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Abortion Policy Environments and Maternal Mortality in the European Union

Construction of an EU-specific Abortion Policy Index

Author	*Isabelle Schmitz*
Supervisor	*Dr. Carl Bonander*
Examiner	*Ailiana Santosa*
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ABSTRACT

Introduction

Access to safe abortion is recognised by the World Health Organization (WHO) as an essential component of reproductive health care, yet access varies considerably across the European Union (EU). Existing comparative frameworks lack transparency or fail to capture the multidimensionality of abortion policy.

Aim

This study aimed to develop and validate an EU-specific Abortion Policy Index (EU API) to systematically compare abortion policy environments across all 27 EU Member States.

Methods

The Guttmacher abortion policy hostility framework was adapted to the EU context using a four-step modification model, resulting in 12 indicators grounded in the WHO Abortion Care Guidelines. For all Member States, an EU API score was calculated. Convergent validity was assessed through Pearson correlation with the European Abortion Policy Atlas and a regression analysis explored associations with maternal mortality ratios.

Results

Most Member States scored in the restrictive range, only France achieved the maximum supportive score. The EU API correlated strongly with the European Abortion Policy Atlas ($r = 0.782$, $p < 0.001$), supporting convergent validity. No statistically significant association was found between EU API scores and mean maternal mortality ratios ($b = -0.025$, $p = 0.607$), likely reflecting the limited variance of maternal mortality ratios within the EU context.

Conclusion

The EU API provides a transparent, reproducible and theoretically grounded tool for comparative abortion policy analysis. It documents persistent inequalities in access across the EU and contributes a new measurement instrument to reproductive health policy research, with potential for adaptation to other regional settings.

Keywords: Abortion Policy, European Union, Maternal Mortality, Comparative Health Policy

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LIST OF ABBREVIATIONS

CAC	*Comprehensive Abortion Care*
CRR	*Center for Reproductive Rights*
EAPA	*European Abortion Policy Atlas*
ECI	*European Citizens' Initiative*
EPF	*European Parliamentary Forum for Sexual and Reproductive Rights*
EU	*European Union*
EU API	*European Union Abortion Policy Index*
GAPD	*Global Abortion Policy Database*
MMR	*Maternal Mortality Ratios*
RFSU	*Riksförbundet för sexuell upplysning*
RQ	*Research Question*
SDG	*Sustainable Development Goal*
TRAP	*Targeted Regulation of Abortion Providers*
US	*United States*
WHO	*World Health Organization*

1. INTRODUCTION

Since 1995, reproductive rights have been recognised as human rights and as a matter of social justice. Although abortion is widely understood as a component of reproductive health, it has not been established as an explicit right, even though it is closely linked to women's health outcomes (Suh & Anderson, 2025). Abortion care is a time-sensitive medical service, where restricted or delayed access can increase health risks. Safe and timely care on the other side are associated with lower morbidity and maternal mortality, as well as improved physical and mental well-being (World Health Organization (WHO), 2024).

In most European countries, abortion has been legalised during the 1960s and 1970s (De Zordo et al., 2023). However, abortion rights still lead to societal debates over ethical, religious and cultural values and can be framed as a morality policy (Levels et al., 2014). In the past decade, abortion policy across the region has developed in different directions. In several European Union (EU) Member States, legal frameworks have been strengthened towards the protection of abortion, for instance in France, where the government recently established the explicit right to abortion in its constitution. At the same time, progressive examples do not conceal the ongoing legal differences in abortion regulation among EU Member States. Although, as reported by the CRR (2025a), 25 of 27 Member States formally allow abortion on request in early pregnancy, this formal permission does not automatically translate into access. Gestational limits[1] vary between countries and additional procedural requirements often restrict abortion accessibility. In several Member States, mandatory waiting periods or counselling are required before a pregnancy can be terminated. Furthermore, service provision in the EU is uneven since Member States differ in which health care professionals are legally authorised to perform abortions. In 11 Member States, women can still face criminal penalties if they seek abortion services outside the legally defined grounds. These legal and structural barriers illustrate that the existence of a formal right does not necessarily guarantee equitable access. Malta and Poland remain the most restrictive cases within the EU, as both countries prohibit abortion on request. In Malta, abortion is only permitted when the woman's life is at risk. Poland tightened its abortion laws in 2020, when a constitutional ruling eliminated fetal impairment as a legal ground for abortion. This regression placed Poland among the very few countries worldwide that have experienced a regression in abortion rights in recent decades (CRR, 2025a).

In response to these societal and political controversies, the European Citizens' Initiative (ECI) *My Voice, My Choice* found its origin to advocate for accessible safe abortion care within the EU (My Voice, My Choice, 2024). The initiative called on the European Commission to propose legislation enabling

[1] Gestational limits define the maximum number of weeks of pregnancy within which an abortion may be legally performed.

EU funding mechanisms to support Member States in guaranteeing safe and accessible abortion services. Women from EU countries with limited access due to restrictive laws could then seek abortion care, free of charge, in EU countries with more liberal abortion laws. In response, the European Commission confirmed in February 2026 that Member States can voluntarily use the existing European Social Fund Plus to finance cross-border abortion care, without establishing a new legal instrument (European Commission, 2026).

The ECI illustrates that international differences in abortion access are no longer mainly a national concern but an emerging matter of EU-level policy, which highlights that a systematic comparison of abortion policy environments across Member States is both timely and necessary.

2. PREVIOUS RESEARCH

Existing research on abortion in the European context spans two interconnected areas. Starting the chapter, the relationship between abortion access and maternal health outcomes situates the topic within a global health context. Thereafter, existing approaches to classify and compare abortion policies across European countries reveal methodological gaps this study aims to fill.

2.1 Abortion in a Context of Global Health

The safety of abortion varies considerably across countries and reflects differences in legal frameworks, health system capacity and broader social conditions. Ganatra et al. (2014) classified abortion safety into three categories based on the WHO guidelines: safe abortions, performed by trained providers using WHO-recommended methods; less safe abortions, where only one of these conditions is met; and least safe abortions, carried out by untrained individuals using dangerous methods. Less safe and least safe abortions are collectively considered as unsafe. During the period 2010-2014, an estimated 55.7 million abortions occurred annually, of which just over half were classified as safe. While the majority of abortions in developed countries were performed under safe conditions, only around half of abortions in developing regions met the safety criteria (Ganatra et al., 2014). However, when abortion is performed with WHO-recommended methods and appropriate clinical support, it is highly safe and an effective health care procedure that can be delivered in a range of settings. This includes the primary care level and, in early pregnancy, by the pregnant person herself, with adequate information and access to care when needed (WHO, 2024). In contrast, barriers to safe abortion care such as legal restrictions, limited service availability, high costs, mandatory waiting periods or required third-party authorisation limit timely access and shift abortion care away from the formal health system. This can result in unsafe procedures and pose health risks to women (WHO, 2025).

2.1.1 Abortion and Maternal Health Outcomes

Beyond moral discourse, safe abortion access is a critical component of reproductive autonomy and public health, while unsafe abortion still remains a major contributor to preventable maternal morbidity and mortality. In total, 7.9% (95% UI 4.7-13.2) of all maternal deaths are attributed to unsafe abortions, resulting in 13 865 to 38 940 lives lost per year when safe abortion is not provided (Say et al., 2014; WHO, 2024). Overall, a substantial proportion of maternal deaths are preventable through effective public health measures, including the prevention and management of chronic and non-communicable diseases, as well as access to skilled medical personnel throughout pregnancy and childbirth. However, deaths of abortion represent a category in which maternal deaths are particularly avoidable, as the majority of abortion-related deaths are not caused by the procedure itself but result from unsafe abortions in contexts where safe and timely abortion care is unavailable (Say et al., 2014).

Forty-five percent of all abortions are unsafe due to barriers that limit access to safe and timely abortion care (WHO, 2025), elevating health risks that range from suboptimal to dangerous. Regarding maternal morbidity, millions of women annually require treatment in health facilities for complications arising from unsafe abortion, including severe bleeding, infections and other organ injuries. Beyond immediate physical health outcomes, delays, denial of care and exposure to unsafe conditions can also cause psychological distress and violate women's rights to privacy, autonomy, equality and non-discrimination (WHO, 2025). Therefore, ensuring safe and equitable access to abortion aligns with the global health goal to reduce preventable maternal morbidity and mortality, particularly in contexts where women lack the necessary resources to carry a pregnancy safely (Bearak et al., 2020; Zori et al., 2025).

2.1.2 Determinants of Safe Abortion Access

The legal status of abortion represents a foundational determinant of the policy environment, as it defines the formal conditions under which a termination is permitted. However, legal permissibility alone does not determine whether women can actually obtain care in practice. Building on this, abortion access describes the extent to which individuals are able to obtain safe, timely and affordable abortion care regardless of what the law formally permits. Together, these dimensions are integrated within the broader construct of abortion policy environments, the central focus of this study, which captures the full range of legal, institutional and structural conditions that shape access (WHO, 2024). Some key factors relate to health system characteristics, since access depends on how services are organised and delivered in practice. This includes the geographic distribution of facilities and clinics, the availability of trained health care professionals and the integration of abortion into primary care, including telemedicine. Europe is currently facing a decline in trained abortion providers, and services are often concentrated in metropolitan centres, which creates gaps between rural and urban areas and limits access (Kolandt et al., 2025; Organisation for Economic Co-operation and Development & European Commission, 2024). In addition, administrative obstacles and financial uncertainties may create delays

that push women closer to gestational limits, which often lie at 12-14 weeks. Women then may be forced to travel to another European country to get an abortion if they have exceeded the gestational limit, involving costs for transport, accommodation, medical fees and lost income (De Zordo et al., 2023). Financial barriers persist even where abortion is publicly funded, as coverage often depends on health insurance schemes and stated reasons for abortion. In practice, this leaves some women with out-of-pocket payments, only partial reimbursement, or even exclusion from public insurance coverage, and disproportionately impacts students, low-income women, migrants and those in uncertain employment situations (De Zordo et al., 2023). Beyond structural and financial barriers, lack of awareness of legal rights and abortion stigma can delay or prevent care-seeking, even in countries with relatively liberal laws (Ghimire et al., 2025; Hanschmidt et al., 2016).

This shows that the liberalisation of abortion laws alone is not sufficient to guarantee safe and equitable access. Instead, safe abortion access in Europe depends on how legal frameworks interact with health system structures, economic conditions, information and education environments and social norms.

2.2 Abortion Policy Classification Methods

Existing approaches to classify and compare abortion policies vary considerably in their scope, methodology and analytical depth. While some focus exclusively on legal frameworks, others attempt to capture broader dimensions of access. However, all share important limitations that the present study seeks to address.

A prominent example is the longitudinal analysis by Levels et al. (2014), who examined the legal development of abortion laws in Western Europe between 1960 and 2010. The authors categorised abortion legislation into nine progressively liberal categories based on legal grounds, ranging from a complete prohibition to abortion available without restriction. They interpret whether legal reforms changed the grounds for abortion and assess whether procedural barriers were introduced or removed. Although they document gestational limits and additional procedural requirements (pp. 97-98), these elements are not incorporated as independent analytical dimensions within the scale itself. Moreover, the authors' focus lies in contextualising the historical development of abortion legislation rather than in constructing a multidimensional classification of abortion policy.

Another approach can be observed in current comparative overviews of abortion regulation. The CRR (2025b) has provided a global map with countries colored in different colors, depending on their right of abortion. The map, presented in Figure 1, is based on the countries' legal framework and categorises on "On request (Gestational limits vary)", "Socioeconomic grounds", "To preserve health", "To save the pregnant person's life", "Prohibited altogether" and "Varies at state level", with only three of them represented in the EU. This categorisation suggests an overall liberal (largely green) pattern, especially in Europe.

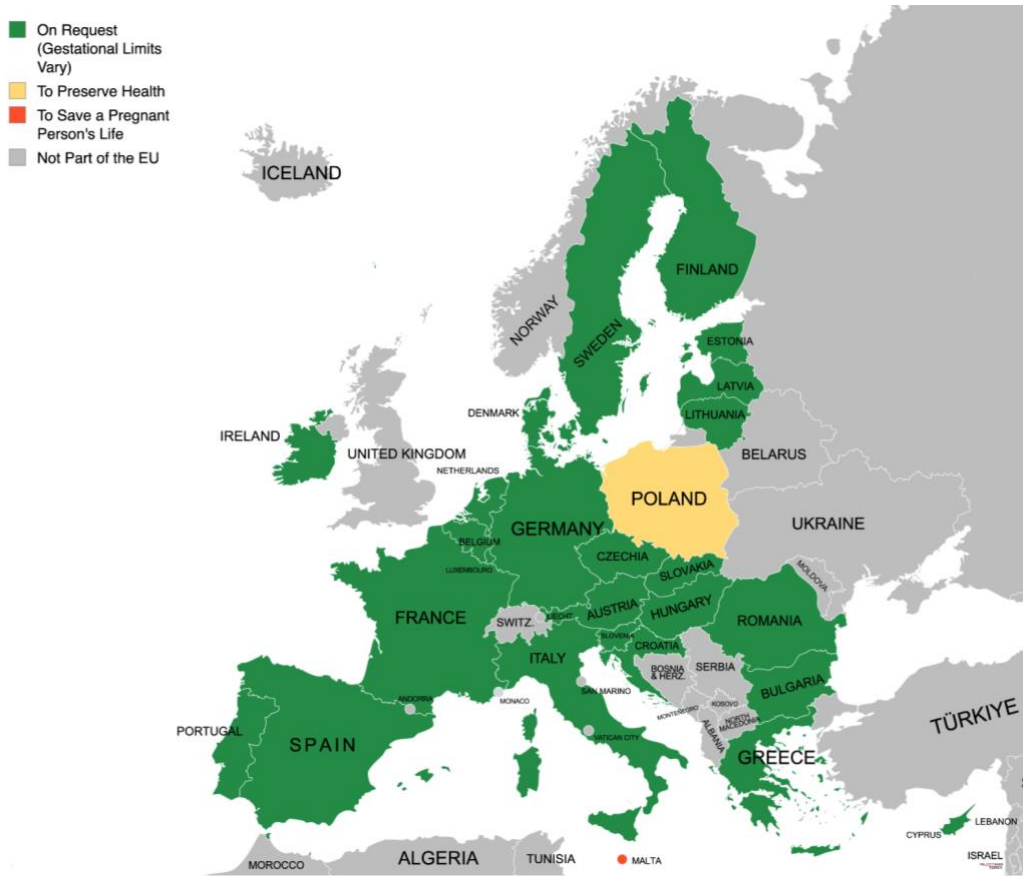

Figure 1. *Definitive Record of the Legal Status of Abortion in EU Countries (CRR, 2025b).*

Note: Own illustration based on data adapted from CRR (2025b).

