrimination, women might also experience violence when requesting an abortion or other reproductive health services by intimate partners, family members and also abortion providers. (Heise, Ellsberg, & Gottemoeller, 1999). Women who are not heterosexual or do not follow cultural gender expectations can also experience violence, called ‘corrective’ sexual assaults.

- **Stigma** causes a person to be reduced to a tainted, discounted one based on characteristic or attribute (Goffman, 1963).

  - Abortion stigma is the cultural belief, even in countries where abortion is legal and abortion services are available and safe, that women who have undergone an abortion are substandard women and should be ashamed of themselves (Kumar, Hessini, & Mitchell, 2009). This stigma is predominant in countries where religion plays a big role as religious leaders describe abortions as immoral and women seeking abortion services acting against their religious beliefs. This stigma also leads health systems to restrict abortion services and misreport statistics.

  - Sexuality stigma is the restriction to discuss sexuality and sex and to deprecatingly label people who are open about their sexuality, also resulting from religion (K. Wood, Aggleton, & University of Southampton, 2002). Young adults who deny knowing anything about sex are seen as good, but this all leads to the problem of teaching about safe sex, obtaining contraceptives and accessing safe abortion care.

  - Age stigma in this case describes the belief that young adults should not be sexual active or use contraceptives. But even in organizations and health services assisting young people with decisions, they do not have any voice in decision making (K. Wood et al., 2002).

- Lack of information about sexuality results in young women not being in the know about menstruation, pregnancy, contraceptives, recognizing the symptoms of pregnancy and how to seek qualified assistance. Young women also tend to seek abortion services later than adult women (Davis & Beasley, 2009).
- **Lack of social support** explains the problem of women wanting to seek for a service, finding themselves in the predicament of stigmata, beliefs and lack of information in their community (Turner et al., 2011).

### 6.2 Economic and Logistical Barriers

These barriers also reinforce each other. As women earn less than men or are not even allowed to work, they might lack the financial resources to obtain the abortion. And as transportation costs money as well, the costs of an abortion increase even more.

- **Financial resources** stands for the aspect of the problem that some women need time to collect the amount of money required. This results on a delay of the abortion, increasing risks and also costs (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2006). As a result, women lacking the financial resources might resort to unsafe abortion practices. This is especially the case in the countries where abortion is illegal.

- **Transportation** regards to the fact that health care facilities are not always close by, public transportation might not be accessible and women might not be allowed to drive (Turner et al., 2011).

### 6.3 Legal and Policy Barriers

Outlawing abortions can be counted as an obvious barrier. In 2009, 26 percent of the world’s population lived in countries where abortion is generally prohibited (Center for Reproductive Rights, 2014).

- **Abortion laws** exist in various forms, outlawing abortions on different grounds. Most countries allow abortions under only a few conditions, such as saving the mother’s life or if the pregnancy resulted from rape or incest (Center for Reproductive Rights, 2014). The different abortion policies in the world will be covered later in the thesis.

- **Third-party involvement laws** restrict the access to safe abortions in such that the consent or the notification of a third-party, such as a parent, a guardian, a psychiatrist or another adult, is necessary in order for the women
to receive the abortion. This can especially be a problem in regions where sexuality and abortion stigma are prevailing. And even though this law might allow young women to ask the permission of a judge (judicial bypass), the third-party involvement law can tend to delay care, also up to the point where abortion is no more an option (Human Rights Watch, 2010). In 2003, in at least 24 countries this law was active (Bruyn et al., 2001).

- Sexual violence is one of the indications legalizing abortion in many countries. But as proof of rape may be required, this makes getting the official permission even more difficult. This can be even harder in countries where male witnesses have to be present and the rape itself has to investigated and validated, making it even more emotionally painful for the women and resulting in possible discrimination (Turner et al., 2011).

The WHO published recommendations which all levels of law should follow. Unless specifically prohibited by law, policies, standards and protocols should make abortion care available to unmarried and married women, without spousal or parental notification or consent, without proof of police certification, legal action or court authorization for rape cases, without minimum age requirement, without a waiting period, without authorization required by hospital abortion committees, without mandatory contraception after abortion, and with the ‘conscientious objector’ providers required to refer the woman to another provider (World Health Organization, 2012).

6.4 Health System Barriers

After overcoming the first three barriers, women can still be faced with obstacles in the health care system itself, according to Turner et al. (2011).

- Lack of or unavailability of facilities providing abortion regards to the fact that sometimes the facilities offering abortions may be far away or have opening hours conflicting with the women’s working hours. Additionally, the access to the facilities can be restricted if they only operate in the private sector.

- Lack of privacy and confidentiality are a problem especially in areas where stigma and discrimination is high. Women will be more unlikely to obtain an abortion if they have to fear that their privacy is compromised.
- Process and forms, such as paperwork requiring the husband’s name in order to undergo an abortion need to be included as a barrier, as well as the process of requiring numerous visits.
- Negative provider and staff attitudes about sexuality and abortion may also hinder a woman seeking an abortion to go through with it, as she might be discouraged by the behavior of the staff. This negative attitude can have a long term effect, as women hearing about this will be unlikely to visit the same facility when in the same predicament.
7 Abortion in Poland

As it has been shown, Eastern Europe still has one of the highest rates of abortion in the whole world, and Poland contributes a lot to this high number. Even though the official numbers lack reliability, which will be discussed further on in this paper, the numbers are still frightening, especially since higher numbers than the official numbers provided by the government are calculated by several organizations. This section will first cover the demographics and the economy of Poland and continue with the influence the Roman Catholic Church has on the Polish government. The section will also cover the history of abortion law, the official numbers of abortions in Poland and go into detail about the consequences the Anti-Abortion Act of 1993 had. Furthermore, it will cover the reasons for the restricted access to the vested right and give some possible solutions.

7.1 Demographics and Economy of Poland

The Republic of Poland has over 38.5 million inhabitants, spread out over 312,679 km², leading to a population density of 123 inhabitants per km². The population is concentrated in the center in Warsaw and Lodz, in the south in Krakow and extended to the north in Gdansk. 60.5% of the population live in urban areas. The neighboring countries include the Czech Republic, Germany, Russia, Slovakia and the Ukraine. The population growth rate is at -0.11%, with the birth rate at 9.6 birth for every 1,000 people and the death rate at 10.3 for 1,000 people. The sex ration of the total population is 0.94 males to females. Mean age of the mother's first birth is 27.2 years, maternal mortality rate is at 3 deaths per 100,000 live births and infant mortality is at 4.5 deaths per 1,000 live births. The life expectancy at birth is calculated to be 73.7 years for males and 81.7 for females. The total fertility rate comes to 1.34 children being born for every woman (Central Intelligence Agency, 2017).

Poland has a health expenditure of 6.4% of the GDP, a physicians' density of 2.27 physicians per 1,000 people and 6.5 hospital beds per 1,000 people. The State spends 4.9%of their GDP in education resulting in a literacy level of 99.8% and a school life expectancy of 16 years (Central Intelligence Agency, 2017).
Concerning the economy of Poland, it has followed a policy of economic liberalization since its independency in 1990 and interestingly, it was the only country in the EU which was able to avoid a recession in the 2008–2009 economic crisis. But it has a GDP which is still significantly below EU average and is faced with an unemployment rate above the EU average, at 9.6% but with 17.78 million people in the labor force. The GDP is estimated to be $ 467.4 billion in 2016 with a GDP of $ 27,700 per capita, resulting in a Gini index of 32.4 in 2012 (Central Intelligence Agency, 2017).

### 7.2 Influence of Church on State

In a consensus done in Poland in 2011, illustrated in Figure 1, 88.9% of Poles described themselves as belonging to a religion. 87.6% of all Poles described themselves as Roman Catholic, which also accounts for 96% of all religious people. Orthodox Jews, Jehovah’s Witnesses and people belonging to the Lutheran church make up most of the rest of the people. In total there is more than 150 different religious groups and movements in Poland (Szaltys et al., 2015).

*Figure 1: Religious Structure of the Polish Population in the Year 2011*

*Data source: Szaltys et al., 2015, author’s own presentation*
As religion has played a big role in Poland over the centuries and is also part of the national identity, it only makes sense that the church also has a significant influence on the political scene of Poland (Committee on the Elimination of & Discrimination against Women, 2004). It is even stated in the Central Intelligence Agency Fact book that the church acts a political pressure group (2017).

With religion being such a dominant factor, religion and the attitude of the health staff and approach to clients, and the social and cultural attitude of the society towards abortions can count as additional barriers, hindering women to carry out their lawful right to abortion. The church also has a big influence on the amount of sexual education taught at school, which is, quantitatively, much less than in other European countries (Wellings & Parker, 2006).

As the Church has played a crucial role in taking down state socialism, it is logical that it still had a lasting influence on legislators and the government. And even though most of the population is against a total ban on abortion, the close connection in direct involvement of the Church hinder a better organized pro-choice movement (Nowicka, 2008).

