

Discussion Paper Series

IZA DP No. 19004

October 2026

25 Years of Induced Abortions in Europe

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25 Years of Induced Abortions in Europe*

Abstract

This article provides descriptive evidence on induced abortions over the past 25 years in Eastern, Northern, Western, and Southern Europe, combining publicly available abortion data with restricted-access administrative datasets. We document diverse abortion-related institutional environments across European regions, the evolution of the total abortion rate, and differences by age, parity, and education. We find a decreasing trend with strong convergence across European countries, regardless of institutional settings and social norms. The largest declines occurred in Eastern Europe, while rates changed comparatively little elsewhere. The declines were the steepest among women with at least one child. Abortion rates were consistently the highest among women with primary education and lowest among those with tertiary education. However, the long period of convergence appears to have come to an end recently: since 2021, abortion rates have risen substantially in several Northern, Western, and Southern European countries, while continuing to decline in Eastern Europe.

JEL classification

I12, J13, J65

Keywords

abortion rate, abortion ratio, abortion trends, abortion heterogeneity

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* We are grateful for their helpful comments to Libertad González, Martin Bujard, Mathias Huebener, and the participants of the EAPS and Szirak Labor Economics conferences and the KRTK Seminar Series. Design: Szabolcs Tóth Zs, BANDART Productions. *Acknowledgment to administrative data providers:* Data Bank of ELTE KRTK (Hungary): This article was prepared using the Live Birth and Pregnancy Termination datasets of the Hungarian Central Statistical Office. The calculations contained herein and the conclusions drawn from them are solely the intellectual property of the authors. We are grateful for the data quality control executed by Eva Czethoffer (Data Bank of ELTE KRTK). Data for Italy were provided by the Italian Statistical Office (ISTAT). Data for Slovakia were provided by the Slovak Statistical Office. Data for Spain were provided by the Spanish Ministry of Health. The Finnish register data were analyzed under the license numbers TK/2182/07.03.00/2024 (Statistics Finland) and THL/3141/6.02.00/2022 (Finnish Institute for Health and Welfare). *Data availability:* The data used for the analysis are freely available and downloadable from GitHub. *Disclosure Statements:* Szabó-Morvai: The project was implemented with the support provided by the National Research, Development and Innovation Fund of the Ministry of Culture and Innovation of Hungary, based on the Grant Certificate issued by the NKFIH Office (Grant no: 149508). Supported by the University of Debrecen Program for Scientific Publication. Nisén was supported by the Academy of Finland (INVEST, nr. 369118) and the Strategic Research Council of Finland (FLUX, nr. 364374). Slabá was supported by the Czech Science Foundation, Project 25-18424S: Contemporary reproduction challenges: fertility in Czechia at a time of multiple crises. Tóth was supported by the Hungarian National Research, Development and Innovation Office (NKFIH) under Grant No. FK-145991. Szabó-Morvai, Adamecz, Cavallini, Nisén, Slabá, Tóth, and Trommlerová declare that they have no conflicts of interest. The views expressed in this paper are those of the authors and do not necessarily reflect those of the institutions the authors are affiliated with. IRB: No primary data collection was involved in this study, thus, no IRB approval was obtained. *Usage of AI:* In this research, ChatGPT 5.2, Gemini 3.7, and Claude Fable 5 were used for language editing purposes.

1. Introduction

Abortion and its regulation have long provoked heated public debate and political conflict (Mayall, Ajayi and Gruer, 2025).¹ Perhaps because of its contested status, as well as social stigma and restricted data access that accompany it, abortion remains far less studied than other demographic phenomena, even though it is anything but marginal: globally, roughly three in ten pregnancies end in an induced abortion (Bearak et al., 2020), and in the United States, one in four women is expected to have an abortion in her lifetime (Guttmacher Institute, 2024). Apart from being common, abortion is a significant event in the reproductive life of women who undergo it, shaping the timing, spacing, and completion of their child-bearing. Additionally, access to safe and legal abortion is a core component of reproductive rights and reproductive health. Understanding abortion decisions and dynamics is therefore indispensable for understanding the family-demographic changes of recent decades. This is particularly true for the period since the early 2010s, when fertility rates declined sharply in many European countries (Hellstrand et al., 2021; Ohlsson-Wijk and Andersson, 2025) and in the United States (Kearney, Levine and Pardue, 2022). Across Europe, fertility rates have converged, as fertility fell the most in countries that used to have relatively high rates, with declines concentrated among first births and younger women (Hellstrand et al., 2021). However, our knowledge of concurrent developments in abortion rates across Europe remains much more limited.

This paper provides an overview of trends in induced abortions (hereafter, abortions) across European regions over the past 25 years. To our knowledge, no previous study has offered such a comprehensive account of the evolution of European abortion rates, and none has systematically examined how abortion trends differ across population subgroups. Subgroup estimations are essential for understanding abortion as a social phenomenon and for drawing policy-relevant conclusions, because aggregate trends can conceal which groups of women are driving the observed changes. Subgroup analyses have become increasingly feasible as administrative and register data are linked and made available to researchers (Root et al., 2024). Therefore, we first present an overview of the abortion landscape across European countries, and then examine whether the observed abortion trends are driven by shifts in population structure, by changes in abortion rates within particular groups of women, or both. Answering these questions is all the more pressing at a time when fertility is declining steeply across much of the world (Sobotka, 2026), and abortion remains one of the least understood components of these changes.

Existing evidence on recent abortion-related developments is limited. A substantial literature maps abortion legislation and its restrictiveness across countries (Mayall, Ajayi and Gruer, 2025; Fiala et al., 2022), but tells us little about the actual abortion incidence. Although Europe has long been characterized by sharp institutional, cultural, and historical differences related to abortion access and behavior, global analyses of abortion incidence typically treat Europe as a single entity or divide it into broad regional groupings without providing country-specific estimates (Bearak et al., 2020; Sedgh et al., 2016). Where country-level information is available, it usually covers a single period and overall rates only (Bearak et al., 2022). Whereas research on earlier decades in Europe emphasized a per-

¹ChatGPT 5.2, Gemini 3.7, and Claude Fable 5 were used to collect related literature.

sistent East-West divide (Dereuddre, Van de Putte and Bracke, 2016; Kocourková, 2019), other comparative studies show that the initially much higher abortion rates of Central and Eastern Europe have been converging towards Western European levels (Frejka, 2008; Fiala et al., 2022; Cihak, Kotrba and Borosova, 2025). These studies focus on aggregate rates; the few exceptions examine only the age gradient until around 2010. They find the highest abortion rates among women in their twenties, while the behavior of younger cohorts in Eastern and Western Europe becomes increasingly similar (Sedgh et al., 2013; Kocourková, 2019). What we know about other group differences comes largely from single-country studies: the likelihood of abortion tends to rise with parity (Mackenziel et al., 2011) and is consistently higher among women with low levels of education, as shown for Finland, Denmark, and Spain (Väisänen, 2015; Hegelund, Poulsen and Mortensen, 2019; Requena and Stanek, 2024), partly because more highly educated women engage in less risky sexual behavior (Gil-Lacruz, Gil-Lacruz and Bernal-Cuenca, 2012). Whether these gradients hold across countries, and how much they contribute to the aggregate abortion trends, has not been examined in comparative perspective.

We fill this gap by assembling a novel database that combines open-access data from EUROSTAT, the World Health Organization, the Abort-Report Project, the Human Fertility Database, Johnston’s Archive, national statistical offices, and national ministries, with aggregate data constructed via access to restricted administrative records from Czechia, Finland, Hungary, Slovakia, Spain, and detailed publicly available data from Italy and England and Wales. These data extend the observation window to 2023 and, crucially, allow us to examine abortion rates by age, parity, and education – dimensions that have rarely been observed in cross-country research (for single-country decomposition studies, see Serbanescu, Stupp and Westoff, 2010; Requena and Stanek, 2025). This analytical breadth comes at a price: data availability differs across countries, years, and dimensions. We deliberately chose coverage over strict comparability, presenting all available evidence rather than restricting the analysis to a balanced sample of countries and years.² Our main analysis covers 1999 to 2023 (Table A.2), though coverage is shorter for some countries.³ The results should therefore be interpreted with appropriate caution. Alongside the empirical analysis, we summarize country-specific characteristics of abortion regulation, contraceptive availability, and prevailing norms and beliefs regarding abortion to contextualize our findings.

We find that abortion rates declined and converged strongly across Europe between 1999 and 2023, despite large and persistent differences in institutional settings and social norms. The convergence was driven primarily by steep declines in Eastern Europe, where abortion rates started at a much higher level around the year 2000 but had approached Western and Northern European levels by the 2010s. The decline was broad-based but uneven across groups: it was the steepest in the prime reproductive cohort (ages 20-39) in Eastern Europe, among women who already had children, and among women with secondary education. The educational gradient persisted over time, with the least educated women continuing

²We conducted a thorough search for administrative data broken down by parity and education for as many countries as possible. For countries that are not included in this analysis, we could not find such data. The authors welcome further related data; please write an email to: szabomorvai.agnes@krtk.elte.hu.

³For some countries, data are available from 1960 to 2024, but we utilize only data from 1999 and later for the purposes of the analysis.

to exhibit the highest abortion rates. Our decompositions show that these developments reflect, above all, changes in abortion rates within population groups rather than shifts in population composition, although compositional change also contributed in most countries. Finally, the most recent data suggest that the long period of convergence may have come to an end: abortion rates stopped declining in Eastern Europe around 2020, and several Northern and Western European countries have experienced a modest rebound since 2021, at a time when fertility has continued to fall. Whether this marks a temporary fluctuation or a new phase in European reproductive behavior is a question the most recent data cannot yet settle.

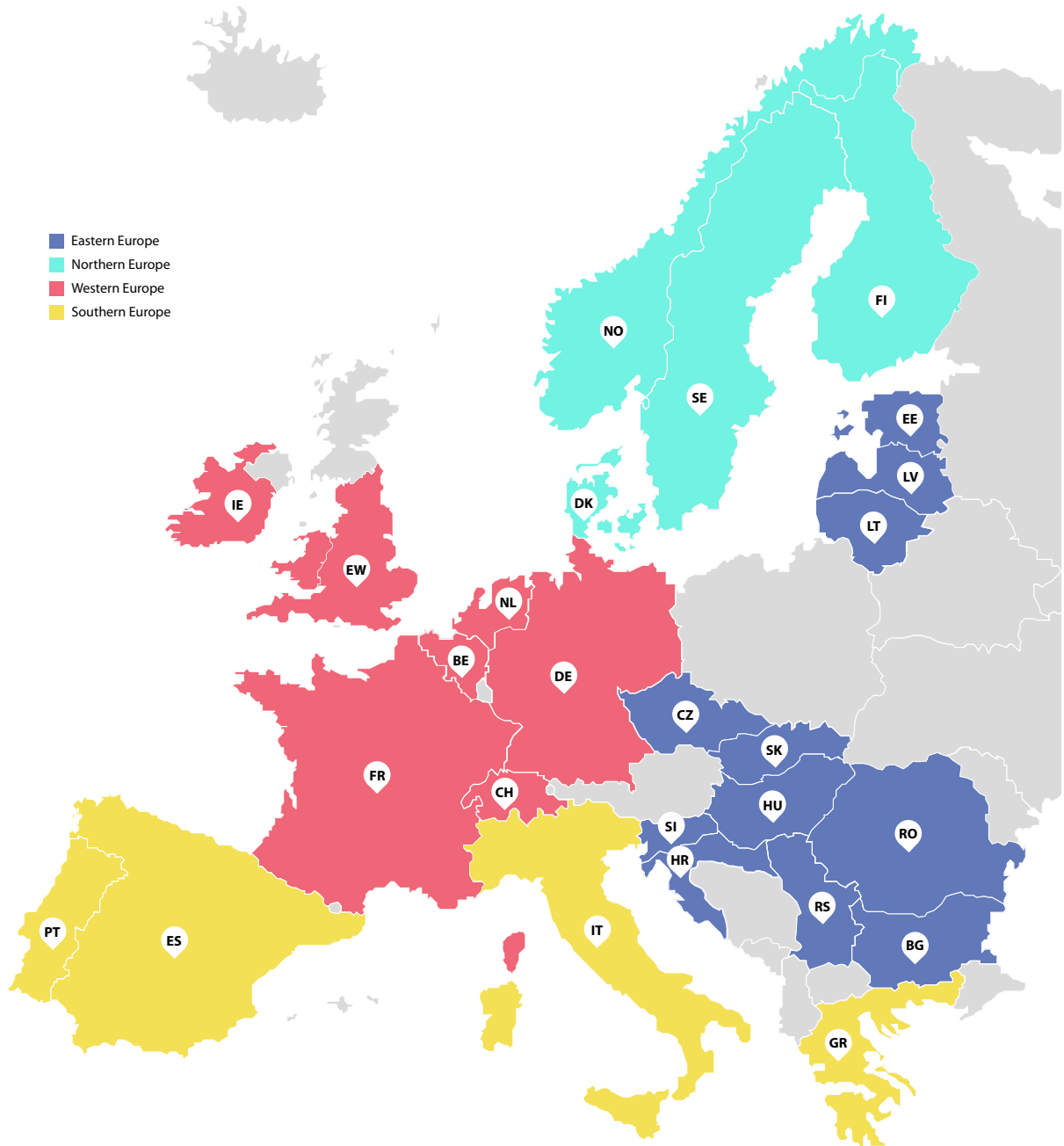
2. The European abortion landscape

2.1. Country groups

Throughout the paper, we report results for four groups of countries: Eastern, Northern, Western, and Southern Europe (Figure 1). This grouping follows a division that is conventional in comparative European demography, and that combines geography with two dimensions the literature has repeatedly shown to structure family behavior, relationship patterns and policy outcomes, as well as attitudes towards abortion: the historical geography of household formation and family ties, and the institutional legacy of state socialism.

The first dimension has a long tradition. [Hajnal \(1965\)](#) identified a line running roughly from Trieste to St. Petersburg, west of which marriage was late and households predominantly nuclear and neolocal, and east of which marriage was early and complex households more common. [Laslett \(1983\)](#) refined this into a set of regional family forms, separating the European West from a Mediterranean and Eastern pattern. [Reher \(1998\)](#) recast the same geography in terms of the strength of family ties, contrasting the weak-tie societies of Northern and Western Europe, where individual autonomy and early residential independence are the norm, with the strong-tie societies of the Mediterranean, where obligations towards kin remain central. These contrasts have proved persistent and continue to shape family behavior and fertility intentions until today ([Mönkediek and Bras, 2018](#); [Heady, Gruber and Ou, 2010](#)). Comparative analyses of value surveys recover broadly similar country clusters along the traditional–secular and survival–self-expression dimensions ([Inglehart and Welzel, 2005](#)), and the same geography is echoed in welfare-state typologies that distinguish the Nordic, Continental, and Southern European models ([Esping-Andersen, 1990](#)). The second dimension is more recent but, for abortion specifically, at least as consequential: the state-socialist countries legalized elective abortion decades before most of Western Europe, while simultaneously restricting access to modern contraception (Section 2.2). The resulting reliance on abortion as a means of fertility control long outlived the regimes that produced it. We therefore treat a state-socialist past as the defining criterion for the Eastern group, which is why the Baltic states, Croatia, Slovenia, and Serbia are grouped with Central Europe rather than with their immediate geographic neighbors.

Figure 1: Map of the country groups



Notes: Countries that are not included in the analysis are in gray. Country codes: BE - Belgium; BG - Bulgaria; CH - Switzerland; CZ - Czechia; DE - Germany; DK - Denmark; EE - Estonia; ES - Spain; EW - England and Wales; FI - Finland; FR - France; GR - Greece; HR - Croatia; HU - Hungary; IE - Ireland; IT - Italy; LT - Lithuania; LV - Latvia; NL - Netherlands; NO - Norway; PT - Portugal; RO - Romania; RS - Serbia; SE - Sweden; SI - Slovenia; SK - Slovakia.

Eastern Europe (Bulgaria, Croatia, Czechia, Estonia, Hungary, Latvia, Lithuania, Romania, Serbia, Slovakia, and Slovenia) is a region where the family remains a core element of identity and marriage is still considered the normative framework for childbearing. Religiosity is higher than in Western Europe, and conservative gender norms are more prevalent. At the same time, economic uncertainty, out-migration, and increasing female educational attainment create tensions between traditional ideals and modern life realities. Fertility remains below replacement level, not because family ideals are weak, but because practical barriers hinder achieving the desired family size. Poland, where abortion is near-totally banned, is excluded from the analysis.

