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Precarity and pills in a pandemic: online abortion care-seeking in Poland during COVID-19

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ABSTRACT

COVID-19 and subsequent policy measures (e.g., lockdowns) impacted abortion care-seeking and provision, including availability and accessibility of care services. We examine the impact of COVID-19 on abortion-seeking in Poland using quantitative and qualitative secondary data from abortion care-seekers' (n = 8577) online consultations (April–Dec 2020) with an abortion telehealth provider working in Poland.

COVID-19 amplified job and financial insecurity and precarity, influencing abortion decision-making. COVID-19 measures like lockdowns limited privacy, exacerbating the need for secrecy as a key element in abortion care-seeking, particularly when at risk of interpersonal violence. Personal support systems, often essential in pregnancy, birthing, and parenting, were altered by COVID-19. The loss of key family members (e.g., wage earners or carers) heightened financial and social vulnerability. This collapsing of support systems and networks during the pandemic, shaped abortion decision-making. Pregnancy during COVID-19 potentially exposed people and their families to greater precarity and forms of structural violence, making it a 'cliff edge'.

Locating abortion experiences in Poland within macro-level intersections of the pandemic, neoliberal policies, and shifting abortion governance (e.g., further restricting of abortion), we highlight the difficulties in accessing abortion care and support. Shifting away from predominant health or rights framings of abortion, we offer new empirical evidence that explores how the pandemic heightened existing structural violence and precariousness, shaping abortion care-seeking and decision-making.

1. Introduction

I have never been in such a hopeless situation in my life. I even have to borrow money to buy some bread. Because of coronavirus, I lost my job (I hope that it's only temporary). I'm working odd jobs, but in a world where most companies are being shut down, it is very difficult […]. *I don't know what to do, how to save myself. I feel like I am going to lose my mind in a moment.*

- H, 26 years old (Poland, April 2020), e-mail.

In early 2020, governments around the world implemented directives and policies to mitigate the spread of COVID-19, with some having immediate and sometimes harmful impacts on sexual and reproductive health (SRH). In some countries, SRH was initially framed as 'non-essential' or 'elective', meaning SRH services were closed in line with government lockdown directives (Riley et al., 2020). The resulting reduction in access to SRH care in many countries globally was compounded by commodity shortfalls, supply chain failures, clinic closures, and diversion of health workers to other services (Aly et al., 2020;

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Church et al., 2020). At the same time, the need for SRH increased. For example, domestic and intimate partner violence (IPV) surged under quarantine and lockdown conditions across the world, referred to as a 'shadow pandemic' of violence against women and girls (UN Women, 2020), which may have increased the need for abortion or other reproductive health access.

While restrictive laws, unavailability of services, and social/legal sanctions have always shaped abortion care and access, pandemic conditions heightened these barriers to care (Rød et al., 2023; Tang et al., 2020; Todd-Gher & Shah, 2020). In highly restrictive contexts like Poland, abortion care has been provided by organisations such as Women Help Women, who similarly faced increased barriers as a result of the pandemic. While some countries in Europe introduced abortion telemedicine measures to enable access (Rød et al., 2023; Parsons & Romanis, 2021), others like Poland utilised COVID-19 to restrict abortion further (Bojovic et al., 2021; Krajewska, 2021a). Travel restrictions also affected abortion access. Lockdown and border closures in Poland and other European countries affected care as those in later gestations or living under restrictive laws could not travel to other cities or countries for care (e.g., Poland to Czech Republic) (Bojovic et al., 2021).

At the same time, the COVID-19 pandemic heightened people's precarity across the globe – an unavoidable, shared condition of social, economic, and physical vulnerability, politically induced by neoliberalism (Butler, 2009). Neoliberalism, the dominant global economic ideology, is critiqued for entrenching inequalities and dismantling state welfare and social protections in favour of emphasising individual responsibility and freedom (Biebricher & Johnson, 2012; Dilts et al., 2012). The pandemic highlighted 'just how many people previously considered to be "doing well" are but one or two pay cheques away from hardship' (Lohmeyer & Taylor, 2021, p. 626). Precarity is unequally distributed along multiple axes of difference (Majewska, 2021) and pandemic impacts were similarly stratified along lines of gender, race, and ability; disproportionately affecting those already experiencing structural and systemic inequalities. For example, in Europe, income inequality shaped the health impacts of the pandemic with those in lower income groups less likely to be able to access healthcare services and more likely to contract COVID-19 (Eurofound, 2023). This stratification exposed people differently – according to class, race, gender, (im) migrant status, amongst other differences-to the risks and consequences of pandemic-related policies (Fiske et al., 2022).

Such inequalities-predating and intensified under pandemic conditions-are manifestations of structural violence, which can shape reproductive and abortion trajectories (Nandagiri, 2020). For example, in Poland neoliberal policies might affect reproductive decision-making (e.g., delaying parenthood) as people attempt to navigate insecure, shifting circumstances and their implications (e.g.: childcare, maternity leave) (Mishtal, 2012). Such policies, when intertwined with neoconservative ideologies aimed at entrenching traditional gender roles (e.g., valorising motherhood) can restrict abortion access through criminalisation, stigmatisation, and moralisation (Chełstowska, 2011; Chełstowska & Ignaciuk, 2023; Graff & Korolczuk, 2022).

Distinct from direct or interpersonal forms of violence, structural violence is the violence of injustice and inequity (Galtung, 1990). Focusing on intersecting systems, institutions, and structures (legal, political, religious, economic, and sociocultural), structural violence makes visible how entrenched, everyday violence(s) are exerted cumulatively, systematically, and indirectly to form the 'social machinery of oppression', causing pain and social suffering (Farmer, 2004). Structural violence is evident in previous health emergencies, and has followed gendered pathways, shaping abortion and reproductive care (Harman, 2016; Wenham et al., 2019; Wenham et al., 2020; Wenham, Smith, Morgan, et al., 2020).

As the epigraph above reflects, abortion and abortion care-seeking in Poland during the pandemic were shaped by structural violence and precarity. Some public health policies and social measures during the pandemic exacerbated unjust conditions surrounding peoples' lives and their pregnancies. It made visible the fragility of their employment (e.g., unstable jobs, seasonal industries), the instability of daily life (e.g., food, employment, and economic insecurity), and limited access to care (e.g., restricted appointments). This precarity permeated beyond the individual to encompass the relational and the affective– their relationships and emotions. As such, it is important to highlight the interplay between everyday and interpersonal reproductive experiences and the structural and institutionalised violence(s) that were exacerbated during the pandemic.

In this study, we examine the impact of COVID-19 on abortion-seeking in Poland by analysing qualitative and quantitative data from a feminist organisation – Women Help Women (WHW) providing abortion information and support in Poland between April 1st - December 31st, 2020. Locating individual abortion experiences in Poland within macro-level intersections of the pandemic, structural violence, and shifts in abortion governance, we highlight the difficulties abortion-seekers faced in accessing care and support. We explore how the pandemic heightened existing structural violence and precariousness, shaping abortion care-seeking and decision-making.

2. Background

2.1. COVID-19 pandemic in Poland

In March 2020, Poland invoked the legal provisions of a state of epidemic (Ministry of Health, 2020a, 2020b) which included suspension of 'elective care' to enable workforce and add bed capacity for COVID-19 treatment, as well as designating 'single infection' hospitals for exclusive treatment of COVID-19 (Sagan et al., 2022). Poland, already facing a shortage of doctors and nurses compared to other European countries, undertook significant redeployment of its limited medical staff to pandemic response (Winkelmann et al., 2022).