Despite the visual impression of broad access, there are large differences in actual access between the countries in Europe, due to differences in health systems and other social conditions (Fiala et al., 2022). While the map acknowledges that gestational limits vary, it does not capture different waiting periods, mandatory counselling, written consent requirements or provider availability, nor does it incorporate clinical regulations that may shape women's ability to seek abortion care (CRR, 2025b). Although the map presents a simplified overview of legal permissibility, it risks equating legal status with access.

A more comprehensive documentation effort is provided by the WHO in collaboration with the United Nations Department of Economic and Social Affairs through the Global Abortion Policies Database (GAPD). Launched in 2017, the database shows country-specific information on abortion laws, policies, health standards and guidelines for WHO and UN Member States (Johnson et al., 2017; WHO & United Nations Department of Economic and Social Affairs, 2017). It covers a broad range of domains, including legal grounds and related gestational limits, third-party authorisation requirements, mandatory waiting periods, criminal penalties, provider restrictions, service-delivery standards and insurance coverage. In doing so, the GAPD offers detailed documentation of abortion regulation and makes visible a variety of policy barriers that may restrict access. However, despite its level of detail, the database

remains primarily descriptive and does not categorise how restrictive characteristics combine to shape a broader policy environment.

The most detailed comparative monitoring effort to date for the European context is the European Abortion Policy Atlas (EAPA), published by the European Parliamentary Forum for Sexual and Reproductive Rights (EPF) (2025) and presented in Figure 2. The Atlas ranks European countries using a percentage-based scoring system derived from 31 indicators across four domains: policies, access, clinical care and service delivery and information. It represents the first in-depth analysis to demonstrate that Europe is not as progressive as it might seem (EPF, 2025).

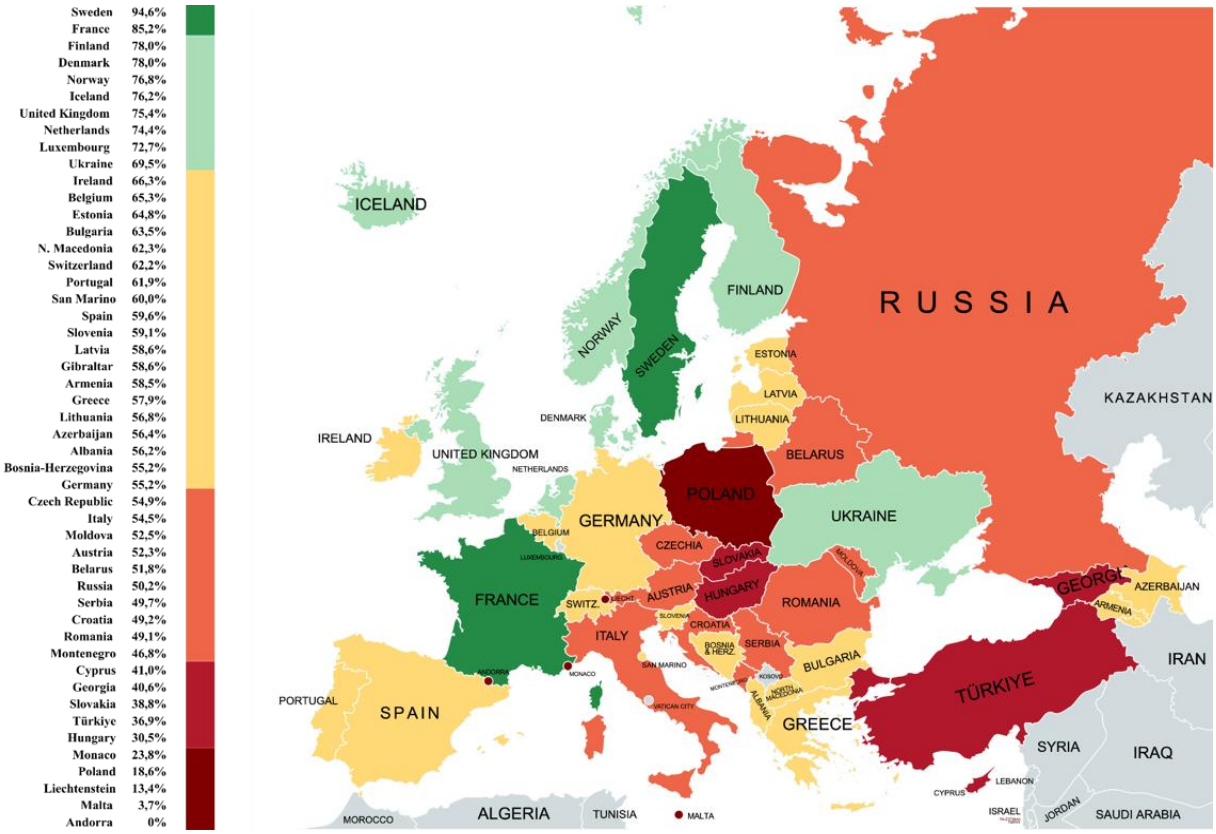

Figure 2. *Abortion Access in Percent According to the EAPA (EPF, 2025)*

Note: Own illustration based on data adapted from European Parliamentary Forum for Sexual and Reproductive Rights (2025).

However, the EAPA has important methodological limitations. Although the EAPA acknowledges its reliance on the GAPD for country-level data, as well as input from a group of sexual and reproductive health experts, it does not specify which information was drawn from which source, making it difficult to trace scoring decisions back to their origin. However, in comparative policy research, coding from primary national legal sources is considered best practice and secondary databases are only consulted to clarify or supplement information that is unclear or unavailable from primary sources (Raub et al., 2021). Where the underlying sources are not clearly documented, as it is the case here, the reproducibility of

the ranking is limited. Beyond the question of data sources, the Atlas does not reveal how individual indicators are weighted within the overall score, making it difficult to assess which dimensions carry the most analytical influence. Finally, although the Atlas represents the most detailed comparative mapping of abortion access conditions in Europe to date, it does not empirically test whether its country rankings correspond to public health outcomes, limiting its analytical utility beyond descriptive monitoring.

These limitations point to shared methodological gaps across existing approaches. Tools that focus on legality alone, such as the CRR map and the Levels et al. classification, do not capture the full policy environment. More comprehensive instruments such as the EAPA capture a broader range of access dimensions, but lack theoretical grounding, source transparency and empirical exploring whether policy environments are associated with health outcomes. No existing instrument has been developed specifically for the EU context combining these elements in a single, theoretically grounded and reproducible framework. The Guttmacher Institute's abortion policy hostility framework (Nash, 2019), originally developed for the United States (US) context and described further in 4.2, offers a promising basis for addressing this gap. The next chapter outlines the aims of the present study, which seeks to adapt this framework to the EU context and address the limitations identified above.

3. AIM

The aim of this study is to modify the Guttmacher Institute's abortion policy framework to the EU context to develop an abortion policy index (EU API). In addition, the study seeks to assess whether the index converges with existing European monitoring instruments, particularly the EAPA 2025, and whether it has empirical relevance for maternal mortality outcomes.

3.1 Research Questions

Since the Guttmacher Institute operates in the US and developed the indicators in context of American federalism, some indicators have to be modified to suit EU policy environments. This leads to the first research question (RQ).

RQ1: How can the Guttmacher Institute's abortion policy framework be adapted to reflect EU legislations, health systems and socio-economic contexts?

Based on the modified framework, EU Member States are scored and classified according to the derived indicators. The resulting classifications are further compared to the EAPA rankings to assess patterns of

convergent validity, examining whether the EU API captures similar environments of abortion access as the existing monitoring instrument. This comparison leads to the second question:

RQ2: To what extent do EU Member States' classifications under the EU API align with the EAPA 2025, and where do the two approaches diverge?

H_0: There is no significant association between EU Member States' classifications under EU API and their rankings in the EAPA 2025.
H_1: There is a significant positive association between EU Member States' classifications under EU API and their rankings in the EAPA 2025.

Furthermore, as an exploratory step, the study examines whether EU API scores show any association with maternal mortality ratios (MMR) across EU Member States. This gives rise to the third question:

RQ3: To what extent are EU API scores statistically associated with maternal mortality ratios across EU Member States?

H_0: EU API scores are not statistically associated with MMR across EU Member States.
H_1: EU API scores are statistically associated with MMR across EU Member States.

Taken together, these RQs guide the study through three steps: modifying an existing framework so it fits to the EU context, assessing patterns of convergent validity by comparing the resulting index with an established monitoring instrument and examining whether EU API scores show any association with health outcome data.

3.2 Contribution

The study aims to contribute to existing research on abortion policy in Europe, specifically in the EU. First, it develops a new measurement instrument for abortion policies in the EU context, adapted from an established US framework, and thereby adds a theoretically grounded tool to the existing landscape of abortion policy monitoring. Second, by working with a reduced and clearly defined set of indicators, the EU API prioritises coding and scoring simplicity. This enhances transparency and makes the classification process more accessible to independent replication in further research. Additionally, each indicator is scored directly from primary legal and policy sources at the country level, rather than relying on a secondary database, which reduces interpretive layers and strengthens reproducibility (Raub et al., 2021). Fourth, the study is the first to explore the association between an EU-specific abortion policy

index and MMR across Member States, which examines the index's potential as a health-relevant policy tool.

4. THEORETICAL FRAMEWORK

The following chapter introduces the two frameworks that form the theoretical basis of the present study: the WHO Comprehensive Abortion Care framework, which provides the normative foundation for the indicator adaptation, and the Guttmacher abortion policy hostility framework, which serves as the methodological basis for the index developed in this study. The chapter concludes by discussing the rationale for the outcome and external comparison measures used to empirically test the new index EU API.

4.1 The World Health Organization's Abortion Care Guidelines

During the Covid-19 pandemic, the WHO developed a conceptual framework on abortion care that explicitly addresses an enabling environment for women seeking abortion. In 2022, comprehensive abortion care (CAC) was classified as an essential health service, in response to the limited accessibility of many sexual and reproductive health services (Todd-Gher & Shah, 2020). CAC is understood as the provision of abortion-related health services delivered in a safe and high-quality manner across the entire continuum of care, based on a human rights approach (WHO, 2024). Using the term "continuum of care" (WHO, 2024, p. 162), the WHO refers to services before, during and after abortion care, which reflects a broader understanding of abortion as an integral component of sexual and reproductive health and rights, rather than an isolated clinical intervention.

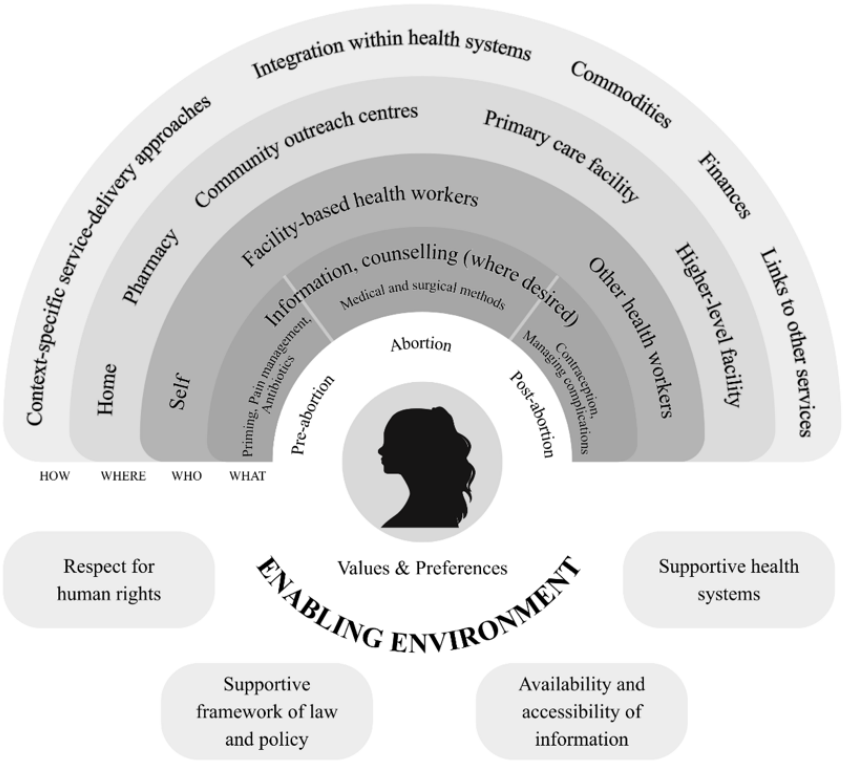

Figure 3. *Conceptual Framework for Abortion Care from the WHO (2024)*

Note: Adapted from World Health Organization (2024). Abortion care guideline (2nd ed.). CC BY-NC-SA 3.0 IGO.

Figure 3 illustrates how the WHO operationalises the conceptualisation of CAC. At the centre of the framework is the individual seeking care, with explicit attention to their values and preferences, reflecting the WHO's person-centred approach and emphasis on autonomy and informed choice. Surrounding this core are the key components of abortion care across the continuum: pre-abortion, abortion and post-abortion services. The framework further addresses *who* can safely provide abortion-related services. In addition to physicians, a broad range of health workers, including midwives, nurses, pharmacists, pharmacy workers and community health workers, are recognised as capable of delivering specific components of abortion care. The next stage refers to the *where* of abortion care services and highlights that it can be delivered in higher-level health facilities, primary care settings, community outreach centres, but also in pharmacies and home-based care, including telemedicine. By including this into their framework, the WHO emphasises that abortion care has to be flexible and decentralised to overcome barriers related to geography, legal restrictions, weak health system infrastructure and public health emergencies. The outer layers of the framework address how abortion care is integrated within health systems, including access to essential commodities, financing mechanisms, referral pathways to higher-level care and linkages to other health and social services.

The enabling environment covers all dimensions of the framework and is a prerequisite for effective CAC. This environment is characterised by respect for human rights, supportive legal and policy frameworks, availability and accessibility of information and well-functioning, supportive health

systems. The WHO emphasises that such conditions are necessary not only to ensure access to safe abortion care, but also to contribute to broader health and development goals. In this context, strengthening abortion care is explicitly linked to progress towards the Sustainable Development Goals (SDG), particularly SDG 3 on good health and well-being and SDG 5 on gender equality (United Nations, 2015; WHO, 2024).