The access to modern contraceptives is not simple, and state provided family planning is not as extensive as well (Beaumont, Maguire, European Parliament, & Directorate-General for Internal Policies of the Union, 2013), even though a study conducted by the Population Resource Centre (2008) showed that the encouragement of use of modern contraceptive methods to meet the wish for smaller families additional to expanded family planning counseling are the best options to reduce numbers of abortions.
7.3 History of Abortion Laws in Poland

Before the re-establishment of the Polish State there were no unified legal settings justifying abortion. As the ex Polish territory was ruled by different states, the laws of these countries also applied in their territory. In the Austrian part, an abortion was punished with six to twelve-month imprisonment, the Russian law outlawed abortion with a sentence ranging from one to three-year in prison (Szczuka, 2004). After the unification of the country in 1918, a new penal code had to be discussed; this was mostly done by the Codifying Commission, which was in charge of revising existing legislations and creating a new Polish penal law. After a proposal to penalize abortion with a five-year imprisonment, a Lawyers’ Congress declared they were against a total abortion ban (Walsh, 2011). In 1932 a penal code was passed, legalizing abortion if the pregnancy resulted from a criminal act, such as rape, incest or underage sex, or threatened the life of the mother. The woman executing an illegal abortion or anyone helping her would be imprisoned for five years (Szczuka, 2004).

Up until the communist regime this law stayed intact until it was replaced by the Abortion Admissibility Law in 1956, allowing women to have an abortion due to socio-economic reasons, requiring the doctor’s approval of the woman’s living conditions. After some changes in 1959 introduced by the Ministry of Health, the doctor’s final decision was removed and the woman alone had the choice. The law did not include a time limit (Lee, 1998). From then on, if performed in public institutions, abortions were free of charge, but had to be paid for in private clinics (Nowicka, 1996). Doctors did not have the right to refuse to execute an abortion on religious or ethical ground according to this law, but the Catholic Church kept trying to persuade physicians not to perform abortions. But after the Catholic Church kept pressing on this subject, the Ministry of Health introduced a change in the abortion law in 1981, requiring doctors to produce a detailed justification of the difficult living conditions as well as in depth information about the health risks the woman was under in order to perform the requested abortion (Fuszara, 1991). And despite the pressure of the Catholic Church and also because the women did not have access to contraceptives, during the communist period abortions became and remained the main method of birth control (Hadley, 1996), therefore resulting in the practice of abortion being the main and sometimes only method of family planning. This is especially interesting as 95% of the Poles belonged to the Catholic Church and it
stated its opposition against abortion multiple times (Fuszara, 1991). As modern contraceptives were not widely available, and abortions were the birth control of choice, as they were provided for free in public hospitals, the number of abortions between 1960 and 1988 was between 108,000 and 168,000 according to the official statistics.

From the health perspective it has to be mentioned that during the socialist state the access to health care improved radically, as health care was free of charge and for the first time available to ordinary people. Also, a six-year plan was adopted, which aimed at increasing the number of doctors by 75% and to have more hospital beds available, especially in the obstetric and gynecological wards. In the time span of 6 years 100 more clinics, specialized on preventive and curative assistance for women were set up, and clinics specially for pregnant women were established, asking every pregnant woman to have a monthly check-up (Barański & Kula, 2012).

In the transition phase from communism to a democracy, the Catholic Church acted as the preserver of “Polishness” and continued to fight against abortions being legal, contributing in drafting a bill protecting the unborn child. This bill included the absolute abortion ban as well as the imprisonment of women undergoing or self-inducing an abortion, as well as the doctor or another person helping her (Jankowska, 1991). After it was discussed in the upper-house, the Senate and later passed to the lower-house, the Sejm, it received immense media coverage and demonstrations in Polish cities, also resulting in the establishment of various women’s organizations (Fuszara, 1991). Meanwhile, the access to abortion was restricted even more, as the Ministry of Health issued regulations now requiring women to have four consultations with doctors – previously only one consultation was required. It furthermore allowed doctors to refuse to perform an abortion (Jankowska, 1991). After a new draft on restricting abortion was filed in November 1992, a Committee was formed, trying to create a referendum on this case. By January 1993 more than 1.3 million signatures were collected, and even though only 50,000 are constitutionally needed to hold a referendum, both the Prime Minister and the president rejected these signatures as significant enough, even though polls showed 70% of Poles were against an abortion ban (Nowicka, 2008).

Despite efforts taken by various left-wing activists and organizations, all inspired by the Parliamentary Group of Women (Nowicka, 1993), Poland passed an Act on Family Planning, Protection of the Human Fetus and Conditions for Termination of
Pregnancy – commonly known as the Polish Anti-Abortion Act, on January 7th 1993, making abortion law stricter than it had been in the previous years of communism. In this act, several issues of reproductive rights are covered, stating for example that pregnant women should be provided with medical, social and legal care, specifying which form this care should take. It is illegal for the mother to have an abortion for economic and social reasons and upon request. It is legal to undergo an abortion on the grounds of saving the life of the woman, preserving her mental and physical health, if a fetal impairment would occur and also if the pregnancy is resulting from either rape or incest. (Republic of Poland, 1993).

If the abortion is done because the pregnancy endangers the woman's life or health, which is often referred to as abortion on medical grounds, the threat to the health or life has to be confirmed by another physician than the one carrying out the abortion, who is also a specialist in this medical field. This case has no time limit, but must be performed in a hospital (Republic of Poland, 1993).

In case the abortion is done because the prenatal tests or other medical findings imply severe and irreversible damages to the fetus or the fetus is suffering from an incurable, life-threatening disease, this disease or malformation must be confirmed by either a doctor specialized in genetic defects and based on genetic tests, or by a doctor specialized in gynecology and obstetrics and be based on ultrasound findings. This case is often referred to as abortion on teratogenic or embryo-pathological grounds and is legal until the fetus is viable outside the mother's womb. It has to be mentioned that the law does not state or define viability, nor does is define which diseases count as incurable and life-threatening, which leaves this decision to the physicians and parents. Just like the first case, this case has to be carried out in a hospital (Republic of Poland, 1993).

In the third case, in which the pregnancy results from a criminal act, sometimes referred to as abortion on legal grounds, the abortion can only be carried out until the end of twelve weeks of the pregnancy. Furthermore, a public prosecutor has to confirm that the pregnancy resulted from a criminal act such as incest or rape (Republic of Poland, 1993).

The law further states that an abortion has to be performed by an obstetrician or gynecologist having passed the national proficiency test, and the abortion itself has to take place in a medical institution with the consent of the woman. The procedure
Abortion in Poland

has to be executed in the first 12 weeks of pregnancy, with the exception that a prolonged pregnancy would jeopardize the health or life of the pregnant woman. The act also stated the differences in consent required by the mother, her representative or the Custody Court. The procedure is also to be performed free of charge, the costs are covered by the public health insurance (Republic of Poland, 1993).

If the abortion is done in violation of the law, the woman does not suffer any legal consequences. However, the doctor or the person carrying out the abortion, on the other hand, are threatened with imprisonment up to three years. Terminating a pregnancy, whether through induced abortion or violence, without the consent of the mother is illegal and put under punishment according to the criminal code of 1997 (Nesterowicz, Bagińska, & Exter, 2011), leading to imprisonment form 6 months to 8 years. It is important to notice that the law does not refer to a fetus, but rather uses the term of unborn child.

As it is not allowed to have an abortion on socio-economic grounds, some women are face with financial difficulties. The law states that the government and local authorities have the obligation to provide assistance to the mothers facing these financial difficulties. Furthermore, it has the obligation to offer information about entitlements and benefits guaranteed by law to families, mothers and their children, and is required to provide information about adoption procedures (Republic of Poland, 1993).

With this law Poland made the step towards a restrictive abortion law opposite to most European laws, with the exceptions of Ireland and Malta.

And as doctors and hospitals under the conscience clause included in the Medical Code of Ethics, Article 4 (Nesterowicz et al., 2011) have the right to refuse to perform abortions, women seeking abortions in clinics might be denied their quest. This is also stated in the law for doctors and dentists in Article 39 (Republic of Poland, 1996). The physician had to provide the mother with a real possibility to obtain the desired service, but this law was changed recently. In contrast to public hospitals refusing to perform abortions, Poland has a number of private hospitals, which basically count as underground clinics, willing to perform abortions, but also charging much higher fees for these from the women.

Following the enactment of the anti-abortion law in 1993, several attempts have
been made in order to liberalize the law again, but the Polish president Lech Wałęsa refused all of them. But after the democratic left won the presidential elections in 1995, a new and liberalized bill was approved which not only changed the preamble of the present abortion law, stating that the human life is to be protected from the moment of conception to the protection of life, including the prenatal phase. It also removed the terms unborn child and also the rights of the fetus from the civil law (Girard & Nowicka, 2002). Additional to that, a woman was now allowed to receive an abortion under socio-economic grounds until 12 weeks of gestation, needing a written consent from two doctors. Furthermore it postulated affordable birth control as well as sexual education in school (Caytas, 2013). The content of these sexual education classes is not further described, it has been replaced by family life education and therefore focuses on traditional values of family planning, gender and sexuality (Girard & Nowicka, 2002).

In 1997 the liberalized law was then challenged in front of the Constitutional Tribunal which found it unconstitutional. The reasons for this decision brought forward at the Tribunal were that the life protection of the fetus according to civil law violates the protection of human life. The Tribunal concluded with treating the fetus as a citizen, granting him the right for undisturbed development and suing the mother if such development was compromised. It also stated that socio-economic grounds were not sufficiently described in the previous law and therefore removed these grounds from the law. As new elections were around the corner, the left wing parliament ran out of time and the newly elected government, consisting of two pro-life parties, endorsed the Tribunal's decision and therefore re-inserted the legislation of 1993 (Holc, 2004).