In early March 2020, new legislation (*the COVID Act*) was adopted to manage the pandemic response and set out budgetary, administrative, and epidemiological measures (EUAFR, 2020). The *Anti-Crisis Shield* was introduced to counteract the pandemic's economic impacts (e.g., wage subsidies, postponement/cancellation of social insurance contributions, school closure-related allowances for parents of young children, and unemployment benefits during the first 90 days of unemployment) (Eurofound, 2020; IMF, 2021). Following relatively few infections and COVID-19 related deaths, restrictions were eased by end April 2020 (Sagan et al., 2022). By mid-May, most restrictions were lifted, and European borders were re-opened in mid-June (Zabdyr-Jamróz, 2020). New restrictions and measures were imposed in October 2020 as infection rates increased. Additional measures in early November included social distancing and mobility restrictions. A national quarantine was announced in December (28/12/2020–18/01/2021) (IMF, 2021). Whilst pertinent for mitigating disease transmission, these measures created downstream impacts, affecting employment, and catastrophically affecting some incomes. In a July 2020 survey (More in Common Poland, 2020) more women (49 %) than men (41 %) reported that their financial situation had worsened. More women (51 %) than men (40 %) reported being worried about financial difficulties and job loss (39 % v. 30 %). Pandemic diaries also reflected the exacerbation of mental health issues due to forced isolation and torn social bonds, alongside concerns about the future, job losses, and uncertainty about the labour market (Rodak & Malusà, 2021; Łukianow et al., 2021).

Controversially, Poland's 'state of epidemic' declaration required enactment of special provisions and resolutions and was not time limited; risking a violation of the Constitution (Sagan et al., 2022). The COVID Act was criticised for potentially threatening fundamental rights and freedoms and equipping the government with unlimited powers (EUAFR, 2020). Critiques were particularly trenchant in October 2020 around efforts to further restrict abortion (Krajewska, 2021a; Sagan et al., 2022).

2.2. Abortion in Poland

Under state socialism in Poland, abortion was legal and widely available for health and socio-economic grounds under the 1956 abortion law, despite objections from Catholic groups (Krajewska, 2021b, 2022; Nowicka, 2007). At the time, abortion was also subsidised in public hospitals (Mishtal, 2010). In 1989, sweeping political and socio-economic changes followed the end of state socialism in Poland. Solidarność, the democratic opposition movement, formed the new government. The Catholic Church played a prominent role in this victory and continued to exert considerable social and political influence over the state (Caytas, 2013; Krajewska, 2022). Neoliberal reforms led to social welfare cuts, privatisation, deregulation and commercialisation of healthcare (Chełstowska, 2011; Mishtal, 2010).

Simultaneously, the Catholic Church revitalised its efforts to restrict abortion access - a draft bill on an absolute abortion ban was debated in parliament in 1989, followed by a modified second draft in 1990 (Borowik, 2002; Fuszara, 1991). A 'conscience clause' was introduced via a Health Ministry regulation in 1990, allowing doctors to refuse to perform abortions. It led to a wave of conscientious objections, ending the 'availability of abortion throughout entire hospitals' (Caytas, 2013, p. 68). The new Code of Medical Ethics, adopted by the National Congress of Doctors in 1991, made abortion on social grounds a violation of professional medical ethics with a possible suspension of medical licence despite abortion remaining lawful at the time (Caytas, 2013). In 1991, a Bill proposing punishments for doctors and pregnant women was rejected (Szelewa, 2016). Two MPs tabled a Bill calling for a national referendum on abortion. Women's organisations led public protests against the proposed bans, defending the right to abortion. They also collected 1.3 million signatures supporting the petition for a referendum (Nowicka, 2007). Ceding to Polish Catholic bishops, parliament rejected the bill proposing a national referendum on abortion (Szelewa, 2016; Nowicka, 2007).

In 1993, the *Act on Family Planning, Human Embryo Protection, and Conditions for the Lawful Termination of Pregnancy* came into force. Under this law, abortion was only permitted due to risk to the life or health of a pregnant woman, due to foetal ill-health or if the pregnancy was a result of rape or incest. Performing or assisting with an illegal abortion is punishable by law, but pregnant people seeking an abortion are not penalised. Koralewska and Zielińska (2022) and Mishtal (2015) highlight how the abortion law reflected a renewal of traditional, Catholic, Polish values as intrinsic to the formation and identity of the Polish state. This Catholic-nationalist discourse also had the effect of solidifying traditional gendered notions, redefining women in relation to others (e.g., as mothers, wives), and calling for the 'rights of the family' (Mishtal, 2015, p. 44).

This combination of 'right-wing Catholic ideology and neoliberal economic reforms' created and exacerbated conditions of reproductive and social injustice (Chełstowska, 2011, p. 104). Abortion remains under threat, with repeated attempts to amend the law or introduce a total ban, which feminist groups and collectives continue to resist (Chełstowska & Ignaciuk, 2023; Hussein et al., 2018). In 2015, the Polish Constitution Tribunal issued a judgement widening the scope of conscientious objection, with individual doctors no longer obliged to refer abortion-seekers to care providers (Krajewska, 2021a). This effectively meant that people were unable to 'obtain even the abortions to which they are legally entitled' (CRR, 2012, p. 1).

Feminist networks and groups like Kobiety w Sieci (established 2006), and Women Help Women (WHW, established 2014) have provided abortion services in Poland. This includes information about medication abortion via helplines or moderated internet forums, as well as sending pills via post (Baum et al., 2020; Endler et al., 2019; Foster, 2018). Abortion pills, also called medical or medication abortion, are oral pharmaceuticals – misoprostol and mifepristone, or misoprostol alone used to induce an abortion. Medication abortion is well-studied, safe and effective. Decades of experiential and scientific evidence show that self-management of abortion is both acceptable and safe (WHO, 2022). Self-management of abortion is legal in Poland as the law does not criminalise pregnant people themselves for having abortions. Most abortions in Poland are managed with pills - an estimated 120,000–150,000 self-managed or procedural terminations are performed every year in Poland (Foundation for Women and Family Planning FEDERA, 2021) outside of the 'institutional medical system' (Braine, 2020). People also travel abroad for abortion care later in pregnancy, particularly for terminations in the second and third trimester (AWB, 2024).

On October 22, 2020, the Polish Constitutional Tribunal ruled that abortions on the grounds of 'severe and irreversible foetal defect or incurable illness that threatens the foetus' life' were unconstitutional (Gliszczyńska-Grabias & Sadurski, 2021). Prior to this ruling, nearly all (98 %) legally obtained abortions in Polish public hospitals were based on the high probability of severe and irreversible foetal damage or incurable foetus illness (FEDERA, 2021). This judgement effectively imposed a de facto ban on pregnancy termination in almost all cases.