This study builds on this conceptual approach by adopting the perspective of an enabling environment surrounding abortion care. The WHO Abortion Care Guidelines (2024) play a central role for the development of the EU API.

4.2 The Guttmacher Abortion Policy Hostility Framework

The Guttmacher Institute is a US-based leading research and policy organisation committed to advancing sexual and reproductive health and rights worldwide. It produces peer-reviewed research, policy analyses and data tools covering topics such as abortion, contraception and pregnancy, with a focus on translating evidence into policy impact (Guttmacher Institute, 2024). The Guttmacher Institute's method for assessing abortion policy restrictiveness is a systematic approach to evaluate the overall abortion policy environment at the state level within the US (Nash, 2019). This method employs a point-based system that aggregates the presence of multiple policy measures, presented in Table 1: six types of restrictions, each assigned a negative point, and six types of protective policies, each assigned a positive point. Restrictive policies include abortion bans, mandatory waiting periods often requiring multiple clinic visits, limitations on Medicaid or public funding coverage, prohibitions on telemedicine for medication abortion, parental involvement laws for minors and targeted regulations on abortion providers (Nash, 2019). Protective measures include state constitutional protections for abortion, legal standards guaranteeing access, mandated public and private insurance coverage, permission for advanced-practice clinicians to provide abortion services and legal safeguards for clinic operation and patient access (Nash, 2019).

Table 1. *The Guttmacher Institute's Protective and Restrictive Indicators on Abortion Access*

Restrictive Indicators (-1p. per restriction)	Restriction #1	Ban pre- or postviability abortions in violation of constitutional protections
	Restriction #2	Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility)
	Restriction #3	Restrict Medicaid coverage for abortion
	Restriction #4	Prohibit the use of telemedicine to provide medication abortion
	Restriction #5	Limit access to abortion for those younger than 18 without parental involvement
	Restriction #6	Impose unnecessary and onerous abortion clinic regulations

Protective Indicators (+1p. per restriction)	Protection #1	Affirm a right to abortion in the state constitution
	Protection #2	Establish a legal standard that protects access to abortion
	Protection #3	Guarantee abortion coverage through Medicaid
	Protection #4	Allow advanced practice clinicians to provide abortion by law or Attorney General Opinion
	Protection #5	Mandate private health insurance plans cover abortion
	Protection #6	Protect access to abortion clinics

When applying the indicators, each state is assigned a score ranging from -6 to +6, depending on which indicators are in place. States are categorised as very hostile when the full set of six restricting policies is in place and as very supportive when all six protective measures are enacted, with the exact scale presented in Figure 4. Intermediate scores reflect gradations between these poles, ranging from hostile and leaning hostile through middle-ground to leaning supportive and supportive.

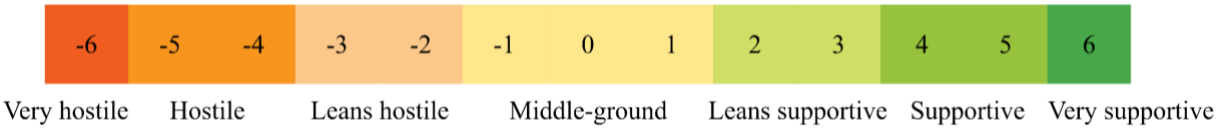

Figure 4. *The Guttmacher Institute's Scores and Classification Scheme*

Until now, the classification method has only been applied within the US context to compare abortion policies between the States. However, the indicators provide a strong basis for developing an EU-specific index, as they capture a broader range of dimensions, such as health system support, waiting periods, professional eligibility and clinic protection. These dimensions show considerable conceptual overlap with the items used in the EAPA, suggesting that the Guttmacher framework can be adapted to capture both legal and practical dimensions of abortion access in the EU context. The framework's indicators also align closely with the WHO's cornerstones of an enabling environment for quality abortion care. The WHO identifies accessibility and availability of services, respect for human rights through supportive legal and policy frameworks and a well-functioning and affordable health system as central conditions for effective abortion care (WHO, 2024). The Guttmacher protective indicators reflect each of these dimensions: constitutional and legal protections for abortion correspond to the human rights cornerstone, insurance coverage indicators address affordability and health system support and the inclusion of advanced-practice clinicians alongside clinic protection measures reflects the WHO's emphasis on decentralised and accessible service delivery. This alignment suggests that the Guttmacher indicators, while developed in a US context, are conceptually grounded in the same standards that

support international abortion care guidance, which strengthens the case for their adaptation to the EU setting.

Having established the theoretical basis of the framework, the following section considers which outcome measures are best suited to test the EU API's empirical performance.

4.3 External Comparison Measures

To assess the empirical relevance of the EU API, two external measures are used for comparison: the EAPA 2025 and MMR.

The EAPA 2025 serves as the reference instrument for assessing patterns of convergent validity. Convergent validity refers to the degree to which two instruments that are intended to measure the same or similar constructs produce comparable results (Carlson & Herdman, 2012). Although the EAPA has methodological limitations, as outlined above, it remains the most comprehensive existing instrument for mapping abortion access across European countries and therefore represents the most suitable available benchmark for this comparison. Although convergent validity cannot be fully established by comparing the EU API with one single instrument, patterns can be assessed. Where the two instruments agree, this supports the plausibility of the EU API. Where they diverge, the differences can shed light on what the EU API captures differently.

MMR serves as the primary health outcome measure for the exploratory analysis in this study. MMR is defined as the number of maternal deaths per 100 000 live births and is widely used as a key indicator of reproductive health system performance and women's health outcomes at the population level (WHO, 2024). It is directly relevant to the present study because unsafe abortion remains a significant contributor to preventable maternal death and restricted access to safe abortion care is associated with higher maternal mortality (Say et al., 2014). MMR is furthermore a standardised, comparable and publicly available indicator across EU Member States, which makes it suitable for cross-national analysis. However, given that MMR is a low-frequency, low-variance outcome in the EU context, the analysis is framed as an exploratory test of the index's empirical relevance in reproductive health outcomes at the country level.

5. METHODS

The study employs a qualitative comparative policy analysis to assess the current status of abortion access across all 27 EU Member States, with quantitative analyses applied to assess patterns of the EU API's convergent validity and empirical relevance. In light of the recent ECI *My Voice, My Choice*, the country-selection was made because the EU includes a diverse set of countries with varying legal traditions, health system structures and socio-cultural norms (Levels et al., 2014; Wager & Cox, 2025),

yet shares common institutional frameworks and commitments to human rights and public health (Treaty on the Functioning of the European Union, 2012). Moreover, the EU's institutional structures and shared public health goals mean that findings from this study can be directly relevant for EU-level policymaking and advocacy, especially in relation to reproductive rights. The study conceptualises abortion access as a multidimensional public health and health systems issue which is shaped by legal, institutional, financial and service-delivery factors.

5.1 Methodological Framework

The Guttmacher framework consists of rule-based indicators, which aligns with the WHO's recommendations on health governance indicators (WHO, 2010). Rule-based indicators assess whether a specific policy or legal measure is formally in place and records its presence or absence. This makes them particularly suitable for international comparisons, as they can be applied consistently across different political contexts (WHO, 2010). However, since the paper applies a US framework to an EU context, some items need to be modified.

The methodological foundation for this adaptation follows a structured four-step model of contextual adjustment as proposed by Kublik et al. (2003). The authors argue that transferring dominant frameworks to new political or cultural settings requires (1) identification of gaps and structural bias, (2) development of an adaptation strategy, (3) implementation of the adapted framework and (4) testing of its efficacy (each item is described further below). Their original project was to develop a methodological approach for adapting dominant classification systems to marginalised or context-specific settings. There, they addressed the adaptation of the Dewey Decimal Classification, a globally dominant knowledge organisation system rooted in Western epistemological traditions, to better represent feminist and women's studies perspectives. While their work is situated in library and information science, the underlying methodological logic is transferable to other domains in which dominant frameworks are applied across differing political or cultural environments.

In this study, Kublik et al.'s (2003) adaptation logic with its four-step model is applied to the transfer of the US-based Guttmacher framework to the EU context. Adapting the framework to the EU therefore requires a (1) definition of the original indicator and assessment of indicator transferability, (2) a modification and contextualisation of indicators for EU application, (3) country-level coding and comparative policy analysis and (4) the empirical comparison with EAPA 2025, as well as measuring the association with maternal mortality outcomes. This methodological framework is presented in Figure 5.

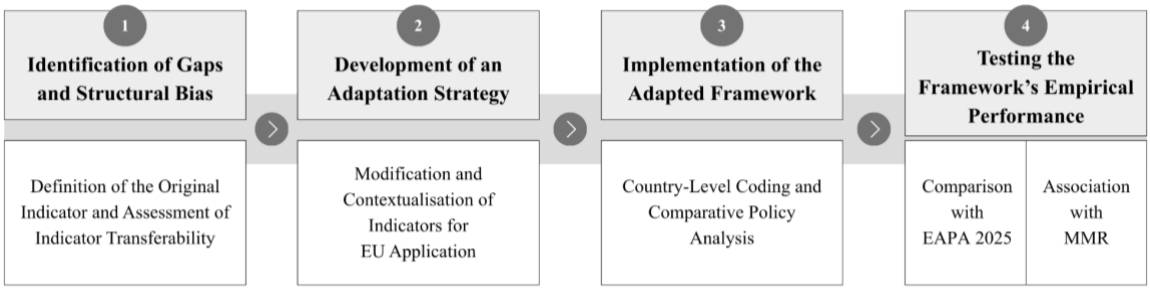

Figure 5. *Overview of the Methodological Framework Adapted and Modified from Kublik et al. (2003)*

5.1.1 Identification of Gaps and Structural Bias

According to Wager and Cox (2025), it is difficult to compare international health systems since politics, society and economy differ between the countries and therefore also their health system and its funding. As Tolonen et al. (2021) argue, international comparisons of health indicators require standardised definitions and comparable data sources to "allow [...] the national level evaluation of trends and differences between regions and population subgroups" (p. 7). This highlights the need to identify what each US indicator actually measures, how this can be translated and how data sources are used. While using the Guttmacher framework together with the WHO Abortion Care Guidelines 2024 as basis, each indicator is analysed and defined in terms of its indicator objective. This step corresponds to the first phase of the adaptation model, namely the systematic identification of conceptual gaps and contextual mismatches between the original US-based indicators and the EU legal and institutional environment.

5.1.2 Development of an Adaptation Strategy

The second phase of the four-step adjustment strategy (Kublik et al., 2003) develops a modification strategy, in which the indicators are either maintained, modified or completely excluded, based on their EU-contextual suitability. If an indicator does not match the EU legal or institutional context, modification is needed, as long as the underlying construct remains relevant. In such cases, the modification aims to preserve the original purpose of the indicator while adapting to the EU setting. This is done based on current literature and the legal context of EU Member States. The goal is to ensure that the adapted indicator reflects the same conceptual dimension of abortion access, even if its formulation differs slightly from the original US-based version. Furthermore, the adaptation process allows for the addition of new indicators where the WHO Abortion Care Guidelines provide sufficient justification and existing literature supports their relevance for the EU context. Any additions must, however, maintain the balance of the scoring system, ensuring that the number of restrictive and protective indicators remains equal. Indicators are classified according to their type: restrictive indicators are scored as either present (-1) or absent (0), while protective indicators are scored as either present (+1) or absent (0). Binary scoring is adapted from the Guttmacher framework because the indicators assess formal legal provisions, which are most naturally either present or absent. This binary

approach may leave less room for subjective interpretation, which is particularly relevant given that the coding is conducted by a single author. Thus, no judgement concerning a legal provision's degree or intensity is needed. Also, the equal weighting of all 12 indicators is adapted from the original framework, because no theoretical or empirical basis exists for treating any single policy measure as more important than another. As Greco et al. (2019) note, equal weighting is the most common approach in index construction when different weights cannot be justified by a theoretical framework. In the present study, each indicator represents one distinct dimension of the abortion policy environment. Assigning higher weight to one of them would require assumptions about the relative burden of these barriers that go beyond what current research supports.

5.1.3 Implementation of the Adapted Framework

After identifying and modifying the indicators, each EU Member State is analysed and scored according to the new indicator set, representing the third phase of the adaptation framework (Kublik et al., 2003). For each country, every indicator is assessed individually and scored as either present or absent, resulting in a total score ranging from -6 to +6. In cases where a country maintains a complete abortion ban, all restrictive indicators are scored as present and all protective indicators as absent. This is because a total prohibition represents the most restrictive policy environment possible and makes any form of legal protection or facilitated access impossible. Where sources are ambiguous, a conservative coding rule is applied to avoid overestimating restrictiveness or protectiveness: an indicator is only coded as present if its existence can be confirmed from at least one primary source or two independent secondary sources. In cases where ambiguity cannot be solved, the indicator is coded as absent (0). Moreover, when applying the indicators to individual countries, it might become apparent that some indicators are difficult to code consistently across all 27 Member States, for instance because the relevant legislation is ambiguous, comparable data are not available for all countries, or other reasons. In such cases, the indicator is revisited and, where necessary, further refined to ensure that it can be applied consistently and meaningfully across all cases. Consequently, step two and three of the framework are not entirely separate but inform each other throughout the research process. This back-and-forth between coding and indicator refinement reflects what Yom (2015) describes as inductive iteration, in which researchers revise their framework when unexpected challenges arise during data analysis. The data sources used for this stage are described in detail in section 5.2.

5.1.4 Testing the Framework's Empirical Performance

This paper includes two mechanisms to test the EU API's empirical relevance. Firstly, patterns of convergent validity are assessed through a Pearson correlation between the EAPA ranking and the EU API. Pearson's r is selected as the relationship between the two indices is assumed to be linear and normality is tested for both distributions using the Shapiro-Wilk test. To assess the robustness of this result, Spearman's rank correlation is additionally reported as a sensitivity analysis. This test evaluates

whether the EU API captures similar patterns of an abortion policy landscape within the EU as the EAPA does. Secondly, as an exploratory step, two regression analyses are conducted. The first regresses log-transformed MMR on the EU API to determine whether abortion policy environments are associated with maternal health outcomes across Member States. The second regresses log-transformed MMR on the EAPA ranking, serving as a comparative benchmark to evaluate whether the EU API performs similarly to the established measure. The logic applied here follows an established approach in public health index construction, in which an index is tested against health outcomes it should theoretically be associated with. Strömberg et al. (2023) illustrate this approach by validating a small-area deprivation index through its association with mortality rates and demonstrate that empirical associations with relevant outcomes serve as evidence of an index's empirical relevance. However, given the small number of countries and the low variance of MMR within the EU context, this study's analyses are not intended as a validation test but as a first attempt to explore whether abortion policy environments may be relevant for population health outcomes. To account for year-to-year fluctuations and improve the stability of the outcome measure, the mean MMR over the most recent five-year period available is used. Given the low absolute values and compressed range of MMR across EU Member States, the mean is subsequently log-transformed prior to analysis to stabilise variance and improve the fit of the linear regression model. Following log-transformation, the normality of regression residuals is additionally assessed using the Shapiro-Wilk test to assess if the assumptions of linear regression are met. MMR is obtained from the World Bank's World Development Indicators database, where the indicator *Maternal mortality ratio (modeled estimate, per 100 000 live births)* provides comparable country-level data for EU Member States (World Bank, 2023). Together, these four steps (presented in Figure 6) ensure that the EU API is theoretically grounded, contextually appropriate and empirically explored in context of population health outcomes.