Northern Europe (Denmark, Finland, Norway, and Sweden) combines strong individualism with family egalitarianism. Cohabitation and childbearing outside marriage are highly accepted, and gender equality is deeply embedded in both norms and policy design. Parental leave, childcare availability, and flexible work–family arrangements are institutional cornerstones, enabling high female labor force participation. The outcome of this configuration is medium–high fertility relative to the rest of Europe, though it has declined recently (Hellstrand et al., 2021). Family satisfaction is high even when family life deviates from traditional marriage-centered paths.

Western Europe (Austria, Belgium, France, Germany, Ireland, the Netherlands, Switzerland, and England and Wales) is a region in which the family is viewed primarily as an emotional and voluntary partnership rather than an institution. Diverse family forms (including cohabitation, single parenthood, and same-sex parenting) are socially accepted, trust in the state and in social policy is relatively high, and family policy often succeeds in mitigating fertility decline (France demonstrates how supportive institutions can help maintain fertility close to the replacement level). We include England and Wales in this group, even though they represent a somewhat distinct pattern, in which moderate individualism coexists with residual Christian cultural influence, acceptance of non-marital births is high and the welfare state plays an important role in supporting single parents. However, abortion regulation and abortion-related social norms are close to the Western continental Europe. Ireland is a historically Catholic and familistic country but it has been converging rapidly towards Western European norms in terms of family diversity and social attitudes.

Southern Europe (Greece, Italy, Portugal, and Spain) is characterized by strong intergenerational ties and a moral emphasis on family obligations. Traditional role expectations (mother as main caregiver, father as breadwinner) persist, even though views among younger cohorts are gradually changing. Limited trust in public childcare, lower levels of institutional support for working mothers, and the expectation of economic stability before parenthood contribute to very low fertility rates and late family formation. Family is highly valued, yet structural barriers discourage earlier or higher fertility. Malta, where abortion is prohibited in almost all circumstances, is excluded from the analysis.

It is important to note that these groupings are heuristic rather than absolute, and we use them to organize the presentation of the results rather than as an explanatory variable. Countries exhibit internal regional variation and norms evolve. The categories should therefore be understood as value clusters designed to clarify how certain belief systems and institutional arrangements tend to co-occur with specific family behaviors and abortion patterns across Europe. Section 2.3 documents the corresponding institutional and attitudinal differences empirically, supporting the chosen groupings.

2.2. Historical background

The evolution of abortion access since the mid-twentieth century has reflected distinct histories, cultures, geopolitical shifts, and waves of mobilization across Europe. The path toward liberalization has been neither linear nor uniform, resulting in a highly differentiated institutional landscape. Figure 2 provides a summary timeline of abortion liberalization across the regions under consideration, while detailed chronologies and legal references are documented in Appendix Table A.7. Figure A.16 presents abortion rates from 1960 onwards, illustrating how these differing policy regimes coincided with markedly different abortion levels. Notably, the initial striking differences in abortion rates have narrowed over time and the four country groups eventually converged, at least until the recent turning point around 2020, to which we return in Section 5.

In *Eastern Europe*, elective abortion was liberalized remarkably early, largely driven by the socialist wave of the 1950s (for example, USSR 1955; Hungary, Poland, and Bulgaria 1956; Romania 1957). This early liberalization, combined with a systemic lack of modern contraception, led to exceptionally high historical abortion rates. Access did not evolve monotonically thereafter. Pronatalist concerns drove a wave of re-restriction from the mid-1960s onwards, most drastically in Romania (1966) but also in Bulgaria (1968 and 1973) and Hungary (1973). These restrictions were reversed only between 1987 and 1990.

The post-socialist transitions of the 1990s were characterized by profound volatility in several Eastern European countries. The most striking example is Romania, where abortion was strictly criminalized during the Ceaușescu dictatorship (1966–1989) and abortion rates immediately spiked after the decree was repealed, peaking at around 175 abortions per 1,000 women aged 15–49.⁴ Since the late 1990s, however, Eastern European rates have experienced a steady decline as socio-economic conditions stabilized and access to modern contraception expanded, ultimately reaching similar levels to Western and Northern Europe by the 2010s. Notable institutional exceptions to this regional trajectory include Poland, where access has been progressively dismantled and is near-totally banned today (hence it is excluded from our analysis), and Hungary, where recent decades have introduced significant regulatory burdens and limitations to abortion access.

In *Northern Europe*, reproductive policy evolved through gradual, state-led institutionalization. Abortion was initially permitted only under specific circumstances during the first half of the 20th century, followed by the broad liberalization of elective abortion in the 1970s.⁵ Supported by robust public healthcare systems and comprehensive sex education, historical abortion rates in Northern Europe have consistently remained stable and low-to-medium, rarely exceeding 25 per 1,000 women until around 2020.

In *Western Europe*, the path to liberalization was the most protracted and heterogeneous in Europe. Austria and France liberalized elective abortion during the social reforms and feminist mobilizations of the 1970s (both in 1975), but the rest of the region followed considerably later: the Netherlands in 1984, Belgium in 1990, and Switzerland only in 2002 (and conditional on a declared state of distress, replacing a 1942 framework that had been

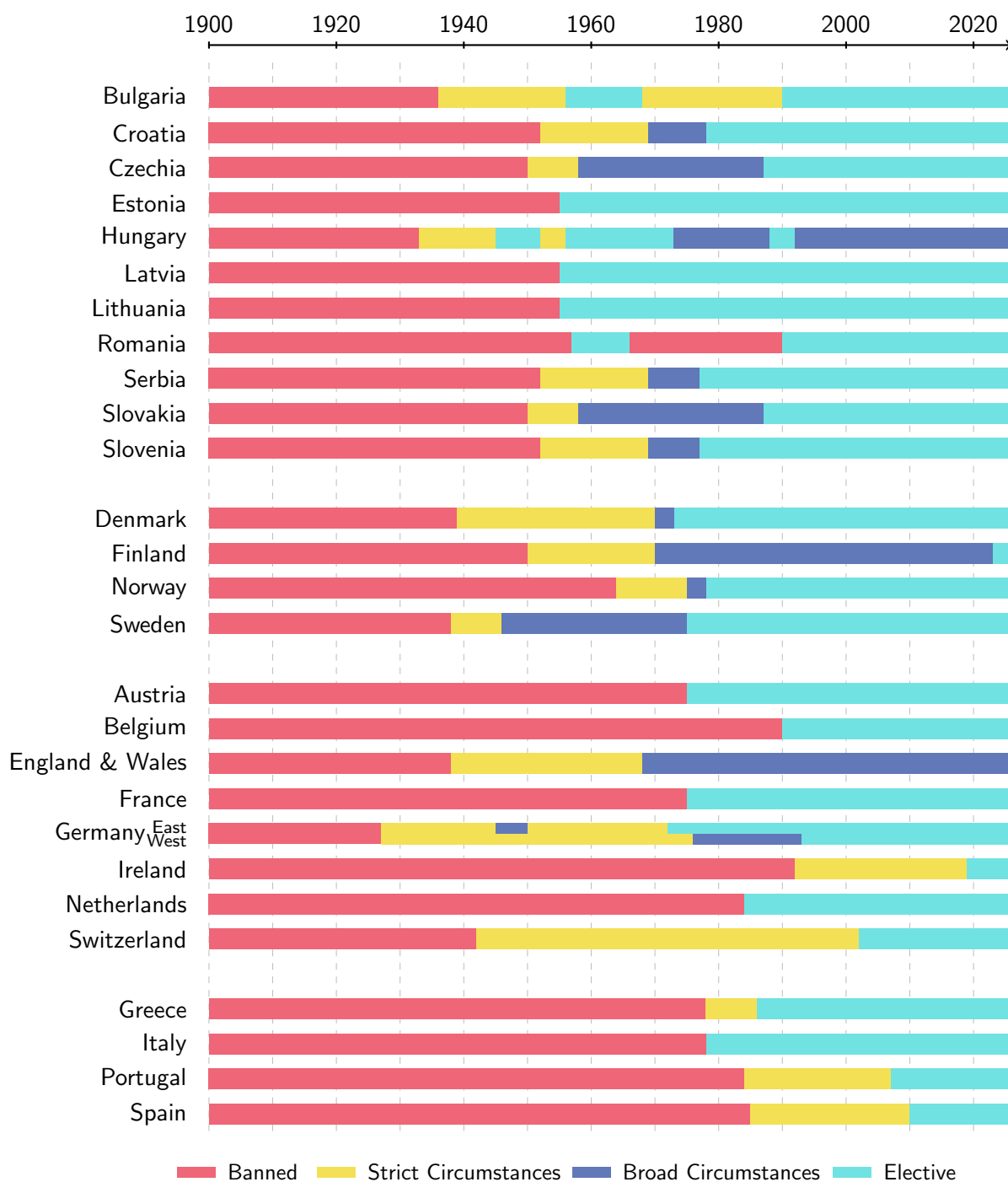
⁴Part of this recorded increase reflects previously clandestine procedures entering official statistics rather than a behavioral change.

⁵Finland is an exception, as it officially allowed elective abortion only in 2023, though abortion for broad socio-economic reasons was allowed since 1970.

applied very differently across cantons). Germany has a different setting, since under the counseling model established in 1993 and codified in 1995, abortion in the first 12 weeks remains formally unlawful though exempt from punishment. England and Wales is a formal exception, as the 1967 Act has never provided abortion on request but permits it on statutory grounds (mainly risk to the woman’s physical or mental health, certified by two doctors). In practice, these grounds are interpreted broadly, and early medical abortion has been available by telemedicine since 2020. Thus, access resembles that of on-request regimes even though the legal basis differs. Ireland maintained a near-total constitutional ban until the 2018 referendum, with elective abortion up to 12 weeks becoming available in 2019. Overall, Western European countries have mostly maintained low and steady rates over the last sixty years, with only France and England and Wales showing higher abortion rates, between 15 and 20 abortions per 1,000 women, until around 2020.

Southern Europe exhibits clear regional variation in timing. In Italy and Greece, liberalization occurred during the feminist and democratization waves of the late 1970s and 1980s. Conversely, Spain allowed abortion under specific circumstances in 1985, but elective procedures were officially legalized only in 2010. Similarly, Portugal maintained heavily restrictive regulation until a national referendum in 2007 finally decriminalized elective abortion in the first 10 weeks of pregnancy. Overall, the legislative hesitation across the region was structurally reinforced by religious traditions, which heavily contested these reforms. Elective access is now inscribed in law in all four countries, but significant administrative and structural barriers persist in practice (see Section 2.3). Abortion rates in the region have remained the lowest in Europe, though not uniformly so, since they declined continuously in Italy over the observed period while increasing in Spain.

Figure 2: Timeline of abortion regulation



Notes: The Figure reports changes in abortion access requirements over time (1990-2026). Red denotes absolute prohibition; yellow indicates abortion permitted strictly under narrow, exceptional circumstances (e.g., life-threatening or criminal indications); blue signifies access under broad socio-economic circumstances and distress clauses; turquoise represents abortion on request. For details, see Table A.7 in the Appendix. England and Wales is the only country not classified as elective by 2026: legislation requires two physicians to certify statutory grounds, though in practice access is broadly comparable to elective (see Section 2.3).

2.3. Institutional background

This section presents the institutions, regulations, social norms, and values related to abortion in the four country groups: Eastern, Northern, Western, and Southern Europe (see Figure 1). We draw information from the Abort-Report Project, the Center for Reproductive Rights, the European Institute for Gender Equality, the European Parliamentary Forum for Sexual & Reproductive Rights, the European Values Study, EUROSTAT, the Foundation for European Progressive Studies, the Generations & Gender Contextual Database, and the World Health Organization. Table A.6 in the Appendix details the definitions and sources of the variables used.

We investigate the institutional background across five domains: abortion regulation, access to contraception, family benefits and the wider economic environment, social norms and beliefs, and gender equality. Alongside these five domains, we indicate which countries have a state-socialist past.

Abortion regulation is captured by whether abortion is legal for reasons other than medical grounds or rape, whether a mandatory waiting period separates the request from the procedure, whether counseling or medical information from doctors is compulsory beforehand, whether women must justify the request by their social or family circumstances or by the distress that a continuing pregnancy would cause (CRR, 2023), whether medical abortion (abortion pill) is available (Abort-Report Project, 2023), and whether contraception information is included in post-abortion care (WHO, 2025). We also consider the monetary cost of an induced abortion (0: Free; 1: Low; 2: Middle or high; according to expert classification), the number of years since abortion became legal, and the gestational limit for abortion on request (FEPS, 2023).

Contraception is measured by scores for access to modern methods and for the availability of online information (EPF, 2020), and by actual contraceptive use (Generations and Gender Contextual Database, 2026).

To capture family benefits and the economic environment, we draw on evidence showing that child-related cash transfers (González, 2013; González and Trommlerová, 2021) and economic development (Gonzalez and Quast, 2022; Cihak, Kotrba and Borosova, 2025) influence abortion decisions. Accordingly, we consider family and child benefits (Eurostat, 2025a), both as a share of GDP and in euros per capita, and real GDP per capita (Eurostat, 2025b).

Norms and beliefs are measured by the share of respondents who consider abortion justifiable and who identify with a religious denomination, both taken from Fetterolf and Clancy (2024) using European Values Study data (EVS, 2017).

Gender equality is measured by the Gender Equality Index (EIGE, 2025). The GEI is a composite measure on a scale from 1 to 100, where 100 denotes full gender equality, built from six core domains: work, money, knowledge, time, power, and health. We report the overall index together with the power domain and its political, economic, and social subindices, which capture women’s representation in political decision-making, on corporate boards and central banks, and in research funding bodies, public broadcasting, and sport (EIGE, 2025).

These data show that the regulation of abortion, and the social norms and values surrounding it, vary substantially across the four regions. Historical trajectories, legal frame-

works, and religious-cultural background differ in ways that are reflected both in the conditions of access to abortion and in its social perception. Table 1 reports the underlying variables by region, and Figure 3 displays them as a radar chart in which the values are rescaled to a 0 to 1 range, so that only the relative position of the regions carries information.

In *Eastern Europe*, as discussed in the previous section, abortion has been legal for a relatively long time, although access fluctuated considerably over that period. Nonetheless, present frameworks carry a range of administrative restrictions: a third of the countries impose a mandatory waiting period, a third require counseling, and one in ten requires the woman to justify her request by distress. Abortion on request is usually allowed up to the 12th week of pregnancy, but it can carry medium to high costs when performed on request rather than for medical reasons, and medical abortion is legal in only half of the region’s countries. Access to modern contraceptive methods is the lowest out of the four regions, and only 58% of the population of reproductive age uses any form of contraception. Social norms are among the least permissive in Europe: 44% of respondents consider abortion justifiable, the lowest share of the four regions, while 67% identify as religious (Fetterolf and Clancy, 2024). Family benefits are low, at 1.7% of GDP and 260 purchasing power standards (PPS) per capita (against 810 PPS per capita in the West). Gender equality is the lowest of the four regions, with an average Gender Equality Index of 57 and a particularly low score in the power domain (24), indicating that women remain strongly underrepresented in political, economic, and social decision-making.

Northern Europe has the longest tradition of uninterrupted legal abortion, and all four countries apply a liberal framework today. None requires a waiting period between the request and the procedure, mandatory counseling or medical information sessions, or a justification on social, family or distress grounds. Abortion on request is generally available at low cost up to the 12th week of pregnancy, except in Sweden, where the limit is the 18th week, and medical abortion is available everywhere. Post-abortion care is the most consistently provided of the four regions. Information about contraception and access to modern methods are good, second only to Western Europe, while actual contraceptive use, at 74%, is the highest of the four regions. Social norms are equally permissive: 75% of respondents state that abortion can be justified (the highest share of the four regions), while 43% identify as religious (Fetterolf and Clancy, 2024). These countries also spend the highest share of GDP on family and child-related benefits, 3.1% (357 PPS per capita). Gender equality is the highest of the four regions, with an average Gender Equality Index of 71 and a power-domain score of 66.

In *Western Europe*, abortion has been legal for about four decades. The present frameworks are permissive in outcome but heterogeneous in law. Abortion on request is accessible under normal circumstances up to a limit ranging from the 12th week in most countries to the 24th week in the Netherlands, and medical abortion is available everywhere. The cost of abortion is high in German-speaking countries and low in the rest of the region. Germany is a distinctive case: under their counseling model, abortion in the first twelve weeks remains formally unlawful although exempt from punishment. 29% of the region’s countries require women to justify their request by distress, the highest share of the four regions, and an equal share requires counseling. Access to contraceptive information and to modern methods is the best of the four regions, and 70% of the population of reproductive age uses some form of

contraception. Social norms are permissive: 59% of respondents think that abortion can be justified, while 46% identify as religious (Fetterolf and Clancy, 2024). An average of 2.2% of GDP is spent on family and child-related benefits (810 PPS per capita). Gender equality is high, with an average Gender Equality Index of 67, second only to Northern Europe, though the region’s social power score of 37 falls well below its political power score of 71.