The newest law, which was approved in 1998, was extended insofar as anyone damaging the conceived child or its health would be imprisoned for up to two years, but not if the mother’s health or life were in danger (Republic of Poland, 1998). This law is still in place.
7.4 Official Numbers of Abortions in Poland

Although the Polish government is supposed to publish an annual report on the realization of the act of family planning, it does not fulfill its duties, or if it does, these reports lack sufficiently in the parts of pregnancy termination. Additionally, it only provides the official amount of terminated pregnancies carried out lawfully, omitting the estimated amount of procedures done in the so-call abortion underground. And even these officially reported numbers seem false, as for example there was no abortion reported resulting from rape. In 2011 alone there were 3,000 sexual assault crimes, understandably resulting in pregnancies including some which were most likely terminated. Additionally, as the numbers of official abortions have not changed over the past few years, NGOs are keeping a close eye on the unofficial numbers (Kacpura, Więckiewicz, Jawień, Grzywacz, & Zimniewska, 2013).

By doing so the government most likely does not want to admit its failure in realizing the act of family planning. As the official numbers also only state births and miscarriages, it can only be estimated whether – in percentage terms – fewer women become pregnant or whether fewer women decide to continue their pregnancy.

Graph 1 shows the official number of induced abortions in Poland from 1966–2015, retrieved from the United Nations Demographic Yearbooks (1973) (1983) (1992) (2000) (2016). It has to be mentioned that these numbers are the official numbers, provided by the State through the public hospital records. As there were also abortions carried out in the underground, these numbers are not completely reliable. One can see a significant decline of abortions throughout the years, as in 1966 there were 225,991 reported abortions compared to 1,100 in 2015.
When considering the years before and after the comprehensive changes of the Polish abortion law, one can see that in the years leading up to the Anti-Abortion Act in 1993 the number of abortions had declined already due to the change of the Medical Code of Conduct, the establishment of the own state, the substantial influence of the church and the various discussions about the abortion law. The rise of the number of abortions in 1997, which can also be seen in Graph 1, to 3,171 from 491 abortions in 1996 can be explained by the change of law in this year, making it legal to have an abortion on socio-economic grounds and therefore reducing the obstacles of access to safe and legal abortion.

Concerning the number of illegal abortions and the impact on women’s health and life, the United Nations expressed their concern about the lack of official data and also the research on the prevalence. It urges the State to guarantee that abortions on legal grounds are actually performed and not limited due to the conscience clause. It furthermore states that the State should increase measures aimed at the prevention of unwanted pregnancies, making contraceptives widely available at affordable prices, as well as increase the knowledge about various methods of
family planning (Committee on the Elimination of Discrimination & against Women, 2007).

7.5 The Consequences of the Anti-Abortion Act of 1993

The Anti-Abortion Act of 1993 had consequences in many fields, including the access to contraception, to prenatal testing, to abortion itself, therefore influencing abortion tourism and the abortion underground and it also had an impact on sexuality education in schools and family planning. The specific impacts will be described in the further sections.

In the further sections, the responses from the interviews of Krystyna Kacpura and Gina Horst will be presented along with further literature research. The numbers in brackets correspond to the number of the line in which the quote can be found in the respective interview.

Access to Contraception

Male condoms and spermicides are the only contraceptives which are available without limitations in Poland, as female condoms are only accessible in sex shops or online and additionally are quite expensive. There are only four kinds of contraceptive pills available in Poland and only one of these is subsidized, making oral contraception too expensive for most women. It is being disputed about subsidizing intrauterine devices, but the verdict on this topic has not yet been reached (Sejm Rzeczypospolitej polskiej & Prezes Rady Ministrów, 2015).

In her interview Krystyna Kacpura (l. 132–133) states on this topic in her interview that “contraception is accessible, but it's not subsidized by the State, so it's rather expensive”.

As modern contraceptives are not available over the counter, women have to acquire a prescription from a doctor. Additionally, emergency contraception is also only available with a prescription of a doctor, who are sometimes reluctant to write the required prescription. Even here the doctors evoke their conscience clause and sometimes deny women the access to contraception. Gina Horst (l. 34–36) here points out that at her workplace they hear about cases where doctors and pharmacists do not want to prescribe or hand out hormonal contraception. An
opinion poll in Poland showed that 55% of Poles think doctors should not be able to refuse to write prescriptions for contraceptives if no medical contraindication exists. Also 76% of Poles think pharmacists should not have the right to refuse to hand out contraceptives because of their conscience as they now do (Centrum Badania Opinii, 2014).

It has to be mentioned that globally the use of contraception rose to 63% in 2007 in women aged 15–49, who were married or in a cohabiting union (United Nations et al., 2014). Resulting from the increased use of contraception, the incidence and prevalence of induced abortion also declined in countries where abortion is available upon request (Bongaarts & Westoff, 2000) (Marston, Cleeland, 2005). It is estimated that if all women wanting to avoid pregnancy used modern contraceptives, the rate of unintended pregnancies would drop from 74 million to 22 million every year by 70% (Singh et al., 2015). Concerning this topic, Krystyna Kacpura (l. 135–138) mentions that “contraception is not so popular in Poland because of lack of knowledge about it. As far as I know there is around 18% of women who use oral contraception in Poland. Mainly this is condoms and so-called natural methods”.

Access to Prenatal Testing

The healthcare services during the pregnancy as well as labor and postnatal period are free of charge in Poland and are financed by public funds or the Ministry of Health (Republic of Poland, 2004). The Minister of Health set a standard of prenatal and perinatal care in September of 2012, in which it states that every pregnant woman is entitled for example three extensive ultrasound examinations (Republic of Poland, 2012b). The Minister of Finance further released on which grounds the pregnant woman may obtain prenatal tests in addition to ultrasounds, i.e. if the pregnant woman is more than 35 years old, if a previous child or fetus was affected by a chromosomal aberration, if one or both parents suffer from a known chromosomal rearrangement, if there is a considerably higher risk to give birth to a child with monogenetic or multigenetic disease and if biochemical tests or ultrasound scans show abnormal results and imply a chromosomal aberration or fetus defect (Republic of Poland, 2012a).

In the context of prenatal testing, the report by Kacpura et al. (2013) points out that there are important flaws in the legal texts. The current legal legislation allows
women to request further fetus testing, according to the services guaranteed in the health programs. But the regulation defining the scope of these services, including prenatal testing, is no longer valid. The access to prenatal testing is regulated by indications and criteria, which make women eligible and by the age of the pregnant woman. However, the two regulations in place for this access are inconsistent with each other.

Nowadays, even if the patient has reasonable concerns about a potential fetus impairment, the doctors often stop the conversation about prenatal testing either because of the conscience clause or because they are uninformed about the necessary criteria. The women only have the option to go into the costly private sector for the tests, but some doctors do not even inform their patients about this option. Doctors sometimes even deny a referral to another doctor on the grounds of the conscience clause, thus breaching the patients’ rights. In her interview Krystyna Kacpura (l. 19–23) indicates that doctors refuse to give a referral to another hospital as “gynecologists are not obliged to give information, if they signed the conscience clause. They are not obliged to give information to women where and who can provide them with abortion services. Because this is also against their conscience clause”. Some doctors also think that women only want prenatal tests in order to get access to abortion, which is an inappropriate behavior of the medical staff (Kacpura et al., 2013).

There were various cases in which the access to prenatal testing was denied to the women, even though substantial concerns were in place. The European Court of Human Rights has been approached several times about this issue and without actions of the government it will be as well in the future.

**Sexuality Education and Family Planning in Poland**

Sexuality education is also a topic covered by the Act on Family Planning which states the school curriculum should cover topics such as the human sexuality, conscious parenthood, value of family and methods of conscious procreation. The subject called Preparation for Family Life was briefly renamed to Knowledge on Human Sexuality in 1996, but in 1999 renamed back to Preparation for Family Life. Just the name shows that international standards for sexual education are not met, as these include sexual and reproductive health, gender equality, STDs and responsible sexual behavior (Kacpura et al., 2013). Krystyna Kacpura also mentions
in her interview (l. 146–147) “they concentrate their efforts on natural methods, calendar etc.” and furthermore notices (l. 152–157) also that “there is no comprehensive sexual education in school. This is the subject called ‘Preparation to the family life’. So, it’s more about traditional values, traditional families – mother, father, children. Men and women. There is nothing about LGBT issues, diversities of families, about single mothers, single fathers, or same sex couples, nothing about sexuality, about contraception, only at the last stage of this subject they will provide information about natural methods”. The WHO Regional Office for Europe and The Federal Centre for Health Education published standards for sexuality education containing recommendations about the format and content for this subject (2011).

A survey conducted in 2006 showed that only 85% of school offered Preparation for Family Life classes. But when looking at the attendance of sexuality classes in Poland, it has to be mentioned that attendance is lowest in secondary school level, also due to the fact that many students ask to opt out of this class as they find the content to be strictly conservative, regarding sexuality and family. And as most teachers who teach the subject of Preparation for Family Life do not have comprehensive qualifications, students lack extensive education on this subject. Studies also show that the content and the teaching aids show a conservative model of families, additional to gender stereotypes, resistance of contraception, missing issues of sexual orientation.

