Netwerk VN - Vrouwenverdrag

Symposium

Safeguarding Abortion Rights:

Dutch Law in Context

Report of the symposium Utrecht, 18 September 2025

Vereniging voor Vrouw en Recht Clara Wichmann

Bureau Clara Wichmann

Safeguarding Abortion Rights: Dutch Law in Context

Symposium Report, Utrecht, 18 September 2025

Introduction

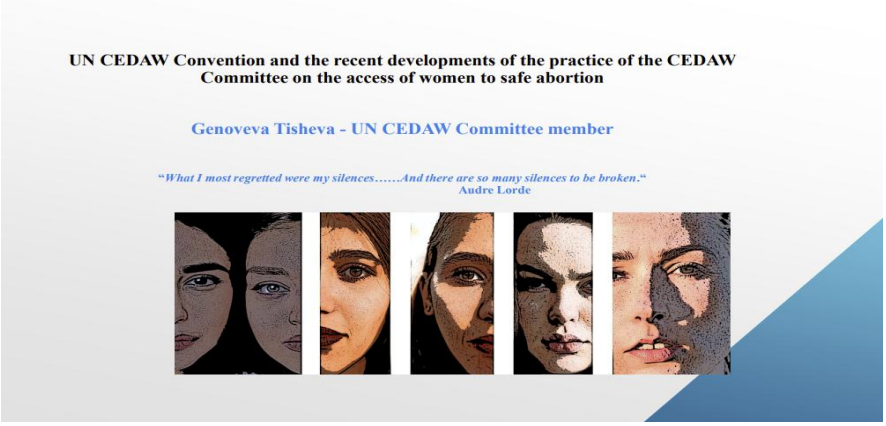
The symposium Safeguarding Abortion Rights: Dutch Law in Context was organized by the Dutch CEDAW Network in collaboration with the Association for Women and Law Clara Wichmann and Bureau Clara Wichmann. It brought together legal scholars, activists, and medical professionals to examine the current state of abortion rights in the Netherlands and beyond. The event focused on how Dutch law measures up to international obligations, such as laid down in the UN Women's Convention. Worldwide, abortion rights are under pressure. Recent setbacks in countries like Poland formed an important part of these discussions.

The program featured a keynote given by Dr. Genoveva Tisheva of the UN CEDAW Committee about the recent developments of the practice of the CEDAW Committee on the access to safe abortion. This was followed by a presentation from Dr. Karolina Kocemba on the situation in Poland and resistance to the right wing legal mobilisation. Gunilla Kleiverda, chair of the Board of Women on Waves, was kind enough to replace Women on Waves director Rebecca Gomperts, who had to apologize that very morning because of illness. Kleiverda delivered an insightful contribution on the Women&More research about a new contraceptive based on Mifepriston and other work of Women on Waves. Dr. Trudy Dehue, professor emeritus of the philosophy of science provided an academic perspective on the use of abortion statistics and framing of concepts in the abortion discourse. The day concluded with a panel discussion, chaired by Dr. Marjan Wijers and preceded by contributions from Dr. Fleur van Leeuwen, lecturer and researcher at Utrecht University, and Drs. Laura van Stein representing AVA, an independent Dutch advocacy organization with respect to contraception and abortion.

Leontine Bijleveld opened the symposium on behalf of the Dutch CEDAW Network and the Association for Women and Law with a warm welcome to the 65 participants and speakers. A special welcome to CEDAW-member Genoveva Tisheva, who came over for the event from Sofia, Bulgaria, and to Mr. Corinne Dettmeijer-Vermeulen re-elected CEDAW-member from the Netherlands and presently vice-chair of the Committee. Bijleveld shared her excitement about the symposium in which her abortion activism since the late 70s comes together with her activities from a later date promoting the rights that women derive from the UN Women's Convention. She recalled that in those early days, almost 50 years ago, neither abortion activists nor politicians paid any attention to international human rights obligations.

Corinne Dettmeijer continued with some words about the Women's Convention, adopted by the United Nations General Assembly in December 1979 and entered into force in September 1981. The Netherlands ratified the convention in 1991. Dettmeijer gave some examples of the broad scope of the Women's Convention and of the work of the Committee. The Inquiry procedure is one of the instruments. It can be initiated if the CEDAW Committee receives reliable information indicating grave or systematic violations by a State of any of the rights contained in the Convention.

Dettmeijer introduced key-note speaker Genoveva Tisheva, rapporteur of the CEDAW Inquiry concerning the restricted access to abortion for women and girls in Poland. At the time Tisheva was vice-chair of the Committee that adopted the report in February 2024.