Southern Europe has the shortest history of legal abortion, but it has still been available for almost 30 years. While abortion on request is free of charge through the public healthcare system, access is often constrained by administrative requirements. Every country except Greece mandates a waiting period, and counseling or a distress-based justification is required in some. Abortion on request is permitted up to a limit ranging from the 10th week in Portugal to the 14th week in Spain, and medical abortion is available everywhere except Greece. A persistent structural barrier is medical conscientious objection, which is explicitly protected by statute in all Southern European countries except Greece. Contraceptive information and contraceptive use are the lowest of the four regions. Social norms are much less permissive than in the North and West: 47% of respondents agree that abortion can be justified, while 71% identify as religious (Fetterolf and Clancy, 2024). At 1.3% of GDP, family benefits are the lowest share of the four regions, though at 324 PPS per capita they exceed Eastern European levels. Gender equality, with an average Gender Equality Index of 63, is higher than in Eastern Europe but below Northern and Western European levels.

Overall, abortion is de facto legal for reasons other than medical grounds or rape in every country we study, and we leave out countries such as Poland from the analysis where this is not the case. What separates the four groups is not legality but the conditions attached to it, and those conditions do not create a clear ordering of the regions. Northern Europe is the only region that is permissive on every regulatory dimension at once: no country imposes a waiting period, mandatory counseling or a distress justification, medical abortion is available everywhere, and post-abortion care is the most consistently provided. Each of the other three regions combines permissive and restrictive features. Southern Europe has the most demanding procedural requirements, with a waiting period in 75 percent of its countries, yet abortion there is free of charge through the public healthcare system. Western Europe has the most generous gestational limit, at 16 weeks on average, and by far the best access to contraception and to contraceptive information, but also the largest share of countries requiring women to justify their request by distress. Eastern Europe has the second longest legal history, but the highest monetary cost, the lowest availability of medical abortion, and the weakest access to modern contraception.

On the contrary, norms, resources, and gender equality reveal a straightforward divide across Europe. Eastern and Southern Europe record similar shares of respondents who consider abortion justifiable and similar levels of religiosity, against higher justifiability and lower religiosity in the North and in the West. The same division appears in family benefits and in gender equality, where the starkest contrast is not the overall Gender Equality Index, whose regional scores span 14 points, but its power domain, which spans 42 points, and social power in particular, where Eastern Europe scores 17 against Northern Europe’s 60. The East and the South have arrived at their similar positions by opposite routes, however. Eastern European countries liberalized early under state socialism, with little access to contraception and abortion acting as a substitute, whereas Southern European countries liberalized late and against sustained religious opposition, with low abortion rates throughout.

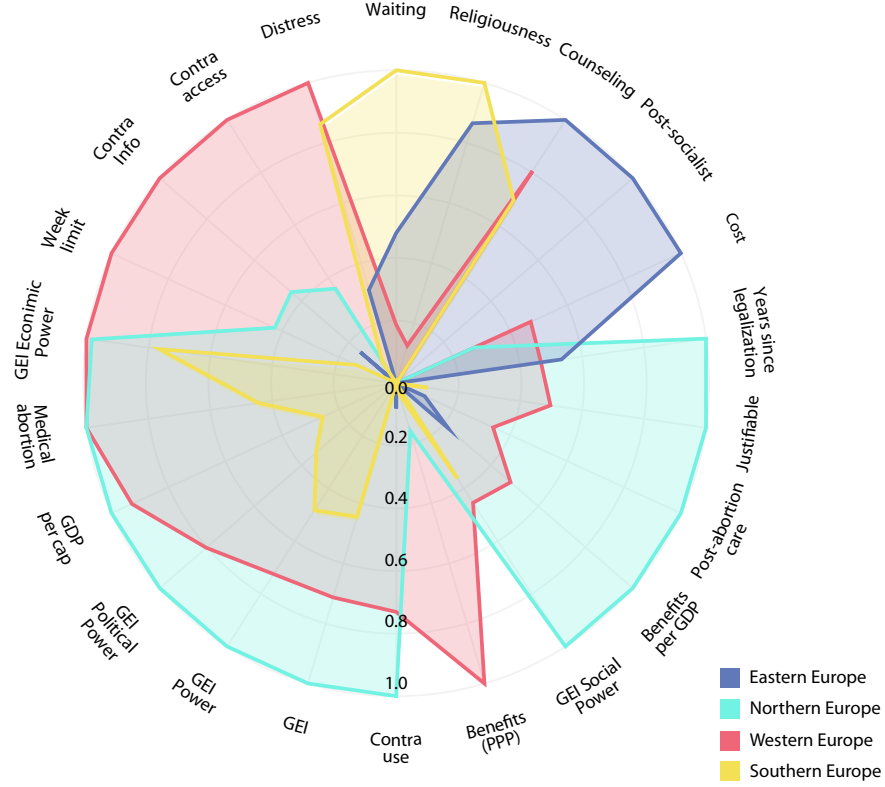
In general, the institutional differences among the four European regions that we documented are substantial and long-standing, which makes the convergence in abortion rates reported in Section 5 the more striking.

Table 1: Institutional environment regarding abortions

Region	East	North	West	South
Countries	BG, HR, CZ, EE, HU, LV, LT, RO, SK, SI, RS	DK, FI, NO, SE	AT, BE, EW, FR, DE, NL, CH	GR, IT, PT, ES
Number of countries	11	4	7	4
Post-Soc	100%	0%	0%	0%
Abortion Regulation				
Legal ^(a)	100%	100%	100%	100%
Medical Abortion	55%	100%	100%	75%
Years Since legalization	43.1	54.8	41.4	29.8
Waiting Period	36%	0%	14%	75%
Mandatory Counseling	36%	0%	29%	25%
Distress Justification	9%	0%	29%	25%
Cost	1.8	0.5	0.9	0.0
Post-Abortion Care	0.6	1.0	0.7	0.5
Limit in Weeks	11.6	13.5	16.0	12.3
Contraception				
Contraception Access	53.0	61.4	76.4	55.0
Contraception Information	55.5	68.3	92.4	49.0
Contraception Usage	58.0	74.3	69.5	56.6
GDP and Family Benefits				
GDP per Capita	12651.8	48310.0	45761.9	21882.5
Benefits (% of GDP)	1.7	3.1	2.2	1.3
Benefits (PPP per capita)	260.18	357	810.14	324.75
Norms and Beliefs				
Abortion Justifiable	43.7	75.3	59.4	46.9
Religiousness	66.8	42.6	46.1	70.6
Gender Equality				
Gender Equality Index (GEI)	56.92	71.27	67.16	63.3
GEI - Power	24.01	66.2	54.6	44.38
GEI - Political power	34.29	80.53	71.42	49.95
GEI - Economic power	26.93	63.9	64.54	55.68
GEI - Social power	17.25	60.47	36.88	32.88

Notes: The source of the data and the definitions are detailed in Table A.6. ^(a) Legal here means "de facto" legal. In some countries, such as Germany, abortion is generally covered by the criminal code, but an abortion requested within 12 weeks of conception is not punishable if the person obtains required counseling, waits at least three days, and a doctor performs it. That is often described as de facto available but not generally de jure lawful.

Figure 3: Radar chart of the institutional environment, by region



Notes: The chart uses the data of Table 1 to summarize the main differences of the institutional environment. The values on the chart are rescaled to 0–1; only the relative position of the region lines carries information. The source of the data and the definitions are detailed in Table A.6.

3. Data on abortion rates

Our database covers 26 European countries between 1999 and 2023 and records, where available, the number of induced abortions and the female population aged 15 to 49, in total and by age, parity, and educational attainment. We assembled it in two steps.

We first collected open-access data on abortion counts and female population from EUROSTAT, the World Health Organization, the Abort-Report Project, the Human Fertility Database, Johnston’s Archive, and national statistical offices and ministries. Tables A.3 and A.4 in the Appendix report the source used for each country and dimension, and where data can be obtained.

We then combined these with country-level aggregates created from administrative register data for Czechia, Finland, Hungary, Slovakia, and Spain and detailed public data for Italy and England and Wales. The Czech register is openly available, while the Finnish, Hungarian, Slovak, and Spanish data were obtained under agreements with the responsible

national authorities. For Italy, we constructed detailed subgroup series from published abortion surveillance reports and statistical yearbooks from the Ministry of Health and ISTAT. These sources supply most of the subgroup information: parity for Czechia, Finland, Hungary, and Slovakia, and educational attainment for those four countries and Italy. These are dimensions that the aggregate sources almost never report. The Spanish register contributes total and age-specific counts. Parity data for England and Wales come from the published national statistics listed in Table A.3. Table A.5 describes each register.

Coverage is uneven across countries, years, and dimensions. Table A.2 and Figures A.11-A.13 show which countries and years are available for the total abortion rate and for each subgroup dimension: the woman’s age in five-year groups, parity (no previous birth versus at least one), and educational attainment (primary, secondary, and tertiary). We deliberately favor coverage over strict comparability, using all available observations rather than restricting the analysis to a balanced panel of countries and years. Note that the data also differ in the population they cover, as documented in Table A.5. Austria is a special case: it has no abortion registration system, since abortion on request is neither notifiable nor covered by health insurance, and no official national statistics therefore exist (Fiala et al., 2022). Thus, we include Austria in the institutional description in the previous section but not in the analysis of abortion rates.

We define the abortion rate as the number of abortions per 1,000 women aged 15 to 49, within each subgroup. We also report the abortion ratio, i.e., the number of abortions per live birth, which does not depend on the female population size. Therefore, it helps to distinguish changes in abortion behavior from changes in fertility.

4. Decomposition method

In this study, our most policy-relevant questions are the following: What is the source of the abortion trends observed? Do these changes stem from changes in population structure (composition effect), or changes in abortion rates in particular subpopulations?

To answer this question, we perform the decomposition of the abortion rates along three dimensions: age, parity, and educational level for each country with available data. The groups in the age decomposition are women aged 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, and 45-49. In the parity decomposition, we split women into those with zero versus at least one child. In the education decomposition, we use the International Standard Classification of Education (ISCED) categories (European Commission, 2025). We use three categories: primary (ISCED 0 to 2), secondary (ISCED 3, 4), and tertiary (ISCED 5 to 8) education.

We describe the decomposition method in detail in Section A1.1 in the Appendix. To calculate the composition effect, we first fix the initial population composition of a country (share of groups within the population) in the first year of observation between 1999 and 2023. Then, we let group-specific abortion rates change as they did in real life, throughout the observation period in the country. Then, in the last year of observation, we compute the difference between the actual and the calculated (with fixed composition) change in the abortion rate over time. This difference is the change in abortions due to composition change.

Similarly, to compute changes in abortions due to the abortion rate change in a particular group, we fix the initial abortion rate of the group and calculate its later abortion rates,

letting the population composition and the abortion rates of other groups change as they actually did. In the last year of observation, we compute the difference between the actual and the calculated (with a fixed abortion rate in that group) change in the abortion rate over time. This difference is the change in abortions due to the abortion rate change in that group.

The decomposition is calculated for all available countries and years in a given dimension. We document data availability in each dimension in Section A1.2. As Figures A.11, A.12, and A.13 indicate, there is a strong tradeoff between harmonized, comparable data and data coverage, as mentioned in the introduction. In this article, we always choose data coverage over comparability, which means that the decomposition results may include very different years by country. Even though the decomposition results should be interpreted with caution, they seem to perform well in catching the overall trends. We use them to draw cautious conclusions.

5. Results

5.1. Overall abortion trends in Europe

Between 1999 and 2023, abortion rates converged substantially across Europe (Figure 4). Despite this convergence, important regional differences persisted throughout the study period. Eastern Europe experienced the most pronounced decline in abortion rates. However, initial levels and paces of decrease differed. Croatia, Czechia, Slovakia, and Slovenia started at lower levels and the decline was gradual, whereas Romania, Estonia, and Bulgaria experienced exceptionally rapid declines, from levels exceeding 30 abortions per 1,000 women aged 15–49 in 1999 to fewer than 15 per 1,000 by the early 2020s.

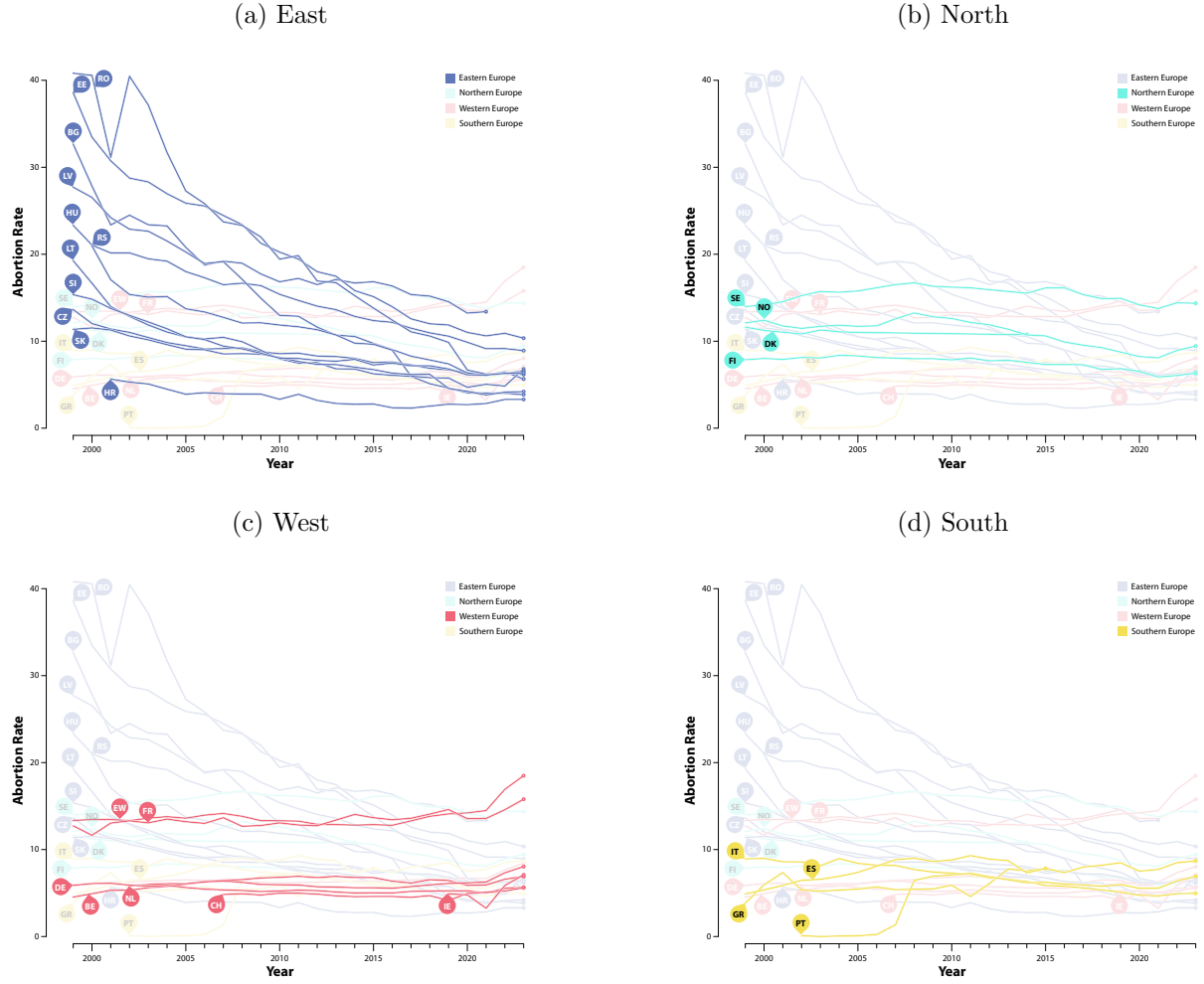
Western Europe displayed a different pattern: In most countries, abortion rates remained relatively stable at low levels up until 2021, followed by some increase in recent years. France and England and Wales consistently exhibited higher abortion rates than other countries in the region.

Northern European countries also maintained relatively stable rates throughout the period, while the lowest levels were observed in Southern Europe. Developments in Southern Europe, however, were not homogeneous. Whereas Italy experienced a small but continuous decline in abortion rates over the study period, Spain, Portugal, and Greece displayed increases followed by new plateaus.