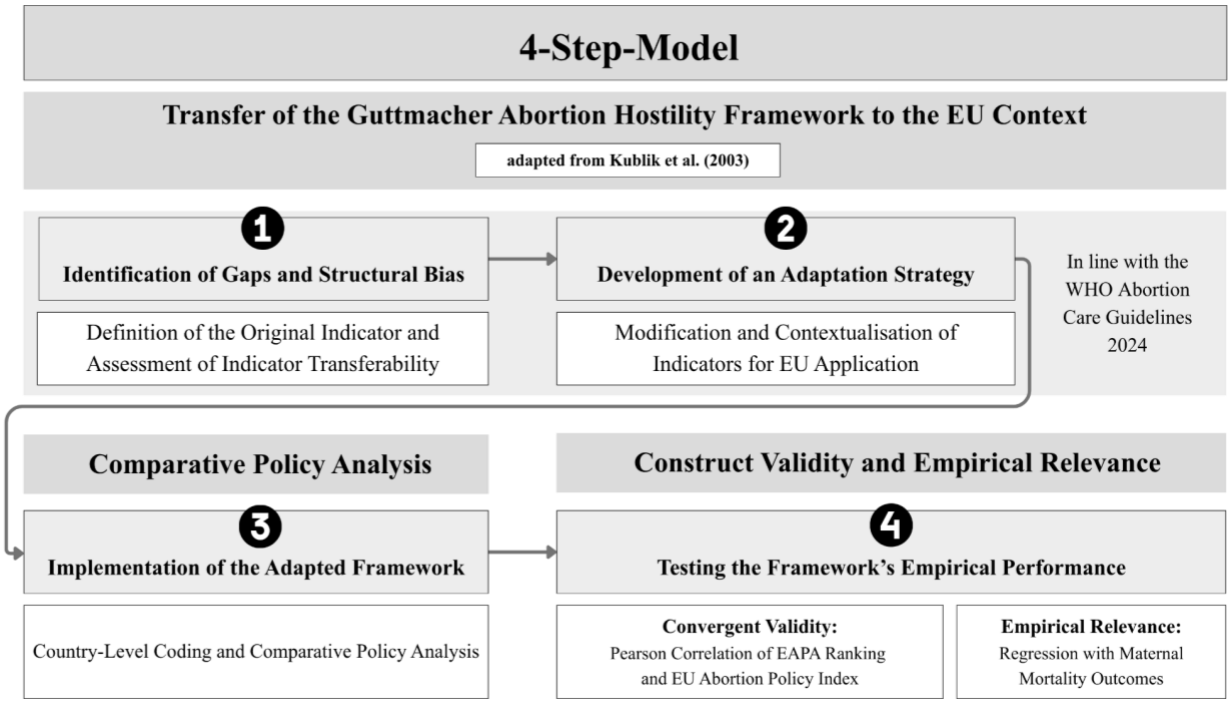

Figure 6. *Methodological Framework for the Development of the EU API*

5.2 Data Sources

For the modification and contextualisation of indicators in step two, peer-reviewed literature is consulted to ensure that adaptations are grounded in current evidence. Relevant studies and reviews are identified through targeted searches in academic databases including PubMed, Google Scholar and Scopus, using search terms related to abortion policy, reproductive health legislation, health system indicators and EU Member State contexts. Literature is included where it provides empirical or normative justification for the modification of specific indicators. The WHO Abortion Care Guidelines 2024 serve as the primary reference throughout the adaptation process.

For the country-level scoring in step three, national legal texts are prioritised as the primary source for each indicator. Legal sources are identified through targeted web searches to locate the relevant national legislation regulating abortion in each EU Member State. Where official English translations are available, these are prioritised. Where no official translations exist, texts are translated using DeepL, which is selected because comparative studies have found that it captures translations and contexts better than other machine translation tools in translating legal texts (Greńczuk et al., 2024). This approach is chosen to ensure that all 27 Member States can be included in the analysis, as relying only on officially translated sources would exclude several countries and introduce systematic bias into the index. Where legal texts cannot be located through direct web searches, two secondary legal sources are consulted: the CRR, which provides country-specific abortion legislation in the original language as well as

translations and LegislationOnline, an online legal database providing access to national legislation across a broad range of countries. Where legislation does not provide sufficient detail, governmental information sources are consulted as secondary sources, including official websites of ministries of health and national health authorities, which often provide more information on how abortion care is organised and financed in practice. Where these sources are also insufficient, publicly available information from abortion-providing clinics and hospitals is used, as these sources reflect how services are delivered and accessed at the practice level. Only in cases where none of the above sources provide the necessary information, NGO reports and press articles are consulted as a last resort. These sources are treated as grey literature but are valuable for legal access conditions that may not be reflected in official documents. Where grey literature is used, information is only included if it can be verified through at least two independent credible references.

5.3 Ethical Considerations

This study relies exclusively on publicly available legal and policy documents as well as country-level data. No individual-level personal data were collected or processed and no human participants were involved. Formal ethical approval was therefore not required. The study follows principles of academic integrity, including transparent documentation of data sources and reproducible coding procedures.

6. RESULTS

The results are structured along the four steps of the methodological framework. As the first two steps are closely interrelated, they are presented jointly as a summary of the indicator adaptation process, with the full rationale for each modification documented in Appendix A. The third step presents the country-level scoring and comparative analysis across all 27 EU Member States. The fourth and final step explores the EU API's empirical relevance through two mechanisms: a Pearson correlation with the EAPA ranking to assess patterns of convergent validity and two regression analyses of log-transformed mean MMR on EAPA and EU API to explore whether abortion policy environments show any association with reproductive health outcomes.

6.1 Development of an EU-Specific Abortion Policy Index

The following section presents the assessment of each original Guttmacher indicator for transferability to the EU context and the modification applied, representing step one and two of the methodological framework. Table 2 provides an overview of all 12 indicators, their modification status and the resulting EU-specific formulations. The full rationale for each modification decision, including the assessment of structural bias and the contextual evidence from EU policy environments, is documented in Appendix A. All modifications are grounded in the WHO Abortion Care Guidelines (2024), which serve as the

primary reference throughout the adaptation process, and are likewise provided in Appendix A.

Across the 12 indicators, two were maintained without any modification in wording: the requirement for in-person counselling followed by a waiting period (Restriction #2), which is directly applicable across EU Member States (CRR, 2025a), and the protection of access to abortion clinics from harassment and obstruction (US-Protection #6, EU-Protection #5), as the underlying construct is equally relevant in the EU context (Parliamentary Assembly of the Council of Europe, 2022).

Six indicators were contextually modified to reflect EU legal, health system or institutional structures while preserving the underlying construct. The abortion ban indicator (Restriction #1) was rephrased from a viability-based constitutional framing to a prohibition of abortion on request, since this reflects better how abortion policies are regulated in EU countries (CRR, 2025a). The parental involvement indicator (Restriction #4) was modified to account for varying general medical consent ages across EU Member States (European Union Agency for Fundamental Rights, 2017) and the clinical regulation indicator (US-Restriction #6, EU-Restriction #5) was narrowed to facility-type restrictions specifically, since targeted regulation of abortion providers (TRAP) laws have no direct EU equivalent. The constitutional protection indicator (Protection #1) was adjusted from state to national constitution. Furthermore, the protective Medicaid coverage indicator (Protection #3) was broadened to public or national health insurance and the advanced practice clinician indicator (Protection #4) was modified to remove the reference to Attorney General Opinions, which have no institutional equivalent in the EU.

Two indicators were removed, since three of the Guttmacher indicators addressed the same underlying dimension of financial access to abortion care: Guttmacher Restriction #3 (Medicaid coverage restriction), Protection #3 (Medicaid coverage guarantee) and Protection #5 (Private insurance coverage mandate). In the EU context, where near-universal public health coverage is the norm, maintaining three separate indicators for this dimension would have created analytical overlap and inconsistency. They were therefore merged into a single protective indicator capturing whether abortion care is covered by public or national health insurance (EU-Protection #3).

Two indicators changed sides of the bipolar scale and were rephrased accordingly: the telemedicine indicator (US-Restriction #4) was shifted from a restrictive to a protective indicator (EU-Protection #2), as many EU Member States neither explicitly permit nor prohibit telemedicine for abortion, making coding unreliable. Shifting the indicator to the protective side allows for a more consistent and reproducible coding approach. The US-Protection #2 on legal standards that protect abortion access was firstly rephrased to capture whether abortion is regulated through criminal law, since several EU Member States continue to regulate abortion predominantly through the penal code, making criminal law framing an analytically relevant dimension. After modification, the indicator was then shifted to the

restrictive side (EU-Restriction #3) to better reflect its nature as a structural barrier to abortion access (De Londras et al., 2022; Kolandt et al., 2025).

Finally, two entirely new indicators were introduced to capture EU-specific policy dimensions absent from the original Guttmacher framework: EU-Restriction #6, addressing the prohibition of mifepristone[2] for medication abortion, and EU-Protection #6, addressing the regulation of conscientious objection[3] through mandatory referral obligations or equivalent institutional safeguards. Conscientious objection still represents a critical access barrier in several EU Member States where objection rates among providers are high (Autorino et al., 2020).

Table 2. *The Guttmacher Indicators in Comparison to the New Indicators for the EU Context*

US order	US-Indicator	Modification	EU order	New Indicator for EU context
R#1	Ban pre- or postviability abortions in violation of constitutional protections	Yes	**R#1**	**Legal prohibition of abortion on request**
R#2	Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility)	No	**R#2**	**Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility)**
R#3	Restrict Medicaid coverage for abortion	Removed		
R#4	Prohibit the use of telemedicine to provide medication abortion	Yes, see Protection #2	**R#3**	**Abortion is regulated through criminal law**
R#5	Limit access to abortion for those younger than 18 without parental involvement	No	**R#4**	**Limit access to abortion for minors without parental involvement, where this exceeds the general medical consent age or applies up to the age of 18**
R#6	Impose unnecessary and onerous abortion clinic regulations	Yes	**R#5**	**Restrict abortion provision to specific facility types**
		Newly introduced	**R#6**	**Prohibit access to mifepristone for medication abortion**

[2] Mifepristone is a medication used in combination with misoprostol to induce medical abortion.

[3] Conscientious objection in this context refers to the refusal of health care providers to perform legal medical procedures on moral or religious grounds.

P#1	Affirm a right to abortion in the state constitution	Yes	**P#1**	**Affirm a right to abortion in the national constitution or equivalent fundamental law**
P#2	Establish a legal standard that protects access to abortion	Yes, see Restriction #3	**P#2**	**Allow the use of telemedicine to provide medication abortion**
P#3	Guarantee abortion coverage through Medicaid	Yes	**P#3**	**Guarantee abortion coverage through public or national health insurance**
P#4	Allow advanced practice clinicians to provide abortion by law or Attorney General Opinion	Yes	**P#4**	**Allow non-physician health professionals to provide abortion services**
P#5	Mandate private health insurance plans cover abortion	Removed		
P#6	Protect access to abortion clinics	No	**P#5**	**Protect access to abortion clinics**
		Newly introduced	**P#6**	**Regulate conscientious objection through mandatory referral obligations or equivalent institutional safeguards**

Together, these modifications result in a balanced 12-indicator framework that reflects the legal, institutional and health system realities of the EU context while preserving the bipolar scoring logic of the Guttmacher framework. In the following section, this indicator set is applied to all 27 Member States to classify their abortion policy environments along a spectrum from very hostile to very supportive.

6.2 Country-Level Scores and Classifications

Table 3 presents the indicator-level scores and overall classifications for all 27 EU Member States, revealing a predominantly restrictive policy landscape across the EU, with the majority of Member States scoring below zero. No country reaches the supportive range of +4 or +5 and only France achieves the maximum score of +6, driven by a full set of protective measures including constitutional protection, telemedicine access, public insurance coverage, expanded provider eligibility, clinic protection and regulated conscientious objection. At the opposite end of the scale, Malta and Poland are classified as very hostile with a score of -6, reflecting the most hostile policy environment across the EU. Hungary and Slovakia fall into the hostile category with scores of -4, while eight countries score between -2 and -3, indicating a leaning hostile policy environment. Nine countries score in the middleground category (-1, 0, 1), namely Austria, Belgium, Bulgaria, Croatia, Estonia, Lithuania, Portugal, Sweden and the

Netherlands. The leaning supportive range is occupied by Denmark, Finland, Ireland, Slovenia and Spain. Data sources are grouped by country in Appendix B for transparency and readability.