Dr. Genoveva Tisheva: UN CEDAW Convention and the recent developments of the practice of the CEDAW Committee on the access of women to safe abortion

Dr. Genoveva Tisheva began by pointing out that "*the access to safe abortion is an inherent part of women's sexual and reproductive health and rights (SRHR)*". Reproductive rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

Reproductive health is a component of reproductive rights and is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system, including the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD Program of Action definitions of reproductive rights, reproductive health and sexual health as components of reproductive rights).

Yet, women all around the world are still shamed, controlled, and punished by states, laws, and communities. Dystopian narratives such as *The Handmaid's Tale*, no longer feel entirely fictional when compared to recent legal setbacks in countries like the United States.

Despite ongoing challenges, significant progress has been made in the recognition and protection of women's reproductive rights. The role of treaty monitoring bodies, in particular the CEDAW Committee, has been crucial in advancing reproductive rights worldwide. The CEDAW Convention has been ratified by 189 countries so far. It sets an important international standard for women's rights, guaranteeing equality, autonomy, and economic independence and empowerment.

The Committee has been reinforcing these rights by explicitly addressing women's health and reproductive autonomy. They did this through constructive dialogues with governments, the issuing of Concluding Observations (COBs), and investigations into serious violations, such as in Poland. The Committee has increasingly pushed for decriminalization of abortion and regulation of conscience-based refusals of care. The ongoing revision of General Recommendation 24 on Women and Health further reflects this progress, seeking the progressive realization of reproductive rights and liberation of women.

Dr. Tisheva provided examples of recent recommendations to State parties:

Guatemala (2023): Amend article 139 of the Penal Code to legalize abortion and decriminalize it in all cases and ensure that women and adolescent girls have adequate access to safe abortion and post-abortion services to ensure full realization of the rights of women, their equality and their economic and bodily autonomy to make free choices about their reproductive rights; and strengthen measures to counter the alarming rate of maternal mortality.

Brazil (2024): Legalize abortion, decriminalize it in all cases and ensure that women and girls have adequate access to safe abortion and post-abortion services, so as to guarantee the full realization of their rights, equality and economic and bodily autonomy to make free choices about their reproductive rights.

Germany (2023): Ensure that sufficient numbers of adequately trained medical professionals are available to perform abortions and reduce regional disparities in this regard and that medicines needed for non-surgical abortion are available. Ensure that women have access to a safe abortion in compliance with the guidelines on abortion care of the World Health Organization, which recommends the full decriminalization of abortion, and without subjecting them to mandatory counselling and a three-day waiting period, and that safe and legal abortion services are reimbursed by health insurance, and carry out a study to assess the reasons why women travel abroad for an abortion, with a view to addressing their needs.

Italy (2024): Ensure that the exercise of conscientious objection by health-care personnel does not prevent women from having access to safe abortion services, including by requiring mandatory referrals, remove the requirement for mandatory waiting periods, in line with the recommendations of the World Health Organization, and adopt effective measures to prevent and address the defamation, victimization and harassment of women who choose to have an abortion.

The main principle of CEDAW and of the work of the Committee is the commitment to the universality of human rights. There is no space for cultural relativism that undermines the rights of women, like invoking culture, religion, and family as justifications. The right to reproductive health is contingent upon the realization of other fundamental human rights, including the right to education, human dignity, life, non-discrimination, equality, the prohibition against torture and other ill-treatment, privacy, and access to information, all socio- economic rights.

She referred to CEDAW General Recommendation No. 35, in which violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender –based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment. It condemns gender stereotyping and stigmatization of abortion and of women undergoing abortion, while exposing attacks against them and against women's NGOs by the anti- abortion movement and activists. The GR clearly affirms the decriminalization of abortion and the obligation of State Parties to liberalize restrictive laws as an obligation that derives directly from the rights of women and girls to non-discrimination, bodily autonomy, and health.

Dr. Tisheva highlighted how other international treaty bodies increasingly interpret access to safe abortion as a fundamental human right. As examples she mentioned the Committee on the Rights of Persons with disability (Comment No. 3 on Article 6 , 2016); the Committee on Economic Social and Cultural Rights (GR No. 14 on the right to the highest attainable standard of health, 2000, and No. 22 on the right to sexual and reproductive health, 2016); the Human Rights Committee (General Comment No. 36 on Art. 6, the right to life, 2019); and the Committee on Racial Discrimination (GR No. 37 on racial discrimination and the right to health).

These developments reflect a broader shift toward recognizing women's bodily autonomy and rejecting cultural or religious justifications for limiting reproductive freedom.