Coming to the point of family planning, Krystyna Kacpura (l. 133–135) states “we do not have family planning centers in Poland. So one gynecologist does everything, takes care of your pregnancy, of some illness as well as family planning, so there is only two minutes for family planning”. She also mentions (l. 140–142) that people “are afraid of the word reproductive rights and reproduction, they use procreation and procreative rights. Which means that a woman is allowed only to give birth, not allowed to plan the maternity, when and how many children to have”.

Abortion Tourism

Due to the restricted access to abortion in Poland, women not only resort to underground or clandestine abortions, but they seek safe abortion services in other countries. This has been made easier since Poland joined the European Union, opening the borders and allowing people to travel visa-free within the Schengen area. Even though acquiring abortion services in other countries might be costlier,
abortion is legal in almost all European countries and facilities offering these services have to meet certain requirements, are checked regularly, guaranteeing much more safety for these procedures than underground abortions performed in Poland. If any harm or complications occur, the women are – unlike at home – able to demand compensations. However, this abortion tourism to various countries leads to the fact that is impossible to precisely assess the numbers of abortions. The demand for abortion tourism, however, is so big, that several clinics along the border employ Polish-speaking staff. One example is the clinic of Doctor Janusz Rudzisnki, a Polish doctor working in a German clinic close to the Polish border who says that his clinic had more than a thousand Polish patients every year (Kacpura et al., 2013). Another example is the Gynmed Klinik in Vienna, which is visited by about 250 Polish women every year, undergoing abortions (Tulej, 2017).

Gina Horst (l. 30–34) worries about this phenomenon as she thinks this is merely transferring the problem somewhere else, i.e. Polish women just bypass the restrictive legal base and travel to another country such as Germany. She also points out that women who are not mobile and who do not possess the necessary resources for this tactic are excluded from this possibility.

Krystyna Kacpura acknowledges this phenomenon as well (l. 46–48), mentioning that “Polish women prefer to go abroad, because it’s cheaper, safer and legal. Even if women are not punished, they feel like doing something against the law”. She also recounts a newspaper article about eight Polish women seeking abortions in Germany (l. 60–68), half of them actually entitled to abortions in their home country. “One woman was seriously sick with heart problems, the second one was raped by four men, and the other two had prenatal tests and were informed that the fetuses are seriously damaged. But they tried to get access in Poland, but they failed and went to get access in these clinics”.

Abortion Underground

Krystyna Kacpura (l. 177–179) points out that “the official rate of legal abortion is nearly 1,000 abortions a year, but could you imagine 1,000 abortions yearly in a society with 10 million women of reproductive age? It’s impossible, so we estimate this number should be 150,000 abortions a year”. And as no hard and reliable data is available on the numbers of abortions, Nowicka (2008) carried out a calculation on the basis of demographic data and her own research findings and came to the
conclusion that about 80,000 to 190,000 abortions were performed every year in Poland. In the study conducted, Poland was compared to other European countries based on statistical data especially on the population size and the number of abortions in these countries. It has to be mentioned that the number of abortions does not only depend on the population size, but there are other factors that have to be included, such as the health and education policies of each country, for instance the access to sexuality education and modern contraception (Van Look & von Herzen, 2016). This difference for example can be found when comparing Western and Eastern Europe, as in the West many policies have been put in place and also carried out, whereas in the East policies might be in place, but are not carried out. As mentioned earlier, the abortion rates in Eastern European countries are therefore also higher than the abortion rates in Western Europe, even though the difference has decreased in the 21st century (Henshaw, Singh, & Haas, 1999).

Nowicka (2008) first calculated the number of abortions on the basis of the abortion index per 1,000 women of reproductive age and the number of abortions performed based on the official abortion numbers of Slovakia, Hungary and France. These results are shown in Table 4, and all three simulations exceeded 100,000 abortions annually.

Table 4: Abortion in Europe compared

<table>
<thead>
<tr>
<th>Countries</th>
<th>Population</th>
<th>Live births</th>
<th>Number of abortions</th>
<th>Abortions per thousand women (of reproductive age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>62,400,000</td>
<td>767,816</td>
<td>203,000 (2005)</td>
<td>14.6</td>
</tr>
<tr>
<td>Hungary</td>
<td>10,037,768</td>
<td>95,137</td>
<td>88,000 (2004)</td>
<td>27.9</td>
</tr>
<tr>
<td>Poland</td>
<td>38,157,000</td>
<td>366,095</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Poland - simulation 1</td>
<td>146,000</td>
<td>14.6 (at the level of France)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland - simulation 2</td>
<td>279,000</td>
<td>27.9 (at the level of Hungary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland - simulation 3</td>
<td>139,000</td>
<td>13.9 (at the level of Slovakia)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data source: Nowicka, 2008, author's own presentation
Nowicka (2008) also points out that nowadays the opponents of abortion rights have acknowledged the fact that an abortion underground exists and is widely developed. The good thing here is that they have stopped pretending that this abortion underground does not exist, but they still shut their eyes at the actual numbers, as they only admit there are tens of thousands of abortion performed. And in addition to denying the amount of underground abortions, they ignore the fact that the number of births has fallen since the introduction of the Anti-Abortion Act, even though the policy makers anticipated the number would increase with the ban of abortion.

Another method to calculate the number of abortions carried out in Poland is to refer to the number of legal abortions performed in the 1980s, when abortion laws were not as strict as now. During that time, about 150,000 abortions were carried out annually. But even here the numbers are assumed to be underestimated as this number only considers abortions in public hospitals and not private clinics (Nowicka, 2008). Krystyna Kacpura (l. 233–240) mentions on this topic that even though every fourth woman in Poland had an abortion in her life, it has to be kept in mind that this was during the past 25 years “when about was still legal in Poland. And in that time contraception was not popular or accessible, women were not educated, no access to internet and no information. So nowadays we mostly take advantage of the Internet to search for information, in order to be well informed about many issues, among them contraception”.

Krystyna Kacpura (l. 242–250) also declares that she thinks the abortion rate “rate is probably as it is in other countries from this region. I am sure that the rate in Poland is higher when compared to France or Germany, because we basically don’t have sexual education, we have no access to free and broad to modern contraception, no family planning centers, so we are not well informed as a society. Because even if educated women living in towns have information and use contraception, we are thinking about the majority of those living in small towns and villages with one doctor, one cabinet and no access to internet, as there still are some regions in Poland like this. So we are afraid for those women”.

Abortion in Poland
7.6 Restricted Access to Abortion

Even though Poland is a developed country and is progressive in many ways, the access to safe abortion is still not common practice to women. As actual numbers of unsafe abortions are unavailable, it can only be estimated how many procedures actually take place. One would think that in this highly developed country basic rights would be carried out, but the reality looks somewhat different.

In her interview Krystyna Kacpura (l. 5–8) points out that even though abortion in Poland is legal in three cases, “this is on paper, but on practice right now we have no access to legal abortion in Poland”. It has to be clear that when talking about the vested right to abortion, only the three cases in which abortion is legal in Poland are included. There are several reasons why women in Poland do not have access to their vested right to abortion. In the following sections these reasons will be covered more into detail.

Domaradzka (2008) points out three major barriers that are put into women’s paths on their quest to have an abortion. She first points out the unclear legal situation, as the law does not state in which situations a mother’s life is in danger or when her life is threatened, and the laws themselves are inconsistent, resulting in confusion about the fines about the damage or death of the fetus. The author also points out that difficulties occur in terms of diagnostics in the first stage of the pregnancy, when only some cases of malformations can be detected. Furthermore, the author criticizes the politicization of abortion, where the term of abortion is most of the time defined as taking life, as well as the fact that most doctors rather avoid problematic situations and therefore deny performing abortions. And lastly she points out that women resort to other options, such as underground abortions or abortion pills, as the procedure in order to gain access to a safe and legal abortion is complicated and long stretched. These three barriers will be described in detail in the following.

Legal Side and Confusions

In the Criminal Code of Poland in Article 152, § 1 it is stated that abortions carried out against the Act will face imprisonment for up to three years, followed by § 2, stating that the same punishment will be put upon anyone assisting or pressuring the pregnant woman to get an abortion. § 3 of Article 152 states that if violations
against § 1 or 2 are carried out when the fetus is capable to live independently outside of the woman’s body, imprisonment will be 6 months to 8 years. Article 153, § 1 announces imprisonment for 6 months to 8 years for anyone who harms the pregnant woman so much that her pregnancy is terminated without her consent or forces the woman to have an abortion. In § 2 it is stated that if the violation of § 1 is done, once the fetus is capable of living outside of the mother, imprisonment is raised to up to 10 years. Article 154 continues by stating any violation of Article 152 §1 or 2 leading to the death of the pregnant woman will be punished with imprisonment from one to 10 years. If violating Article 152 §3 or Article 153 result in the death of the woman, imprisonment will be from 2 to 12 years (Republic of Poland, 2016).

This has to be considered when talking about restricted access as assisting in having an abortion is understood as even just recommending a doctor and providing transportation, financial means or abortion pill, making these actions illegal according to the Criminal Code.