Table 3. *Scores According to the EU API Indicator Set for All 27 EU Member States*

Country	R#1	R#2	R#3	R#4	R#5	R#6	P#1	P#2	P#3	P#4	P#5	P#6	**Score**
Austria	0	0	-1	0	0	0	0	0	0	0	0	0	**-1**
Belgium	0	-1	0	0	-1	0	0	0	1	0	1	1	**+1**
Bulgaria	0	0	0	-1	-1	0	0	0	0	0	0	1	**-1**
Croatia	0	0	0	0	-1	0	0	0	0	0	0	0	**-1**
Cyprus	0	0	-1	-1	0	0	0	0	0	0	0	0	**-2**
Czechia	0	0	0	-1	-1	0	0	0	0	0	0	0	**-2**
Denmark	0	0	0	0	0	0	0	0	1	0	0	1	**+2**
Estonia	0	0	0	0	-1	0	0	0	0	0	0	0	**-1**
Finland	0	0	0	0	0	0	0	0	1	0	0	1	**+2**
France	0	0	0	0	0	0	1	1	1	1	1	1	**+6**
Germany	0	-1	-1	0	-1	0	0	0	0	0	1	0	**-2**
Greece	0	0	-1	-1	-1	0	0	0	1	0	0	0	**-2**
Hungary	0	-1	0	-1	-1	-1	0	0	0	0	0	0	**-4**
Ireland	0	-1	0	0	0	0	0	0	1	0	1	1	**+2**
Italy	0	-1	-1	-1	-1	0	0	0	1	0	0	0	**-3**
Latvia	0	-1	0	-1	-1	0	0	0	0	0	0	0	**-3**
Lithuania	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Luxembourg	0	-1	0	-1	-1	0	0	0	1	0	0	0	**-2**
Malta	-1	-1	-1	-1	-1	-1	0	0	0	0	0	0	**-6**
Netherlands	0	0	-1	0	-1	0	0	1	1	0	0	0	**0**
Poland	-1	-1	-1	-1	-1	-1	0	0	0	0	0	0	**-6**
Portugal	0	-1	-1	0	0	0	0	0	1	0	0	1	**0**
Romania	0	0	-1	0	-1	0	0	0	0	0	0	0	**-2**
Slovakia	0	-1	0	-1	-1	-1	0	0	0	0	0	0	**-4**
Slovenia	0	0	0	0	0	0	1	0	1	0	0	1	**+3**
Spain	0	0	0	0	0	0	0	1	1	0	0	1	**+3**
Sweden	0	0	0	0	-1	0	0	0	1	0	0	1	**+1**

Protective measures are poorly distributed across EU Member States. R3, the regulation of abortion through criminal law, and P3, public insurance coverage, are the most consistently present indicators across the Union, while P1, constitutional protection, and P2, telemedicine access, are the least common protective measures, present in only two and three Member States respectively. No country in the *hostile* or *very hostile* category holds any protective indicator, reflecting the compounding nature of restrictive policy environments. Overall, two Member States are classified as *very hostile*, two as *hostile*, eight as *leans hostile*, nine as *middle-ground*, five as *leans supportive* and one as *very supportive*. No Member State falls within the *supportive* category.

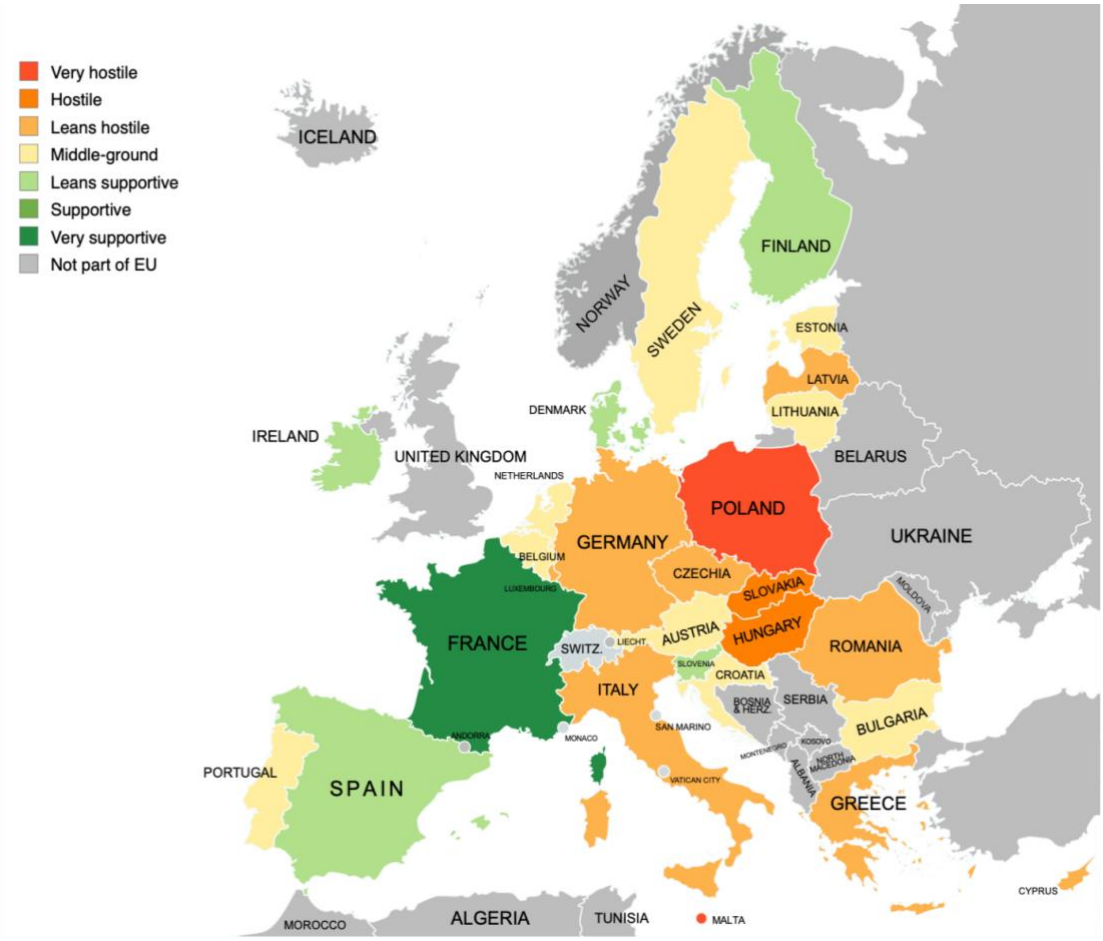

Figure 7. *Abortion Policy Environment Across EU Member States Based on the EU API*

Figure 7 illustrates the geographic distribution of the classifications presented in Table 3. The map reveals a visible geographic pattern, with more supportive classifications concentrated in Western and Northern Europe and more restrictive classifications predominant in Central and Eastern Europe.

6.3 Comparison with the EAPA: Patterns of Convergent Validity

For the purpose of statistical analysis, the EU API scores were rescaled from the original bipolar range of -6 to +6 to a unipolar scale of 1 to 13 to avoid negative values during the statistical analysis, while

preserving all relative differences between countries. Prior to analysis, the Shapiro-Wilk test showed no strong evidence of deviations from normality for either variable (EU API: W = 0.980, p = 0.872; EAPA: W = 0.949, p = 0.202), supporting the use of Pearson correlation. The Pearson correlation between the EU API and the EAPA 2025 score was strong and statistically significant (r = 0.782, p < 0.001, n = 27). As a sensitivity analysis, Spearman's rank correlation confirmed the result (rho = 0.788, p < 0.001), supporting the robustness of the finding given the ordinal nature of the EU API scores. This indicates that the EU API and the EAPA capture broadly similar patterns of abortion policy environments, while remaining sufficiently distinct to offer independent analytical value. Figure 8 displays this relationship: the scatterplot shows a clear positive linear trend, with higher EU API scores generally corresponding to higher EAPA scores, consistent with the Pearson's r. The null hypothesis of no significant association between the two instruments is therefore rejected in favour of H_1.

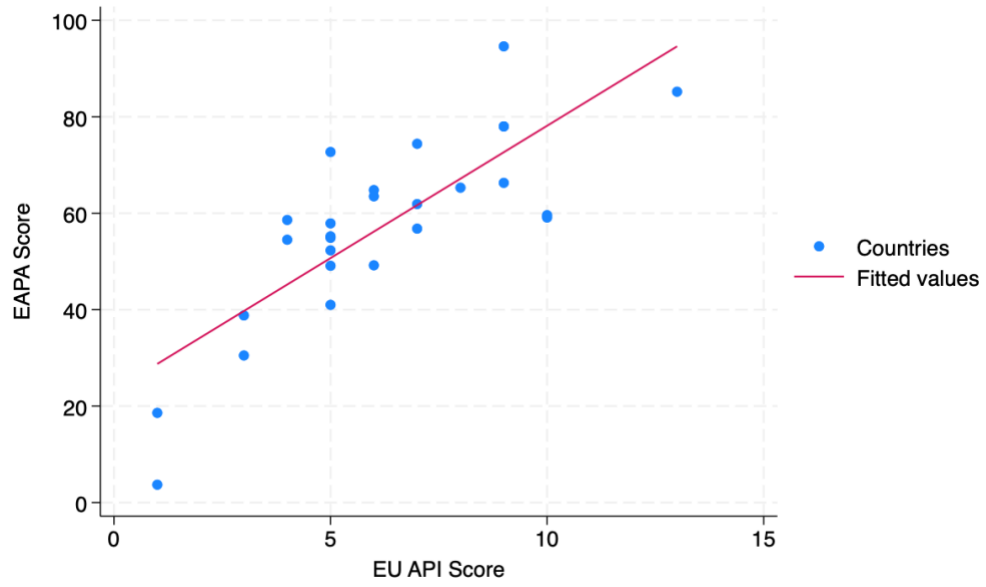

Figure 8. *Correlation Between the EU API and the EAPA 2025 Across EU Member States*

While the overall correlation is strong, notable divergences exist for individual countries. The Netherlands score at the middle-ground in the EU API (0) but rank considerably higher in the EAPA (74.4%), placing it among the more accessible countries in Europe according to that instrument. Germany scores in the leans hostile range in the EU API (-2) but reaches 55.2% in the EAPA, positioning it in the middle of the European ranking. Portugal scores 0 in the EU API, placing it in the middle-ground category, while the country reaches 61.9% in the EAPA. Bulgaria scores -1 in the EU API but achieves 63.5% in the EAPA, ranking it higher than several Western European countries according to the instrument. Sweden scores +1 in the EU API, placing it in the middle-ground range, while the EAPA assigns it the highest score of all European countries at 94.6%, reflecting a more favourable assessment of its abortion policy environment. By contrast, France scores at the maximum in both instruments, with +6 in the EU API and 85.2% in the EAPA. Poland and Malta score at the minimum in both, with -6 in

the EU API and 18.6% and 3.7% in the EAPA respectively. Beyond the extremes, several countries show relatively consistent rankings across both instruments. Denmark and Finland fall in the leans supportive range in the EU API (+2) and achieve comparably high scores in the EAPA (78.0%). Hungary and Slovakia are classified as hostile in the EU API with scores of -4 and similarly rank among the lower scoring countries in the EAPA at 30.5% and 38.8% respectively.

6.4 Association Between Abortion Policy Environments and Maternal Mortality Ratios: An Exploratory Analysis

Prior to regression analysis, the Shapiro-Wilk test indicated that the average MMR (mean of 2019-2023) was not normally distributed ($W = 0.585$, $p < 0.001$). The variable was therefore log-transformed prior to analysis. Table 4 presents the EU API scores, EAPA rankings and mean MMR values (not log-transformed) for all 27 EU Member States and provides an overview of the country-level data underlying the regression analyses.

Table 4. *Country-Level EU API Scores, EAPA Rankings and mean MMR (2019-2023)*

Country	EU API Score	EAPA Score	Mean MMR (2019-2023)
Austria	**-1**	52.3	6.4
Belgium	**+1**	65.3	6
Bulgaria	**-1**	63.5	8
Croatia	**-1**	49.2	6
Cyprus	**-2**	41	53
Czechia	**-2**	54.9	3.2
Denmark	**+2**	78	5.2
Estonia	**-1**	64.8	6.4
Finland	**+2**	78	8.2
France	**+6**	85.2	8.4
Germany	**-2**	55.2	4
Greece	**-2**	57.9	7.2
Hungary	**-4**	30.5	17.4
Ireland	**+2**	66.3	5.4
Italy	**-3**	54.5	7.6
Latvia	**-3**	58.6	26.6
Lithuania	**0**	56.8	8.6
Luxembourg	**-2**	72.7	8.2

Malta	**-6**	3.7	9.2
Netherlands	**0**	74.4	4.4
Poland	**-6**	18.6	2.2
Portugal	**0**	61.9	15.8
Romania	**-2**	49.1	15
Slovakia	**-4**	38.8	6
Slovenia	**+3**	59.1	8.4
Spain	**+3**	59.6	3.6
Sweden	**+1**	94.6	4.6

The regression of log-transformed mean MMR on the EU API showed a non-significant result (b = -0.025, p = 0.607, R^2 = 0.011), indicating that no statistically detectable association between abortion policy environment and MMR was found in this setting. To provide a comparative reference, the same regression model was applied using the EAPA score as the predictor variable, which was similarly non-significant (b = -0.005, p = 0.510, R^2 = 0.018), with both models presented in Table 5. Following the regressions, the Shapiro-Wilk test showed no strong evidence of deviations from normality in the regression residuals for both models (EU API model: W = 0.941, p = 0.129; EAPA model: W = 0.938, p = 0.107), indicating that the key assumption of residual normality was met.

Table 5. *Regression Results for the Association Between Abortion Policy Restrictiveness and Log-Transformed Mean Maternal Mortality Ratio (2019-2023) Across EU Member States*

	Model 1 (EU API)	**Model 2 (EAPA)**
Coefficient	-0.025	-0.005
Std. Error	0.047	0.007
95% CI	[-0.122, 0.073]	[-0.019, 0.009]
p-value	0.607	0.510
R^2	0.011	0.018
n	27	27

Dependent variable: log-transformed mean MMR (2019-2023)

Figure 9 illustrates the relationship between each instrument and log-transformed mean MMR across EU Member States. In both plots, the regression line shows a slightly negative slope, suggesting a weak tendency for more supportive policy environments to be associated with lower MMR, though this pattern is not statistically significant. The majority of Member States cluster in the mid-range of both scores with relatively low MMR values. Cyprus emerges as a visual outlier in both plots since the country

reports a high MMR (mean of 2019-2023 at 53 per 100 000) compared to the other countries. Notably, Poland displays the lowest MMR of all Member States (mean of 2019-2023 at 2.2 per 100 000) despite holding one of the most restrictive policy scores.