Civil society and feminist groups protested and opposed these changes, including critiquing the Constitutional Tribunal; seen as an undemocratic instrument of the authoritarian and right-wing government run by the Law and Justice Party (Chełstowska & Ignaciuk, 2023; Fazan, 2023; Gliszczyńska-Grabias & Sadurski, 2021). The pandemic created an opportunity structure for regressive policies to be pushed through under the radar or with reduced resistance, such as the 2020 ruling in Poland (Krajewska, 2021a). More than 1000 Polish women who were denied abortions or who postponed their reproductive decisions out of fear of ill treatment or lack of access to care, filed cases in the European Court of Human Rights (Foundation for Women and Family Planning FEDERA, 2021; Kapelańska-Pręgowska, 2021). The Constitutional Tribunal has been described by legal scholars as a 'dangerous and unhinged institution, which uses judicial review as a blunt sword both to punish opponents and to promote the illiberal agenda of the ruling majority', pointing out that the 2020 abortion ruling is the 'most dramatic illustration of this incremental subjugation' (Koncewicz, 2022, p. 303).

The government was criticised for utilising COVID-19 to consolidate authoritarian rule and push through new abortion restrictions (FEDERA, 2021; Gliszczyńska-Grabias & Sadurski, 2021). Critics linked abortion restrictions to broader anti-gender, neo-conservative and neoliberal backlash against feminist and LGBTQI rights and freedoms, underpinned by the government's effort to restore 'traditional family and values' (Berro Pizzarossa & Sosa, 2021; Bielska-Brodziak et al., 2020; Korolczuk, 2020; Szczygielska, 2019). Poland now has one of the most restrictive abortion laws in Europe.[1]

While the judgement to ban abortions for foetal health indications came into effect in January 2021, the chilling effect of the ban was immediate. Abortion Without Borders (AWB), a cross-European initiative supporting people in Poland to access abortions, reported that 17,000 people contacted them for an abortion in the six months following the Tribunal ruling (ASN, 2021). In contrast, government data reported 1076 abortions in 2020 and 107 abortions in 2021 (Sejm, 2022, 2024).

[1] At the time of writing, these restrictions remain in place. Donald Tusk, elected Prime Minister in December 2023, promised abortion reform. Legislative discussions on ending the near-total abortion ban are ongoing. In July 2024, a bill proposing an easing of abortion restrictions was defeated by a slim majority (Skujins, 2024). In August 2024, Tusk conceded that there was no majority to change abortion laws, and announced that the party would resume efforts to relax the law after the Presidential elections in May 2025 (Kassam, 2025). Karol Nawrocki, backed by the anti-abortion Law and Justice party, was elected President in June 2025, reigniting concerns about continued opposition to any changes to the abortion law.

3. Conceptual underpinnings

In this section we introduce key concepts that guide our abductive analyses and discussions.

3.1. Structural violence

Structural violence is the violence of systems (legal, political, religious, economic, sociocultural) that shape individual experiences and their life conditions (Rylko-Bauer & Farmer, 2017; Scheper-Hughes, 1996). An indirect, 'everyday violence' built into the fabric of society, it is experienced cumulatively over generations and individual lifetimes and causes unequal life chances (Galtung, 1969; Scheper-Hughes & Bourgois, 2004). This focus on systems (e.g., neoliberalism) offers analytical insights for abortion research by interrogating structural forces that shape individual abortion experiences (Nandagiri, 2020).

3.1.1. Neoliberalism

We follow Lohmeyer and Taylor (2021) in understanding neoliberalism as an institutional framework that prioritises free market logics, integral to enabling and securing individual freedoms. This includes the dismantling of welfare mechanisms and protections, re-casting public services (e.g., healthcare) in purely economic terms, and valorising individualism, where social problems occur due to individual ir/responsibilities rather than structural obstacles or the product of social conditions (Lohmeyer & Taylor, 2021). Neoliberalism, as an economic system, creates and reinforces conditions of structural violence. For example, the health crisis in Poland during the pandemic was a consequence of neoliberal reforms including low public investment in health (Szymborska & Szymborski, 2025). Neoliberalism's violence is in the slow, everyday but deliberate removal of support mechanisms for those already experiencing vulnerability and marginalisation (Giroux, 2015). This includes cutting access to or reducing investments in SRH services and programmes (e.g., abortion or childcare) or framing them as 'elective'– thereby requiring out-of-pocket payments.

3.1.2. Neoconservatism

Neoliberalism links with cultural, political, and social ideologies (e.g., neoconservatism) aimed at organising and disciplining lifeworlds (Lerch et al., 2022). Neoliberalism also functions as a cultural paradigm, permeating 'all spheres of human activity, including cultural production, practices and citizenship and intimacy, identity and emotions' and transforming social relations and value systems. This individualistic paradigm is intertwined with neoconservatism, where a focus on 'family responsibility and moralisation of social inequalities' makes 'neoliberal policies appear inevitable and natural' (Graff & Korolczuk, 2022, pp. 30–31).

In Poland, the re-traditionalisation of gender roles accompanied the post-communist, neoliberal transition of the 1990s. In this transition, women were relegated to the private sphere, with family and motherhood as their primary responsibility (Szelewa, 2016). Scholars (Bielska-Brodziak et al., 2020; Mishtal, 2012) point to *Matka Polka* (Polish Mother) as a key symbol of post-socialist national imaginary. The 1993 restriction on abortion forms part of this re-traditionalising alongside subsequent efforts to limit sexuality education, access to contraception, and other reproductive health services (Desperak, 2023).

Abortion stigma, enshrined in the 1993 law, permeates public and legal discourse, shaping stigmatised public perceptions of abortion (Kwiatkowska et al., 2023). Religious and nationalist discourses reinforce abortion stigma (Kumar et al., 2009; Millar, 2020), alongside gendered and classed expectations around what constitutes responsible motherhood. For instance, Kwiatkowska et al. (2023) document how abortion stigma in Poland is embedded in legal and social frameworks that mark certain pregnancies—especially those occurring outside idealised norms (e.g., premarital sexual activity)—as deviant. Similarly, Cullen and Korolczuk (2019) describe how women's reproductive decisions are assessed through moral frameworks that valorise sacrifice and maternal responsibility, leading to the stigmatisation of those who deviate from these ideals (e.g., pregnancy among very young or older women).

Subsequent right-wing governments (e.g., the Law and Justice Party, PiS) continue to draw on neoconservative ideas including the defence of traditional family and heterosexuality as political tools. These neoconservative efforts to restrict abortion, amongst other sexual and gender rights, are supported by the Polish Catholic Church and other right-wing forces (Bielska-Brodziak et al., 2020). This combination of neoliberalism and neoconservatism creates a unique synergy that significantly shapes abortion in Poland.

However, as Graff and Korolczuk (2022) caution, not all neoconservative mobilisations are inevitably neoliberal. Anti-gender movements, powerful allies of neoconservative or right-wing populism, can also be understood as a reaction and opposition to both neoliberalism as a market force and gender progressivism as a cultural project (Graff & Korolczuk, 2022).

3.1.3. Responsibilisation

'Responsibilisation' places the burden of responsibility or risk of managing care and access on the individual. This reformulates social problems in two ways – (i) as a problem of problematic individuals, and (ii) as a moral problem of how individuals conduct themselves and the ir/rational choices they make. It constructs 'prudent citizens' with responsibility for optimising their and their families' health through 'good' and 'moral' economic and lifestyle choices (e.g., reproducing 'responsibly') (Rose, 2007). For example, as Wenham, (2021) demonstrates in her exploration of the Zika outbreak, policy responses at national and global levels shifted responsibility onto women to avoid mosquito bites, reduce mosquito breeding grounds, and avoid pregnancy, without ensuring they had the means to do so (e.g., access to contraceptives). If people ignore, contravene, or do not action this advice, it allows apportioning blame for their irresponsible and irrational individual 'choices'.