Poland was presented as a particularly grave situation. The 2024 Inquiry Report found grave and systematic violations of the Convention: women were forced to continue pregnancies against their will, seek clandestine and potentially unsafe abortions, or travel abroad at great personal cost. Such state control over women's reproductive health, results in grave and systematic human rights violations. The report clearly recognised that abortion must be fully decriminalised, legalised, and recognised as a fundamental human right. This formed a breakthrough not only for the protection of SRHR, but also for the achievement of substantive gender equality, in line with the WHO Safe abortion guidelines.

The Committee therefore issued urgent recommendations, calling on Poland to adopt legal reforms that place women's autonomy at the centre of policy and law-making, to recognize abortion as a fundamental right, and to introduce a moratorium on the enforcement of criminal laws against abortion until full decriminalization is achieved. In addition, the Committee further recommended halting all prosecutions of healthcare professionals and private individuals providing abortion-related assistance.

It calls for evidence-based medical protocols and training for healthcare providers, and guaranteeing that all women, including those with disabilities, can make autonomous decisions based on accurate and unbiased information. Finally, it stressed the need to reinstate mandatory referral obligations for doctors who claim conscientious objection, and to prosecute cases where such objection is misused to block access to care.

Q&A Reflections

In the discussion that followed, participants asked about inclusive language for transgender and non-binary people. Dr. Tisheva noted that while the wording in the Convention itself cannot be altered, it can be interpreted progressively to cover diverse gender identities. On internal Committee dynamics, it was acknowledged that consensus is often difficult, but that reaching an agreement on reproductive rights is too important to rush.

A reflection was also made on undocumented women, whom often remain excluded from services or fear reporting due to their legal status. In some cases, layers of control beyond the abortion law itself create further obstacles. Here, art. 14 of the Convention is especially relevant, as it addresses the situation of marginalized women and requires states to ensure that all women, regardless of status, can access reproductive health services without discrimination.

Dr. Tisheva admitted that while it is impossible to put force on the government, the process still produces positive effects. She highlighted the indirect power of CEDAW: even without immediate reforms, its reports raise awareness, educate the public, and sustain international pressure. This constant reminder, amplified by media and civil society, keeps governments from ignoring their obligations.

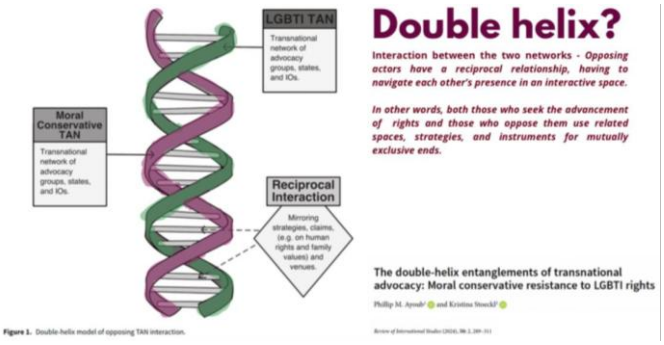
Dr. Karolina Kocemba - Poland's Battle over Reproductive Rights. Legal Mobilization in Changing Political Landscapes: Right-wing and Progressive Lawyers in the Fight over Reproductive Rights

Karolina Kocemba's presentation examined the struggle over abortion rights in Poland within the wider transnational context of right wing legal mobilization, defined as "the organized efforts, resources, and strategies employed by individuals, groups, or organizations with conservative or right-leaning ideologies to embody their values in positive law and its interpretation". In the process, such agents use legal tools, institutions, and concepts based on liberal and progressive political ideas like human rights or constitutional review. Often, this mobilization appeals to a vision of 'real' or

'natural' law, in which authority is combined with a homogeneous vision of the community and which is contrasted with its corrupt and degenerate contemporary use by liberal elites.

She began her research by looking at Poland but soon discovered that the strategies used there are part of a broader international pattern. Actors seeking to restrict reproductive rights are not limited to governments. Conservative non-state organizations play an active role, drawing on significant funding, close political connections, and cross-border networks to advance their agenda.

In Poland, early attempts to tighten abortion law were made through parliament but met with strong public protests. To avoid losing votes, the ruling party turned to the Constitutional Court, where fundamentalist organizations promoted a motion challenging the constitutionality of abortion. This strategy illustrates the tactical use of courts to bypass democratic resistance. A central element of this approach is the manipulation of language, for example, replacing the term *"foetus"* with *"conceived child"*.