Since 2021, a substantial increase in abortion rates has been observed in several, mainly Western European countries, most notably in England and Wales, the Netherlands, and France. This increase contrasts with the longer-term pattern of declining or stable abortion rates observed across most European countries.

Trends in the abortion ratio closely mirror trends in abortion rates (Figures A.15 and A.14), suggesting that the convergence reflects a real narrowing of differences in the incidence of induced abortion across Europe. Thus, this convergence is not driven by differences in fertility trends across European regions, which varied considerably in both the quantum and the tempo of fertility change during the study period.

Figure 4: Abortion rates in countries by region (1999-2023)



Note: Abortion rate: number of abortions per 1000 women of age 15-49.

5.2. Differential abortion rates by age, parity, and education

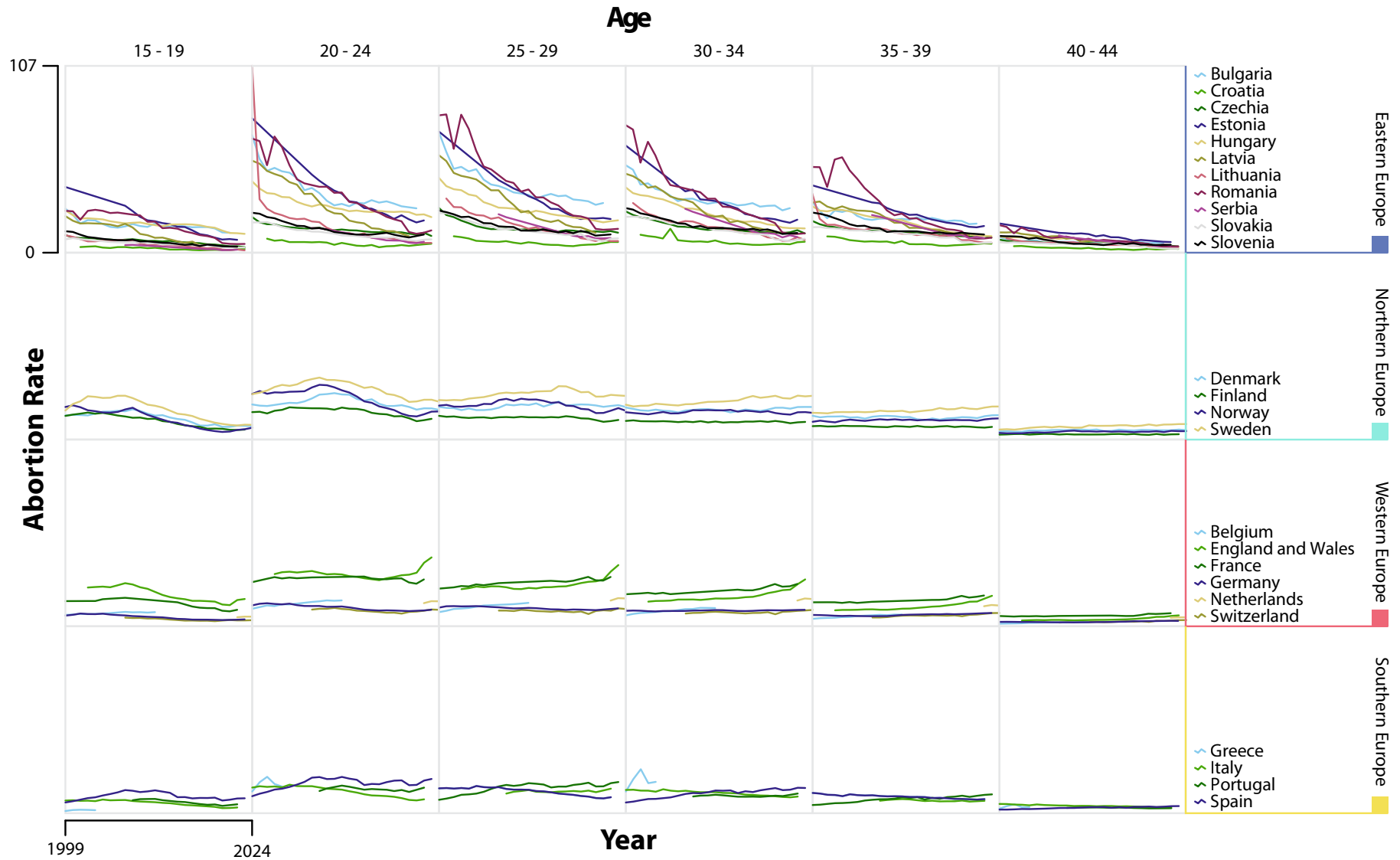
While overall abortion rates converged across Europe, important differences may have persisted across age groups, parity categories, and educational levels. The following analyses examine whether the aggregate trends described above were universal across these subgroups.

5.2.1. Age

An examination of age-specific abortion rates (Figure 5) shows that, while trends in Eastern Europe were relatively uniform between 1999 and 2023, changes in other European regions were more heterogeneous across countries. In Eastern Europe, abortion rates declined across all countries and age groups under study, with the most pronounced decreases generally observed among women in prime reproductive age (20–34 years). In Northern Europe, abortion rates declined primarily among younger women aged 15–24 years. At the same time, Sweden experienced modest increases in abortion rates at older reproductive ages (30–44 years). Another noteworthy feature is the reversal of declining trends among ages

20-29 in Norway after 2021. France and England and Wales share a similar age profile. In France, the increase in abortion rates after 2021 was concentrated primarily among women at younger and prime ages (20-34 years). In England and Wales, however, rising abortion rates among women of this age were already evident before 2021, suggesting that the post-pandemic period further reinforced an existing trend there rather than initiating it. In most other Western European countries, age-specific abortion rates remained relatively stable, characterized by modest declines among younger women and slight increases among women aged 30+. Southern Europe exhibits considerable country heterogeneity. While Italy experienced declining abortion rates across all age groups, Spain displayed the opposite pattern, with abortion rates increasing (and plateauing) across most reproductive age categories.

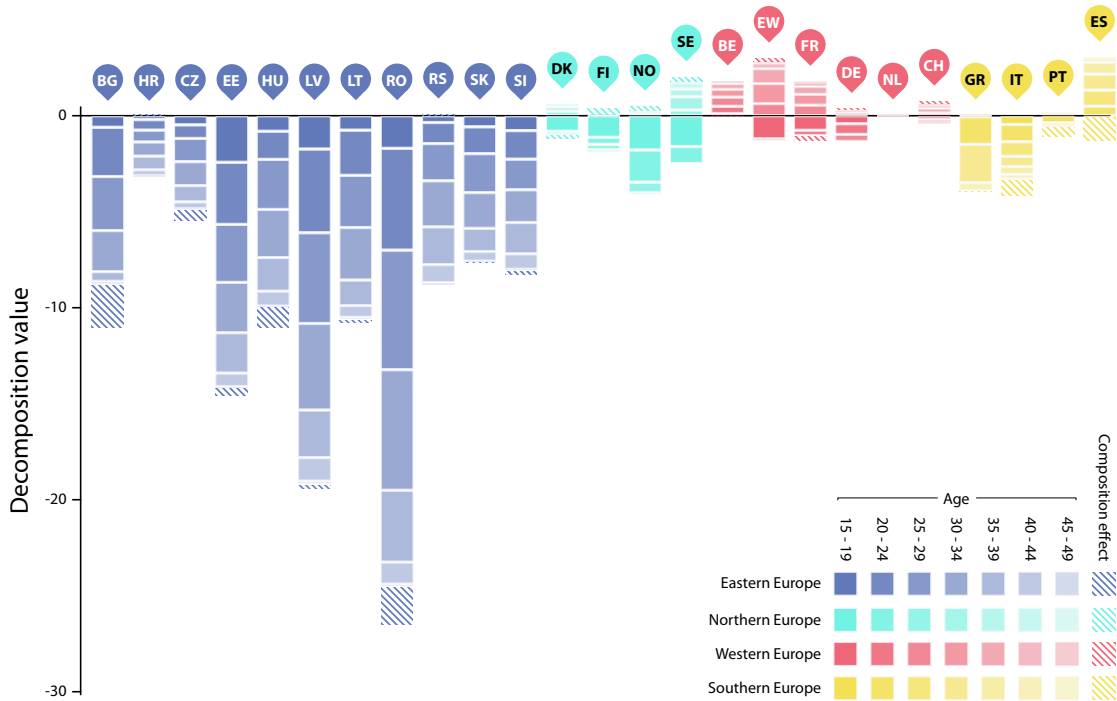
Figure 5: Abortion rates by age category



Note: Abortion rate: number of abortions per 1000 women of the relevant age group. In the case of Denmark, Norway and Sweden, the abortions in the 40-44 age group include all abortions of women of age 40 or older.

The decomposition of changes in the overall abortion rate by age (Figure 6) indicates that the decline in abortion rates in Eastern Europe was driven both by changes in age-specific abortion intensities and by shifts in the population age structure. In Northern and Western European countries, while the overall rates are roughly stable on average, there is a "negative" contribution from the decline in abortion rates among younger women (15-24). By contrast, older age groups made a "positive" contribution to the changes in abortion rates, as did changes in the age structure of the population. This pattern did not hold, however, in France and Denmark. A markedly different trend can be observed in the two Southern European countries included in the analysis. In Italy, both changes in age-specific abortion rates and shifts in the age structure of the population contributed to the decline in the overall abortion rate. In Spain, by contrast, abortion rates increased despite a "negative" compositional effect (that is, changes in the age composition of the population would have led to a decline in the abortion rate). This increase was driven by rising age-specific abortion rates across all age groups.

Figure 6: Decomposition of the changes in abortion rates by age

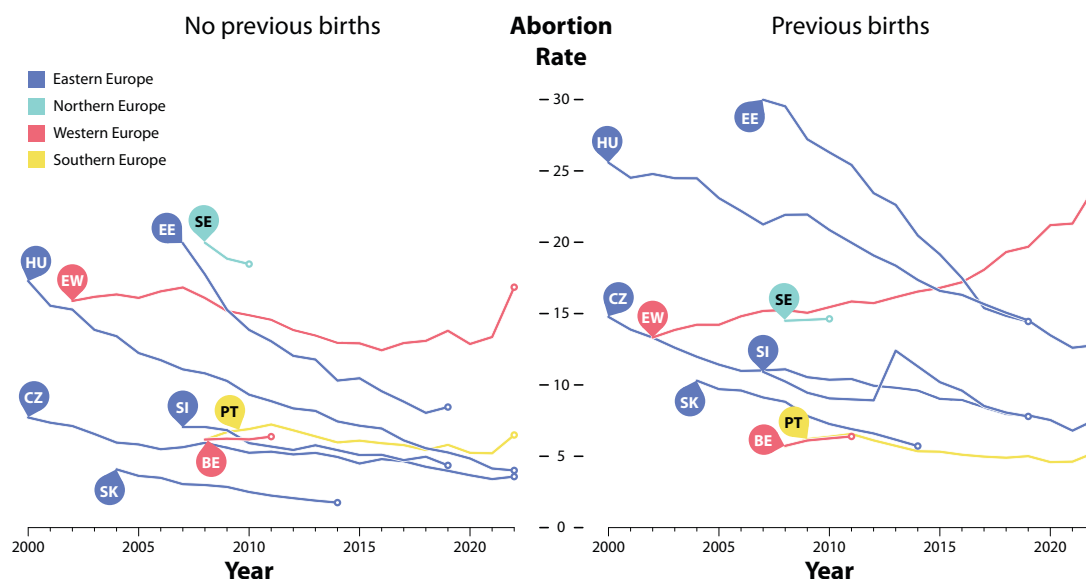


Note: The decomposition method is detailed in Sections 4 and A1.1. The starting and final years of the decomposition differ by country subject to data availability; see Figure A.11 for the included years. In the case of Denmark, Norway, and Sweden, the 40-44 age group includes all abortions of women aged 40 or older.

5.2.2. Parity

Compared to age-specific analyses, the parity-specific analysis of abortion rates is more constrained by data availability. Figure 7 shows that in most countries, total abortion rates tended to decline among both childless women and women who already had children. In Hungary and Estonia, the decline was rather steep, starting from relatively high levels. Exceptionally, in the case of England and Wales, abortion rates among women who had already given birth increased throughout the entire observation period. In contrast, abortion rates among childless women there showed a slight decline from 2007 until 2016, followed by stagnation, and a jump-wise increase after 2021. Interestingly, a similar increase in abortion rates after 2021 can also be observed among Portuguese women, especially the childless ones. In Eastern Europe, the abortion rate was higher among women who had any children than among childless women. In Portugal, Belgium, and England and Wales, the abortion rate levels were similar between women with different parity, on average.

Figure 7: Abortion rates by parity

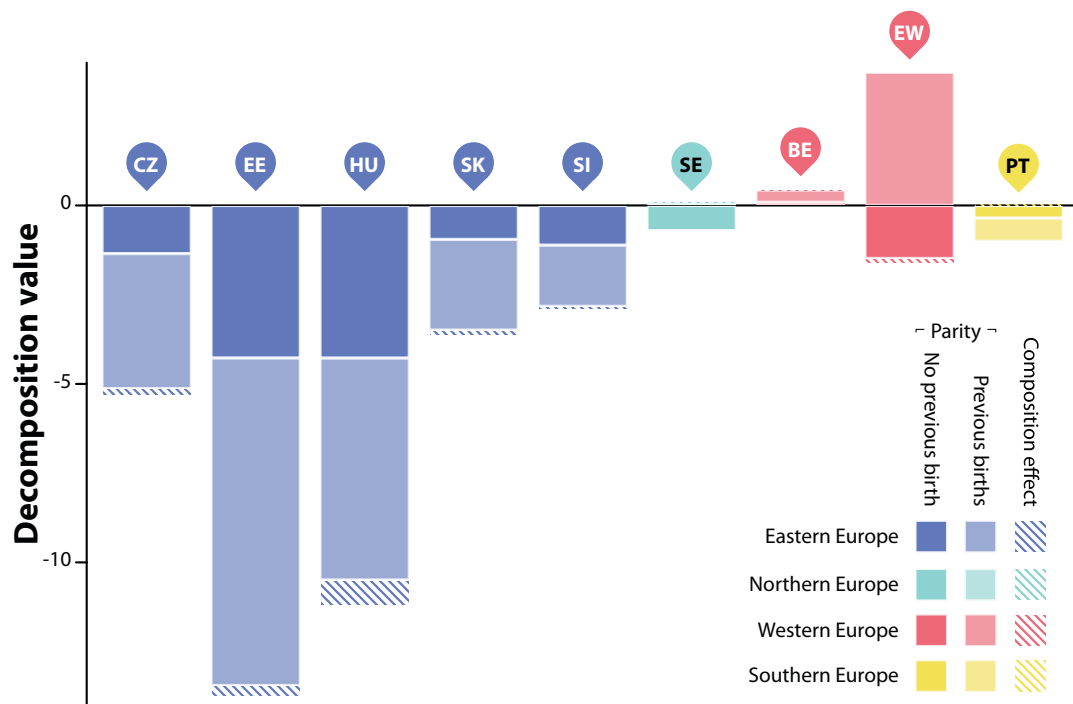


Note: Abortion rate: number of abortions per 1000 women of age 15-49.

In terms of decomposition, the decline in abortion rates in Eastern Europe was driven primarily by reductions among women who already had children, but childless women and to a lesser extent also compositional changes contributed to the overall decline as well (Figure 8). England and Wales were an exception, where increasing abortion rates among women with at least one child counteracted decreases among childless women and slight "negative" compositional changes, leading to a rather stable total abortion rate during most of the observation period (see Figure 4).

In general, compositional changes in parity contributed very little to the observed changes in the abortion rate. In most cases, the contribution was "negative", exceptions being Sweden, Belgium, and Portugal (Figure 8).