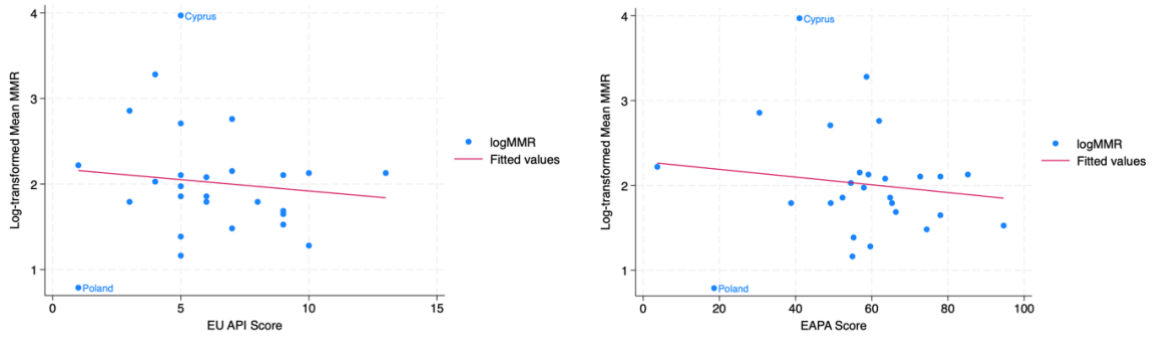

Figure 9. *Association Between Abortion Policy Environment Scores and Log-Transformed Mean Maternal Mortality Ratio (2019-2023): EU API (left) and EAPA 2025 (right)*

The null hypothesis of no significant association between abortion policy environments and MMR cannot be rejected in either model. This finding should be interpreted considering the exploratory nature of this analysis: with n = 27 and a low-variance outcome such as MMR in the EU context, the statistical power to detect an association is limited and the absence of a significant result does not necessarily rule out the existence of a relationship.

7. DISCUSSION

The following section summarises and interprets the results of the four-step methodological framework in relation to the three RQs and discusses their broader methodological significance.

7.1 Summary and Interpretation of Main Findings

Addressing RQ1, the adaptation of the Guttmacher framework to the EU context required both the removal of US-specific indicators and the introduction of new ones reflecting EU policy realities, showing that it needs contextual modification when translating frameworks from other contexts, as stated by Kublik et al. (2003). The new indicator set can be taken from Table 2 in section 6.1 and is established from the Guttmacher abortion hostility framework (Nash, 2019) and the WHO Abortion Care Guidelines (WHO, 2024). Of the original indicators, two were maintained without modification: the restriction on in-person counseling with a waiting period and the protection of abortion clinics. Other items required substantive modification: for example, the constitutional abortion ban was reframed as a legal prohibition on abortion on request and clinic regulations were reformulated as a restriction to specific facility types, both better reflecting EU legal realities. Two indicators were removed entirely as

they were specific to the US Medicaid system and private insurance landscape, which have no sufficient equivalent in EU health systems. To maintain scoring balance, two new indicators were introduced: the prohibition of mifepristone, justified by the WHO's inclusion of medication abortion as essential care and the regulation of conscientious objection through mandatory referral obligations, also supported by the WHO. The decision to use an inductive-iterative approach was beneficial, as it allowed the indicator set to be tailored to the EU context during analysis, while retaining the theoretical grounding of the original framework.

Concerning RQ2, the country-coding reveals a predominantly restrictive policy landscape across EU Member States, with the majority of countries scoring below zero and only France achieving the maximum supportive score of +6. No country falls within the supportive range of +4 or +5, which highlights the absence of a comprehensively protective policy environment across the Union. A potential concern in this context is whether the predominance of hostile and neutral scores are not due to unprotective policy environments, but reflect methodological bias. However, this interpretation is not supported by the EAPA data, which similarly shows that the majority of EU Member States cluster in the lower and middle ranges of its scoring scale. Overall, the findings indicate a strong and statistically significant positive association ($r = 0.782$, $p < 0.001$) between the EU API and the EAPA 2025 ranking. Pearson's $r = 0.782$ exceeds the threshold of $r = 0.70$ recommended by Carlson and Herdman (2012) as the minimum level of convergent validity required to justify the use of alternative measures of the same construct. The result therefore supports the convergent validity of the EU API and H_1 is accepted. However, agreement with one single existing instrument is not sufficient to fully establish convergent validity. Multiple comparisons across independent measures are generally required (Carlson & Herdman, 2012), and further validation steps are needed to validate the EU API more comprehensively. Nonetheless, the strong correlation is reassuring, given that both instruments were developed independently using different methodological approaches. At the same time, $r = 0.782$ implies that the two instruments do not overlap entirely and a closer look at individual country scores reveals notable divergences. While the EAPA assigns Germany a mid-range score of 55.2%, the EU API scores it at -2 (hostile). Germany scores restrictive points in the EU API for instance for criminal law regulation of abortion and mandatory counselling with a waiting period (Germany, Criminal Code, §218), but since the EAPA does not disclose its weighting criteria, it remains unclear how much analytical weight these dimensions receive in the EAPA scoring. Similarly, Italy scores -3 on the EU API but 54.5% on the EAPA, placing it in the hostile category on one instrument and the mid-range on the other. Again, this is a divergence that cannot be fully traced due to the EAPA's limited weighting transparency. Another interesting finding to discuss is that Sweden, widely regarded as one of the most progressive countries in terms of abortion access in Europe (Fiala et al., 2022; Levels et al., 2014; Riksförbundet för sexuell upplysning (RFSU), 2020a), scores only +1 on the EU API, placing it in the upper middle-ground range rather than the clearly supportive category one might expect. This result particularly needs

methodological reflection, since it highlights one of the EU API's limitations. Sweden legalised abortion on request up until week 18 in 1975, making it one of the earliest countries to do so, and has since integrated abortion care fully into the public health system as a standard medical procedure (RFSU, 2020a). Abortion in Sweden costs the same as an ordinary visit to the physician and medical abortion accounts for 93% of all procedures (RFSU, 2020a). In this context, the absence of active protection does not reflect a restrictive policy environment, but rather the degree to which abortion has been depoliticised and integrated into reproductive health care, highlighting a structural limitation of this index. The EU API may be better suited to capture variation in contexts where abortion is politically contested and where protective measures have been enacted in response to restrictive pressures. Furthermore, the Swedish government proposed a new Abortion Act including telemedicine provision, statutory anchoring of the right to abortion up to 18 weeks, home-based medical abortion and non-physician provision (Statens offentliga utredningar, 2025:10). As these proposals had not yet entered into force at the time of coding, they are not reflected in Sweden's score, illustrating a broader methodological limitation: scores represent a snapshot in time and do not capture policy environments in active legislative flux. A parallel dynamic is observable in Lithuania, where a proposed Reproductive Health Law seeking to shift abortion regulation into statutory law and expand access had likewise not yet been enacted at the time of coding (LRT, 2025). It is therefore not reflected in Lithuania's score, which may underestimate the country's policy environment.

Addressing RQ3, neither the EU API ($b = -0.025$, $p = 0.607$, $R^2 = 0.011$) nor the EAPA ($b = -0.005$, $p = 0.510$, $R^2 = 0.018$) showed a statistically detectable association with mean MMR across EU Member States and H_0 cannot be rejected. This is likely attributable to structural features of the EU context. MMR within the EU is among the lowest globally and shows very limited variance across Member States, severely limiting statistical power. Moreover, even at the global level, unsafe abortion accounts for only around 8% of maternal deaths (Say et al., 2014), meaning that within the EU, where maternal mortality is exceptionally low, this proportion translates into absolute numbers too small to detect meaningful variation. The two countries that stand out most clearly in the scatterplot illustrate this well: Cyprus reports the highest mean MMR among all Member States despite scoring -2 (leans hostile) on the EU API, suggesting that its high MMR is unlikely to be explained by abortion policy environment alone. However, the considerable year-to-year fluctuation across the 2019-2023 period (12, 87, 98, 53, 14 per 100 000 respectively) may point to data instability rather than an underlying trend (World Bank, 2023). This is further supported by Hadjigeorgiou et al. (2024), who note that the WHO's model-based estimates for Cyprus are likely overestimated due to the country's small population and limited maternal mortality data, which can lead to statistical adjustments that inflate reported values. This suggests that Cyprus' outlier status in the scatterplot may partly reflect a measurement limitation. Poland, by contrast, reports the lowest mean MMR of all Member States despite holding a very hostile policy score. Research on maternal care in Poland attributes this low MMR to significant improvements in general obstetric

care provision over recent decades (Mastylak et al., 2023). However, the same authors document substantial quality gaps in maternal care, for instance high out-of-pocket costs, limited women's autonomy and staff shortage, suggesting that Poland's low MMR does not reflect underlying systemic problems.

These country-level examples, together with the regression results, indicate that MMR shows limited utility as an outcome measure for exploring the EU API's empirical relevance in a low-mortality setting. However, since the finding is consistent with the EAPA's equally non-significant association with MMR, one could argue that the non-significant finding between EU API and MMR could be due to MMR data limitation rather than the developed index. This does not, however, imply that restrictive abortion policy environments are without health consequences. Beyond maternal mortality, restricted access to abortion has been associated with a range of adverse outcomes including psychological distress, delayed care-seeking, financial hardship and increased rates of unsafe abortion in lower-resource settings (WHO, 2025). In the EU context, other relevant outcome measures may include rates of cross-border abortion travel, out-of-pocket costs, gestational age at time of procedure and actual provider availability, taking conscientious objection into account (Autorino et al., 2020; De Londras et al., 2023; De Zordo et al., 2023). All these are dimensions MMR cannot reflect and future research should consider these variables for exploring the index's empirical relevance in a low-mortality setting.

7.2 Methodological Considerations

The following section reflects on the methodological strengths and limitations of the EU API, as well as considerations regarding statistical power and validity.

7.2.1 Strengths

One of the present study's methodological strengths is that each stage of index construction and process focuses on transparency and reproducibility. Each item is scored directly from primary national legal and policy sources, with secondary sources consulted only where primary sources were insufficient or unavailable. This approach reduces interpretive distance between policy reality and its measurement and ensures that every coding decision can be traced back to a specific, publicly accessible source (Raub et al., 2021). The index is furthermore grounded in two complementary frameworks: the Guttmacher abortion policy hostility framework (Nash, 2019), which provides the structural and scoring logic, and the WHO Abortion Care Guidelines (WHO, 2024), which serve as the basis for indicator selection and adaptation. This dual grounding ensures that the index is methodologically coherent, as well as aligned with current international standards in reproductive health governance. Since the index's structure is bipolar and every indicator carries the same weight of one point, the weighting ensures that no single policy measure is treated as more important than another, which avoids the need for weighting decisions that could be difficult to justify empirically. Additionally, it adds simplicity to the methodology and

makes it easy to replicate across different settings. The EU API therefore offers a level of transparency that comparable instruments, including the EAPA, do not fully provide. Finally, the adaptation process itself follows the structured four-step model proposed by Kublik et al. (2003), developed to guide the transfer of frameworks to new political and cultural settings. Combined with the inductive-iterative approach applied during coding, this ensured that the indicator set was both theoretically grounded and contextually tailored to the EU. Furthermore, it reduced the risk of systematic bias that a one-to-one transfer of US-based indicators would have introduced.

7.2.2 Limitations

The decision to apply equal weighting does not only add methodological strength, but also contains some limitations. Although equal weighting is a widely used approach and is considered appropriate when no empirical basis exists for assigning different weights (Greco et al., 2019), it carries the risk of missing meaningful nuances. It may over- or underestimate the relative influence that individual policy measures may have in practice. However, equal weighting was retained because it mirrors the scoring logic from the original framework on which the EU API is based (Nash, 2019). Additionally, the relative weight of individual policy measures may likely vary across Member States depending on legislation, stigma or other societal contexts, and makes any differential weighting scheme difficult to justify. Another fundamental limitation of the index is that it captures the presence or absence of formal legal provisions without being able to reflect the degree to which those provisions are implemented in practice. Where the gap between legislation and lived reality is large, the index will produce scores that underestimate the actual restrictiveness of the policy environment. Cyprus and Romania illustrate this: despite formally permitting abortion, both countries face significant implementation gaps, including limited public provision, high rates of conscientious objection without mandatory referral and informal institutional refusals (Human Rights Watch, 2025; Pitta, 2022; Spanou, 2025). Beyond lived access, the index also does not capture abortion stigma or unequal access to information, both of which can constitute meaningful barriers to access even where legal permission formally exists (Hanschmidt et al., 2016). Another limitation is that gestational limits are not considered in the indicator set. The WHO Abortion Care Guidelines do not recommend gestational limits as a component of safe abortion care policy (WHO, 2024), which provides justification for their exclusion. However, gestational limits vary substantially across the EU, ranging from 10 to 18 weeks for abortion on request (EPF, 2025), and represent a meaningful dimension of access the present framework does not capture. Nevertheless, including the gestational limit as a binary indicator would require a fixed threshold of a specific week as a recommended limit, which is difficult to justify on empirical grounds. This is acknowledged as a limitation and future applications of the index might explore how gestational limits can be incorporated in a methodologically consistent manner. Moreover, while the inductive-iterative approach allows the indicator set to be refined during coding, it also introduces an element of retrospective adjustment. Two indicators required revision during the coding phase: the facility-type restriction was extended to include

supervised mifepristone intake requirements and the parental involvement threshold was revised after a fixed age limit produced inconsistent results across Member States. These adjustments were methodologically justified and documented, but future replications of the index should be aware of them. Additionally, where no official legal text was accessible, the coding relied on grey literature sources such as NGO reports and clinical information pages. When used, they were verified across multiple sources where possible, however, they introduce greater uncertainty than primary legal texts. This mainly applied to the items of conscientious objection, clinical protection and insurance coverage. Additionally, where legal texts or webpages were not available in English, DeepL was used to produce translations for the purposes of policy coding. While research indicates that machine translation of legal texts can produce terminology errors due to complex legal language and missed context, DeepL has nonetheless been found to provide translations of comparatively better quality than other available tools (Greńczuk et al., 2024). Any resulting inaccuracies in the translation of legal texts should therefore be acknowledged as a potential source of bias and limitation of the present study. A further limitation concerning the coding process is that it was conducted by a single author, which may introduce subjective bias. Although in comparative policy analysis, double coding is considered best practice (Raub et al., 2021), this was not feasible within the study's scope, given that it covered 27 Member States across 12 indicators and was conducted by a single author. It should be noted that the binary coding approach may leave less room for this concern, since each indicator captures only whether a legal provision is in place, requiring less interpretive judgement than continuous scales. However, this is noted as a limitation and future applications of the index should incorporate double coding to reduce subjective bias. Finally, the index represents a snapshot of abortion policy environments at a single point in time, meaning that scores for countries currently undergoing active legislative change, such as Sweden and Lithuania, do not yet reflect planned policy changes that had not entered into force at the time of coding.

Overall, these limitations do not undermine the utility of the EU API as a comparative policy tool, but they do define the boundaries within which its results can be interpreted and point to concrete directions for future refinement.