Kocemba emphasized that such tactics are not unique to Poland. Conservative groups across Europe and beyond share knowledge, resources, and legal strategies. These groups often argue in terms of rights and legal procedures, such as human rights arguments and constitutional review, to advance conservative goals. This reflects the "*double helix*", a term adopted by Kocemba to describe: progressive and conservative networks interacting in the same legal and political spaces, adapting to and learning from one another's strategies.

Resistance to these setbacks has taken multiple forms. Pro-choice movements in Poland have organized both mass protests, as well as quieter legal strategies. Lawyers have pursued cases before the European Court of Human Rights, and pressed for broader interpretations of health exceptions, to include also mental health, to permit abortions. A key example is the *M.L. v. Poland* case (ECHR 354 (2023), in which the applicant was denied access to abortion under new restrictions and forced to travel abroad at great costs and mental strain. The Court found that the fact that was forced to travel abroad to have an abortion violated the Convention. Media attention has been particularly powerful in exposing the human costs of restrictions, such as cases where doctors hesitated to act out of fear of prosecution, leading to preventable deaths due to sepsis.

Comparative examples underline the unevenness of reproductive rights in Europe. In Italy, the widespread application of conscientious objection makes legal abortion difficult in practice. In France, abortion was recently declared as a constitutional right, but access barriers remain. These examples highlight the gap between legal recognition and effective implementation.

Kocemba stated that Polish authorities often dismiss the problem by pointing to the possibility of seeking abortions abroad, refusing to acknowledge that this "solution" is inaccessible to many due to financial or social limits. Activists in Poland continue to operate with limited resources, achieving symbolic but fragile gains.

Her conclusion was a stark reminder that reproductive rights cannot be taken for granted: "*If it can happen in Poland and the US it can happen everywhere, pro-life movements are just waiting for an opportunity.*"

The dramatic setbacks seen in Poland and elsewhere demonstrate that even long-standing protections are vulnerable. Well-funded and highly organized pro-life movements remain prepared to exploit political opportunities. The Polish case shows how fragile reproductive rights can be, even in countries who once appeared secure. It

highlights the importance of continued vigilance, advocacy, and transnational solidarity. Next steps in research are mapping cases and the engaged pro- and anti-reproductive rights non-state actors and investigating their motivations, knowledge and choice of strategies to explain their influence in shaping reproductive rights in Europe through legal mobilisation.

Expanding women's autonomy over their reproductive health: empowering local communities, broadening access to information & research Gunilla Kleiverda, Women on Waves

Founded twenty-five years ago, Women on Waves (WOW) became known for sailing to countries where abortion was illegal, providing services in international waters under Dutch law. These missions offered abortion pills within the first six weeks of pregnancy, when no special license was required in the Netherlands (overtijd behandeling – menstrual regulation). Countries visited included Poland, Ireland, Portugal, Spain, Morocco, and several in Latin America. The initiative attracted widespread public attention, particularly when Portuguese authorities attempted to block entry with warships. The latter illustrates how a peaceful act of care could be distorted into a perceived national threat worthy of military response.[1]

The group recognized that direct intervention could only help a limited number of women. Therefore they combined this with focusing on empowering local movements and providing broader access to information and medication. In Ireland and Portugal, they were able to raise activism for "Doctors for Choice" and developed educational resources to help women understand self-managed abortion. This raised public questions about safety, but also fostered open discussion where silence had previously prevailed. She explained that the idea of using misoprostol as an abortion method arose from medical warnings on the instruction manual on certain pain medications, which warned pregnant women to not take them because they could induce abortion

Today, WOW abortion activities works largely through online platforms such as womenonwaves.org, womenonweb.org, and aidacces.org. These sites provide resources for women in restrictive countries as well as in the USA, including guidance on safe use of abortion pills and information on donating to support ongoing initiatives.

Kleiverda highlighted current research into the use of mifepristone not only as an abortion pill but also as a potential weekly contraceptive: womenandmore.org . Unlike traditional hormonal contraceptives, mifepristone contains neither estrogen nor progesterone and is therefore less likely to cause harmful side effects. In the same way as ulipristal, which is already available as a morning-after pill, mifepristone could give women greater autonomy over their reproductive health.

Despite what should be a positive development, research into this has been limited because mifepristone is no longer under patent, and therefore lacks pharmaceutical profitability. WOW raised funds independently, securing the cooperation of fourteen hospitals to conduct clinical studies. The research involves monitoring menstruating women who use the drug weekly, tracking side effects, the lining of the uterus, liver function, and overall safety. Early studies in other countries suggest few side effects, making it a strong candidate for safer, non-hormonal contraception as well as on demand (emergency) contraception The project also explores potential applications for treating conditions such as endometriosis and abnormal bleeding.