Figure 8: Decomposition of changes in abortion rates by parity

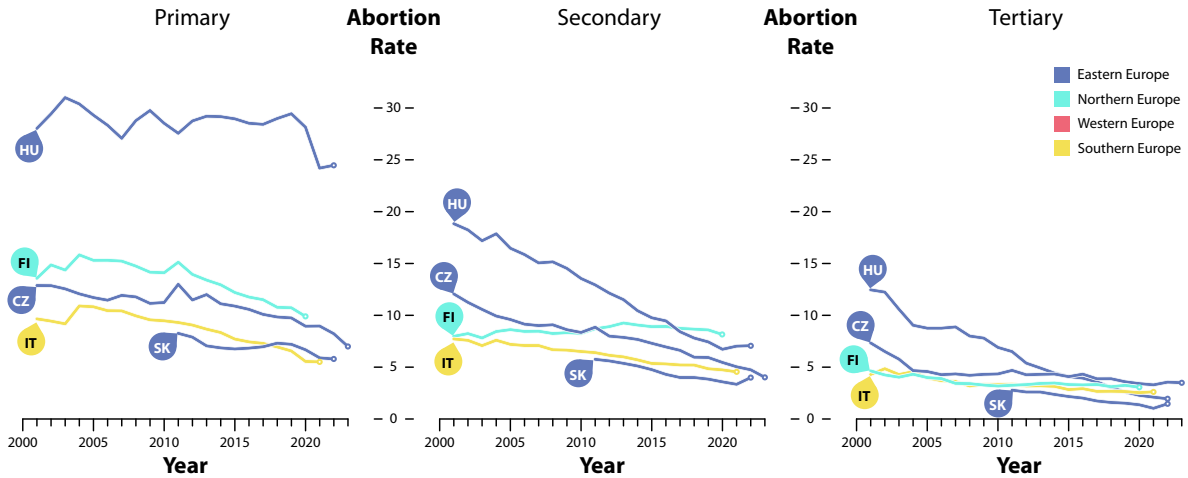


Notes: The decomposition method is detailed in Sections 4 and A1.1. The starting and final years of the decomposition differ by country according to data availability. For the included years, see Figure A.12.

5.2.3. Education

Information on the educational attainment of women undergoing induced abortions is among the least available characteristics in the studied countries, yet it adds valuable insights into the existing knowledge. Despite data limitations, the results reveal a remarkably consistent pattern (Figure 9). In all countries examined, a negative educational gradient is evident. Women with primary education exhibit the highest abortion rates, while women with tertiary education the lowest rates. At the same time, abortion rates declined within almost all educational groups over the study period, leading to rather persistent educational gradients. In Hungary, the gradient even widened, as abortion rates of least educated women stagnated.

Figure 9: Abortion rates by education level



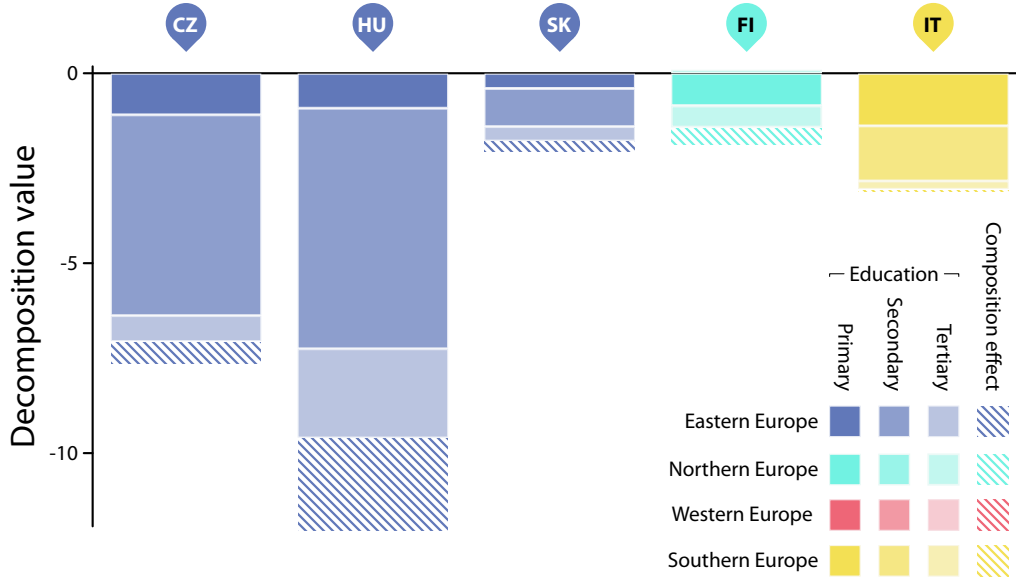
Note: Abortion rate: number of abortions per 1000 women of age 15-49.

The decomposition analysis shows that both changes in the abortion rates within educational groups and, to a lesser extent, improvements in the educational level of the female population, contributed to the decline in the overall abortion rate during the period in the five countries examined (Figure 10). The pronounced overall declines in abortion rates in Eastern Europe (Czechia, Hungary, Slovakia) were strongly driven by declines in abortion rates among women with secondary education. In contrast, in Italy and Finland, it was abortion rate declines in both primary and secondary educational groups that contributed to the overall decline. In general, the contribution of the composition effect is much stronger in education than in parity groups, where it was hardly noticeable.

6. Discussion and conclusions

This study provides a comprehensive assessment of induced abortion dynamics across European regions over the past 25 years (1999-2023), including how these trends differ by age, parity, and education. Our main contribution is the construction and use of a broad

Figure 10: Decomposition of the changes in abortion rates by education



Notes: The decomposition method is detailed in Sections 4 and A1.1. The starting and final years of the decomposition differ by country according to data availability. For the included years, see Figure A.13.

comparative database on abortions in Europe, combining publicly available sources with restricted administrative data for selected countries. This allowed us to cover a wider range of countries, years, and population subgroups than is usually available in comparative research. We documented both long-term and recent trends in abortion rates and abortion ratios, and complemented them with decompositions by age, parity, and education. The decomposition separates changes in group-specific abortion rates from changes in the composition of female population. Throughout, we interpreted country-level trends via a regional classification, because legal frameworks, welfare institutions, contraceptive access, and family norms differ systematically across the continent.

Abortion rates declined substantially across Europe. Despite large differences in the legal and normative embeddedness of abortion, we observed strong convergence across countries. This convergence was driven primarily by large declines in Eastern Europe, where abortion rates were much higher at the beginning of the observation period. Large differences observed in 1999 largely reflected distinct historical developments (see Figure A.16). Induced abortion rates were considerably higher in post-socialist countries than elsewhere in Europe, partly because modern contraceptive methods were historically less available there. As a result, a substantial share of unintended pregnancies in Eastern Europe was resolved through induced abortions (Bongaarts and Westoff, 2000). The rapid diffusion of modern contraception after 1990 likely contributed to the substantial decline in abortion rates across much of the region (Frejka, 2008). By the 2010s and early 2020s, these differences had narrowed considerably. The comparison between Northern and Southern Europe shows that similar abortion outcomes may emerge through different reproductive regimes. Low abortion rates

in Northern Europe are likely closely associated with widespread contraceptive use, whereas the Southern European pattern suggests that cultural norms, family systems, and religious traditions also play an important role in shaping reproductive behavior.

The decline in abortion rates was visible across most demographic and socioeconomic groups, but the size and structure of the decline differed. In Eastern Europe, abortion rates declined across all countries and age groups, with the most pronounced decreases generally observed among women in prime reproductive age (20-34). Changes in population's age structure also contributed to the decline in abortion rates in Eastern Europe. In Northern and Western Europe, the decline was driven mainly by decreasing abortion rates among younger women (15-24), while older age groups and age composition changes often contributed in the opposite direction. This pattern is consistent with the broader postponement of family formation and suggests that abortion is increasingly connected not only to early reproductive transitions, but also to decisions about the timing, spacing, and completion of childbearing later in the life course.

Parity was a central dimension of abortion trends. In countries where parity-specific data were available, the decline in abortion rates was driven primarily by reductions among women who already had children, although childless women and compositional changes also contributed to the overall decrease. This pattern was particularly visible in Eastern Europe. One possible explanation is that unintended pregnancies are more often carried to term when women do not have children yet, as having at least one child remains a strong desire for many. Women who have already reached their desired family size may be more likely to terminate an unintended pregnancy. At the same time, parity patterns should be interpreted with caution, because parity is closely linked to age and family formation histories. The available data did not allow us to fully disentangle these dimensions across countries.

Although the number of countries with abortion data by educational background was limited, the decomposition showed that the decline in abortion rates was driven mainly by decreasing abortion rates among women with secondary education. Abortion rates declined across all educational groups, but the decline was slower among women with the lowest educational attainment, thus contributing to a persistent educational gradient over time. One possible explanation is the increasing selectivity of this group. As (women's) educational attainment has risen across Europe ([Delaney et al., 2020](#)), women with only primary education may have become a smaller and more disadvantaged subgroup, often facing economic insecurity, weaker labour market attachment, or other forms of social disadvantage. This interpretation is consistent with evidence from England and Wales showing higher abortion rates in socioeconomically deprived populations and areas ([Solomon et al., 2024](#)). Compositional change, driven by educational expansion, also contributed to the decline in abortion rates, although to a lesser extent. The persistence of differences by parity and educational attainment further suggests that reproductive behavior remains strongly stratified along social and family-life dimensions. Abortion seems to be continuously linked not only to fertility regulation but also to broader forms of social inequality that influence reproductive opportunities and constraints.

The decomposition results corroborate the aggregate convergence story. In most cases, changes in group-specific abortion rates were the dominant factor behind the decline in overall abortion rates, while demographic compositional changes contributed to a lesser extent. This means that aggregate trends cannot be explained only by changes in the age, parity, or

educational structure of the population. Instead, they reflect behavioral shifts in reproductive decision-making among women with given demographic or socioeconomic characteristics. At the same time, the contribution of compositional changes was not negligible (except for parity), especially in contexts where the population structure changed substantially. For example, in Spain between 2000 and 2023, changes in the age composition of the female population contributed "negatively" to the overall abortion rate, while increasing age-specific abortion rates across age groups more than offset this compositional effect.

Importantly, the period of convergence appears to be coming to an end, as abortion rates have started to increase in several countries post 2020. At this point, we cannot determine whether the observed upward pattern in 2021-2023 represents a new stable trend because a longer period of observation is needed. Nevertheless, the most recent data suggest two important developments. The long period of convergence, particularly in Eastern Europe, may have ended around 2020, and several Northern and Western European countries show signs of a rebound post 2020.

What makes this recent development particularly puzzling is that the rise in abortion rates began during the post-pandemic period, when fertility continued to decline across much of Europe (Ohlsson-Wijk and Andersson, 2025). This pattern is somewhat unexpected because fertility declines in recent decades have generally been accompanied by declining abortion rates. Lower fertility rates have typically reflected more effective fertility regulation through modern contraception, thereby reducing both fertility and abortion rates simultaneously (Bongaarts and Westoff, 2000; Kocourková, 2019). The concurrent occurrence of declining fertility and increasing abortion rates may therefore indicate a different underlying mechanism than previously.

However, the observed increase in abortions is unlikely to be explained by changes in contraceptive use. Recent research suggests that the relationship between modern contraceptive use and induced abortion rates is not necessarily straightforward, and that declining contraceptive use does not automatically lead to increasing abortion rates (Idlbeková and Kocourková, 2026). An alternative explanation is that growing economic and social uncertainty during the post-pandemic period may have changed reproductive intentions or life circumstances, leading to higher likelihood of terminating already established pregnancies. At the same time, it may be that part of the recent increase in abortions reflects a growing share of pregnancies terminated for medical reasons. This possibility is particularly important because induced abortions performed for medical reasons versus at a woman's request represent fundamentally different reproductive experiences and fulfill different functions within the reproductive life course (Slabá, Šťastná and Kocourková, 2026). Unfortunately, the available data do not contain information on the reasons for pregnancy termination, making it impossible to distinguish between these mechanisms.

Another possibility is that part of the recent increase reflects changes in how abortion is provided. During the COVID-19 pandemic, several European countries introduced or expanded telemedicine for early medical abortion, allowing remote consultation, the use of both mifepristone and misoprostol at home, and in some cases delivery of the medication by mail (Moreau et al., 2021). England and Wales adopted these arrangements temporarily in 2020 and made them permanent in 2022, while France legalized teleconsultation permanently in 2022 alongside an extension of the gestational limit (Table A.7). Germany and Belgium made similar use of remote provision. Three of the countries with the largest increases after

2021 in our data, England and Wales, Portugal, and France, are among these countries that adopted remote provision of abortion. Easier access may raise measured abortion rates by removing practical barriers, and to a small extent by moving procedures that previously took place outside the formal system, through self-managed online provision, into official statistics: requests to online telemedicine providers from Great Britain fell by 88 per cent once fully remote services became available (Aiken et al., 2021). However, this mechanism is likely marginal, since the increase among women aged 20 to 34 in England and Wales was already visible before 2020, and other countries with substantial recent increases in abortions, including the Netherlands, did not introduce comparable remote abortion options.

More broadly, the present study contributes to our understanding of reproductive behavior patterns in Europe during the first two decades of the 21st century and the early 2020s. While total fertility rates diverged across European countries in the first decade of the century (Sobotka, 2011; Frejka and Gietel-Basten, 2016), they converged in the 2010s as fertility declined in many countries with relatively high rates (Hellstrand et al., 2021). The present study provides evidence of concurrent convergence in abortion rates during the 2010s, driven by particularly large declines in Eastern Europe. Reproductive behavior has thus become more similar across European countries, both in terms of occurrence of an induced termination of a pregnancy and in terms of occurrence of a pregnancy leading to a childbirth, albeit with persistent population heterogeneity.

Taken together, our findings contribute to the literature in three ways. First, the paper provides a more comprehensive descriptive account of abortion trends in Europe than was previously available from single data source or single country analyses. Second, it documents both the convergence of abortion rates and the possible end of this convergence period, while showing that aggregate convergence coexists with persistent heterogeneity across population subgroups. Third, we demonstrate the value of decomposition methods for abortion research by distinguishing changes in group-specific abortion rates from changes in the relative size of population groups.

Our findings carry important implications for the design of reproductive health policies. The persistence of educational gradients suggests the importance of access to reliable contraceptive information, affordable contraception, and reproductive health services for socially disadvantaged groups. Finally, the weak link between cross-national variation in the institutional context of abortion and observed abortion trends hints that legal and institutional frameworks might influence abortion levels but not necessarily trends.

The paper also has important limitations. First, data availability differs across countries, years, and subgroup dimensions. We chose to use the widest possible set of available information rather than restricting all analyses to a perfectly balanced sample. However, this means that cross-country comparisons must be interpreted with care. Second, definitions and reporting practices may differ across countries, especially regarding the inclusion of medical indications and the distinction between abortions on request and abortions for medical reasons. Third, the decomposition analyses are limited to the countries and dimensions for which sufficiently detailed data are available. Fourth, the analysis is descriptive. It documents patterns and decomposes changes, but it does not estimate causal effects of specific policies, economic conditions, contraceptive access, or cultural norms.

Future research should build on this database in several directions. A first priority is to improve harmonization and coverage, especially for subgroup-specific abortion data by age,

parity, education, and reason for pregnancy termination. A second direction is to connect abortion trends more directly to fertility trends, contraceptive use, economic uncertainty, and family policy. A third direction is to examine whether recent post-pandemic changes represent a temporary fluctuation or a new phase in European reproductive behavior. Finally, future work could move from descriptive comparisons to causal analyses if institutional changes, policy reforms, or administrative data structures make such research designs possible. The evidence presented here provides a foundation for the proposed next steps by showing that European abortion trends can only be fully understood when aggregate convergence is studied together with (persistent) subgroup differences.

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A1. Supplementary material

A1.1. Decomposition of changes in abortion rates

To assess the factors underlying changes in the aggregate abortion rate, we decompose the observed change into changes associated with (i) changes in the composition of the population across groups and (ii) changes in group-specific abortion rates. The approach relies on counterfactual calculations in which one component is held fixed at its value in the first year of observation, while all other components are allowed to evolve as observed. Conceptually, this approach is related to demographic decomposition methods that distinguish changes in population composition from changes in group-specific demographic rates (see, for example, [Reimondos et al., 2025](#)).

Let a_{gct} denote the abortion rate of group g in country c and year t , and let p_{gct} denote the share of group g in the relevant population. The aggregate abortion rate is

$$A_{ct} = \sum_{g=1}^G p_{gct} a_{gct}. \quad (\text{A.1})$$

For each country, let t_0 denote the first year for which observations are available and t_1 the last year. The country-specific observation windows fall within the period 1999–2023. The observed change in the aggregate abortion rate is

$$\Delta A_c = A_{ct_1} - A_{ct_0}. \quad (\text{A.2})$$

A1.1.1. Population composition

We first quantify the contribution of changes in population composition. To do so, we construct a counterfactual abortion rate in which the population composition is fixed at its initial, country-specific level, while group-specific abortion rates are allowed to evolve as observed. Specifically,

$$A_{ct}^{\text{comp}} = \sum_{g=1}^G p_{gct_0} a_{gct}. \quad (\text{A.3})$$

Thus, A_{ct}^{comp} represents the abortion rate that would have prevailed in year t if the relative size of each population group had remained at its initial level, while abortion rates within the groups had evolved as they actually did.