Kacpura et al. (2013) stated in their report that there are three reasons, which lead to restricted access to legal abortion from the legal perspective. The first one results from the vagueness of the Act and the Criminal Code itself. Many people in Poland are scared they will be liable to prosecution if they provide even just information or advice about the possibility of the termination of pregnancy. Solely providing information without the intent of convincing the pregnant woman to have an abortion or assisting her do so is not prohibited. The second one is that in all cases the doctor has to decide whether or not the requested abortion is legal, frequently relating to genetic malformation of the fetus. The problem here is that after the genetic malformation is identified, the doctor asked to carry out the abortion has to determine whether this malformation is severe enough to justify an abortion. If the mother’s health or life are in danger on the other hand, the diagnosing doctor should state this and no additional test should be necessary from the doctor carrying out the abortion. The third reason deals with the problem of the lack of standards, recommendations and code of conducts for doctors who want to carry out a legal abortion. Doctors are afraid they might act against the Act and therefore rather decline the abortion, calling upon their conscience or using other techniques. The European Court of Human Right recognized this phenomenon and called it chilling effect.
Krystyna Kacpura (l. 35–37) further mentions in her interview that her Federation was told in secret “that every single case of legal abortion is carefully checked and investigated, in every hospital”. She goes on (l. 39–40), stating that “they just step by step want to introduce very restrictive, not law, but measures, to exclude abortion from public health services”.

Involvement of the Polish Catholic Church & Politics

Another aspect it that doctors are either afraid they might upset the church or they modify their behavior to the one that is expected from them by the society or politicians. As abortions are viewed as bad in the eye of the church, some physicians are scared that once they perform abortions, their actions will cause trouble or will be blamed with committing a legal or moral crime, so they choose to not perform abortions and rather stand aside (Rozynska & Chánska, 2013). Krystyna Kacpura speaks of this as well in her interview (l. 24–26) as she says “the most important is the problem of stigma of abortion and the influence of fundamental Catholic groups, with the Polish Catholic Church in front of them, supporting them”. She comes back to the topic later on in her interview (l. 54–59), mentioning that “gynecologists are frightened because of their position, their profession of the fundamentalist groups, which have been staying day and night in front of hospitals, with bloody posters. This is the kind of manipulation that goes on, obviously it doesn’t look like on their posters. They prefer to be neutral, but that means for us that they are not helpful, they are rather helpful for the fundamentalists, because they just want to do everything to avoid having to make a decision about abortion”. She later on also points out (l. 224–227) “the doctors just don’t want to have trouble. This is not their religion or ideology; this is not real conscientious objection, this is just ‘I am neutral, I don’t want to have any trouble’. If the political climate will be better and more pro-choice, they will change their conscience, and will be more with women and for women’s rights”.

It has to be mentioned that more than half of the Poles do not think a doctor can refuse to perform a legal abortion basing this decision on his conscience. And 62% think a doctor should have to offer a referral for an abortion, if the woman is legally entitled to an abortion (Centrum Badania Opini, 2014).
A study was conducted by Domaradzka (2008) in order to gather information concerning the quality as well as the actual access to gynecological services and in particular focusing on the termination of pregnancy. The author interviewed several directors of hospitals and clinics, consultants and other experts in the gynecological field. The main results from this research were that there is inequality in the access for women to gynecological services as differences in education, age, income level and place of residence occur. This also occurs due to the fact that there is a diversity of quality also affected by the human factor, meaning the behavior and attitude of doctors and directors of health facilities. Doctors usually use an emotional rather than a scientific language when talking about abortion and prenatal tests and no tendency to rationalize these topics is expected.

This is also mentioned by Krystyna Kacpura (l. 26–31) as she talks about that the doctors’ “language is very emotional, talking about the right to life of so-called unborn child. We are called by them murderers, killers. And our language is based on human rights standards, and in their language there is not a word of woman’s autonomy, right to choose, woman’s reproductive right”. She furthermore states that “they are taking on life which isn’t existing, they don’t care for life which exists, they don’t care about women at all”.

In the study by Domaradzka (2008) some doctors even state they have never encountered a situation in which the mother’s life is in danger, so they negate women the indications to terminate their pregnancy legally. Furthermore, the topic of abortion as well as the topic of family planning are still seen as a taboo and are rather not talked about. Domaradzka also found that the access to abortion is restricted more than necessarily by doctors unwilling to perform abortions when referring women to other institutions, prolonging the period until the abortion can be carried out and therefore endangering women to exceed the legal time period.

These are the three main barriers women have to face right now when wanting to obtain a legal abortion in Poland. But in the past year even more restrictive proposals have been made.

In the fall of 2016, the Polish government was handed a controversial proposal by a citizens’ initiative, trying to make the abortion law in Poland even more strict than it already is. The proposal was backed by many members of parliament but aroused immediate protests in the women’s right movement, leading to 30,000 people gathering in Warsaw’s Castle Square, and more than 100,000 in all of Europe. The
proposal was denied, but the liberal party warns about further attempts to make the law stricter in matters of abortion.

Krystyna Kacpura (l. 70–81) mentions a law that was proposed in January 2017, proposing that every difficult pregnancy, meaning a pregnancy with a severely damaged or ill fetus, brought to term would result in a onetime payment of 4,000 zloty (900 €) for the mother, resulting in the fact that women are pushed towards having sick babies, no matter their expected lifespan. The proposed law also includes post-natal hospice care, as the “so-called unborn child has the right to die in its mother’s arm and right to be baptized and to have a burial as well. But nobody asked the women, if they agree with this, women are just subjects, we have no basic human rights”.

In her interview, Krystyna Kacpura (l. 95–105) also mentions that three more petitions are on their way, including a total ban of abortion, but the Church has now realized that women are threatening to leave it, “so right now they showed more humanity for women. But instead of this, there is also a ban of oral contraception right now which will be voted on in two weeks in the Polish parliament, excluding emergency contraception to be sold over the counter. This is the last step of possible contraception for women, last possibility, especially important after rapes for example. So they want to withdraw the possibility to sell it over the counter. If we need prescription for this it will not be emergency contraception, because for this you have to wait for a visit at a doctor for at least two to three weeks”.

Refusal by Doctors to Perform Abortions

Rozynska and Chánska (2013) state that sometimes women have difficulties to receive the required certificate in order to obtain an abortion, as some doctors believe the life of the fetus has priority over the life of the pregnant mother. Other times the doctor acknowledges the fact that the mother’s health is in danger in case she gives birth, but does not have enough courage to state his fear on paper in order for the women to have the legal right for the requested abortion. This can result in women being denied their right to abortion, even though their health or life is in serious danger. Here Krystyna Kacpura (l. 32–35) points out that actually it is rather a miracle to get access to abortion as “it’s not enough to have a certificate from any doctor that pregnancy threatens the woman’s health, they just demand a certificate which states that the pregnancy threatens the woman’s life. Health is not
enough for them”. The case of Tysiak is a famous case which proceeded to the European Courts of Human Rights as the life of the mother was put in serious danger because doctors refused to perform an abortion.

In other cases doctors purposely misinform their prospective patients about their rights, especially in cases where the previous tests expose fetal abnormalities, so the women would either be entitled to further prenatal testing or termination of the pregnancy (Rozynska & Chánska, 2013). In the case of Barbara Wojnaroska, a woman whose first child suffered from achondroplasia and well-founded suspicion existed, was denied the referral to further prenatal testing. She had to birth a child, knowing it would probably have the same malformation and it happened like she expected. She now has financial issues (Federacja na rzecz Kobiet i Planowania Rodziny, 2005).

At other times, doctors put up more barriers for the women requesting the abortion, barriers which are not requested by the law, such as additional documents and consultations, or they require the women to undergo further examinations. These techniques all aim towards the goal that the extended period of time required for a woman to gather the asked documents will be longer than the legal time limit for abortion. In cases where the pregnancy results from a crime, there are reports that the women also have problems acquiring the required certificate stating that their pregnancy actually results from this crime. Either the prosecutor does not believe the woman that her pregnancy results from rape as she is unable to produce witnesses, or the prosecutors just deny the women the right to the legal abortion (Nowicka, 2008).

It also has to be mentioned that doctors reserve the right refuse to perform an abortion on the grounds of the conscience clause, which was already described earlier in this paper. Gina Horst (l. 8–12) also supports this claim in her interview as she states that in her eye the biggest obstacle women have to face when wanting to obtain an abortion is the number of hospitals and doctors who are still willing to perform this procedure. She also points out that this is a problem especially in rural areas, but also in bigger cities as more and more medical personal will deny to perform abortions as well as follow-up care on the grounds of the conscience clause. In the law it is exactly defined on which groound physicians can enact this clause, but some doctors use this clause on choosing which services they will perform and which not, deliberately whether the reason they bring forth is stated in
the clause (Mishtal, 2009). Doctors are obliged to refer their patients to other doctors as soon as they enact the conscience clause and to record the refusal for medical documentation, but referrals seldom take place. Krystyna Kacpura (l. 12–13) also mentions that “there is broadly introduced conscience clause, or conscience objection”. Furthermore, she points out (l. 18–19) that sometimes women come to hospitals seeking an abortion but are told “we don’t have staff, that means all doctors of this hospital signed the conscience clause”.

7.7 Comments on the Situation by European Institutions

The three cases against Poland which were decided by the European Court of Human Rights (ECtHR) show how Poland’s restrictive and unclear abortion law framework poses limitations on women and violates human rights.