Kleiverda acknowledged the likelihood of political resistance. Funding has already been denied by major health research bodies. She noted the contradiction in labeling the drug unsafe when it is already approved for abortion treatment but restricted as an abortion method.

[1] "European Court rules that Portugal violated Freedom of Expression of Women on Waves" Press realease issued by the Registrar ECHR 3.2.2009

"*There are many ways to help and support women outside of abortion laws,*" she stated. By investing in drugs like mifepristone and misoprostol, women can gain more control over their reproductive lives outside the limits imposed by restrictive laws or the availability of medical practitioners. For this to succeed, cooperation is essential: lawyers must defend reproductive rights, and progressive doctors must continue to push for safe, accessible options. Kleiverda illustrated both the obstacles and the opportunities facing the future of reproductive health.

Prof. Trudy Dehue - What counts as an abortion?

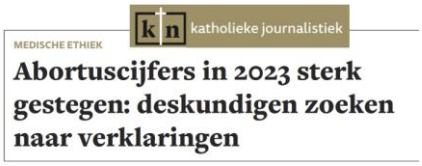
Professor Trudy Dehue's contribution shifted focus from law and activism to how definitions and statistics shape reality. To start with, she challenged recent media reports of a 27% rise in abortions, which led to parliamentary motions by the SGP putting women's motivations for abortion in question, and discussed how this increase was largely due to reclassification, or "concept creep".


NOS Nieuws • Woensdag 6 november, 17:02

NOS

Vorig jaar opnieuw flink meer abortussen in Nederland

Het aantal abortussen in Nederland is vorig jaar opnieuw flink toegenomen: met zo'n 10 procent ten opzichte van 2022. Dat blijkt uit cijfers die de Inspectie


katholieke journalistiek

MEDISCHE ETHIEK

Abortuscijfers in 2023 sterk gestegen: deskundigen zoeken naar verklaringen


deVolkskrant

Het aantal abortussen stijgt snel. Het gebruik van natuurlijke anticonceptie ook


Beau-kijkers storen zich aan 'anticonceptie-toon' voor vrouwen: 'En de mannen die hen bezwangerden?'

"*Before you count, you decide what counts as.*"

51% of the population is a woman. Who do we count as a woman? Do we look at hormones, clothes, organs, or genes? What do we count as an abortion? Early miscarriages, overdue treatments, and even very early fertilizations identified by the new technology of the Clearblue test now count as pregnancies and hence, undoing them show in the abortion-figures. As a result, numbers reflect conceptual stretching rather than real change.

This "*concept creep*" reflects other expansions in categories such as ADHD or autism. She explained that if you stretch definitions they obviously can be applied to many more people, which causes numbers to rise due to redefinition rather than real growth. Abortion figures are therefore less about women's supposed irresponsibility, as some political actors claim, and more about shifting definitions. The far-right (FvD) in the Netherlands used misleading figures on late abortions between 21–23 weeks to argue against abortion, even displaying dolls of fetuses to dramatize their claims. On top of that, they failed to acknowledge that these abortions in fact concerned wanted rather than unwanted pregnancies. A crucial detail which they conveniently left out because it did not align with their agenda. This reveals how selective framing shapes the public debate. In fact the majority of abortions take place within the first 8 weeks.

Dehue pointed out that while women are scrutinized for unintended pregnancies, men's daily fertility and irresponsibility seems to fly under the radar. "*For ages, men have unsolicited fertilized women and on top of that have forbidden them to prevent it or end it*," or, as she states "*Men cause all unwanted pregnancies. We've put the burden of pregnancy prevention on the person who is fertile for 24 hours a month, instead of the person who is fertile 24 hours a day, every day of their life"*. Hardly ever do we mention how hard it is to carry a child and how tough this period can be. These are things that

can be pleasurable, but only when wanted, just like having sex and eating. The "*pro-life*" movement, she stated, is more accurately described as "*pro-force*," seeking to compel women to continue pregnancies against their will. In this context she referred to Art. 11 of the Dutch Constitution, which stipulates the inviolability of the body, holding that all human beings have the right to decide what is being done with their body.

Furthermore, she mentioned the distinction between zoë (biological life/matter) and bios (lived human life), between 'being alive' and 'having a life'. Plants and vaccines are also "alive," yet they are not granted the same protections. When it comes to women's reproductive autonomy, the balance shifts, favoring biological potential (zoë) over lived experience (bios). By interrogating language, Dehue revealed how deeply social norms, technological innovations, and political agendas structure our understanding of abortion.