Constructions of ir/responsibility and ir/rationality are unevenly distributed. Mishtal (2012, 2019), in her exploration of reproduction and fertility in Poland, shows that low fertility rates have been framed by the state, media, and the Polish Catholic Church as an irrational rejection of motherhood. This pronatalist rhetoric, tied to re-traditionalising, recasts Polish women as biological citizens expected to 'live responsibly and rationally in order to maximise their contribution' (p. 155, 2012) to population growth and national goals. The emergence of a single child norm as 'rational' and 'responsible', frames those who have more than one child as irrational and irresponsible. Mishtal (2012) highlights how this can be stratified for low-income Polish or Roma women, where their reproduction can be labelled reckless and pathological if they have multiple children.

3.2. Precarity/precariousness

'Precarity' and 'precariousness' have been used to describe people, conditions, and objects (e.g., migrants, housing, labour, the planet), but these are more than a sense of extreme vulnerability, insecurity, or instability (Millar, 2017; Puar, 2012).

Butler (2009, p. 25) identifies precarity as a 'politically induced condition' of neoliberalism, 'in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death'. These processes are underpinned by the notion that market rationality decides whose health and life should (not) be valued, and is stratified by age, race, class, gender, and other axes of difference. Social and political institutions thus distribute these life conditions unequally and in differentiated ways (Millar, 2017; Puar, 2012). These neoliberal logics become the logics of life itself, making precarity the 'norm of everyday life' (Butler, 2009, p. xix).

Precariousness is the unavoidable, shared condition of social and physical vulnerability (Butler, 2009). By extending precarity beyond labour, Butler (2004, 2009, 2011, 2015) engages with life conditions, where the precariousness of life is intimately tied to questions of the body, social connections, health, politics, governance, and the environment. Infrastructures that shape life conditions, also shape what makes life un/liveable, and the kinds of decisions and options available to one. Thus, precariousness is a 'social condition from which clear political demands and principles emerge' (Butler, 2009, p. xxv).

3.3. Structural violence and precarity/precariousness

When abortion is difficult to access, the consequences of abortion denial or lack of access are heightened for those made-marginalised due to class, immigration status, disability, race and ethnicity, sexuality, or other intersecting identities. During the pandemic, already precarious life conditions were heightened by lockdown or quarantine measures, restrictive laws, travel restrictions, financial insecurity, and other forms of structural violence.

We use these two large ideas – structural violence, and precarity/precariousness – to examine abortion in Poland in the context of the COVID-19 pandemic. These two concepts allow an accounting of linked but separate elements (i) the structurally violent systems (e.g., neoliberalism, neoconservatism) that shape peoples' life conditions, and (ii) the unequal distribution of those life conditions; making precarity an everyday norm. These permeate abortion – how it is accessed, perceived, experienced, and why.

Examining pregnancy and abortion within these infrastructures of structural violence and precarity moves away from individualised framings of 'health' or 'choice' alone. It instead allows for an examination of social conditions from which abortion emerges as a political demand.

4. Methods

This mixed-methods study is a secondary analysis of qualitative and quantitative data collected by Women Help Women (WHW) via an online consultation form and e-mail communications as part of routine service provision. WHW is a global feminist organisation providing information, support, and access to medication abortion.

Abortion-seekers complete a detailed online consultation form that is reviewed by WHW staff. WHW staff then follow-up with abortion-seekers via email as part of the consultation process. When submitting a consultation form, the first step of the consultation process, abortion-seekers agree to the 'usage of anonymised data for research purposes'.[2] On the WHW platform, a 'consultation' encompasses this submitted intake form, subsequent email communication, and the evaluation form that is sent a few weeks after the pills. Abortion-seekers included in this dataset consented to the use of their anonymised data from this full consultation pathway for research purposes.

Pills are sent via post if they qualify (e.g., gestation, location) and if there are no medical contraindications. If eligibility is uncertain, additional evaluations are conducted. A donation of EUR 75 is requested, but those who cannot afford it are requested to donate what they can, or the request for donation is waived.

WHW anonymised data before sharing them with the research team via a secure server.

4.1. Data

People seeking abortion care from WHW complete a detailed online consultation form (available in 13 languages) on their website. For this study, we analysed quantitative data from the online consultation form and qualitative data from the consultation form's open-ended responses and from any subsequent e-mail communications between April 1st and December 31st, 2020.

Consultation forms: We analysed data from 8577 unique consultation forms completed by abortion-seekers living in Poland who requested their medications be shipped to a location in Poland. The consultation form included socio-demographic variables (e.g., age, gender, educational attainment, location), confirmation of desire to end a pregnancy and to use medical abortion with support of the WHW e-service, information about the pregnancy (e.g., gestational age and how it was confirmed), medical information (e.g., presence of any contraindications for medical abortion, specific illnesses or use of medications), contraception use, and reason(s) for abortion. For this study, we added a specific question to the consultation form: 'Has COVID-19 impacted your decision-making around abortion?' with the response categories being: Yes/No/I don't know/I don't want to share. If 'yes', a sub-question asked: 'How did Covid-19 impact your decision-making?' and allowed a free text response. Both questions were optional. The questions were included in the form from April 1st, 2020.

E-mail communications: After the initial consultation form was submitted, WHW staff followed up via e-mail. We included e-mails (n = 80) specifically mentioning COVID-19 in our corpus. E-mails offered more contextual information on abortion-seekers' lives and experiences.

E-mail and consultation data were linked with an anonymised unique ID number, so that we could use quantitative data about abortion-seekers' characteristics to contextualise individual care trajectories described in the e-mail communications and open-ended consultation form responses.

4.2. Ethics and data management

The project received ethics approval for secondary analysis from the London School of Economics and Political Science's Research Ethics Committee (REF:60740).

All data were cleaned before translation. Linkage keys were destroyed, original files were permanently deleted, and all new files were stored separately on secure servers. New files were created for translation and shared with the translator via a secure system. Data were translated from Polish to English by Maria Lewandowska, a native Polish speaker and abortion researcher. All translated data were stored on secure servers. Quotes are presented with names replaced by randomly selected identifiers and, where appropriate, indirect identifiers are obscured.

4.3. Analyses

Quantitative Data Analysis: Quantitative data were imported into Stata 17 (StataCorp, 2021) and cleaned. Author 4 conducted descriptive analysis of specific variables of interest (e.g., reasons for abortion, whether COVID impacted abortion decision-making) and assessed monthly trends in the number of consultations over the study period. 311 people explicitly responded that on the form that COVID impacted their decision-making.

Qualitative Data Analysis: After processing and translation, all qualitative data (e-mail communications and consultation form open-ended responses for all questions) were imported into Dedoose (2021). This resulted in 311 consultation open-text responses and an additional 89 emails, of which 9 were from people who had also responded to the consultation. We included and analysed all open text responses, in addition to the two COVID-19 specific questions. We included these responses on their reasons or abortion experiences because first, they are analytically impossible to separate from the context in which they occur (i.e., the pandemic), and second, abortion-seekers sometimes articulated pandemic-related concerns in open-text boxes which asked questions

[2] Women Help Women (2020). Get Abortion Pills consultation form. https://consult.womenhelp.org/es/get-abortion-pills?z_language=en. Retrieved 1 June 2023.

unrelated to the pandemic. This was also true for those who answered 'No' to 'Has COVID-19 impacted your decision-making around abortion?'.