The counterfactual change in the abortion rate between the first and last years is

$$\Delta A_c^{\text{comp}} = A_{ct_1}^{\text{comp}} - A_{ct_0}^{\text{comp}}. \quad (\text{A.4})$$

Since the actual and counterfactual population compositions are identical in the initial year,

$$A_{ct_0}^{\text{comp}} = A_{ct_0}. \quad (\text{A.5})$$

The contribution associated with changes in population composition is defined as the difference between the observed change and the counterfactual change:

$$C_c = \Delta A_c - \Delta A_c^{\text{comp}}. \quad (\text{A.6})$$

Since the actual and counterfactual rates are identical in the initial year, this is equivalent to

$$C_c = A_{ct_1} - A_{ct_1}^{\text{comp}}. \quad (\text{A.7})$$

A positive value of C_c indicates that changes in population composition contributed to a higher aggregate abortion rate relative to the counterfactual scenario in which population composition remained unchanged. A negative value indicates that compositional changes contributed to a lower aggregate abortion rate.

A1.1.2. Changes in group-specific abortion rates

We next quantify the contribution associated with changes in the abortion rate of each population group separately. For a given group k , we construct a counterfactual abortion rate in which the abortion rate of group k is fixed at its initial level, a_{kct_0} . Population composition and the abortion rates of all other groups are allowed to evolve as observed. Specifically,

$$A_{ct}^{(k)} = p_{kct} a_{kct_0} + \sum_{\substack{g=1 \\ g \neq k}}^G p_{gct} a_{gct}. \quad (\text{A.8})$$

Thus, $A_{ct}^{(k)}$ represents the aggregate abortion rate that would have prevailed if the abortion rate of group k had remained at its initial level, while population composition and abortion rates among all other groups had changed as they actually did.

The corresponding counterfactual change between the first and last years is

$$\Delta A_c^{(k)} = A_{ct_1}^{(k)} - A_{ct_0}^{(k)}. \quad (\text{A.9})$$

Because the actual and counterfactual abortion rates coincide in the initial year,

$$A_{ct_0}^{(k)} = A_{ct_0}. \quad (\text{A.10})$$

The contribution associated with the change in the abortion rate of group k is then defined as

$$R_{kc} = \Delta A_c - \Delta A_c^{(k)}. \quad (\text{A.11})$$

Equivalently,

$$R_{kc} = A_{ct_1} - A_{ct_1}^{(k)}. \quad (\text{A.12})$$

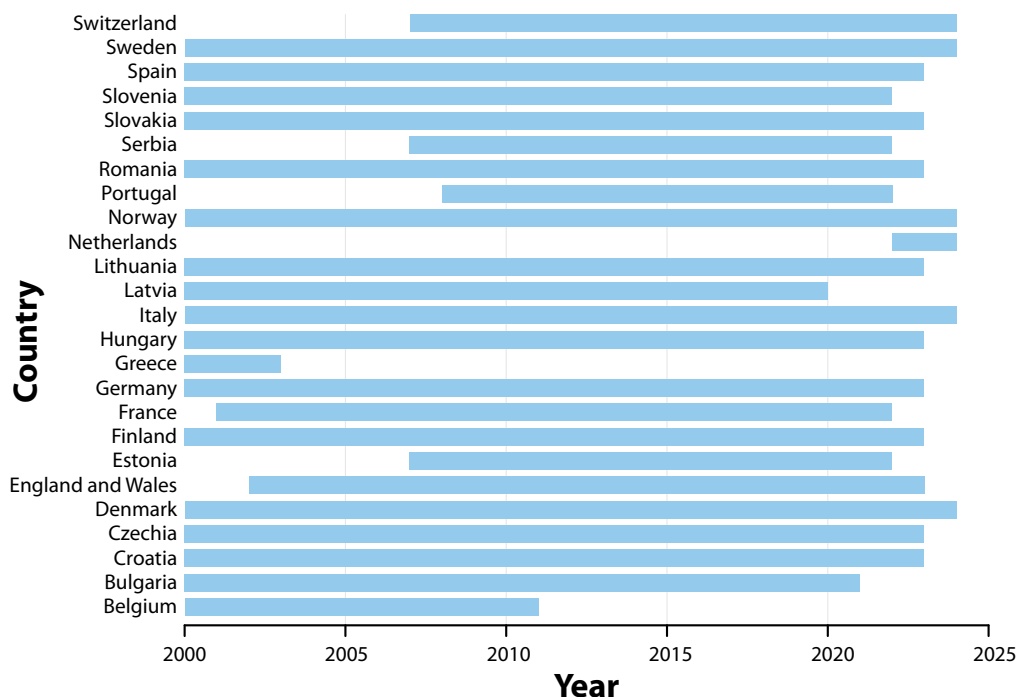
A positive value of R_{kc} indicates that the observed change in the abortion rate of group k contributed to a higher aggregate abortion rate relative to the counterfactual in which that group's abortion rate remained at its initial level. A negative value indicates that the change in the group's abortion rate contributed to a lower aggregate abortion rate.

This procedure is repeated separately for each population group. The resulting estimates should be interpreted as counterfactual comparisons with the observed change. Each calculation asks how the aggregate abortion rate would have evolved if one component had remained fixed at its initial level while all other components evolved as observed. Because changes in population composition and group-specific abortion rates may interact, these counterfactual contributions are not constructed as mutually exclusive components that necessarily sum to the total observed change.

A related application to fertility is provided by [Reimondos et al. \(2025\)](#), who distinguish between changes in population composition by relationship status and changes in relationship-specific fertility rates. Although their formal decomposition differs from the baseline-fixed counterfactual approach employed here, the underlying distinction between changes in population composition and changes in group-specific demographic rates is analogous.

A1.2. Decomposition data availability

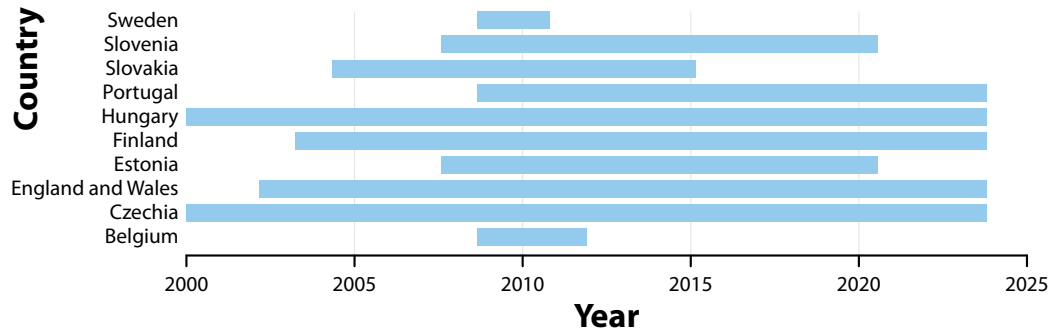
Figure A.11: Years available for age decomposition



Notes: The bars indicate the calendar years for which the abortion and population data required for the age decomposition are available in each country.

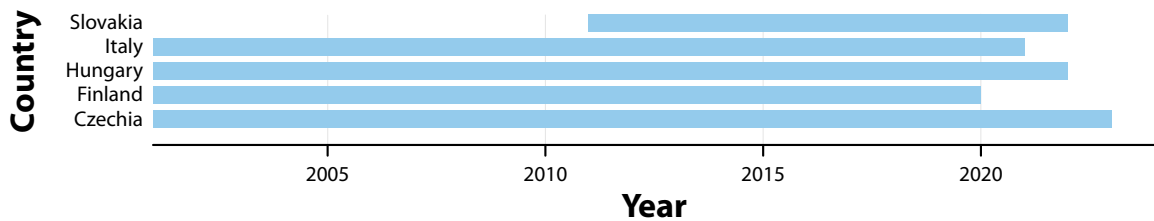
A1.3. Data descriptions, data sources

Figure A.12: Years available for parity decomposition



Notes: The bars indicate the calendar years for which the abortion and population data required for the parity decomposition are available in each country.

Figure A.13: Years available for education decomposition



Notes: The bars indicate the calendar years for which the abortion and population data required for the education decomposition are available in each country.

Table A.2: Available years by country

Country	Min Year	Max Year
Austria	1960	1988
Belgium	1985	2023
Bulgaria	1960	2021
Croatia	1965	2023
Czechia	1960	2023
Denmark	1960	2014
England and Wales	2002	2023
Estonia	1965	2023
Finland	1970	2024
France	1990	2024
Germany	1977	2024
Greece	1989	2015
Hungary	1960	2023
Italy	1980	2023
Latvia	1990	2023
Lithuania	1960	2024
Netherlands	1971	2024
Norway	1965	2024
Portugal	2002	2023
Romania	1960	2023
Serbia	2000	2023
Slovakia	1960	2023
Slovenia	1979	2023
Spain	1987	2023
Sweden	1960	2023
Switzerland	2007	2024
United Kingdom	1972	2016

Notes: There are separate datasets for England and Wales, and the United Kingdom. These are non-comparable data series, covering different regions.

Table A.3: Data sources for each country and dimension

Country	Number of abortions				Number of women (15–49)			
	Total	Age	Parity	Education	Total	Age	Parity	Education
Austria	ES (Eurostat)	-	-	-	ES	ES	-	-
Belgium	WHO, ES, Abort- Report Project	ES	ES	-	ES	ES	HFD	-
Bulgaria	ES	ES	-	-	ES	ES	-	-
Croatia	ES	ES	ES	-	ES	ES	HFD	-
Czechia	ES	ES, REG	ES, REG	REG	ES	ES	HFD, REG	REG
Denmark	ES	ES, Health Data Bank of Den- mark	-	-	ES	ES	-	-
England and Wales	DHSC	DHSC	DHSC	-	ONS	ONS	ONS	-
Estonia	ES, WHO	ES	ES	-	ES	ES	HFD	-
Finland	WHO, ES,	ES	ES, REG	REG	ES	ES	HFD, REG	REG
France	ES, WHO, Directorate for Research, Studies, Evaluation and Statis- tics, France	ES	-	-	ES	ES	-	-
Germany	ES, WHO	ES	-	-	ES	ES	-	-
Greece	ES, Johnston's Archive	ES	-	-	ES	ES	-	-
Hungary	ES	ES, REG	ES, REG	REG	ES	ES	HFD, REG	REG
Italy	ES, Ministry of Health	ES, Min- istry of Health	-	Ministry of Health	ES, ISTAT	ES, ISTAT	-	ES, ISTAT
Latvia	WHO, ES	ES	-	-	ES	ES	-	-
Lithuania	ES, WHO	ES	-	-	ES	ES	-	-

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Table A.3 – continued from previous page

Country	Number of abortions				Number of women (15–49)			
	Total	Age	Parity	Education	Total	Age	Parity	Education
Netherlands	ES, Ministry of Health, Welfare and Sport of The Netherlands	Ministry of Health, Welfare and Sport of The Netherlands	-	-	ES	ES	-	-
Norway	ES, WHO	ES, Norwegian Institute of Public Health	-	-	ES	ES	-	-
Portugal	ES	ES	ES	-	ES	ES	HFD	-
Romania	ES	ES	-	-	ES	ES	-	-
Serbia	WHO, ES	ES	-	-	ES	ES	-	-
Slovakia	ES, WHO	ES	ES, REG	REG	ES	ES	HFD, REG	REG
Slovenia	ES, WHO	ES	ES	-	ES	ES	HFD	-
Spain	ES, REG	ES, REG	-	-	ES, REG	ES	-	-
Sweden	ES, WHO	ES, National Board of Health and Welfare of Sweden	ES	-	ES	ES	HFD	-

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Table A.3 – continued from previous page

Country	Number of abortions				Number of women (15–49)			
	Total	Age	Parity	Education	Total	Age	Parity	Education
Switzerland	ES, Federal Statistical Office of Switzerland	ES, Federal Statistical Office of Switzerland	ES	-	ES	ES	HFD	-

Notes: DHSC: Department of Health and Social Care; ES: EUROSTAT; HFD: Human Fertility Database; ISTAT: Italian National Institute of Statistics; ONS: Office for National Statistics; REG: Register data. Table [A.4](#) details the websites and locations where each data source can be found.

Table A.4: Source of abortion and population data

Data source	Data content	Website
EUROSTAT (Eurostat, 2026a)	Number of abortions (Total, By age and parity)	EUROSTAT webpage
EUROSTAT (Eurostat, 2026b)	Number of abortions (By parity)	EUROSTAT webpage
EUROSTAT (Eurostat, 2026c)	Population in private households by educational attainment level (By age)	EUROSTAT webpage
EUROSTAT (Eurostat, 2026d)	Number of women, 15-49 (Total, By age)	EUROSTAT webpage
WHO (WHO, 2026)	Number of abortions (Total)	WHO webpage
Abort-Report Project (Abort-Report Project, 2026)	Number of abortions (Total)	Abort-Report webpage
Directorate for Research, Studies, Evaluation and Statistics, France (DREES, 2025)	Number of abortions (Total, France)	DREES webpage
Johnston's Archive (Johnston, 2026)	Number of abortions (Total, Greece)	Johnston's Archive webpage
Ministry of Health, Welfare and Sport of The Netherlands (IGJ, 2025)	Number of abortions (Total, By age, the Netherlands)	Dutch Ministry of Health webpage
Federal Statistical Office of Switzerland (OFS, 2026)	Number of abortions (Total, By age, Switzerland)	Swiss Federal Statistical Office webpage
Health Data Bank of Denmark (Danish Health Data Authority, 2026)	Number of abortions (By age, Denmark)	Danish Health Data Bank webpage
Norwegian Institute of Public Health (FHI, 2026)	Number of abortions (By age, Norway)	Norwegian Institute of Public Health webpage
Human Fertility Database (HFD, 2026)	Number of women (By parity)	Human Fertility Database webpage
Czech Statistical Office (CZSO, 2024a,b)	Number of abortions, Number of women (By parity, by education – Registry data, Czechia)	Czech Demographic Handbook ; Demographic Yearbook(s)

Table A.4 – continued from previous page

Data source	Data content	Website
National Institute for Health and Welfare (Medical Birth Register), Statistics Finland (all other register data) (THL, 2026 ; Statistics Finland, 2026)	Number of abortions, Number of women (By parity, by education – Registry data, Finland)	THL webpage ; Statistics Finland webpage
Central Statistical Office, Hungary (KSH, 2026)	Number of abortions, Number of women (By parity, by education – Registry data, Hungary)	KSH webpage
Italian Ministry of Health (annual surveillance reports), Italian National Institute of Statistics (ISTAT) (historical volumes) (Italian MOH, 2026 ; ISTAT, 2026)	Number of abortions (Total, By age, By education)	Ministry of Health reports ; ISTAT Digital Library
Italian National Institute of Statistics (ISTAT) (ISTAT, 2026)	Number of women, 15–49 (Total, By age)	ISTAT data portal
Ministry of Health, Spain (Spain MOH, 2026)	Number of abortions, Number of women (By age – Registry data, Spain)	Ministry of Health, Spain webpage
National Health Information Centre, Slovakia (NCZISK, 2026)	Number of abortions, Number of women (By parity, by education – Registry data, Slovakia)	National Health Information Centre webpage
Department of Health and Social Care, England and Wales (Department of Health and Social Care, 2026)	Number of abortions (Total, By age, By parity, England and Wales)	DHSC abortion statistics webpage
Office for National Statistics, United Kingdom (Office for National Statistics, 2026)	Number of women, 15–49 (Total, By age, By parity, UK)	ONS population estimates webpage
National Board of Health and Welfare, Sweden (National Board of Health and Welfare, 2026)	Number of abortions (By age, Sweden)	Socialstyrelsen webpage

Notes: Table A.3 details the data sources used for each country and dimension.

Table A.5: Description of detailed national and register data sources

Country	Data access	Included: abortions due to rape or health reasons	Included: surgical or medical abortions	Population covered
Czechia	Open access	Yes	Both	Residents and foreign residents
Finland	Restricted	Yes	Both	Permanent residents
Hungary	Restricted	Yes	Only surgical (no medical abortions allowed)	Residents and foreign residents
Italy	Open access	Yes	Both	Residents and foreign residents
Slovakia	Restricted	Yes	Only surgical (no medical abortions allowed)	Residents
Spain	Restricted	Yes	Both	Residents

Notes: The table describes the register datasets marked REG in Table A.3. In the Italian case, data come from published aggregate tables based on register data. The remaining countries are covered by the aggregate sources listed in Table A.3, which details the data sources used for each country and dimension.