Abortion is a rather new word. Before this they called it "*evoking menstruation*". Dehue mentioned how the word "*abortion*" was initially used for cows and later adopted by doctors for humans. In the 19th century medical writings described *dispositio abortiva* as the condition of women who risked losing a wanted pregnancy which needed preventive treatment. The meaning of the word here described something quite different from today's meaning. Later, around 1900 Hector Treub, a Dutch gynaecologist, introduced the term *abortion provocatus*, which referred to an abortion intended to save the lives of ill women with a wanted pregnancy. However, Treub subsequently coined the term "*criminal abortion*" in case of a healthy woman with an unwanted pregnancy. Undoing an unwanted pregnancy became a medical-ethical issue and doctors declared themselves superior in moral respects too. When asked by the audience which terms could replace the word abortion, Dehue suggested using "*undoing fertilization*" or "*menstrual regulation*".

Dehue moved into the technological evolution of reproductive control. In the early seventies the *Del Em menstrual extraction kit* was used to evoke one's menstruation. In the early 20th century pregnancy-tests allowed no privacy because they needed a doctor and a lab technician, as well as, an animal immensely suffering for you. In 1970 the first at home pregnancy test was invented by Margaret Crane. This was met with wide protests. In 1971 the Netherlands Medical Journal, for example, published a report stating:

"*It is plausible to assume that the Predictor pregnancy test mainly finds its way to a group of women who (…) are in a state of mental and/or emotional instability, in whose hands the Predictor is a great danger.*"

The New York Times' headline stated: "*Could Women Be Trusted With Their Own Pregnancy Tests?*"

The next step was taken in the 70s by women themselves by using an inexpensive stomach medicine, Cytotec, which contains the hormone misoprostol to evoke menstruation. At the time, this was met with sympathizing newspapers mentioning these pills as "*wonderpills*".

She continued with the next major shift: the invention of mifepreston by Etienne Baulieu, as a "*contragestivum*". Newspapers speculated optimistically that the new overtijdpil/overdue pill might soon be available over the counter without having to know if there is an actual pregnancy illustrating an imagined future of accessible reproductive freedom.

However, these small celebrations of hope were soon met with political backlash, as illustrated by the 1974 headline of the Calvinist newspaper denouncing the overdue-pill as: "*For sure an abortion!*" This was followed in 1979 by the Catholic prime minister Van Agt, who declared that the law had to limit abortion.

With that she circled back to uproar about the abortion figures nowadays, stating that it is not women who have become more careless, but the meaning and definition that have been stretched.

Panel Discussion: The future of Dutch abortion law

The panel was introduced by Dr. Marjan Wijers who highlighted the topicality of the debate as the Dutch Parliament is right now discussing a proposal of D66 to secure the right to access to a safe abortion as a human right.

Significantly, the current parliamentary debate mirrors the discourse in the 70s which traditionally centres on the competing claims of 'dignity as life' – the duty of women to pregnancy - versus 'dignity as liberty and equality' – the right of women to decide themselves if and how many children they want. To quote Betty Friedan in one of her speeches in 1969!:

"[T]here is no freedom, no equality, no full human dignity and personhood possible for women until we assert and demand the control over our own bodies, over our own reproductive process...The real sexual revolution is the emergence of women from passivity, from 'thing-ness', to full self-determination, to full dignity"

The two panel members each represent an important perspective: the legal perspective and that of the women affected.

Dr. Fleur van Leeuwen is a lecturer in law and human rights researcher at Utrecht University, focusing on the intersection of human rights, gender, and intersectional feminism. She published extensively on reproductive rights, gender equality, women's rights, and human rights monitoring, among others recently in De Volkskrant with the title "De Nederlandse abortuswet is een draak van een wet" ("the Dutch Abortion Law is a terrible bit of legislation)". She also is the national gender equality law expert of the European Equality Law Network, and a board member of the Association for Women and Law (VVR)

Laura van Stein is head of policy & partnerships and secretary at Ava, an independent Dutch advocacy organization that is committed to providing reliable and neutral information about contraception and abortion and towards building a society where everyone has access to good, well-informed and tailormade reproductive care. AVA means 'voice' of 'sound' in Persian and stands for their key values: anti-conception, free choice and abortion. Their work is based on the experiences, wishes and needs of women themselves, or more broadly, people with a uterus, in relation to contraception and abortion care. This includes trans and non-binary people who can get pregnant and/or menstruate. For practical reasons we will mostly use 'women' during the discussion, but pls keep this in mind.

The panel focuses on 3 questions:

- What's wrong with the current law (that stems from 1984)?
- What do we want? Should there be a new law and how should a new law look like?
- What are the dangers and risks?