Our analytic approach to qualitative analyses was abductive. This is an iterative process of moving between data and theory, drawing on authorial a priori knowledge and understandings, to generate explanations and insights (Tavory & Timmermans, 2019). A sample of e-mail data (n = 35) were abductively coded by the team to develop a preliminary codebook. Initial codes included, for example, all mentions of un/employment or explicit references to COVID-19. Authors 1, 2, and 3 conducted additional abductive coding of consultation and e-mail data to further refine the codebook. Codes were reorganised to link patterns and themes observed in the data. For example, 'un/employment' was re-coded as a main code with sub-codes including job loss, pay deductions, job in/stability, or job search. Using this codebook, all data were coded by Authors 1, 2, 3, 5, and 6.

4.4. Data limitations

WHW's primary purpose of data collection (consultation forms and e-mails) is to provide effective and supportive abortion services. Research design and requirements are not their main purpose. The question on COVID-19 was added by the WHW team to enable analysis of the impact of the pandemic on abortion care-seeking. This question was not tested and therefore may have been interpreted differently by respondents. For example, respondents may have interpreted the question 'Has COVID-19 impacted your decision-making around abortion?' as being related either specifically to the infection or to broader consequences of the pandemic. Our analysis is inclusive of any ways the question may have been interpreted and centres the respondent's own perception of how COVID-19 may have impacted their decision-making around abortion. Linking the qualitative data with the quantitative data allowed deeper analyses (e.g., the impact of COVID-19 was more widespread in the qualitative data than initial quantitative consultation form responses indicated). We are also limited in our analyses of the impact of the Constitutional Tribunal decision on abortion in October 2020, as our data collection period was April–December 2020.

5. Findings

In this section, we first describe abortion seekers and their reasons for care-seeking. Then, focusing on the macro (e.g., policies) and micro (e.g., relationships) levels, we explore the impact of COVID-19 on abortion-seekers' lives and experiences.

5.1. Abortion care-seekers contacting WHW

Abortion-seekers contacting WHW were largely between 20 and 29 years old (47 %), 18 % were between 30 and 34 years old and 16 % were between 10 and 19 years old, with an age range of 11–57 years. In some cases, the parent or guardian of a legal minor contacted WHW on their behalf. Most abortion-seekers reported having tertiary (44 %) or university level (46 %) education, which may be indicative of access to resources (including internet) and knowledge proliferation (Table 1).

The consultation form did not require respondents to specify gender, instead offering a free textbox option. 70 % did not respond (Table 1). The most common non-missing (28.5 %) responses indicated female gender, using words such as 'women', 'girl', 'female', or 'wife'. Importantly, given the limited evidence on abortion experiences of trans and non-binary persons, 26 abortion-seekers explicitly identified themselves as such, while 133 chose not to share their gender.

Table 1
Characteristics of WHW abortion service users in Poland (n = 8577), 1st April - 31st December 2020'

	N	Percentage
Age		
Under 20	1409	16.4
20–24	2211	25.8
25–29	1847	21.5
30–34	1517	17.7
35–39	1043	12.2
40+	525	6.1
Missing	25	0.3
Education status		
Primary level or less	261	3.0
Secondary level	580	6.8
Tertiary level	3770	44.0
University +	3966	46.2
Gender		
Missing	5967	69.6
Identified as female	2447	28.5
Identified as trans or non-binary	26	0.3
Chose not to share	133	1.6
Other	4	0.1

5.2. Reasons for care-seeking

Respondents could choose several reasons for care-seeking from a predetermined list in the consultation form (Fig. 1). An optional open textbox in response to 'other' allowed expansion. Respondents chose multiple options from the list, reflecting the overlapping and intersecting reasons that underpin abortion decision-making. The most common reason listed was financial problems. Over a fifth (22.4 %) of respondents chose 'do not want to share' – an important reflection of abortion-seekers' agency instead of being required to disclose. A small percentage (0.13 %) chose 'afraid of Zika' – an artefact of a historic data collection system from a previous study on Zika in Brazil examining women's decision making on accessing abortion using the same methods. It may also reflect some conflation of Zika with COVID-19.

311 respondents reported that COVID impacted their decision-making around abortion (Table 2), with an additional 80 respondents opting to email WHW with specific reference to the impact of the pandemic on their abortions.

This may be because of how the question was understood- i.e., testing positive for COVID-19 as shaping decision-making, rather than broader pandemic conditions. In the optional open-text question, 'How has COVID-19 impacted your abortion decision-making'? and in the 'other reasons' free textbox, respondents detailed the impact of the pandemic on employment and financial security, access to care, and the pandemic's future implications. As we go on to show, for many people COVID-19 and their financial resources were tied together through furlough, job loss, and fewer opportunities for remuneration because of the pandemic response. This may mean that people's responses are interwoven between their financial position as an immediate reason for seeking an abortion, nested within the macro effects of COVID-19.

5.3. COVID-19 policy measures shaped abortion care-seeking experiences

Some pandemic measures like lockdown and quarantine requirements were barriers to abortion care-seeking. This, along with fears about the virus and its potential impact on foetal health, prompted care-seeking through WHW. Concerns about delays in care – not just due to identifying doctors willing to provide care or referrals, but the additional costs of COVD-19 tests, and queueing for care; potentially exposing yourself to the virus were all present. For abortion, where time is particularly important due to legal gestational limits, it can increase anxiety and fear around access to care.

> Difficult to access a doctor, restrictions that we have to follow, waiting in queues, raising fees for tests, and the general panic over what's going to happen to the child.

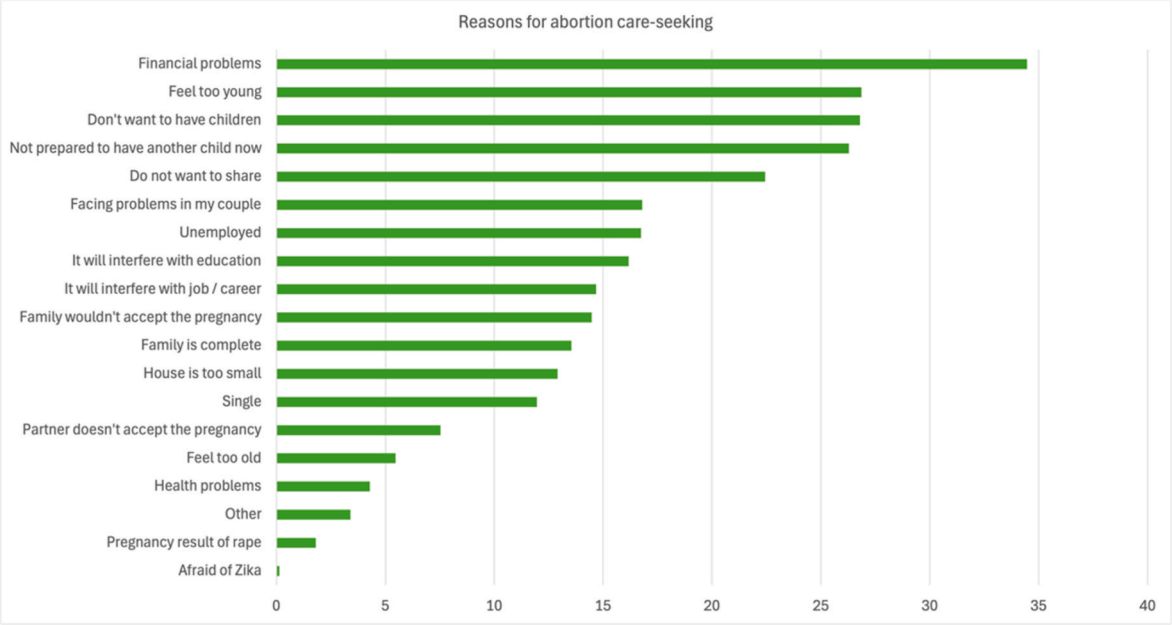

Fig. 1. Reasons for abortion care-seeking among WHW service users (April–Dec 2020).