In 1999 the UN Human Rights Committee was already concerned about the strict abortion law in Poland, leading to a high amount of clandestine abortions (1999). In 2009, ten years later, Poland was advised by the Committee on Economic, Social and Cultural Rights to make sure that women did not need to have unsafe abortions due to the rejection of doctors and hospitals to perform abortions (2009). And just a year later the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Poland indicated that the access to legal abortion is seriously restricted (UN Human Rights Council, 2010).

In addition to that the Council of Europe Commissioner for Human Rights remarked about the situation in Poland that women’s access to legal abortion is often restricted and therefore urged Poland’s government to make access to abortion available to women who are legally entitled to it (2007).

The government of Poland adopted the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) in 1980 and is therefore obliged to provide advice and information about family planning in schools and also develop family codes. These should guarantee women’s rights including the right to decide herself about the number and timing of children and therefore also the right to access information and education in order to enable her to exercise these rights. But 37 years after adopting these requirements, the Committee on the Elimination of
Discrimination against women pointed out that women experience further restrictions in accessing abortion than the laws of Poland already pose. It furthermore pointed out that abortions are unavailable even if the law permits them, criticizes the amount of information on when doctors are allowed to use the conscience clause and also points out the lack of information about the amount of illegal abortions (Committee on the Elimination of Discrimination against Women, 2006).

Furthermore, the members of the Committee on Women’s Rights and Gender Equality went to Poland in the end of May 2017 and raised concerns about the access to legal and safe abortion. The press release states that they are concerned that the current legal situation does not guarantee safe abortion and this access might be restricted even more in the future. As the European Parliament’s position is that it is against the fundamental women’s rights to deny access to sexual and reproductive health services, the Committee wants the government to fully implement the national legislation. The Committee also points out that active prevention, providing of information and education, also including access to contraception, are important to decrease the need of abortions. The shrinking public space for civil society worries the Committee as adequate funding for women’s rights organizations have to be ensured (European Parliament, 2017).

7.8 Possible Solutions and Future Chances

The experts were also asked what possible solutions and future chances they see for the issue of restricted access to legal abortion in Poland right now.

Gina Horst (l. 23–26) does not see a real possibility to increase the access to safe abortion at the moment. She points out that Polish women have prevented an additional deterioration of the situation, but new attempts to tighten the abortion law from the pro-life party are still feared. She furthermore points out (l. 36–39) that the situation rather seems to worsen than to improve, even though women need consultations and hospitals located nearby to support them in their right to decide for themselves.

Krystyna Kacpura (l. 69–70) states that she does not “know what we can do right now, because they do everything to stop any kind of abortion in Poland”. But she
goes on (l. 82–85) stating that “luckily we live in the center of Europe, have access to internet, we are educated and are standing in solidarity with others living outside of big cities and villages, so we help each other. But still, we live in a democratic country, in the EU member country, so it’s extremely difficult for us to understand our position”.

Furthermore, Krystyna Kacpura (l. 90–93) expresses “Right now we count on women’s solidarity. This is the huge weapon, and hope that we will manage to stop them. And we did stop them for the first time, they didn’t finally introduce this draconian law for a total ban of abortion including punishment for miscarriages”. She also states (l. 108–113) that “we can do more, if we have political support, but right now, we have one ruling party, which has a majority in the Parliament and which formulated a government alone, without any coalition. And they are of course connected to Polish Catholic Church. And I’m afraid that right now we will show that this society doesn’t allow them to introduce the law more restrictive, but for changing the law, there is no chance right now”.

After the proposal of the draconian law thousands of women took on the streets and protested against it as already mentioned, but “this was the first draft law which was withdrawn by peace and justice by the fundamental party” as Krystyna Kacpura points out (l. 120–123). As Krystyna Kacpura (l. 123–128) further mentions, the fundamental party does not “allow us to have a rest, so everyday there is new development, taking care of unborn, closing hospitals, hospitals are told by the national health fund that they will not sign a contract with them, if they provide abortion services, which is of course an illegal procedure, but we know this is happening. Right now they are waiting for a next black protest, so we don’t put down our umbrellas”.

When asked about the actual possibilities women seeking abortions have right now, Krystyna Kacpura (l. 206–209) confirms that one of the only possibilities is to either order an abortion pill online or to go to another country, pay a lot of money and receive the abortion there. The ordering of the abortion pill online can be done on a website called ‘Women on Web’ which then sends the needed abortion pills to women all over the world (“Women on Web,” n.d.).

In conclusion Krystyna Kacpura (l. 213–214) points out that she does not “don’t see any real possibility to change the law right now. Maybe after the next elections. So in 2 ½ years”. And she furthermore proposes (l. 218–220) that “if the law would be
changed, we will do everything that the law is the same in practice as in paper. But right now we don’t have any support, we have only us women”. She sees possibilities (l. 228–231) in devoting “our time and power for raising awareness among women, to educate them. We just want to have an increased amount of the pro-choice population. This is extremely important. Right now this is 42% totally pro-choice, but 87% are against more restrictive abortion laws. So we will work on this“.
The aim of the research was to identify the obstacles that Polish pregnant women experience when they want to obtain a legal abortion in their home country. The Polish legal system allows abortions on three grounds, if the mother's health or life is in danger, if the fetus suffers from severe genetic malformation or if the pregnancy results from either incest or rape (Republic of Poland, 1993). But, as it has been shown in the literature research, the women who have the vested right to undergo an abortion in their home country face obstacles such as a confusing legal system, which does not clearly state and explain which acts are outlawed. Confusions occur in case whether recommending a doctor counts as assisting in having an abortion or whether does merely counts as providing information (Kacpura et al., 2013).

Pregnant women also often see the refusal of doctors to perform the service they are seeking as the doctors rely on the conscience clause, allowing doctors to decline the performance of a service in case this service collides with their conscience (Republic of Poland, 1996). But as Krystyna Kacpura points out in her interview, many doctors only pretend these services are against their conscience in order to avoid trouble with the fundamentalist groups, but they would change their behavior as soon as the law changes in favor of legal abortions. But the conscience clause is not the only tool doctors use in order to hinder women from having abortions. Doctors refuse to issue the required certificate in order to obtain an abortion, sometimes putting the life of the fetus above the life of the mother. Another way to obstruct the access to abortion doctors have is to misinform their prospective patients about their rights, or they delay the actual abortion for a long time by having the pregnant woman acquire more unnecessary certificates or perform needless testing that the legal limit for abortion is exceeded and the woman has no right to the abortion anymore (Rozynska & Chánska, 2013).

As already mentioned, fundamentalist groups apply a lot of pressure on doctors and as religion and the anti-abortion Catholic Church still play an important role in Poland and its society (Nowicka, 2008), they basically force more and more doctors into using the conscience objection by protesting in front of their hospitals and threatening them, as Krystyna Kacpura mentions in her interview. She also points out that the Catholic Church does not use a scientific language when talking about abortion, but rather an emotional language, appealing to mothers not to murder their
innocent child. The Catholic Church therefore uses the influence and power it has in order to keep pregnant women from their rightful abortions.

The aim of the thesis is also to provide possible solutions for the issue of unsafe abortions due to restrictions in vested rights of pregnant women. Many women either resort to these unsafe abortions or, if they have enough resources, to traveling to another country where abortion is legal and actually performed, but this cannot be a solution the Polish State is aiming for (Kacpura et al., 2013). Sadly, in the past years several more restrictive laws were proposed, resulting in protests from women and men not just in Poland but all over Europe. And as both interview partners as well as the literature point out, there is not actual possibility right now to improve the access to safe and legal abortion. The aim of the Federation of Women and Family Planning, according to Krystyna Kacpura, right now is to raise awareness and to educate them about the situation, to count on solidarity from women and to hope that the ruling party does not get through with a more restrictive law in their ruling time. But Krystyna Kacpura points out that she does not see any possibility to change to law in favor of women. She wants to increase the percentage of people in the total pro-choice part in order to change the ruling party and thus have a chance at changing the law. The next elections are 2 ½ years away, and in this period she and her Federation will work on this.
Abortions have been around for thousands of years, but with the advancement in technology and medicine, they have become safer and safer and – with the development of contraception, traditional and modern – abortions have become less frequent. But when sexually uneducated people do not have the access to contraception, especially modern, repeated unwanted pregnancies occur. If this is the case and the woman lives in a country where the access to abortion is not restricted and abortions are conducted frequently, this does not pose a big problem, as it was the case during the Communist time in the Soviet Union. But if the access to abortions is restricted and women are denied abortions, it becomes a huge problem.

Unsafe abortion is a global problem as the total number of unsafe abortions in 2008 ranges between 21 and 22 million and the consequences of these unsafe abortions can have long term effects on the woman such as infertility or in the worst case death from complications. The WHO published recommendations about the methods of abortions, but sometimes due to lack of resources or knowledge, these recommendations are not put into action.

The access to abortion can be restricted by social barriers, such as stigma against abortion as such and the lack of information about sexuality. But the access can also be restricted by economic and logistical barriers, as some women do not have the resources or the means for transportation to hospitals. It furthermore can be limited by legal barriers, such as restrictive abortion laws, but also by health system barriers, including the unavailability of facilities providing abortions or the negative attitudes of the providers towards abortion.

