THE IMPACT OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE ON LABOUR MARKET OUTCOMES OF EUROPEAN WOMEN

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Author's Declaration

I, the undersigned Amara Germaine Scheitlin hereby declare that I am the sole author of this thesis. To the best of my knowledge this thesis contains no material previously published by any other person except where proper acknowledgement has been made. This thesis contains no material which has been accepted as part of the requirements of any other academic degree or non-degree program, in English or in any other language.

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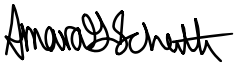
Signature: 

Abstract

Recognizing sexual and reproductive health rights (SRHR) as fundamental human rights requires commitments across sectors of society to promote the wellbeing of all women. Previous studies have shown that the relationships between fertility decisions, educational attainment, and labour force participation are often influenced by a number of factors. In order to better understand the policy implications of access to sexual and reproductive health (SRH), this paper analyzes the relationship between the availability of SRH care providers – namely obstetricians and gynecologists – and gender inequalities in European labour markets, including gender differences in employment rates and average wages across 31 countries. Using data from the EU statistical office and World Health Organization, a regression model was used to determine if there is a significant negative association between access to SRH and labour market outcomes among women. However, results indicate that the prevalence of alternative influences, such as childcare policies and sexual health education, can work simultaneously to impact gender inequalities in the labour market. More SRH data is needed to identify more conclusively how access to SRH impacts gender gaps in employment and wages, as well as to produce stronger evidence-based policy measures targeting vulnerable subpopulations most in need of SRH support.

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List of Abbreviations and Country Codes

Abbreviations

ACRJ	Asian Communities for Reproductive Justice
CEE	Central and Eastern Europe
CSE	Comprehensive Sexuality Education
EC	Emergency Contraception
EPF	European Parliamentary Forum
NPS	Non-postsocialist
OGBYNs	Obstetricians and gynecologists
PS	Postsocialist
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
TRAP	Targeted Regulation of Abortion Providers

Country Codes

AT	Austria	LT	Lithuania
BE	Belgium	LU	Luxembourg
BG	Bulgaria	MT	Malta
HR	Croatia	ME	Montenegro
CZ	Czechia	NL	Netherlands
DK	Denmark	MK	North Macedonia
EE	Estonia	NO	Norway
FI	Finland	PL	Poland
FR	France	PT	Portugal
DE	Germany	RO	Romania
EL	Greece	RS	Serbia
HU	Hungary	SI	Slovenia
IS	Iceland	ES	Spain
IE	Ireland	SE	Sweden
IT	Italy	CH	Switzerland
LV	Latvia		

1. Introduction

The global evolution of gender equality in the last few decades can be tracked through changes in labour force participation, educational attainment, and sexual and reproductive health (SRH). This study aims to analyze how variations in access to SRH – as measured by the availability of SRH care providers – in particular might influence labour market outcomes among European women. By mapping global progress towards gender equality from the 1960s onward, it becomes evident that there are relationships between education, labour market behavior, and fertility that flow in many different directions. The relationship between reproductive choice, population change, and the economy often creates tension between policymakers, economists, health experts, human rights lawyers, development agencies, and women's rights organizations when it comes to executing SRH programmes, policies, and laws. At the same time, in order to realize sexual and reproductive health rights (SRHR), coordination among disciplines is necessary. In addition, while several commitments have been made at the international level to protect SRHR, action at the country and local levels often fails to sufficiently address reproductive health needs. Unequal socioeconomic conditions, barriers to education, and gendered divisions of labour – including reproductive labour – obstruct the realization of SRHR. Moreover, the limited availability of SRH information and unaffordability of contraceptive supplies often prevents individuals from accessing vital reproductive healthcare. Educational attainment and its effect on labour market outcomes of women has been widely studied vis-à-vis its influence on fertility decisions, but equally important for understanding why women respond similarly or differently to advancements in SRHR are the socioeconomic, cultural, and racial differences within various contexts.