Table 2
Responses to 'Has COVID-19 impacted your decision-making around abortion?'

Response	N	Percentage
Yes	311	3.63
No	7230	84.3
Do not wish to share	176	2.05
Don't Know	410	4.78
Missing	450	5.25

- B, 41 years old (May 2020), consultation form, open-text response to COVID-19 impact

  No access to doctors, prenatal care on the telephone is a joke.

- S, 28 years old (August 2020), consultation form, open-text response to COVID-19 impact

COVID-19 measures also dismantled personal support networks that people rely on during pregnancy and reproduction, with many referencing 'being alone' or 'loneliness', and a negative impact on their mental health. Many feared having to manage birthing in a clinic without their partners or family members due to isolation guidelines.

> I'm worried that being unable to freely move about will have a negative impact on my mental health. I'm anxious, […] not being able to leave makes me feel trapped.

- Z, 29 years old (April 2020), consultation form, open-text response to COVID-19 impact

Distrust in reproductive healthcare systems and providers was heightened by pandemic induced barriers to care. Distrust reflected frustration with poor quality care and requirements of isolation or tests, and fears of negligence and infection.

> […] my sister-in-law was diagnosed with a high-risk pregnancy, and […] was referred to a specialist in prenatal care. She was refused entry in spite of the referral because she didn't have a coronavirus test. […] This is not a good time for birthing children stress-free.

- T, 25 years old (December 2020), consultation form, open-text response to reasons for abortion

> It's a very difficult time in terms of access to medical care. I'm scared of being infected with coronavirus when I'm far into the pregnancy, of labour without any contact with my close ones, of the newborn getting the virus.

- U, 35 years old (December 2020), consultation form, open-text response to COVID-19 impact

5.4. Increased abortion restrictions during COVID-19 entrenched structural violence

Consultation requests to WHW saw a sharp rise in November after the Constitutional Tribunal 's controversial passing of abortion restrictions under COVID-19 emergency procedures (Fig. 2).

While the law only came into effect in January 2021, it was shaping abortion access immediately after the ruling. The October announcement and the intense public and political discourse surrounding it had an immediate chilling effect. It contributed to a climate of heightened stigma, fear of potential criminalisation and prosecution, and confusion amongst both providers and abortion-seekers. These dynamics shaped the broader context in which abortion-seekers made decisions and sought care, particularly in the latter half of 2020. Women's abortion care-seeking was simultaneously shaped by both the pandemic and the legal context of abortion in Poland.

> Currently, the situation in my country doesn't promise help, even if my child was diagnosed with prenatal defects. The functioning of the hospitals right now is also far from perfect […]. Women in Poland are now fighting for the right to decide about their own body.

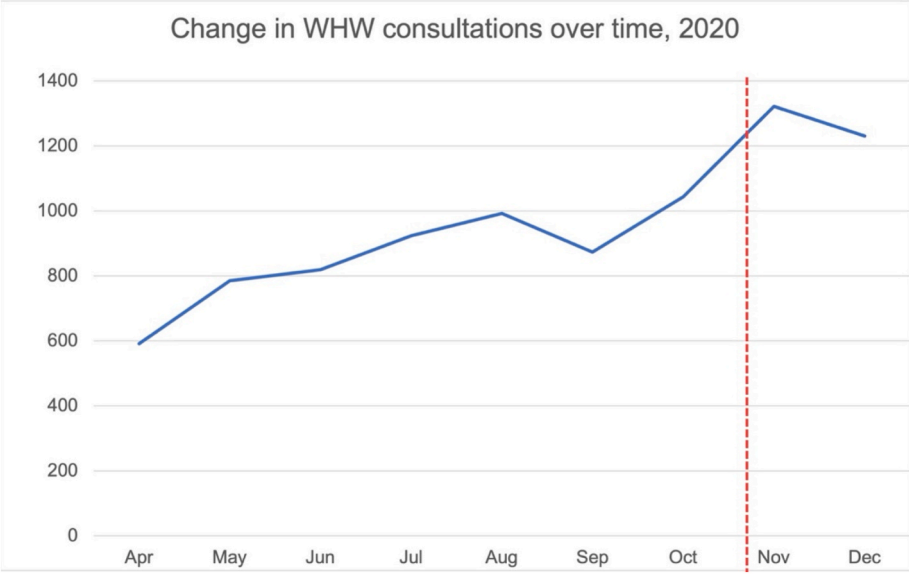

Fig. 2. Number of WHW consultations April–Dec 2020. Red dotted line marks the Constitutional Court's passing of abortion restrictions.

- I, 23 years old (December 2020), consultation form, open-text response to COVID-19 impact

5.5. COVID-19 amplified job and financial insecurity as precarious life conditions

Job and financial insecurity are manifestations of structural violence, shaping reproductive decision-making. Pregnancy heightens exposure to precarity by straining access to limited resources and potentially jeopardising employment. The nature of employment impacted exposure to the virus, contributing to concerns about one's health and of the foetus.

> I'm also scared that the child that I carry might be sick because I work at a gas station. I can get infected any time- every day there are around 200 people coming in and out.

- V, 24 years old (April 2020), consultation form, open-text response to COVID-19 impact

Specific industries (e.g., tourism) and forms of employment (e.g., seasonal) were particularly affected by the pandemic. Driven by lockdowns and an economic downturn, unemployment increased. Financial instability, money concerns, and the lack of job prospects due to the pandemic, and the types/industries people worked in, also shaped abortion decision-making.

> Me and my husband both work in the tourist industry. We don't have a job at the moment, and we don't know when it will be possible to get one. I think this is the most sensible way out of this situation.

- J, 33 years old (May 2020), email

> […] up until now I worked in a bar as a waitress; but when everything was closed, I lost my job. […] I was left without means to live, and I would really like to have the abortion, because if I give birth, I think that this child and me will both die of starvation.

- K, 24 years old (April 2020), email

5.6. COVID-19 heightened differential exposures to stigma, shaping abortion care-seeking

Abortion stigma, a form of structural violence, is tied to the unequal distribution of power and resources. Being considered 'too old' or 'too young' can shape access to care and heighten vulnerability (Beynon-Jones, 2013). Pregnancy – and by extension, an abortion can also be a sign of unsanctioned sexual activity, marking individuals as transgressing social norms and thus, requiring disciplining.