Even Poland allows abortion on three grounds, in case of a threat to the mother’s health or life, if the fetus suffers from severe genetic malformation or if the pregnancy results from either incest or rape. But throughout this thesis is has been shown that the access to safe and legal abortion in Poland is restricted, leading to unsafe abortions performed in country or women traveling to other countries. The actual numbers of women undergoing illegal and also unsafe abortion can only be estimated, but numbers projected by various sources put the number of abortions at around 150,000 per year, while the Polish government only reported 1,100 abortions performed in public hospitals in 2015. This difference in numbers proves the
statement from Sedgh et al. (2012) that women are likely to undergo an abortion, irrespective of legal conditions.

The reasons for the restricted access to safe and legal abortion are threefold. First of all are the various confusing legal documents and the Criminal Code, which do not clearly state which acts are outlawed and what is allowed. This includes assisting in an abortion, as well as the lack of definition what the threat to a woman’s health or life actually is and what malformation the fetus has to have in order to qualify for a legal abortion. Furthermore, doctors do not have clear standards and recommendations which they can fall back on concerning the legal abortions.

The second reason for restricted access identified in the thesis is the involvement of the Polish Catholic Church in politics. As more than 87% of Poles identify themselves as belonging to the Roman Catholic Church, it has enough power to influence many people in their favor.

The third and last reason for the restricted access to the vested right in safe and legal abortion is that doctors tend to refuse to perform abortions, even though the women are actually legally entitled to these. The doctors can evoke a conscience clause if the service they are asked to perform is against their conscience, but this clause is regulated strictly and especially does not apply on emergency situations. Furthermore, some doctors put the life of the fetus above the life of the mother, thus putting the life of the mother in serious danger. Other times doctors misinform pregnant women about their rights, denying them the right to further prenatal testing or they prolong the period until the abortion by requesting additional documents so long that the legal period for abortions is exceeded. They are pressured by fundamentalist groups to deny the right to abortion and enact the conscience clause. By pressing doctors into evoking the conscience clause and protesting against abortions in front of hospitals, they hinder women seeking abortion from access to it.

By proposing further restrictions frequently, the pro-choice party does not have a chance to rest and has to fight against these propositions. This also leads to both interviewed experts not seeing a real chance in increasing the access to safe abortion at the moment or in the near future. Women have to count on solidarity and they have to help each other. The only possibilities right now to have a safe abortion is either to order an abortion pill online or to travel to another country in order to obtain the desired abortion.
It has to be considered whether broad and intensive sexuality education and access to modern contraception should be put in place in order to decrease the need for abortions in Poland in the future.
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Appendix 1: Transcript of Interview with Krystyna Kacpura

Lena Münch: The first question I am trying to find an answer to in my Master Thesis is, what do you see as the biggest challenges and obstacles for the women to get the access to safe abortion?

Krystyna Kacpura: Probably you know that we have in Poland a quite restrictive abortion law, which has been existing since 1993, and according to this law abortion is allowed in three cases: If the fetus is severely damaged, or sick, when the pregnancy form rape or where there is a real threat to woman's life or health. This is on paper, but in practice right now we have no access to legal abortion in Poland. Of course, speaking about legality, legal according to these three exceptions. Not abortion on demand or on socio-economic grounds, but according to existing law. And why, I will try to answer your question, why is it in practice much more restrictive than on paper. First of all, there is a huge stigma on abortion in Poland. Then there is broadly introduced conscience clause, or conscience objection. So, even if doctor in hospitals don't use conscience objection, they think to use it at the end of the procedure. Just an example, a woman is coming to the hospital with a certificate that she is obliged to get access to legal procedure, termination of pregnancy, abortion. And she is told we don't do such procedures, we don't have staff, not here and we don't know where and who. We don't have staff, that means all doctors of this hospital signed the conscience clause. We don't know where and who. This is according to the latest sentence of the constitutional tribunal, that gynecologists are not obliged to give information, if they signed the conscience clause. They are not obliged to give information to women where and who can provide them with abortion services. Because this is also against their conscience clause.

But I think that the most important is the problem of stigma of abortion and the influence of fundamental Catholic groups, with the Polish Catholic Church in front of them, supporting them. Because somehow, 20 years ago we lost the language. It means that their language is very emotional, talking about the right to life of so-called unborn child. We are called by them murderers, killers. And our language is based on human rights standards, and in their language there is not word of
woman’s autonomy, right to choose, woman’s reproductive right. They are taking on life which isn’t existing, they don’t care for life which exists, they don’t care about women at all.

Right now we know that to get access to abortion is like a miracle. It’s not enough to have a certificate from any doctors, that pregnancy threatens the woman’s health, they just demand a certificate which states that the pregnancy threatens the woman’s life. Health is not enough for them. We were told by some directors of hospitals, secretly of course, that every single case of legal abortion is carefully checked and investigated, in every hospital. So, the policy, even if thanks to Black Monday and strikes, even if we stopped this draconian law, proposed by Ordo Iuris to stop abortion, they just step by step want to introduce very restrictive, not law, but measures, to exclude abortion from public health services.

LM: And how is it in the private health care sector?

KK: In the private health care sector it is still that way, that, according to existing law gynecologists are criminalized, up to three years of prison. So, so called Polish underground, I mean private cabinets, clinics, right now it is very difficult to get access. And it is extremely expensive. So Polish women prefer to go abroad, because it’s cheaper, safer and legal. Even if women are not punished, they feel like doing something against the law.

LM: And if these women go to Austria or Germany, they will not be prosecuted in Poland?

KK: No, women are not punished at all, according to existing law. Only gynecologist and so-called helpers. So, people who give information, who accompany them, just like give them assistance. Gynecologists are frightened because of their position, their profession of the fundamentalist groups, which have been staying day and night in front of hospitals, with bloody posters. This is the kind of manipulation that goes on, obviously it doesn’t look like on their posters. They prefer to be neutral, but that means for us that they are not helpful, they are rather helpful for the fundamentalists, because they just want to do everything to avoid having to make a decision about abortion. As far as I remember, a journalist made a research about this and then she went to Germany to some German clinics. And just last Friday she
met 8 Polish women in a clinic close to the border with a Polish gynecologist. She spoke to women waiting in this clinic, and out of these 8 waiting women, four were obliged to get access to legal abortion in Poland. So they went abroad to get access to legal abortion. One woman was seriously sick with heart problems, the second one was raped by four men, and the other two had prenatal tests and were informed that the fetuses are seriously damaged. But they tried to get access in Poland, but they failed and went to get access in these clinics.

I don’t know what we can do right now, because they do everything to stop any kind of abortion in Poland. For example, in January, one law, called ‘For Life’ was proposed, and in this law it is proposed that every woman who decides to bring a so-called difficult pregnancy to term will receive 4,000 zloty. And what does difficult pregnancy mean? It means that the fetus is seriously damaged or very sick or ill. And they proposed 4,000 zloty (900 €) for the women, once in the beginning, if the baby is born alive. They want to push women to give birth to very sick babies. Even if they are aware that these babies will die soon, maybe after 5 minutes, after 1 week, a month or even 10 years. It is incredible sufferings. The second step is that they prepare a special rule, post-natal hospice, this is the kind of final stage of life. Because so-called unborn child has a right to die in its mothers and right to be baptized and to have a burial as well. But nobody asked the women, if they agree with this, women are just subjects, we have no basic human rights.

Luckily we live in the center of Europe, have access to internet, we are educated and are standing in solidarity with others living outside of big cities and villages, so we help each other. But still, we live in a democratic country, in the EU member country, so it’s extremely difficult for us to understand our position.

LM: So, what I understood from your answers so far, in the near future you don’t see possibilities or opportunities to change either the law, the stigma or also the habit of the doctors?

KK: Right now we count on women’s solidarity. This is the huge weapon, and hope that we will manage to stop them. And we did stop them for the first time, they didn’t finally introduce this draconian law for a total ban of abortion including punishment for miscarriages. It was in this law, that an investigation process would be started on any case of miscarriage. And if a woman does something bad for her pregnancy she would be punished. But of course it’s stupid anyway. Right now there is another
petition and another project and a third one is waiting in the parliament, also a total
ban of abortion, but women are not punished as the church is for women and the
church decided that women can’t be punished. They were frightened by women
leaving churches, so right now they showed more humanity for women. But instead
of this, there is also a ban of oral contraception right now which will be voted on in
two weeks in the Polish parliament, excluding emergency contraception to be sold
over the counter. This is the last step of possible contraception for women, last
possibility, especially important after rapes for example. So they want to withdraw
the possibility to sell it over the counter. If we need prescription for this it will not be
emergency contraception, because for this you have to wait for a visit at a doctor for
at least two to three weeks. So it’s rather impossible. The selling over the counter is
allowed in all European countries and it was checked by the European medical
agency so carefully about its safety and everything. We can do more, if we have
political support, but right now, we have one ruling party, which has a majority in the
Parliament and which formulated a government alone, without any coalition. And
they are of course connected to Polish Catholic Church. And I’m afraid that right
now we will show that this society doesn’t allow them to introduce the law more
restrictive, but for changing the law, there is no chance right now. Because we failed
during voting, even though we collected 250,000 signatures in order get a law to the
parliament, but this law was rejected after the first reading, even though it was
promised that both draft laws on total ban of abortion as well as the one on
liberalizing will be sent to the commission. So this was the main reason why women
came into streets and protested. That one was rejected after first reading, which is
unusual when it is a civic initiative, because usually all civic initiatives are sent for
further proceedings to special parliamentary commissions. So this was rejected, the
second one was sent to Commission and it made women furious and angry. They
came out on the streets because of this. So first step was done, they showed our
solidarity, our strength and this was the first draft law which was withdrawn by peace
and justice by the fundamental party. So, we won, but they don’t allow us to have a
rest, so everyday there is new development, taking care of unborn, closing
hospitals, hospitals are told by the national health fund that they will not sign a
contract with them, if they provide abortion services, which is of course an illegal
procedure, but we know this is happening. Right now they are waiting for a next
black protest, so we don’t put down our umbrellas.
LM: And how is the availability of contraception in Poland overall? Is it possible to receive the normal Pill?