Dr. Fleur van Leeuwen - The Dutch legal context in the light of international human rights law

While Dutch abortion law is often celebrated as progressive, abortion remains a crime under the Dutch Criminal Code. Early criminalization under the 1911 Morality Act and Article 296 of the Criminal Code established abortion as a punishable offense, with imprisonment or fines for anyone performing or undergoing the procedure. The 1911 Morality Act states,

"*Anyone who intentionally treats a woman, or causes her to undergo treatment, while indicating or creating the expectation that pregnancy may thereby be terminated, shall be punished with imprisonment not exceeding three years or a fine not exceeding three thousand guilders*."

Although the Pregnancy Termination Act of 1981 later carved out exceptions to this general prohibition, these exceptions remain conditional. Abortions are only lawful if performed by physicians in authorized clinics or hospitals and under specific requirements. In addition, the Pregnancy Termination Act requires that a pregnancy can only be terminated if the woman's emergency situation makes it unavoidable. Physicians are required to discuss alternatives with the person that wants to terminate her pregnancy and, contrary to popular belief, there is still a waiting period that must be observed. The duration of this period is no longer a fixed five days, but since the amendment to the Pregnancy Termination Act of 2022, must be determined by the woman and the physician together. This means that although the waiting period could in theory be only a day, it is also possible that a woman must wait longer than 5 days if her physician does not agree to a shorter term.

The law does not offer the pregnant individual any rights, and she is therefore fully dependent on her physician as to if and when she terminates her pregnancy. The law, moreover, emphasizes the responsibility of the woman toward the "*unborn life*," underlining that the aim of the law is not to ensure a right to, or access to abortion, but rather to balance its aim of protecting unborn life with the need to help a pregnant woman with her emergency situation.

Van Leeuwen highlighted how Dutch abortion law not only restricts access but also perpetuates stigma. By locating abortion within the Penal Code, the Dutch state continues to frame it as a criminal act, tolerated only under specific conditions. The ongoing requirement to justify abortion decisions as "*unavoidable*", and the gatekeeper position of physicians, undermine women's autonomy and suggest mistrust of their capacity to make informed choices.

She further situated the Dutch framework in a comparative and international context. Referring to the CEDAW Committee's recent inquiry on Poland, she emphasized how criminalization is rooted in harmful stereotypes, has a stigmatizing effect, and constitutes gender-based discrimination. Criminalisation may also have a chilling effect on doctors, leading to potential problems with access to this form of care.

Van Leeuwen concluded by warning that access to abortion in the Netherlands is more fragile than often assumed. Because the law does not acknowledge a right to abortion, access depends entirely on physicians' willingness to provide this care. In a political climate increasingly influenced by conservative and anti-abortion movements, more restrictive interpretations or declining provider availability could rapidly curtail access. The current legal framework offers no safeguard against such developments, underscoring the urgent need for fundamental reform.

Laura van Stein (Ava) – representing those in need of abortion care

Speaking on behalf of Ava, Laura emphasized that the voices of those who actually need abortion care are too often excluded from the debate. Abortion, she stressed, is not an abstract debate but part of everyday healthcare. Ava represents women, trans, and non-binary people with a uterus, and its mission is to provide trustworthy information, guarantee free choice, and ensure accessible care.

International human rights standards are clear: the UN Human Rights Council requires states to provide safe abortion care, and laws must not endanger health. Yet Dutch law still falls short of these obligations, creating barriers and reinforcing stigma. Abortion remains in the Penal Code, casting a constant shadow of illegality. As a result, a straightforward medical decision is often experienced as complicated, suspicious, or isolating.

Ava's research, based on 2,449 participants, shows that stigma remains widespread in the Netherlands. Many people keep their abortion secret, and feelings of shame are common. This persists despite the reality that abortion is a routine, safe treatment: 70%

take place within the first eight weeks, 97% are without complications, and 95% of patients affirm it was the right choice. Relief is by far the most common outcome.[2]

Structural barriers continue to exist. There are only 16 abortion clinics in the country, with none in Friesland or the Wadden Islands. Access therefore depends on having a car, financial resources, a supportive partner, or a safe home situation. These are conditions not available to everyone. Even small improvements, such as allowing general practitioners to prescribe abortion pills, have been hard-won battles.

Despite these barriers, Dutch medical care is of world-class quality and, contrary to what the newspapers often suggest, enjoys strong social support. Public opinion is broadly favorable: 87% of the population supports access to abortion, and many patients report backing from partners and family. Society is ahead of the law.