Across disciplines, scholars have analyzed the social, economic, and political forces influencing women's rights, including SRHR, and their general wellbeing. Links between education, SRH, and labour force participation have been widely examined but sometimes overlook structural disparities in access to healthcare that disadvantage marginalized groups. Brzozowska's (2015) work on fertility patterns across Europe highlights how educational attainment alone cannot account for differences in reproductive decisions and labour market outcomes among women of different ages. Kim (2016) contributes similarly to the scholarship by identifying possible alternative influencing factors on fertility decisions, such as knowledge of contraceptives and maternal health, as well as socioeconomic status. Further, while women's rights movements have been successful in some attempts to equalize the labour market, gendered divisions in reproductive labour remain prevalent globally. Kim and Choi's (2013) research on poverty among female-headed households acknowledges how variations in welfare schemes can influence the economic wellbeing of mothers, while Thévenon (2009) shows how the labour force participation of women is significantly influenced by the age of their children and availability of part-time work. Further, Goldin and Katz's (2002) seminal study on the impact of contraceptive use among young women's college completion rates indicates the importance of SRH care in improving economic opportunities. These scholars have contributed to a greater understanding of the relationship between SRH and the economic wellbeing of women, but there are questions which still remain.

The key interest in this study is the precise nature of the relationship between access to SRH care and services and the labour market outcomes of European women, as measured by the severity of inequalities between men and women in terms of employment and wages. Using the number of OBGYNs (per 100 000 population) as an indicator of SRH care access, this study

estimates the impact of greater access on the gender gaps in employment and average wages in 31 European countries. The underlying assumption is that improving access to SRH services could positively influence the ability of women to participate more fully in the labour force and generate stronger opportunities for promotion and labour mobility over the course of their working lives. This type of finding would have important implications for health policies throughout the region, including contraception and abortion access, sexual health education, and healthcare reimbursement schemes for SRH services. Notably, influence from SRH care access on labour market outcomes also begets consideration for vulnerable populations, such as LGBTQI people, racial/ethnic minorities, and refugees, who may benefit most from targeted policies which address structural barriers to SRH care that negatively affect labour market participation and wages. After analysis of country-level data on SRH access and gender inequalities in employment and wages, the nature of the relationships is still mixed across the region. However, the results highlight the need for policy measures to support greater SRH data collection, identify unmet SRH needs, and reduce inequalities in reproductive labour in order to better understand the role of both reproductive health and labour policies in influencing women's labour market outcomes. The recent shift to restrictive, demographically motivated reproductive policies – often with underlying motives to discriminate against marginalized populations – as well as limitations in childcare and reproductive labour policies that exist in multiple countries exemplify the necessity of greater protections for SRHR in order to promote inclusive and equitable policies across multiple sectors of society.

The following section of this paper examines current scholarship focused on SRHR, education, and gender inequalities in the labour market. This research provides the theoretical framework from which the data analysis is based. Section 3 details the research design of this study

in greater detail, including the methodology used and the sources of macro data. Section 4 discusses the results of the analysis, as well as their policy implications regarding data collection, SRH access and unmet needs for family planning supplies and services, and gendered divisions in care work and the labour market. The paper ends with a brief conclusion which reiterates the need for greater research in the realm of SRH specifically related to the needs of marginalized populations and people facing multiple discrimination in the sectors of healthcare and labour.

2. Literature Review

2.1. Sexual and Reproductive Health Rights

Globally, sexual and reproductive health rights (SRHR) have evolved substantially over the last few decades. Feminist and women's rights groups have often been at the forefront of the movement for non-discriminatory and accessible sexual and reproductive health (SRH) care and services. These movements are also inextricably linked to broader social advancements, including better access to education and labour market opportunities, and a large amount of scholarship focusing on SRHR and women's economic empowerment has come out of the US. During the 1960s, feminist scholars and activists contributed significantly to linking personal grievances of gender inequality in the home to broader institutional and social structures. In their 1991 work on gender and the self-organization of American women, Brenner and Laslett identify how even though the women of second-wave feminism largely had more resources for self-organization – including stronger access to education – than their first-wave counterparts, mainstream movements primarily grew out of the middle class (Brenner & Laslett 1991, 327). This is perhaps exemplified most strongly by Betty Friedan's *The Feminine Mystique* which, though pivotal in mobilizing women to reject gendered notions of self-fulfillment, appealed mainly to the white middle class. Black feminist scholars such as bell hooks would later criticize the exclusion of lower-class and black women from these mainstream narratives of women's liberation through work outside the home (hooks 1984, 95). As Brenner and Laslett argue, the notion of the personal as political, combined with the increased educational attainment of women and growing capacities to self-organize (e.g., in trade unions and through social movements), did provide necessary means to push for social and political reform during the 1960s and '70s (Brenner & Laslett 1991, 328).

However, this did not guarantee sweeping success in advancing gender equality, or SRHR, especially when intersections with race and class are considered.