KK: Yes, contraception is accessible, but it’s not subsidized by the State, so it’s rather expensive. Besides, we do not have family planning centers in Poland. So one gynecologist does everything, takes care of your pregnancy, of some illness as well as family planning, so there is only two minutes for family planning. And hormonal contraception is not so popular in Poland because of lack of knowledge about it. As far as I know there is around 18% of women who use oral contraception in Poland. Mainly this is condoms and so-called natural methods. Right now there was a study published in January this year from a special Commission on procreative life. Interestingly, they are afraid of the word reproductive rights and reproduction, they use procreation and procreative rights. Which means that a woman is allowed only to give birth, not allowed to plan the maternity, when and how many children to have. No, they are taking care of her future pregnancy ended with giving birth. So this group is working on securing the life of unborn child – fetus – and include this issue into endless education in school, instead of sexuality education. How to secure and why this is extremely important. And they concentrate their efforts on natural methods, calendar etc. So we have no help political side as well from the governmental institutions.

LM: As you mentioned sexual education in school, is it only based on natural contraception?

KK: Sexual education, there is no comprehensive sexual education on school. This is the subject called preparation to the family life. So, it’s more about traditional values, traditional families – mother, father, children. Men and women. There is nothing about LGBT issues, diversities of families, about single mothers, single fathers, or same sex couples, nothing about sexuality, about contraception, only at the last stage of this subject they will provide information about natural methods.

LM: And how many hours does this subject have in school?

KK: It’s one hour a week, for one year. And of course this is not in the school curriculum, it’s not obligatory. It depends on parents mainly. It is also stated in the new draft proposal, that sexual education depends on the parents’ religion. Young
people stay alone with their problems and stay alone with their knowledge from the
Internet, from pornography and they suffer. There is an increase of HIV and other
STDs in Poland right now and increase of psychological disorder among young
generation. Because they compare themselves with a picture shown in porno-films.
Young boys, aged 14–15 is calling our experts in hotline hours and says he saw a
film where the man looked quite different, thinking that he is abnormal. So how could
he live with this? Usually we answer, if he has seen any science fiction film, as
porno compares to science fiction, as this is also fiction, everything is made
especially for this film. And the length of the penis for example, is made especially
for this film, so he should not worry about this. This might seem funny, but it’s a real
tragedy for young people.

LM: Coming to another topic, do you think that the official rate of abortion is
reliable?

KK: The official rate of legal abortion is nearly 1,000 abortions a year, but could you
imagine 1,000 abortions yearly in a society with 10 million women of reproductive
age? It’s impossible, so we estimate this number should be 150,000 abortions a
year. This is agreed with the previous period in the early 90s when abortion was
allowed in Poland, and compared for example to Spain which has the same number
of women in reproductive age. And a very important research agency conducted a
research among 1,000 women in Poland and the results were terrible, being during
her life, no less 4.5 million and no more than 5 million perform at least once in her
lifetime an abortion. So, that is 1/3 of women, which is agreeable with our
estimations. In the official statistic it is 1,000 legal abortion and 900 were performed
because of fetus illnesses and damages.

LM: In order to help the women in need, there is a website called ‘Women on
the Web’, which sends the required medicine to the women in Poland.

KK: Polish women contact them, as well as some clinics close to the boarders in
Germany, Slovakia, Czech Republic, Switzerland, Austria, Netherland, Swedish,
which is interesting, because 20 or 30 years ago, they went to Poland to get access
to abortion, but right now we are travelling there to get access. But they are very
helpful. But still it has to be quite a different situation in Poland.
LM: The process of ordering the pill online and then having it shipped to the women's house?

KK: Yes, this is very helpful, as these women working on the hotlines of ‘Women on the Web’ are women who had medical abortions and have experience and accompany the women and serve as an assistance to women taking these abortion pills. The procedure of shipping and disguising these pills to the women has changed over time, as some packages were stopped by the post and not delivered, but they now changed it to sent it via a third country, in order to disguise these shipments.

LM: But this is one of the only possibilities these women have. To either order an abortion pill online or to go to another country, pay a lot of money, any receive the abortion there.

KK: Yes, that's absolutely right.

LM: So, to recap, you don’t see any possibilities for the situation to change in the near future?

KK: I don’t see any real possibility to change the law right now. Maybe after the next elections. So in 2 ½ years.

LM: But even if the law was changed, it still wouldn't mean that doctors will perform the abortions, right?

KK: If the law would be changed, we will do everything that the law is the same in practice as in paper. But right now we don't have any support, we have only us women.

LM: And what are the possibilities and chances to change the conscience clause, as obviously it is the right of the doctors to refuse to perform abortions?
KK: Actually, the doctors just don’t want to have trouble. This is not their religion or ideology; this is not real conscientious objection, this is just ‘I am neutral, I don’t want to have any trouble’. If the political climate will be better and more pro-choice, they will change their conscience, and will be more with women and for women’s rights. So right now we would like to devote our time and power for raising awareness among women, to educate them. We just want to have an increased amount of the pro-choice population. This is extremely important. Right now this is 42% totally pro-choice, but 87% are against more restrictive abortion laws. So we will work on this.

LM: You said before, that about every fourth woman in Poland had an abortion in her life, is that due to the fact, that they are not enough educated about sexuality and about contraception?

KK: Yes, that could be, but you have to keep in mind that this was in past 25 years, when about was still legal in Poland. And in that time contraception was not popular or accessible, women were not educated, no access to internet and no information. So nowadays we mostly take advantage of the Internet to search for information, in order to be well informed about many issues, among them contraception.

LM: Do you think the abortion rate has dropped by now?

KK: I think that the rate is probably as it is in other countries from this region. I am sure that the rate in Poland is higher when compared to France or Germany, because we basically don’t have sexual education, we have no access to free and broad to modern contraception, no family planning centers, so we are not well informed as a society. Because even if educated women living in towns have information and use contraception, we are thinking about the majority of those living in small towns and villages with one doctor, one cabinet and no access to internet, as there still are some regions in Poland like this. So we are afraid for those women.
 Appendix 2: Interview with Gina Horst

Lena Münch: Als erstes steht die Frage, was die Damen als die größten Hürden und Hindernisse sehen, die bewältigt werden müssen, um den Zugang zur Abtreibung zu vereinfachen, beziehungsweise ihn überhaupt zu ermöglichen. Es geht mir hier vor allem um die eigentlich legalen Fälle, in denen die Abtreibung erlaubt ist, in denen die Frauen, die eine Abtreibung durchführen lassen wollen aber vom Arzt abgelehnt werden oder es ansonsten Probleme mit dem Zugang gibt.

Gina Horst: Eines der größten Hindernisse ist wohl die Anzahl an Kliniken und ÄrztInnen, die diesen Eingriff noch vornehmen. Gerade im ländlichen Raum stellt dies ein massives Problem dar, aber auch in den Städten findet sich immer mehr medizinisches Personal, das sowohl den Eingriff selbst als auch die Nachsorge aus Gewissensgründen nicht mehr übernehmen möchten.

LM: Die zweite Frage bezieht sich auf die Möglichkeiten oder auch Chancen, die die Damen sehen, dass die Situation verbessert wird. Welche Möglichkeiten gibt es, einen Weg vor allem mit der katholischen Kirche zu finden, um den Frauen das ihnen zustehene Recht durchzusetzen? Und wie stehen hierfür die Chancen? Würden die Damen zum Beispiel die Option als Möglichkeit betrachten, dass die Frauen, die sich gerne einer Abtreibung unterziehen würden, die benötigten Medikamente legal im Internet bestellen könnten? Und wie stehen die Chancen, das Problem an der Wurzel zu fassen und die fehlende Aufklärung und Verhütungsrate zu steigern?

polnische Frauen beispielsweise nach Deutschland fahren. Frauen, die nicht mobil
sind und über keine ausreichenden Mittel verfügen, sind auch von dieser
Möglichkeit die sehr restriktive Rechtslage in Polen zu umgehen ausgeschlossen.
Wir hören zudem immer wieder von Fällen, in denen ÄrztInnen und oder
ApothekerInnen nicht einmal mehr hormonelle Verhütung verschreiben/abgeben
wollen. Die Situation scheint sich also nach wie vor eher zu verschlimmern als zu
verbessern – dabei brauchen Frauen dringend wohnortnahe Beratungen und
Kliniken, die sie in ihrem Recht selbstbestimmt zu entscheiden unterstützen.