7.2.3 Statistical Power and Validity

Regarding statistical power, the present study is based on a sample of 27 EU Member States, which represents the complete population of interest. However, since n = 27, the small absolute number of observations limits the statistical power and findings should be interpreted with caution when drawing inferences about broader policy relationships or future contexts. With n = 27, even moderate effect sizes may not reach statistical significance, which may partly explain the non-significant association between the indices and MMR. The convergent validity analysis is less affected by this limitation, though the correlation estimate remains sensitive to individual country scores at this sample size, as illustrated by

the cases discussed above. Future research covering a broader set of countries, or using longitudinal data across multiple time points, would allow for more powerful tests of the index's empirical relevance. Additionally, more sensitive outcome measures than MMR, such as rates of cross-border abortion travel or gestational age at time of procedure, would better capture the consequences of restrictive abortion policy environments in the EU context.

8. IMPLICATIONS

Building on these findings, the following chapters outline the practical and scientific implications of the EU API, by addressing its relevance for health policy at both the EU and global level as well as directions for future research.

8.1 Implications for EU and Global Health Policy

The EU API contributes to EU health policy by providing a transparent, reproducible and theoretically grounded instrument that can inform both advocacy and policy development. The results confirm that abortion access remains highly unequal across the EU, with a predominantly restrictive policy landscape and high variation between Member States. For policymakers in countries seeking to reform their abortion frameworks, comparative indices of this kind provide a useful reference point, allowing countries to identify where they stand relative to other Member States and to draw on positive examples, such as France, with more protective policy environments. The findings can be particularly relevant in the context of ongoing EU-level debates on abortion access. The ECI *My Voice, My Choice* has brought the question of international differences in abortion access to the EU political agenda (My Voice, My Choice, 2024), highlighting the need for systematic and comparable tools to assess policy environments across Member States. Instruments that can systematically classify Member States according to their policy environments will become increasingly relevant, both for identifying countries with sufficiently protective frameworks to serve as provider countries in context of the ECI, and for documenting the restrictiveness of countries of origin (My Voice, My Choice, 2024). The EU API could serve as a methodological basis for such assessment. Furthermore, the finding that the majority of EU Member States score below zero suggests that abortion care is still not treated as a routine component of reproductive health care across much of the Union which is consistent with evidence that abortion stigma remains a significant barrier to access (Hanschmidt et al., 2016). Together, these findings highlight the need to protect abortion as a right of reproductive health and to promote coordinated EU-level efforts to raise minimum standards of abortion access across the Union.

Furthermore, the findings of the present study carry relevance beyond the EU context. Safe abortion access is directly linked to SDG 3 on good health and well-being and SDG 5 on gender equality (United

Nations, 2015), and the WHO has classified abortion care as an essential health service (WHO, 2024). The policy landscape shows that even within a high-income region with shared institutional frameworks and human rights commitments, the majority of Member States score below zero, indicating a long way ahead for reproductive health research and advocacy. This is a particularly important lesson for health systems in low- and middle-income countries, where the consequences of restrictive abortion policies are considerably more severe. In contexts with limited health system capacity, geographic barriers to care and higher rates of poverty, restrictions on abortion access translate more directly into unsafe procedures and preventable maternal deaths (Ganatra et al., 2017). Unlike the EU, where overall maternal mortality is low (World Bank, 2023) and health system infrastructure can partially compensate for policy gaps, women in low- and middle-income countries often have no fallback when legal or practical access is denied (Ganatra et al., 2017; WHO, 2025). Developing comparable and reproducible policy measurement tools for different settings is therefore not only a methodological contribution but a public health necessity, as it creates the evidence base needed to advocate for policy reform where the public health burden is highest. The methodological approach developed here may contribute to this effort. By grounding the indicator adaptation in the WHO Abortion Care Guidelines, the framework is aligned with internationally recognised standards and could in principle be transferred to other settings where comparable measurement tools are largely absent. From an equity perspective, the index highlights dimensions of abortion policy that disproportionately affect the most vulnerable groups, including women facing financial barriers due to absent insurance coverage (De Zordo et al., 2023; Thomson et al., 2023), minors subject to parental involvement requirements (Kramer et al., 2023) and those in rural areas with limited provider availability (Kolandt et al., 2025). These are precisely the groups that universal health coverage is meant to protect and making these gaps visible is a first step towards addressing them. The indicator structure of the index is useful in this regard, as it allows policymakers to identify not just how restrictive a country's overall environment is, but precisely which protective measures are absent and where targeted legislative action is most needed.

8.2 Future Research Directions

Future research could update the index periodically to reflect ongoing legislative changes across the EU and assess whether the policy landscape is converging or diverging over time. More sensitive outcome measures should be prioritised for empirical testing, as MMR is not suitable in the EU context, due to, among others, its low variance. Relevant alternatives include rates of cross-border abortion travel, gestational age at time of procedure and actual provider availability. The index could furthermore be extended to capture the gap between legislation and lived access more explicitly, for instance through the inclusion of conscientious objection rates and indicators reflecting abortion stigma and information access. Finally, the methodological approach developed in this study could be applied to other regional

settings, contributing to comparable abortion policy measurement tools at the global level and testing whether the bipolar scale captures nuances in more restrictive contexts.

9. CONCLUSION

This study's aim was to develop and introduce a new instrument for measuring abortion policy environments across the EU. By adapting the Guttmacher Institute's abortion policy hostility framework to the EU context and grounding it in the WHO Abortion Care Guidelines, the research introduced the EU Abortion Policy Index (EU API) as a transparent, reproducible and theoretically grounded tool for comparative policy analysis. The findings demonstrate that transferring policy frameworks across contexts require modification, since several US-specific indicators were not applicable within the European health systems, while new indicators were necessary to reflect EU policy realities. This highlights the importance of context-sensitive methodology in comparative health policy research and supports the use of structured adaptation frameworks for transfer across different political and cultural environments. Empirically, the results reveal a predominantly restrictive abortion policy landscape across the EU. The absence of countries in the strongly supportive range, alongside the clustering of scores below zero, suggests that abortion is not consistently treated as a fully protected component of reproductive health care within the Union. At the same time, the strong positive correlation between the EU API and the EAPA ranking provides patterns of convergent validity, despite methodological differences between the instruments. However, the study also identified important methodological limitations. The case of Sweden illustrates that the EU API may underestimate access in contexts where abortion is already implemented into health care and accepted by society and where active protection does not seem necessary. Similarly, the design is limited in capturing ongoing legislative developments, as observed in Sweden and Lithuania. The absence of a significant relationship between abortion policy environments and maternal mortality outcomes further illustrates the limitations of using MMR to explore the EU API's empirical relevance in low-mortality settings such as the EU. Together, these findings emphasise that policy indices must be interpreted within their methodological boundaries and in relation to the broader health system context. Despite these limitations, the EU API makes a meaningful contribution to both research and policy. Regarding methodology, it demonstrates how global normative frameworks can be operationalised into measurable indicators while remaining sensitive to regional specificities. Further, it provides evidence of persistent inequalities in abortion access across the EU and offers a tool for identifying concrete policy gaps at the national level. In doing so, it supports ongoing policy debates and contributes to the evidence base for advancing reproductive health and rights. Looking ahead, future research could build on this work by incorporating longitudinal designs, refining indicators to better capture lived access and stigma and developing more sensitive outcome measures for testing its empirical relevance. Concerning methodology, future studies could

include double coding and explore how different weights of indicators may affect scores. Expanding the framework to other regional contexts would further strengthen comparative research and support global efforts to monitor abortion policy environments.

Ensuring that women can access safe abortion care regardless of where they live is inseparable from the broader goal of achieving health equity and upholding women's health as a fundamental human right. By pointing out policy gaps, the EU API contributes to achieving this goal and provides a promising tool to systematically assess abortion policy environments in the EU. While it cannot fully capture the complexity of access in practice, it offers a transparent and adaptable framework that contributes both to methodological development and the empirical understanding of reproductive health governance.

10. GEN AI DISCLOSURE STATEMENT

During the preparation of this work, I used Claude (Anthropic) to assist for guidance on which national legislation to consult for specific country codings, as well as language refinements. For cases where full legal texts required translation, DeepL was employed as a machine translation tool. After using these tools, I reviewed all information and verified accuracy and source references independently. I take full responsibility for the content of this work.

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APPENDIX

Appendix A: Full Rationale for Indicator Set Modification

US-Restriction #1: Ban pre- or postviability abortions in violation of constitutional protections

(1) Assessment of Indicator Transferability

The objective of this indicator is to capture whether a US state enacted an abortion ban that conflicts with federal constitutional law. Although the indicator references a constitutional conflict, its core objective remains the identification of an abortion ban. Unlike the US prior to Dobbs v. Jackson Women's Health Organization (2022), the EU does not operate under a single supranational constitutional authority that recognises a substantive right to abortion binding on all Member States. Furthermore, the viability-based formulation does not adequately capture the structure of European abortion laws, which are typically organised around gestational limits rather than viability thresholds (EPF, 2025). This introduces structural bias and limits the indicator's transferability to the EU setting.

(2) Modification and Contextualisation of Indicators for EU Application

Given the absence of a comparable supranational constitutional benchmark in the EU, the reference to constitutional protections is removed. The indicator is reformulated to capture whether abortion on request is legally prohibited, as this better reflects how abortion access is regulated across EU Member States (CRR, 2025a). This modification is directly supported by WHO Recommendation 2b, which states that abortion should "be available on the request of the woman, girl or other pregnant person" (WHO, 2024, p. 26).

EU-Restriction #1:
Legal prohibition of abortion on request

US-Restriction #2: Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility)

(1) Assessment of Indicator Transferability

This indicator captures a specific type of procedural abortion restriction, namely requirements for a mandatory waiting period between counselling and the procedure and/or more than one in-person visit to a health facility prior to termination. Such regulations can be a significant barrier to care, particularly for people who must travel long distances, take time off work or arrange childcare, as dual requirements increase costs and complicate scheduling (Rowlands & Thomas, 2020).

(2) Modification and Contextualisation of Indicators for EU Application

Since several European countries mandate counselling and waiting periods prior to abortion (CRR, 2025a), the indicator is directly transferable to the EU context without modification. This is supported by WHO Recommendation 6, which explicitly recommends "against mandatory waiting periods for abortion", on the grounds that they delay access, increase costs and disproportionately affect women with fewer resources, adolescents and those who must travel further for care (WHO, 2024, p. 41).

EU-Restriction #2:
Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility)

US-Restriction #3: Restrict Medicaid coverage for abortion

(1) Assessment of Indicator Transferability

Medicaid is a health coverage program which is jointly funded by the states and the federal government and provides health insurance to eligible low-income individuals and families. The program is a central component of the U.S. public health insurance system (Centers for Medicare & Medicaid Services, 2025). Since Medicaid covers health care costs for low-income individuals, the indicator captures if a state restricts supporting women from low-income settings if they want to terminate a pregnancy. Since EU Member States do not operate a Medicaid-type programme and health financing structures differ substantially across European health systems (Mance et al., 2019), the direct transferability of this indicator is limited and requires contextual modification.

Upon reviewing the full indicator set, it becomes apparent that three indicators address the same underlying dimension of financial access to abortion care: Restriction #3, Protection #3 and Protection #5. In the EU context, where near-universal public health coverage is the norm (Montagu, 2021), maintaining three separate indicators for this dimension would create inconsistencies and overlap in coding. The three indicators are therefore consolidated into a single protective indicator capturing whether abortion care is covered by public or national health insurance, which represents the most consistently applicable measure of financial protection across EU health systems (Mance et al., 2019). This is supported by WHO guidance, which states that the "ability to pay should not have any bearing on women's ability to access legal abortion services" (WHO, 2024, p. 15). Restriction #3 and Protection #5 are consequently removed and their content is absorbed into the new Protection #3. The overall indicator balance is restored through the introduction of a new EU-specific restrictive indicator later in the modification process.

US-Restriction #4: Prohibit the use of telemedicine to provide medication abortion

(1) Assessment of Indicator Transferability

This indicator captures whether a state legally prohibits the use of telemedicine to provide medication abortion, meaning that women cannot receive a prescription for abortion medication remotely and must instead attend an in-person clinical appointment. Telemedicine is a widely used health service which does not require in-person appointments, resulting in facilitated medical procedures and saved resources in the health system (Haleem et al., 2021). In the context of abortion care, telemedicine is applicable during the window in which a medical abortion remains possible, involving a remote consultation and home administration of mifepristone and misoprostol in the first gestational weeks (Hervey & Sheldon, 2019). In the EU, telemedicine for medication abortion has become increasingly available, particularly following the Covid-19 pandemic, during which several Member States temporarily or permanently expanded remote abortion care (Bojovic et al., 2021).

(2) Modification and Contextualisation of Indicators for EU Application

The underlying construct of this indicator is directly transferable to the EU context, as telemedicine represents an increasingly relevant and WHO-recommended mode of abortion service delivery. WHO Recommendation 48 explicitly recommends the option of "telemedicine as an alternative to in-person interactions (...) to deliver medical abortion services" (WHO, 2024, p. 97). However, many EU countries still do not regulate telemedicine in regard to abortion access which is a difficulty in analysing telemedicine as a restrictive indicator. Although some Member States do not officially prohibit it, other requirements such as the intake of mifepristone in special facilities or in front of a doctor, as well as medical consultation before pregnancy termination make the use of telemedicine not possible. To avoid double counting and to provide a valid and reproducible indicator, the indicator about telemedicine is shifted from a restrictive to a protective indicator and replaced by an originally protective indicator, further explained in Protection #2.

US-Restriction #5: Limit access to abortion for those younger than 18 without parental involvement

(1) Assessment of Indicator Transferability

This indicator captures whether minors seeking abortion are legally required to obtain parental consent before accessing abortion care. Such requirements create an additional procedural barrier that does not apply to adult women and can delay or prevent access entirely where parental involvement is unsafe or impossible (Kramer et al., 2023). The indicator therefore captures a legal restriction that specifically targets a vulnerable subgroup and introduces a form of third-party authorisation into the abortion care process, making it relevant in an EU context.