While feminist scholarship in particular largely recognizes the often-exclusionary nature of mainstream social movements during this period, the long-lasting effects on social institutions, educational attainment, and labour market policies remain significant. This is especially true in the US context where, as Blau examines in their 1998 evaluation of the well-being of American women, there are clear distinctions between black and white, as well as higher- and lower-educated women. Though the 1960s and '70s saw landmark cases such as the Civil Rights Act and Title IX – which prohibits gender-based discrimination in education – social and economic barriers often prevented marginalized groups from fully realizing these rights. Blau identifies a growth in households with women as the single head, especially among low-educated and black women, whose economic well-being in turn hinges almost entirely on their participation in the labour force. Notably, Blau addresses an important phenomenon often absent from the literature covering this time period, which is that educational differences in single-headship trends are especially pronounced (Blau 1998, 116, 142-143). This indicates a significant difference *among women* due to the prevalence of structural barriers to education, which disproportionately affect lower-income and racial minority groups. The pronounced differences in single headship between black and white women also raises concerns about access to SRH, such as family planning services, and the potential barriers affecting fertility decisions among different populations of women.

Still, at the same time that educational attainment and labour market participation were on the rise in the 1960s and '70s, advancements in SRHR were also being made. Pizzarossa (2018) blends gender and law to analyze the evolution of SRHR from a matter of demographic concern to one of human rights. According to Pizzarossa, from roughly the 1950s to the 1990s, SRHR are

largely framed as an instrument of population control. Many of the family planning programs supported by governments during this period were rooted in neo-Malthusian beliefs that accelerating population growth incited poverty due to limited resources in densely populated areas (Pizzarossa 2018, 2). It was not until the 1974 Bucharest World Conference on Population that the causal relationship described here was challenged by less developed countries, arguing that it was the inequal distribution of resources – not their scarcity – that fueled the "population problem" (Pizzarossa 2018, 2-3). Through the World Population Plan of Action (WPPA) adopted at the conference, population growth and development came to be more widely understood as matters of human rights, thereby distancing itself from the previous, strictly demographic view. The WPPA also provided that the freedom to make decisions on pregnancy was a basic right of all couples and individuals (Pizzarossa 2018, 3-4). This wording is significant given that it explicitly defines reproductive choice in the frame of human rights for both married and unmarried individuals. While the WPPA's provisions do embody human rights concerns related to reproductive choice, Pizzarossa is careful to point out that efforts to realize SRHR have often coexisted with coercive practices and conditional attachments to international aid (Pizzarossa 2018, 5). This disconnect between recognizing SRHR for all people and implementing *equitable* policies at local and national levels has been discussed by other legal scholars, such as Cook et al. (2003), as there remain today insufficiencies in healthcare provision despite international commitments to support SRH.

Through the 1980s in the US and postsocialist period in Europe, important trends in SRHR and gender equality became established, many of which still influence policymaking today. In the US, the protection of abortion rights through *Roe v Wade* was one of the most significant judicial decisions during the 1970s. But as Pizzarossa (2018) and Fried (2013) have shown, the

conservative movement made large strides in the 1980s to limit advancements in SRHR. This was evidenced by policies under Ronald Reagan, such as the 1984 "Mexico City policy," which blocked federal funding to foreign nongovernmental organizations providing or promoting abortion as a form of family planning (Pizzarossa 2018, 4). Fried's work examines explicitly the attacks on reproductive justice in the US since *Roe v Wade*, arguing that disagreement over priorities and strategies within the reproductive rights movement have weakened the movement as a whole. Speaking as a public policy expert in the field of reproductive justice, Fried highlights multiple feminist perspectives, including from black women, low-income women, health activists, and youth involved in the SRHR movement. Her work highlights a key issue that still exists on a global scale, which is that the feminist movement is still largely divided over the diverse needs of women.

In postsocialist Europe, Pollert (2003) and Thévenon (2009) contribute to the discourse on gender equality and SRHR through their evaluations of labour force participation, educational attainment, and care work. As a sociologist and expert on employment studies, Pollert identifies the ways in which Central and Eastern Europe (CEE) has largely failed to capitalize on the gender equality inroads made under socialism, such as the increase in women's labour force participation in gender-atypical occupations and state provision of childcare programs (though not always of good quality). Instead, the neoliberal transition has brought about significant growth in inequality in the region. Neoliberal justifications for reduced state spending pose a real barrier to implementing stronger family-friendly policies and unemployment support, which Thévenon shows are essential to promoting greater equality from an economic perspective. Using European Labour Force Survey (EU-LFS) data from between 1992 and 2005, Thévenon examines how differences in government polices influence the labour market behavior of European women. In