Younger people are less likely to have access to resources and can be more exposed to structural. symbolic, and interpersonal violence. They also tend to be reliant on others family members, partners, or friends for support (e.g., finances, housing). Job loss during the pandemic can increase financial reliance on family members, shaping whether they are able to afford abortion care or travel or if disclosure or approval is required before being able to access care. During COVID-19, younger people may have returned to their family home, with lockdowns reducing privacy (due to shared spaces); potentially increasing surveillance of their activities and making it harder to access an abortion or disguise a pregnancy.

> I am 20 years old, it's my first pregnancy and I am in quite a difficult life situation. I am studying two degrees, I lost my job due to Covid, I live with my parents. My family is very conservative, I cannot tell them about my situation, I'm too scared that they will force me to keep the pregnancy […]

- W, 20 years old (October 2020), email

For older individuals, similar stigmas surround notions of being 'too old' for a pregnancy. The pregnancy is a marker of 'irresponsible' sexual activity; particularly when coupled with insecure financial conditions (e.g., 'living from day to day') or being unable to care for one's existing children.

> 40 years old, one child, one mortgage for an old house, no savings, living from day to day, alcoholic husband. I cannot count on him, and I cannot provide for a family on my own.

- Q, 40 years old (December 2020), consultation form, open-text response to reasons for abortion

Although age is not always the sole axis of stigma, it becomes salient when combined with other factors that question a person's ability to meet socially prescribed norms of 'good' motherhood. As Odrowąż-Coates and Kostrzewska (2021) argue in the context of teenage pregnancy, there are persistent cultural scripts in Poland about when and under what circumstances motherhood is deemed acceptable. These scripts are also relevant at the other end of the age spectrum.

5.7. COVID-19 intensified exposure to interpersonal violence, shaping abortion decision-making

Lockdown limited privacy as more people lived in close quarters with their families, making secrecy a stronger element in abortion care-seeking. Keeping the confirmation of pregnancy and the decision to abort a secret can shape who, how, and where care is sought from. Secrecy extends not just to discussing abortion care-seeking, but the management of abortion at home when also grappling with limited privacy. Exposure can have severe implications, including homelessness and isolation, which is heightened under pandemic conditions.

> I live with my mother. If she finds out about the pregnancy, she will kick me out of the house, and I will have no one to go to for help.

- P, 32 years old (August 2020), consultation form, open-text response to reasons for abortion

Violence and abuse were also present in care seekers' responses. Pregnancy within relationships marked with interpersonal violence can be particularly dangerous, making it harder to leave or escape the violence. The pandemic also saw a marked increase in intimate partner violence, with some calling it a 'shadow pandemic', particularly as lockdowns made it harder to leave violent situations or seek care (UN Women, 2020). This interpersonal violence intersects with structural violence and precarity to heighten experiences of violence across multiple planes and axes.

> I need to free myself from this man once and for all. I cannot be the mother of his child. I don't know what he's capable of, I cannot imagine being beaten every two weeks when I'm pregnant, which is something he has done in the past ☹

- AB, 26 years old (December 2020), consultation form, open-text response to reasons for abortion

For some, the experience of violence was not limited to intimate relationships but was compounded by precarious interactions with institutions such as family courts or social services, which exerted control over their parenting and reproductive choices. The pandemic added layers of uncertainty, delays, and bureaucratic hurdles to these already fraught dynamics. As one person shared:

> I've been trying to get my [children] back for the past two years, I'm close to achieving that. Another child could impede these efforts […]. My financial situation won't allow me to raise another child, either. I have a lot of commitments, and I only have pennies left to live.

- AC, 32 years old (September 2020), consultation form, open-text response to reasons for abortion

Here, the decision to terminate a pregnancy is deeply entangled with the fear of jeopardising progress in a child custody process — an institutional terrain where motherhood is constantly monitored and evaluated.

5.8. COVID-19 devastated support systems and networks, affecting abortion decision-making

As family members died due to the virus or were made extremely vulnerable to illness, personal support systems shifted dramatically. The loss of key family members (e.g., wage earners or carers) can plunge people into deep precarity, where a pregnancy becomes untenable.

> My mum died of COVID-19, and she was the only person who could help me with another child.

- AD, 29 years old (December 2020), consultation form, open-text response COVID-19 impact

Structurally, COVID-19 heightened and exposed the impact of dismantling essential services (e.g., childcare) on peoples' lives. The collapsing of personal and structural support systems had a catastrophic impact.

> I have found myself in a horrible situation. Two weeks ago, my husband died of Covid in [another country], where he was working. I was left with [redacted number] children, the two youngest have a disability. I have no means to live, I have the bailiff on my plate, I don't even have a bank account, so that they don't take my benefits away. We are in quarantine at home, and if it wasn't for the strangers who leave food outside our door, we wouldn't be able to survive. Now it has turned out that I'm 5 weeks pregnant. I don't know how to live anymore; I have the worst thoughts. I have no help from anywhere […].

- AE, 24 (November 2020), email

5.9. Abortion as a protective act

Pregnancy can be a 'cliff-edge', potentially exposing pregnant people and their families to precarity and violence. Abortion, then, is a protective act – for oneself, for one's imaginations of the future/present, and for one's family and friends. This was heightened under pandemic conditions.

> I'm already raising three children alone. I have to terminate this pregnancy for their good. […]. I have to protect the children that are already with me.

- Q, 40 years old (December 2020), consultation form, open-text response to reasons for abortion

Additionally, implications of a pregnancy on family life were heightened by existing care responsibilities for ill or disabled children or family members. While care responsibilities are not particular to the pandemic, these were heightened by proximity, financial insecurity, increased susceptibility to the virus, and loss of carers.

> My sister has Down's syndrome, and […] I would be another burden in this situation. I cannot burden them with this, and I know that I won't handle it.

- AH, 20 years old (September 2020), consultation form, open-text response to reasons for abortion

  I will soon need to take care of my sick parents. If I had another child, my parents would have to help me, when it's them who need my help.

- AI, 29 years old (September 2020), consultation form, open-text response to reasons for abortion

Butler's (2009) evocation of 'precariousness' as a shared condition of social and physical vulnerability is echoed in this notion of abortion as a protective act. It highlights the affective and relational considerations that shape life conditions, and the decisions that make life liveable (e.g., care work). Here, abortion shifts away from framings of responsibility, health, or even 'choice', and becomes a political demand emerging from one's life conditions.

The pandemic's exacerbation of existing stressors affected and nuanced peoples imagined reproductive futures (Abel, 2024). For some, the pandemic prompted considerations of what kinds of lives are possible for themselves and others.

I would be worried about the child's future because of the pandemic.

- AJ, 21 years old (September 2020), consultation form, open-text response to COVID-19 impact

  The times have become unstable […] I'm not certain how my life will go. I'm scared of the future.

- AL, 34 years old (November 2020), consultation form, open-text response to COVID-19 impact

Abortion-seekers' explanations may read as abortion stigma - a 'maternal pro-choice' narrative which justifies abortion for the sake of future children or as the production of 'foetocentric grief' where the aborting person grieves potential children (Millar, 2016). However, the lens of precarity and precariousness can offer another reading. It highlights, instead, how untenable life conditions – heightened by the pandemic – foreclose options. It points to the multiple forms of structural violence that animate their lives present and future with instability and uncertainty. Then, in these articulations, abortion is a protective act that makes their life (present and future) liveable.