(2) Modification and Contextualisation of Indicators for EU Application

Since EU Member States differ considerably in their general medical consent age, ranging from 14 to 16 years across the Union (European Union Agency for Fundamental Rights, 2017), a single fixed age

threshold cannot be applied consistently across all countries. The adapted indicator therefore assesses the relationship between a country's general medical consent age and its abortion-specific parental involvement requirements. A country is coded as -1 if its abortion-specific parental involvement requirement exceeds the general medical consent age, as this constitutes an abortion-specific procedural barrier imposed on individuals who would otherwise be entitled to make autonomous medical decisions. A country is also coded as -1 if its general medical consent age is set at 18 without any specific relaxation for abortion, as this effectively restricts minors' independent access to abortion care regardless of whether the restriction is abortion-specific. Countries where the abortion-specific requirement is equal to or lower than the general medical consent age, and where that age is 16 or below, are coded as 0. This approach is grounded in WHO Recommendation 7, which states that abortion should be available "without the authorisation of any other individual, body or institution" and explicitly notes that parental involvement must not be imposed through third-party authorisation requirements (WHO, 2024, p. 43). The implications of this coding decision are discussed further in the limitations section.

EU-Restriction #4:

Limit access to abortion for minors without parental involvement, where this exceeds the general medical consent age or applies up to the age of 18

US-Restriction #6: Impose unnecessary and onerous abortion clinic regulations (Clinical regulations, ambulatory surgical centre standards or admitting privileges)

(1) Assessment of Indicator Transferability

This indicator captures whether a state imposes targeted regulations on abortion providers that go beyond standard medical safety requirements and are not applied to comparable outpatient procedures, thereby restricting their ability to deliver abortion care. In the US context, these regulations are commonly referred to as TRAP laws and include requirements such as hospital admitting privileges for abortion providers or mandatory compliance with ambulatory surgical centre standards. Such regulations are widely regarded as medically unnecessary and function primarily to reduce the number of operating abortion facilities, thereby limiting access (Austin & Harper, 2019). Since the specific regulatory mechanisms of TRAP laws are features of the US health care and licensing system which do not have direct equivalents in EU institutional contexts, the indicator requires contextual modification.

(2) Modification and Contextualisation of Indicators for EU Application

Although TRAP laws do not translate directly to the EU context, the underlying construct of disproportionate facility-type restrictions that limit where abortion care may be delivered remains relevant. In the EU context, this manifests in restrictions that limit abortion to specific facility types such as hospitals or specialised clinics, as well as requirements that mandate the in-person administration of mifepristone under direct clinical supervision, both of which restrict service availability beyond what is

clinically necessary. The decision to treat facility-type restrictions as a separate analytical dimension from provider-type restrictions is supported by the WHO CAC framework, which explicitly addresses the *where* and the *who* of abortion service delivery as independent components of an enabling environment (WHO, 2024). This indicator addresses the *where* dimension exclusively. This is further supported by WHO Best Practice Statement 49, which states that there is "no single recommended approach to (...) the location of service provision", and that this should depend on the values and preferences of the individual (WHO, 2024, p. 98). Countries where abortion is restricted to specific facility types or where mifepristone must be administered under direct supervision at a facility are coded as -1.

EU-Restriction #5:
Restrict abortion provision to specific facility types

While the five restrictions capture the most prominent legal and structural barriers to abortion access, the removal of Restriction #3 from the adapted framework requires an adjustment to maintain the overall balance between restrictive and protective indicators on the bipolar scale. At the same time, the adaptation process identified one additional policy dimension that is absent from the original framework. The formal availability of mifepristone represents an empirically relevant dimension of abortion access in the EU context that is absent from the original Guttmacher framework. In the US, mifepristone is federally approved and individual states cannot prohibit its use entirely (Dilek et al., 2026), making the indicator unnecessary in the original context. In the EU, however, pharmaceutical regulation intersects with national health policy competence (Treaty on the Functioning of the European Union, 2012, Art. 168), meaning that Member States can effectively restrict access to mifepristone in practice. WHO Clinical Services Recommendation 27a identifies the combination of mifepristone and misoprostol as the recommended method for medical abortion up to 12 weeks, and mifepristone is classified as an essential medicine (WHO, 2024, p. 70). Where access to mifepristone is prohibited, women are pushed towards more invasive surgical methods or unsafe alternatives, which introduces a new indicator.

EU-Restriction #6:
Prohibit access to mifepristone for medication abortion

This indicator captures whether an EU Member State prohibits access to mifepristone, the primary medication used in WHO-recommended medication abortion protocols. Prohibition of its availability directly limits women's ability to access safe and effective abortion care and push provision towards more invasive surgical methods or unsafe alternatives.

US-Protection #1: Affirm a right to abortion in the state constitution

(1) Assessment of Indicator Transferability

This indicator captures whether the right to abortion is explicitly anchored in the constitution, thereby providing the strongest possible legal protection against legislative attempts to restrict or criminalise abortion. The core concept is directly transferable to the EU context, since France became the first country in 2024 to explicitly enshrine the right to abortion in its constitution (Bojovic & Stanisljevic, 2024). A minor contextual adjustment is needed, as the reference to "state constitutions" reflects the federal structure of the US and must be adapted to the national level.

(2) Modification and Contextualisation of Indicators for EU Application

The indicator is maintained with a minor adjustment in terminology, replacing "state constitution" with "national constitution or equivalent fundamental law" to reflect the EU institutional context. The underlying construct, whether the right to abortion enjoys the highest level of legal protection available, remains unchanged. This is supported by WHO Box 2.1, which states that countries should take positive steps to secure an enabling regulatory and policy environment that ensures "the universal availability, accessibility, acceptability and quality of abortion (...) care (WHO, 2024, p. 21), with constitutional protection representing the strongest available mechanism for achieving this.

EU-Protection #1:

Affirm a right to abortion in the national constitution or equivalent fundamental law

US-Protection #2: Establish a legal standard that protects access to abortion

(1) Assessment of Indicator Transferability

This indicator captures whether a state has established a statutory legal standard that protects access to abortion, beyond merely permitting it through criminal law exceptions. In the US context, this distinction became particularly prominent after Dobbs v. Jackson Women's Health Organization (2022), when states without statutory protections were left without any legal safeguard against legislative attempts to restrict abortion. This approach is driven by dynamics of American federalism and has no direct equivalent in the EU.

(2) Modification and Contextualisation of Indicators for EU Application

In the EU context, the most meaningful distinction in the legal framing of abortion is not between constitutional and statutory protection, but between countries that regulate abortion through criminal law and those that do not. Where abortion is mainly regulated in the penal code, even if exceptions are defined that make it practically accessible, it is fundamentally framed as a criminal act. This framing stigmatises abortion as something punishable and may contribute to provider's education on abortion procedures and stigma in society (De Londras et al., 2022). The German case illustrates this clearly: the persistence of §218 (on pregnancy termination) in the penal code has been linked to a declining number

of abortion providers, gaps in medical training and limited institutional willingness to offer the service, showing the dependence of practical availability on the formal legality (Kolandt et al., 2025).

The indicator is rephrased for the EU context to "Abortion is regulated through criminal law". Since the presence of criminal law regulation is a barrier rather than a protection, the indicator is shifted to the restrictive side of the scale. It replaces the original Restriction #3 (originally addressing telemedicine), which is relocated to the protective side as Protection #2. The balance of the bipolar scale is thereby maintained.

EU-Restriction #3:
Abortion is regulated through criminal law

A country does not receive a restriction score (0) if abortion is primarily regulated through health law, administrative law or a standalone abortion act, treating abortion as a medical procedure that is fundamentally permitted under defined conditions. A score of -1 is assigned if abortion is regulated primarily or exclusively through criminal law, where it is fundamentally treated as a criminal act with exceptions carved out as exemptions from punishment.

As this indicator therefore shifts to the restrictive side of the scale as EU-Restriction #3, the present protective slot is filled by the telemedicine indicator, which was relocated from the restrictive side for the reasons outlined in the discussion of US-Restriction #4.

EU-Protection #2:
Possible use of telemedicine to provide medication abortion

This includes the availability of remote consultations for abortion care and access to mifepristone outside of a clinical setting, for instance through pharmacies or postal delivery. Countries where telemedicine for abortion care is either explicitly permitted or accessible in practice, receive a score of +1. Countries where telemedicine is prohibited, practically inaccessible or where no accessible pathway exists regardless of the regulatory status, are coded as 0.

US-Protection #3: Guarantee abortion coverage through Medicaid

(1) Assessment of Indicator Transferability

This indicator captures whether abortion care is covered by public insurance, thereby protecting women from out-of-pocket costs. As outlined in the section of Restriction #3, this indicator serves as the consolidating point for three original Guttmacher indicators addressing financial access: Restriction #3, Protection #3 and Protection #5. Since Medicaid has no direct institutional equivalent in the EU and

health financing structures differ substantially across Member States, the indicator requires contextual adaptation. However, the underlying concern, namely that the absence of public insurance coverage for abortion creates financial barriers to access, remains directly relevant across the EU context. Research on financial protection in EU health systems confirms that out-of-pocket payments cause disproportionate financial hardship and unmet need and that stronger financial protections are associated with better access to care (De Zordo et al., 2023; Thomson et al., 2023).

(2) Modification and Contextualisation of Indicators for EU Application

Across EU Member States, health care is predominantly financed through public or social health insurance systems providing near-universal coverage (Montagu, 2021). However, abortion care is explicitly excluded from public insurance coverage in several Member States, meaning women must bear the full cost privately. The adapted indicator therefore captures whether abortion care is guaranteed under the national or public health insurance system without restriction. This is supported by WHO guidance in section 1.4.2, which states that abortion services and supplies should be mandated for coverage under insurance plans, as inability to pay is not an acceptable reason to deny or delay abortion care (WHO, 2024, p. 15).

EU-Protection #3:

Guarantee abortion coverage through public or national health insurance

US-Protection #4: Allow advanced practice clinicians to provide abortion by law or Attorney General Opinion

(1) Assessment of Indicator Transferability

This indicator captures whether health care professionals other than physicians are legally permitted to provide abortion services. Expanding provider eligibility beyond physicians has been a key mechanism in the US for increasing abortion service availability, particularly in rural and underserved areas where physician supply is limited (McNamara et al., 2023). The indicator addresses the *who* dimension of the WHO framework and is directly relevant in the EU context to analyse how the legal authorisation to perform abortions varies across Member States.

(2) Modification and Contextualisation of Indicators for EU Application

The indicator is maintained with a minor terminological adjustment. The reference to "Attorney General Opinion" is removed as this mechanism has no institutional equivalent in EU Member States. The adapted indicator instead captures whether non-physician health professionals, including midwives, nurses, general practitioners or other qualified provers are legally permitted to provide abortion services. WHO Recommendation 21 recommends "against regulation on who can provide and manage abortion that is inconsistent with WHO guidance" (WHO, 2024, p. 60). WHO Recommendation 24 further specifies that vacuum aspiration at under 14 weeks can be provided by nurses, midwives and associate

clinicians (WHO, 2024, pp. 65, 66), and Recommendation 30 specifies that medical abortion at under 12 weeks can be provided by the full range of health workers, including community health workers, pharmacists, auxiliary nurses, nurses and midwives (WHO, 2024, pp. 73, 74). Accordingly, this indicator is coded as +1 where national law or regulation explicitly permits at least one category of non-physician health professional to independently provide abortion services, and as 0 where provision is legally restricted to physicians only. This reflects the WHO's (2024) emphasis on expanding practical access, particularly in primary care and community settings.

EU-Protection #4:
Allow non-physician health professionals to provide abortion services

US-Protection #5: Mandate private health insurance plans cover abortion

(1) Assessment of Indicator Transferability

This indicator captures whether a state legally requires private health insurance plans to include abortion coverage. As outlined in the discussion of Restriction #3, this indicator addresses the same underlying dimension of financial access as the original Restriction #3 and Protection #3 and is therefore absorbed into the adapted Protection #3, which captures public or national health insurance coverage as the most consistently applicable measure of financial protection across EU health systems. In the EU context, the boundary between public and private insurance varies considerably across Member States, making private insurance coverage too context-dependent to serve as a reliable and consistently applicable comparative indicator (Janlöv et al., 2023; Mance et al., 2019).

US-Protection #6: Protect access to abortion clinics

(1) Assessment of Indicator Transferability

This indicator captures whether a state has enacted legal measures to protect abortion clinics and their patients from obstruction, harassment or intimidation by anti-abortion protesters or third parties, typically through buffer zone laws or clinic access statutes. This construct is directly relevant in the EU context, as the Parliamentary Assembly of the Council of Europe has explicitly called on member states to introduce buffer zones near reproductive healthcare facilities, acknowledging that harassment, psychological pressure and intimidation constitute tangible barriers to abortion access even where the procedure is legally permitted (Parliamentary Assembly of the Council of Europe, 2022).

(2) Modification and Contextualisation of Indicators for EU Application

The indicator is maintained without substantive modification. The WHO enabling environment framework explicitly identifies a supportive legal and policy framework as a prerequisite for effective abortion care, which encompasses the protection of both providers and patients from external interference that may obstruct access (WHO, 2024). A country receives this protective point if national

legislation includes specific legal measures such as buffer zone laws or comparable provisions that protect abortion providers and patients from harassment, obstruction or intimidation. General public order provisions that apply to all premises are not considered sufficient; the protection must be specifically directed at or clearly applicable to abortion service settings.

EU-Protection #5:
Protect access to abortion clinics from harassment and obstruction

Beyond the five protective indicators adapted from the original Guttmacher framework, the adaptation process identified one additional dimension requiring inclusion. First, the absorption of Protection #5 into Protection #3 reduced the number of standalone protective indicators to five, breaking the symmetry of the bipolar scale. Second, the legal regulation of conscientious objection represents an empirically important axis of abortion access in the EU that has no equivalent in the original US-based framework. Conscientious objection refers to the right of individual health care providers to refuse to participate in abortion care on grounds of personal moral or religious conviction (De Londras et al., 2023). Where no regulatory safeguards exist, high rates of provider refusal can effectively hollow out formal legal access: in Italy, objection rates among gynaecologists exceed 70% nationally and surpass 80% in some regions, directly associated with reduced service availability and delayed care (Autorino et al., 2020). This is explicitly addressed in WHO Recommendation 22, which recommends that "access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection" and specifies that where conscientious objection is permitted, States must regulate it in a way that ensures abortion remains available and accessible in practice, including through mandatory referral obligations (WHO, 2024, p. 61).

EU-Protection #6:
Regulate conscientious objection through mandatory referral obligations or equivalent institutional safeguards

This indicator captures whether national legislation ensures that the exercise of conscientious objection by individual providers does not compromise women's practical access to abortion care, through mechanisms such as mandatory referral obligations or institutional responsibility for service continuity. Countries where conscientious objection is not legally permitted at all are also considered to meet this indicator, as the absence of conscientious objection eliminates provider refusal as a barrier to access entirely.

Appendix B: Data Sources by Country

Austria

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