Ava outlined four key priorities for creating a future-proof abortion framework. First, abortion should be decriminalized and treated as healthcare rather than as a crime. Second, abortion should be integrated into regular healthcare, making use of trusted existing systems. Third, access must be guaranteed everywhere, ensuring that services are available in all regions and for all people. Fourth, autonomy must be respected by removing unnecessary hurdles and paternalistic restrictions.

Laura closed by affirming that abortion is both healthcare and a human right. She concluded that a society which trusts people to make their own choices is a society that protects freedom, dignity, and equality.

Discussion

What is wrong with the law? The narrative behind the law is that women are not capable of making smart decisions. Moreover, what the panellists found frustrating was the moral judgement surrounding abortion when it is in fact a personal decision that should be made without judgement. Access to abortion should be premised on notions of physical and mental integrity rather than stereotypes of weak, vulnerable and/or egocentric women. It was stressed how the media represent abortion as if it is a very controversial topic when in reality 87% of the population think that abortions are part of normal rights. The topic is still very much sensationalized with horror stories even though most people feel fine when they have to get an abortion. It seems to be a very neutral experience but that would not be as interesting to put out in the media.

Furthermore, the panellists discussed government funded organizations pretending to give non biased advice. One example of this is the organization called "*Er is hulp*" which means "*There is help*". It works with volunteers and pretends to give non-biased help but according to their website volunteers are trained by their internal (free) Pro-Life Academy. There are many organizations who claim to offer neutral support to women but in reality promote an anti-abortion agenda. These organizations often receive public funding under the guise of providing help or guidance while subtly discouraging women from choosing abortion through emotional manipulation or misinformation. To fight this AVA set up their own website but without as much funding, the fight remains unequal.

What can be learned from other countries? France decriminalized abortion in 1970, but its legal timeframe is lower in terms of the maximum number of weeks in which abortion is allowed, meaning limitations persist. In Canada, abortion is not regulated by law and is fully recognized as medical care. However, panellists noted that medicalizing abortion at a very early stage when women can help themselves is problematic as well. True

[2] Please note that the figures mentioned above are preliminary results. The studies from which they are drawn were still ongoing.

liberation lies in ensuring access to over-the-counter pills and medical care only when needed. On top of that, we do not need more laws specifically on abortion when the existing protocols within medicine and health law would be more than enough. Our current medical practice is liberal but the law remains restrictive and fragile. However, this could easily shift just like happened in Italy. If a similar shift would occur here, we would have little guarantee that abortion would remain equally accessible. The Netherlands falls short in principle, but functions well in practice. The next step that is needed is to remove abortion from the Criminal Code to ensure long-term protection.

Conclusion

The symposium wove together legal, activist, and academic perspectives into a coherent message: abortion is a fundamental human right and must be treated as such. International bodies like CEDAW continue to push states toward decriminalization and universal access. Activists demonstrate resilience and innovation, from sailing international waters to conducting groundbreaking medical research. While media narratives continue to sensationalize abortion, scholars expose the ways language and classification shape public understanding. And within the Netherlands, practitioners and advocates remind us that liberal medical practice is not the same as legal security.

The Dutch law, still grounded in criminalization, leaves abortion rights vulnerable to political shifts. While most of society supports access, the legal framework falls behind, creating a narrative that women are not able to make responsible decisions without external oversight. The call to action was clear: decriminalize abortion, integrate it fully into regular healthcare, guarantee universal access, including for undocumented women, and dismantle the stigma that continues to surround it. Beyond this, speakers noted that even broader access could be imagined, such as making early abortion medication available over the counter, empowering women to regulate menstruation themselves without medical gatekeeping, and reserving medical intervention for cases where it is truly necessary. Abortion is healthcare and should not be surrounded by extra barriers.

The symposium closed with a reminder that rights once taken for granted can be rolled back, as recent events in Poland and the United States have shown. Safeguarding abortion rights requires vigilance, advocacy, and legal reform. As one participant remarked, even after decades of struggle, the fight is far from over.

Colofon
Report: Yu Xuan (Joann) Qiu
Publication of the Dutch Association for Women and Law (Vereniging voor Vrouw en Recht Clara Wichmann)
in collaboration with the Dutch CEDAW Network (Netwerk VN-Vrouwenverdrag)
Leiden, november 2025

ISBN 978-90-799931-20-0 (PDF download)
NUR: 745

Netwerk VN-Vrouwenverdrag
W | https://www.vn-vrouwenverdrag.nl/
E | schaduwrapportage@gmail.com

Vereniging voor Vrouw en Recht Clara Wichmann
Postbus 778
2300 AT Leiden
W | www.vrouwenrecht.nl
E | info@vrouwenrecht.nl