6. Discussion

Barriers to abortion access are reflective of a longstanding defunding of healthcare, welfare systems and other protections, and these effects are felt in gendered ways (Majewska, 2021). The dismantling and defunding of systems (e.g. healthcare) and individualisation of responsibility for one's health and that of one's family, leave little recourse when confronted by ill-health, interpersonal or structural violence, or deepening precarity. Under these conditions, people often turn to their family or broader community for support. Lockdown and quarantine made this much more difficult as personal support systems were devastated when family members died or were made extremely vulnerable by the virus. Like other contexts (Church et al., 2020), pandemic responses in Poland impacted abortion care-seeking (e.g., increased waiting times), that were heightened by pre-existing barriers to abortion care (e.g., conscience clauses).

Pregnancy, as an embodied experience, reveals the precariousness and unequal life conditions which shape abortion decision-making. Abortion allows people to raise and care for their children and families, protects against a deeper slide into financial precarity, and provides time to grapple with unemployment or other forms of insecurity. Respondents in this study underscored that abortion provided the means to make life 'liveable' within the contexts of precarity and violence, which were exacerbated by the pandemic (Butler, 2001, p. 27). Pregnancy in these conditions can be a deeply destabilising and potentially cataclysmic life event. It can have knock-on effects across multiple domains, particularly when people have been stripped of structural and interpersonal support networks.

Respondents illustrated how precarity and COVID-19 impacted their ability to care for existing children, their life opportunities (e.g., education, career), mental health, quality of life, and their ability to thrive. A pregnancy in these situations would expose people and their families to greater vulnerability, rendering their current life conditions 'unliveable'. The abortion restrictions introduced in Poland during COVID-19 have been described as 're-traditionalising' binary gendered roles (Bielska-Brodziak et al., 2020, p. 44 S), particularly positioning women as mothers and providers of free care labour (Majewska, 2021). Respondents in this study highlight the violence of this process and the impact on their autonomy and capacity to survive. Abortion decision-making was, therefore, shaped by the need to navigate these violences and the precarities they produce.

For respondents in Poland, pandemic policies affected employment – redundancies, reduced wages, and unemployment – in gendered ways. The nature of employment amplified precarity (e.g., seasonal work). This evidences existing work that showed that risk exposure to the virus was linked to class, race, ethnicity and gender, and the kinds of industries and jobs one is working in (Fiske et al., 2022). This heightened exposure is intimately tied to the unequal life conditions that shaped respondents' abortion decision-making (e.g., working in gas station). As illustrated by abortion seeking requests to WHW, defunding welfare and social support affects the kinds of jobs and industries that people take up in order to meet their care responsibilities. Respondents made clear how work insecurity affects pay and finances and, as evident by the pandemic, job stability. This includes not just their own work, but those of their family, friends, and partners. This precarity can be understood within the context of the uneven and inconsistent pandemic response in Poland, in which the irregularity of financial support exacerbated existing precarity around childcare and employment for many people. Such precarity within a structurally violent, neoliberal global economy shapes the decisions a person can make about their pregnancy.

Requests for abortion support from WHW emphasised how abortion-seekers are exposed to significant precarity. This is particularly the case for people experiencing IPV. Macro level conditions (e.g., employment) intersect with individual life circumstances (e.g., housing insecurity) and existing responsibilities (e.g., parenting). Cumulative gendered insecurity and violence increase exposure to precarity, shaping abortion decision-making. IPV, heightened under pandemic conditions, increased exposure to insecure housing, unemployment, and reliance on limited benefits to care for and sustain one's family. In these situations, a pregnancy heightens vulnerability and threatens the limited stability they may have achieved by opening them up to further contact with their abusive partners, and risks exposing them and their families to further violence if the pregnancy continues. For respondents seeking support from WHW, this could manifest as being made homeless by parents or violent (emotionally, physically) reactions from family or partners to another pregnancy. Such violence was exacerbated by the pandemic conditions, particularly given the precarity of financial opportunity that was referenced by a large number of respondents and the inability to travel easily in the event of needing to move residence.

Precariousness is characterised by relationality, which offers potential spaces for hope and survival. Community actors and feminist groups like WHW enable a liveable life (in the present and for the future) by providing abortion pills, care, and support. Respondents articulated their need for organisations like WHW to exist and to support their ability to access abortions, while also highlighting the constellations of

friends, family members, and other social relations that they rely on (Berro Pizzarossa & Nandagiri, 2021). For some, COVID-19 disrupted and dismantled these constellations of actors in ways that made pregnant people even more vulnerable. Abortion, entwined in questions of what makes life liveable, is inherently collective, interdependent and relational. By locating abortion within these infrastructures, it (i) directly challenges neoliberal logics of individualism and responsibilisation that underpin precarity, and (ii) underscores that abortion cannot be removed from peoples' life conditions, and their life hopes. Instead, abortion is what allows survival in the present, making life *liveable* while simultaneously allowing possibilities of a different future.

7. Conclusion

Our research explores abortion decision-making during the COVID-19 pandemic, adding to literature on the pandemic's impact on abortion access (Bojovic et al., 2021), and provision via feminist networks (Atay et al., 2021). We contribute to studies on abortion in health emergencies (Wenham et al., 2019, 2021) and add to nascent empirical research on abortion and structural violence (Rød et al., 2023; Tiew et al., 2022). Locating individual abortion care-seeking within macro-level contexts of the pandemic and structural violence in Poland, we argue that pregnancy is a 'cliff edge'. We find that abortion is what makes life liveable (Butler, 2009) in the (precarious) present whilst also enabling possibilities of future lives. In lifeworlds shaped by entrenched gendered inequalities, persistent precarity, and both direct and structural forms of violence, it enables survival (in the short term), care provision (e.g., dependents) and enables visions of the future (in the longer term).

Our findings highlight the importance of engaging with structural and macro-level conditions, including before and during a pandemic, to understand pregnancy-related decision-making. Importantly, we offer new empirical evidence that engages with abortion outside the predominant 'health' framing. Our research offers empirical evidence relevant to abortion policy making and service provision in Poland. These theorisations are also applicable to other contexts, particularly as gendered inequalities intensify in the pandemic's aftermath (Brysk, 2022).

Finally, our study highlights how important collaborating with feminist actors like Women Help Women is to empirical research on abortion. It enabled access to anonymised, real-time data during a period of rapid change, demonstrating how such collaborations can offer high quality data for abortion research and policy influencing.

CRediT authorship contribution statement

R. Nandagiri: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **E. Coast:** Writing – review & editing, Writing – original draft, Validation, Software, Methodology, Investigation, Formal analysis, Data curation. **J. Strong:** Writing – review & editing, Writing – original draft, Validation, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **K. Footman:** Writing – review & editing, Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **L. Berro Pizzarossa:** Writing – review & editing, Writing – original draft, Validation, Resources, Project administration, Data curation, Conceptualization. **C. Wenham:** Writing – review & editing, Validation, Methodology, Funding acquisition, Formal analysis, Conceptualization. **K. Jelinska:** Writing – review & editing, Validation, Resources, Project administration, Conceptualization.

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Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Data were collected as part of routine service provision by Women Help Women, a feminist abortion helpline and provider. Kinga Jelinska reports a relationship with Women Help Women that includes: employment. Lucia Berro Pizzarossa reports a relationship with Women Help Women that includes: consulting or advisory.

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The other authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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