Table A.6: Data sources of abortion-related institutional features for countries

Variable	Definition	Reference year	Source	Website
Legal	Is it legal to get an abortion on request or on broad social grounds (vs highly restrictive)	2020	Center for Reproductive Rights (CRR, 2023)	https://reproductiverights.org/wp-content/uploads/2020/12/European-abortion-law-a-comparative-review.pdf
Waiting period	Require a mandatory time period to elapse between the date on which an abortion is first requested and the date on which it takes place	2020	Center for Reproductive Rights (CRR, 2023)	https://reproductiverights.org/wp-content/uploads/2020/12/European-abortion-law-a-comparative-review.pdf
Counseling	Require women to undergo mandatory counseling or receive mandatory information from their doctors prior to abortion	2020	Center for Reproductive Rights (CRR, 2023)	https://reproductiverights.org/wp-content/uploads/2020/12/European-abortion-law-a-comparative-review.pdf
Distress	Required to explain that they are seeking an abortion because of their social or family circumstances or because continuing the pregnancy would cause them distress	2020	Center for Reproductive Rights (CRR, 2023)	https://reproductiverights.org/wp-content/uploads/2020/12/European-abortion-law-a-comparative-review.pdf
Cost of abortion	0: Free; 1: Low; 2: Middle or high, according to expert classification.	2023	Foundation for European Progressive Studies (FEPS, 2023)	https://feps-europe.eu/publication/abortion-in-the-eu-country-factsheets/
Years since abortion is legalized	From the year of legalization until 2025.	2023	Foundation for European Progressive Studies (FEPS, 2023)	https://feps-europe.eu/publication/abortion-in-the-eu-country-factsheets/

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Variable	Definition	Year	Source	Website
Abortion limit (weeks)	Time limit of abortions (weeks since last menstrual period)	2023	Foundation for European Progressive Studies (FEPS, 2023)	https://feps-europe.eu/publication/abortion-in-the-eu-country-factsheets/
Contraception access	Access to modern contraception	2020	Contraception Atlas (EPF, 2020)	https://www.epfweb.org/sites/default/files/2020-05/map_cci-english_hires_1%20%281%29.pdf
Contraception information	Availability of online contraception information	2020	Contraception Atlas (EPF, 2020)	https://www.epfweb.org/sites/default/files/2020-05/map_cci-english_hires_1%20%281%29.pdf
GDP per capita	GDP per capita	2012	EUROSTAT (Eurostat, 2025b)	https://ec.europa.eu/eurostat/databrowser/view/sdg_08_10/default/table
Abortion justifiable	Agree with the statement: “Abortion can be justified.”	2017	European Values Survey (EVS, 2017)	https://www.atlasofeuropeanvalues.eu/maptool.html
Religiousness	Percentage of people who say they are religious	2017	European Values Survey (EVS, 2017)	https://www.atlasofeuropeanvalues.eu/maptool.html
Medical abortion	Medical abortion legally available	2023	Abort-Report Project (Abort-Report Project, 2023)	https://abort-report.eu/
Post-abortion counseling	Does post-abortion care include counseling for contraceptive methods?	2017–2025	WHO Global Abortion Policies Database (WHO, 2025)	<a "="" href="https://abortion-policies.srhr.org/countries/?r%5B%5D=c64&r%5B%5D=c65&wr%5B%5D=0&f%5B0%5D%5B%5D=1&i%5B%5D=5&hrt=&co=&pia=">https://abortion-policies.srhr.org/countries/?r%5B%5D=c64&r%5B%5D=c65&wr%5B%5D=0&f%5B0%5D%5B%5D=1&i%5B%5D=5&hrt=&co=&pia=
Family benefits EUR per capita	Expenditure on social benefits on family/children (EUR per capita)	2018	EUROSTAT (Eurostat, 2025a)	https://ec.europa.eu/eurostat/web/social-protection/database

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Variable	Definition	Year	Source	Website
Family benefits per GDP	Expenditure on social benefits on family / children (% of GDP)	2018	EUROSTAT (Eurostat, 2025a)	https://ec.europa.eu/eurostat/web/social-protection/database
Contraception usage	Percentage of married or in-union women of reproductive age (15–49 years) who are currently, or whose sexual partner is currently using, any modern method of contraception.	2022	The Generations & Gender Contextual Database (GGP, 2026)	https://px.web.ined.fr/GGP/pxweb/en/1%20Demography/-/1.3.2_CPMM.px/
Gender Equality Index (GEI)	Relative position of women and men in 6 core domains: work, money, knowledge, time, power, health.	2025	European Institute for Gender Equality (EIGE) (EIGE, 2025)	https://eige.europa.eu/gender-equality-index/2025
GEI: Power (Domain score)	Gender inequalities in political, economic, and social power	2025	European Institute for Gender Equality (EIGE) (EIGE, 2025)	https://eige.europa.eu/gender-equality-index/2025
GEI: Political power (Subdomain score)	Gender inequalities in the highest decision-making bodies of key political institutions.	2025	European Institute for Gender Equality (EIGE) (EIGE, 2025)	https://eige.europa.eu/gender-equality-index/2025
GEI: Economic power (Subdomain score)	Gender inequalities in the highest decision-making bodies of the largest companies.	2025	European Institute for Gender Equality (EIGE) (EIGE, 2025)	https://eige.europa.eu/gender-equality-index/2025

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Variable	Definition	Year	Source	Website
GEI: Social power (Subdomain score)	Gender inequalities in the highest decision-making bodies of sports organizations.	2025	European Institute for Gender Equality (EIGE) (EIGE, 2025)	https://eige.europa.eu/gender-equality-index/2025

Table A.7: Abortion regulatory changes

Country	Year	Event
Austria	1975	Abortion was allowed on request during the first trimester after a mandatory medical consultation (Law BGBl. No. 60/1974 of 23 January 1974).
	1999	Medical abortion was permitted.
Belgium	1990	Abortion was permitted for women in a “state of distress” up to 12 weeks after conception (Law of 3 April 1990).
	1999	Medical abortion was permitted.
	2018	Abortion on a voluntary basis was officially removed from the Criminal Code, permitting elective abortions up to 12 weeks of pregnancy (Law of 15 October 2018).
Bulgaria	1936	Abortion was allowed only under specific circumstances (Criminal Code Amendment of 24 February 1936).
	1956	Abortion was allowed on request within the first 12 weeks of pregnancy on any grounds (Ministry of Health Instruction No. 34 of 27 April 1956).
	1968	Abortion access was severely restricted by the government, largely banning it for childless women (Decree No. 188 of 16 February 1968).
	1973	Abortion regulations were further tightened by implementing strict administrative constraints (Ministry of Health Instruction No. 0-27 of 1973).
	1990	Abortion was allowed on request during the first trimester for personal reasons (Ministry of Health Decree No. 2 of 1 February 1990).
	2014	Medical abortion was permitted.
Croatia	1952	Within Yugoslavia, abortion was allowed only under specific circumstances based on medical, eugenic, or legal indications (Decree No. 4 of 11 January 1952).
	1969	Within Yugoslavia, abortion was allowed up to the 10th week of pregnancy under broad social and economic indications, subject to a commission approval (Law No. 20 of 26 April 1969).
	1978	Abortion rights were consolidated under Croatian law allowing the procedure on request up to the 10th week of pregnancy (Law No. 1252 of 21 April 1978).
	2003	Abortion procedures could be legally refused by doctors on the grounds of conscientious objection (Law No. 121 of 23 July 2003).
	2017	Abortion under the 1978 law was upheld by the Constitutional Court, though Parliament was ordered to update legislation (Constitutional Court Decision U-I-60/1991 of February 21 2017).
	2019	Medical abortion was permitted within 10 weeks of pregnancy.
Czechia	1950	Within Czechoslovakia, abortion was allowed only under strict medical grounds (Act No. 86 of July 18 1950).

Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
	1957	Within Czechoslovakia, abortion was allowed only under specific circumstances on strict social and health grounds, requiring permission from a medical commission (Act No. 68 of 19 December 1957).
	1987	Within Czechoslovakia, abortion was allowed on request without restrictions during the first 12 weeks of pregnancy , removing medical commissions (Act No. 66 of 3 November 1986).
	1993	Prior to the dissolution of Czechoslovakia, the Czech Republic’s ministry removed state funding for elective abortions, making them a paid procedure. (Regulation No. 467/1992.
	2013	Medical abortion was permitted.
Denmark	1939	Abortion was allowed only under specific circumstances based on medical, eugenic reasons, or rape (Act No 89 of March 15, 1939).
	1970	Abortion was allowed on request only for women over 38, those with 4+ children, or those under 18 deemed ill-equipped (Act No. 120 of March 24, 1970).
	1973	Abortion was allowed on request free-of-charge to all permanent residents up to the 12th week of pregnancy (Act No. 350 of 13 June 1973).
	1999	Medical abortion was permitted.
	2008	Abortion regulations from earlier amendments were integrated into a consolidated legislative framework (Consolidated Act No. 95 of 14 June 2008).
	2025	Abortion on request was expanded up to the 18th week of pregnancy (Act No. 404 of 29 April 2025).
England and Wales	1938	Abortion was allowed only under specific circumstances if the pregnancy risked making the woman a “physical or mental wreck” (1938 Rex v Bourne Case).
	1968	Abortion was allowed in the first 28 weeks of pregnancy in case of risk to the mother’s physical or mental health, or fetal abnormality (Abortion Act 1967 c. 87 of 27 October 1967).
	1990	Abortion was limited to the first 24 weeks of pregnancy, with narrow medical exceptions (Human Fertilisation and Embryology Act 1990 c. 37 of 1 November 1990).
	1991	Medical abortion was permitted.
	2020	Medical abortion at home was temporarily allowed via telemedicine measures during the pandemic (Coronavirus Act 2020 c. 7 of 25 March 2020).
	2022	Medical abortion at home was made a permanent option for early gestations up to 10 weeks (Health and Care Act 2022 c. 31 of 28 April 2022).

Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
	2026	Women ceased to be liable to prosecution in relation to their own pregnancies at any gestation, while the rules governing provision by clinicians under the Abortion Act 1967 were left unchanged (Crime and Policing Act 2026 c. 20 of 29 April 2026).
Estonia	1955	Abortion was allowed on request during the first trimester of pregnancy under USSR law (USSR Supreme Soviet Decree of 23 November 1955, Item 425).
	2003	Medical abortion was permitted.
	2015	Abortion for minors no longer required mandatory parental or guardian consent (Act RT I, 20.02.2015, 4 of 18 February 2015).
Finland	1950	Abortion was allowed only under specific circumstances including health reasons, minors under 16, rape, or fetal abnormality (Act No. 82 of 17 February 1950).
	1970	Abortion limits were extended to 16 weeks and expanded to include broad socio-economic reasons or age limits (Law No. 239 of 24 March 1970).
	1978	Abortion limits were lowered from 16 back to 12 weeks of gestation to reinforce preventive counseling (Law No. 564 of 19 July 1978).
	1985	Abortion limits were extended to 20 weeks for minors and 24 weeks for severe fetal impairment (Law No. 572 of 12 July 1985).
	2000	Medical abortion was permitted.
	2001	Abortion could be requested by a legal guardian for a mentally incapable woman under specific legislative terms (Law No. 328 of 6 April 2001).
	2023	Abortion was allowed on request up to 12 weeks, eliminating the required socio-economic justifications (Law No. 1097 of 20 December 2022).
France	1975	Abortion was allowed on request up to 10 weeks of pregnancy in cases of distress (Law No. 1975-17 of 17 January 1975).
	1989	Medical abortion was permitted.
	2001	Abortion limits were extended from 10 to 12 weeks, and mandatory parental consent for minors was abolished (Law No. 2001-588 of 4 July 2001).
	2014	Abortion was solidified as a strict right on request, removing the distress justification text (Law No. 2014-873 of 4 August 2014).
	2016	Abortion access was streamlined by abolishing the mandatory 7-day waiting period between consultations (Law No. 2016-41 of 26 January 2016).
	2022	Abortion limits were extended to 14 weeks, and telemedicine for medical abortion was permanently legalized (Law No. 2022-295 of 2 March 2022).

Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
Germany	1927	Abortion was permitted under narrow medical indications to save the woman's life (Supreme Court Decision RGSt 61, 242 of 11 March 1927).
	1945	In East Germany, abortion was decriminalized under broad social, economic, and eugenic indications through regional state regulations to address post-war distress (Thuringia and Saxony-Anhalt, 1945; Mecklenburg-Vorpommern, 1946; Saxony and Brandenburg, 1947).
	1950	In East Germany, abortion was allowed only under specific circumstances including medical or social indications (Law GBl. S. 1037 of 27 September 1950).
	1972	In East Germany, abortion was legalized on request within the first 12 weeks of pregnancy (Law GBl. I S. 89 of 9 March 1972).
	1976	In West Germany, abortion was permitted under specific medical, eugenic, criminal, or social indications. (Act BGBI. I S. 1213 of 18 May 1976)
	1993	Abortion was ruled unconstitutional but exempt from punishment up to 12 weeks with mandatory counseling (Court Judgement BVerfGE 88, 203 of 28 May 1993).
	1995	Abortion under the 1993 counseling model was formally codified into permanent law (Law BGBI. I S. 1050 of 21 August 1995).
	1999	Medical abortion was permitted.
	2010	Abortion for late-term medical reasons was tightened by introducing a mandatory wait period (Law BGBI. I S. 2990 of 26 August 2009).
Greece	1978	Abortion was allowed only under specific circumstances to save life, for severe abnormalities, or psychiatric reasons (Law No. 821/1978 of 14 October 1978).
	1986	Abortion was allowed on request during the first 12 weeks of pregnancy (Law No. 1609/1986 of 3 July 1986).
	1999	Medical abortion was formally permitted.
	2019	Abortion allowances for late-term interventions for medical reasons were extended (Law No. 4619/2019 of 11 June 2019).
Hungary	1933	Abortion was allowed only in medically necessary cases (High Court verdict B. I. 118/1933 of 1 March 1933).
	1945	Abortion on request was temporarily decriminalized with an emergency resolution (Decision of the Budapest National Committee X/2-1945 of 14 February 1945)
	1952	Abortion was restricted to specific circumstances, in a period marked by intense state surveillance (Directive No. 81/34/1952 of 29 May 1952).
	1956	Abortion was allowed on request within the first twelve weeks of pregnancy (Decision No. 1047/1956 of 3 June 1956).

Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
	1973	Abortion access was restricted by requiring a committee approval, though broad social indications were still accepted. (Decree 1040/1973 (X.18.) Minister Council and Decree 4/1973 (XII. 1.) Minister of Health)
	1988	The 1973 restrictions were abolished, removing abortion approval committees. (Decree 76/1988 (XI. 3.) Minister Council).
	1992	Abortion was allowed only under specific circumstances within 12 weeks (Act LXXIX of 17 December 1992).
	2000	Abortion was made available only in case of "severe crisis" and two separate counseling sessions before approval. (Act LXXXVII of 20 June 2000)
	2012	Medical abortion was permitted; however, it remains unavailable in practice as the state does not allow distribution of the drug.
	2022	Law mandated hearing the fetal heartbeat before the procedure (Decree 29/2022. (IX. 12.) Minister of Interior Affairs).
Ireland	1992	Abortion was allowed only if a substantial risk to the mother's life existed (Supreme Court Judgement in the X Case on 5 March 1992). Law specified that the constitutional protection of the unborn does not limit the right to travel abroad or distribute information regarding foreign abortion services (Thirteenth and Fourteenth Amendment).
	1995	Abortion services information regarding travel outside the state was regulated under a new act (Act No. 5 of 12 May 1995).
	2014	Law codified the 1992 Supreme Court precedent, permitting abortion exclusively in hospitals when a woman's life is at risk and establishing precise medical panel review procedures to legally grant it. (Act No. 35/2013 of 30 July 2013).
	2019	Abortion was allowed on request up to 12 weeks following the repeal of the Eighth Amendment (Act No. 31/2018 of 20 December 2018).
Italy	1978	Abortion was allowed on request up to 90 days of pregnancy, while also recognizing the right to medical conscientious objection (Law No. 194 of 22 May 1978).
	2009	Medical abortion was permitted.
Latvia	1955	Abortion was allowed on request during the first trimester of pregnancy under USSR law (USSR Supreme Soviet Decree of 23 November 1955, Item 425).
	2002	Abortion access was allowed up to the 12th week, and medical abortion was legalized (Act No. 56 of 31 January 2002).
Lithuania	1955	Abortion was allowed on request during the first trimester of pregnancy under USSR law (Supreme Soviet Decree of 23 November 1955).
	1994	Abortion on request was maintained up to 12 weeks (Ministry Order No. 50 of 28 January 1994).

Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
	2023	Medical abortion was legalized up to the 9th week of pregnancy (Ministry Order No. V-1375 of 25 October 2022).
Netherlands	1984	Abortion was allowed on request up to the 24th week in licensed clinics or hospitals with a wait period (Act No.257 of 1 May 1981).
	2000	Medical abortion was permitted.
	2023	Abortion access was streamlined by removing the mandatory reflection period (Act No.326 of 22 August 2022).
	2025	Medical abortion was authorized to be prescribed by general practitioners up to the 9th week of pregnancy (Act No.11 of 21 December 2022).
Norway	1964	Abortion was allowed only under specific medical, genetic, or criminal justifications subject to two-doctor approval (Act No. 2 of 11 November 1960).
	1975	Abortion was allowed under specific circumstances, including broad "social indications", with medical committee approval (Act No. 50 of 13 June 1975).
	1978	Abortion was allowed on request up to 12 weeks of pregnancy (Act No. 66 of 16 June 1978).
	1998	Medical abortion was permitted.
	2025	Abortion on request was extended from 12 to 18 weeks, with a total ban after viability at 22 weeks (Act No. 96 of 20 December 2024).
Portugal	1984	Abortion was allowed only under specific circumstances of risk to the woman's physical or mental health, fetal malformation , and cases of pregnancy resulting from sexual crimes (Law No. 6 of 11 May 1984).
	1995	Abortion kept being allowed only under specific circumstances, integrated directly into the Penal Code (Law No. 48 of 15 March 1995).
	1997	Abortion was allowed only under specific circumstances extended up to 16 weeks for rape and 24 weeks for malformations (Law No. 90 of 30 July 1997).
	2007	Abortion was allowed on request up to the 10th week in authorized facilities following a referendum (Law No. 16 of 17 April 2007).
Romania	1957	Abortion was allowed on request up to 12 weeks of pregnancy (Decree No. 463 of 39 September 1957).
	1966	Abortion was allowed only under narrow circumstances such as being older than 45, having already four children, life-threatening cases, or criminal justifications (Decree No. 770 of 1 October 1966).
	1990	Abortion was allowed on request up to the 14th week of pregnancy (Decree-Law No. 1 of 26 December 1989).
	2008	Medical abortion was permitted.
Serbia	1952	Within Yugoslavia, abortion was allowed only under specific circumstances based on medical, eugenic, or legal indications (Decree No. 4 of 11 January 1952).

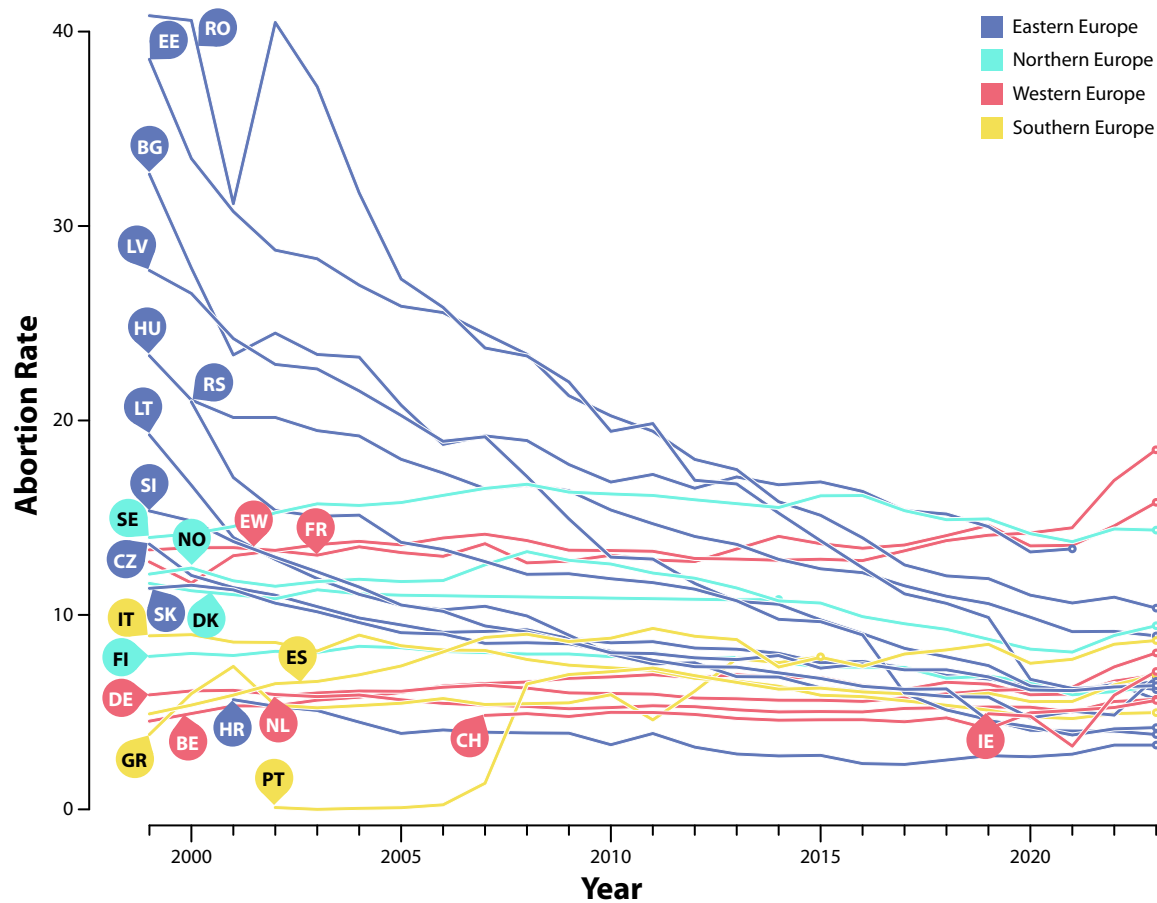
Table A.7: Abortion regulatory changes (continued)

Country	Year	Event
	1969	Within Yugoslavia, abortion was allowed up to the 10th week of pregnancy under broad social and economic indications, subject to a commission approval (Law No. 20 of 26 April 1969).
	1977	Abortion rights were consolidated under Serbian law allowing the procedure on request up to the 10th week of pregnancy (Law No. 26 of 14 October 1977).
	1995	Abortion for elective reasons had its age limit for autonomous request lowered from 18 to 16 (Law No. 16 of 12 May 1995).
	2013	Medical abortion was permitted.
Slovakia	1950	Within Czechoslovakia, abortion was allowed only under strict medical grounds (Act No. 86 of July 18 1950).
	1958	Within Czechoslovakia, abortion was allowed only under specific circumstances on strict social and health grounds, requiring permission from a medical commission (Act No. 68 of 19 December 1957).
	1987	Within Czechoslovakia, abortion was allowed on request up to 12 weeks, introducing conscientious objection for doctors (Act No. 73 of 23 October 1986).
	–	Medical abortion via medication remains legally unavailable.
Slovenia	1952	Within Yugoslavia, abortion was allowed only under specific circumstances based on medical, eugenic, or legal indications (Decree No. 4 of 11 January 1952).
	1969	Within Yugoslavia, abortion was allowed up to the 10th week of pregnancy under broad social and economic indications, subject to a commission approval (Law No. 20 of 26 April 1969).
	1977	Abortion rights were consolidated under Slovenian law allowing the procedure on request up to the 10th week of pregnancy (Act No. 1198 of 20 April 1977).
	2013	Medical abortion was permitted.
Spain	1985	Abortion was allowed only under specific circumstances including rape, health risks, or abnormalities (Constitutional Law No. 9 of 5 July 1985).
	1999	Medical abortion was permitted.
	2010	Abortion was allowed on request within the first 14 weeks of pregnancy (Constitutional Law No. 2 of 3 March 2010).
	2015	Abortion for elective reasons for 16 and 17-year-olds was restricted by introducing mandatory parental consent (Constitutional Law No. 11 of 21 September 2015).
	2023	Abortion for elective reasons for 16 and 17-year-olds was restored without parental consent (Constitutional Law No. 1 of 28 February 2023).
Sweden	1938	Abortion was permitted under limited circumstances and medical permission (Law No. 318 of 18 May 1938).

Table A.7: Abortion regulatory changes (continued)

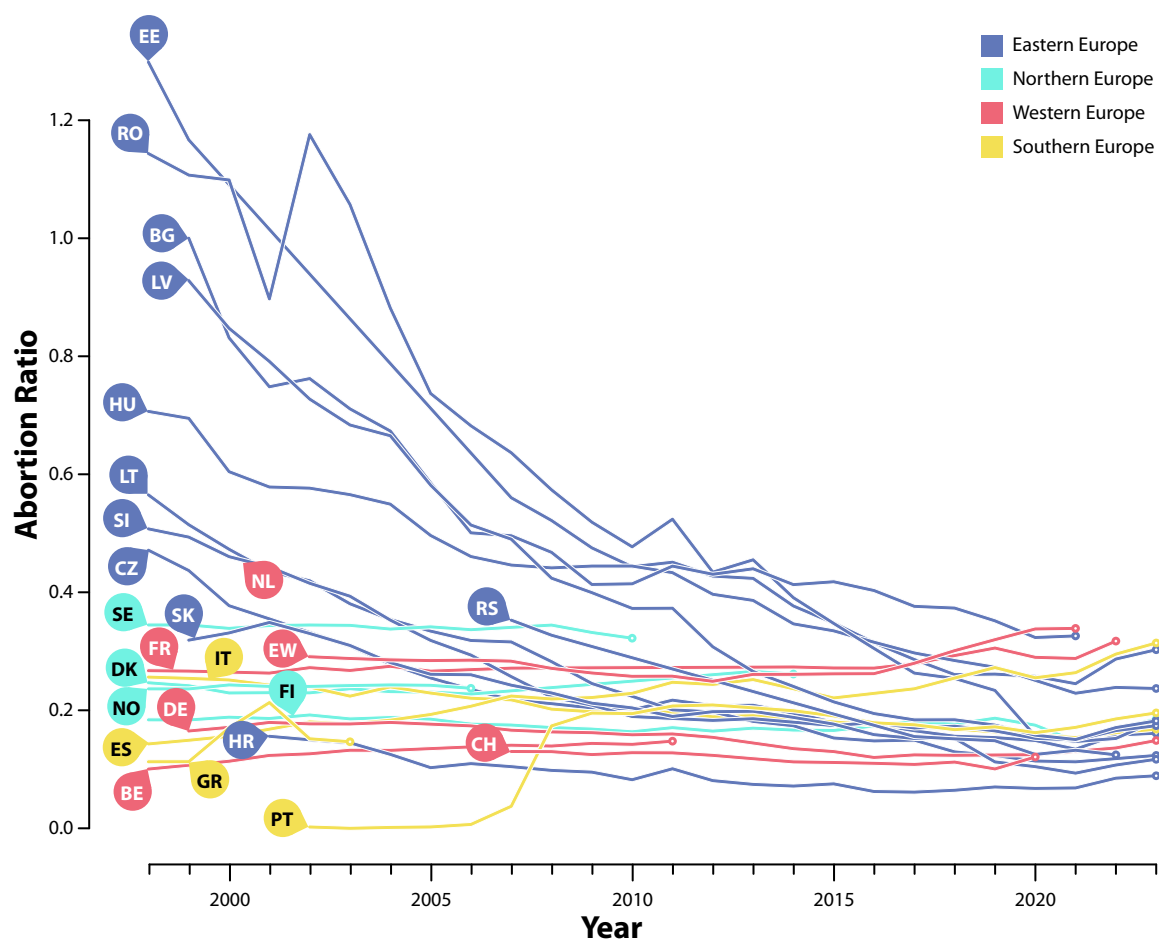
Country	Year	Event
	1946	Abortion access was expanded to include social or socio-medical reasons (Act No. 210 of 21 June 1946).
	1975	Abortion was allowed on request up to the 18th week of pregnancy and covered by public insurance (Act No. 595 of 14 June 1974).
	1992	Medical abortion was permitted.
	1996	Abortion access between weeks 12 and 18 was simplified by removing mandatory counseling (Act No. 660 of 1 June 1995).
	2008	Abortion access was extended to non-resident foreign women (Act No. 842 of 22 November 2007).
Switzerland	1942	Abortion is allowed under strict medical conditions and handled very differently by region (Penal Code Act AS 57 1131 of 21 December 1937)
	1999	Medical abortion was permitted.
	2002	Abortion was allowed on request during the first 12 weeks of pregnancy on the condition of a state of distress (Penal Code Amendment AS 2002 2989 of 23 March 2001).
<i>Notes:</i> The table reports the official date of enforcement, whereas the text specifies the date of legal approval. For nations that underwent territorial dissolution or unification, past regulatory events are contextualized under their respective historical sovereignty.		

Figure A.14: Abortion rate (1998-2023)



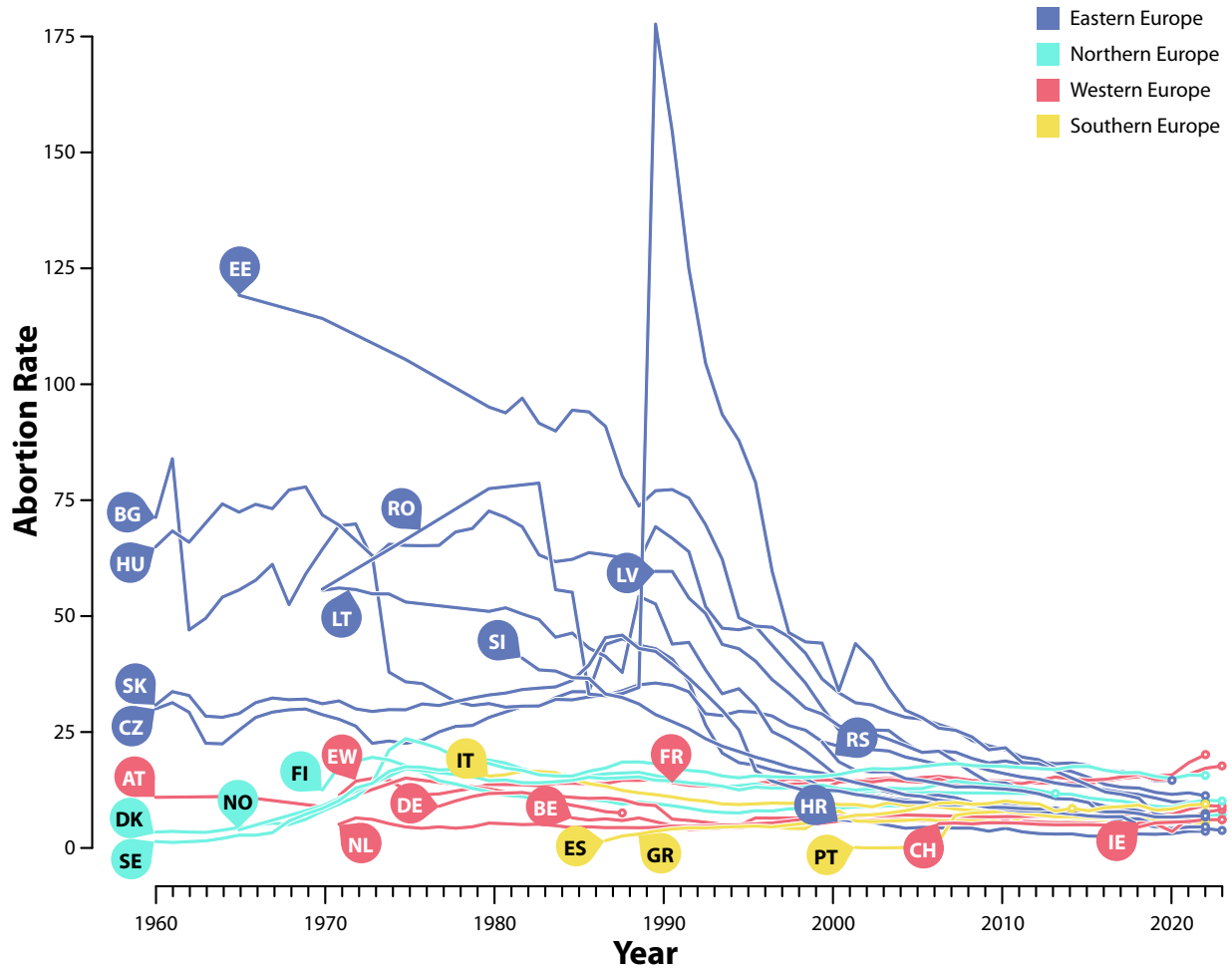
Note: Abortion rate: number of abortions per 1000 women of age 15-49.

Figure A.15: Abortion ratio (1998-2023)



Note: Abortion ratio: number of abortions per number of births.

Figure A.16: Abortion rates in Europe (1960-2024)



Notes: Abortion rate: number of abortions per 1000 women of age 15-49. Country codes are as in Figure 1.