both the CEE and Western countries observed, the labour force participation of women is noticeably influenced by the age of the youngest child and availability of part-time work. These influencing factors are largely contingent upon childcare and leave policies. Unfortunately, Thévenon does not address the impact of educational attainment on divisions in childcare and labour market participation. But this is explored further by Bratti's (2015) work on fertility postponement among higher-educated women in developed countries, which finds evidence that, in addition to the loss of income resulting from leaves from the labour force to have children, the motherhood wage penalty (i.e. lower chances for promotions and wage increases after returning to work post-childbirth) also poses a risk to working women. The impact of family-friendly policies, especially those related to care leave and childcare services, on fertility decisions and labour market behavior of women is therefore significant.

Immediately following the 1994 International Conference on Population and Development, the concept of "reproductive justice" was first coined by a movement of black women activists as a means to address the influence of racial, economic, and social inequalities on people's abilities to control their reproductive health. The reproductive justice movement's main goal is thus to empower vulnerable populations – including immigrants, racial/ethnic minorities, and LGBTQI people – with access to SRH care and greater autonomy over their reproductive decisions. Loretta Ross, a leading activist for reproductive justice and cofounder of the SisterSong Women of Color Reproductive Health Collective, describes the concept in the following way:

> [Reproductive justice] has three primary values: (1) the right *not* to have a child; (2) the right to *have* a child; and (3) the right to *parent* children in safe and healthy environments. In addition, reproductive justice demands sexual autonomy and gender freedom for every human being. The problem is not defining reproductive justice but achieving it (Ross & Solinger 2017, 65).

In this regard, reproductive health is not just a matter for health policy, but also social and economic policy. Achieving reproductive justice expands beyond removing barriers to healthcare and promotes the inclusion of marginalized populations, such as non-white and transgender people, in policymaking processes. Moreover, it champions the advancement of equality within society and the economy, with a focus on improving all women's capabilities to control their reproductive decisions, as well as to support the health and wellbeing of both mother and child during and after pregnancy. Reproductive justice is therefore an extension of both reproductive health and reproductive rights, as outlined in a vital piece of work from Forward Together.[1] Their 2005 essay describes the distinctions and connections between the three frameworks as follows:

> The Reproductive Health framework emphasizes the very necessary reproductive health services that women need. The Reproductive Rights framework is based on universal legal protections for women, and sees these protections as rights. Issues that were historically seen as private issues in the lives of women and girls have been made public and mainstream. And the Reproductive Justice framework stipulates that reproductive oppression is a result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights (ACRJ 2005, 1).

While Forward Together focuses largely on reducing the reproductive oppression of Asian women, its main message applies to all vulnerable populations which face oppression on the basis of race, class, gender, sexuality, ability, age and immigration status (ACRJ 2005, 6). Stemming from the principle of universality, reproductive justice states that all people have the same human rights, including sexual and reproductive health rights, but not everyone faces the same barriers to achieving their full rights (Ross & Solinger 2017, 72). As such, experiences of oppression are vital to understanding unique barriers to SRH that different women, especially those from marginalized populations, face.

[1] Formerly-known-as Asian Communities for Reproductive Justice (ACRJ).

Through this literature and more recent developments in analyses of women's rights, the importance of gender mainstreaming has become increasingly evident when it comes to all three topics of SRHR, labour market participation, and education. Kim (2016) examines the relationship between women's education and fertility, not just from an economic perspective but also through the lens of health and accessibility (to education and care). He makes a crucial recognition that the negative correlation between education and fertility (i.e. higher education among women usually correlates with having fewer children) cannot be properly analyzed without considering factors such as pre-natal health, availability of information on birth control, access to contraceptive supplies, and social and cultural norms. As such, education's impact on health, income, and contraceptive knowledge influences fertility decisions differently depending on the context. Winkler (2016) also contributes to this idea through her analysis of the varying degrees in which labour force participation and educational attainment among women has risen across the globe. The observed differences can be largely attributed to economic and cultural factors, including the generational impacts of women's labour market activity. In order to not only understand what influences the fertility and labour market decisions of women, but also to design policies that empower women inside and outside of the home, policymakers must consider these kinds of multidisciplinary approaches that address relevant variables across contexts.

The past few decades have seen rapid improvement in the realm of SRHR across the globe; however, there is still need for the strengthening of access to SRH care and services, particularly for vulnerable populations. Recent data shows that the EU is no exception to this. According to the European Parliamentary Forum (EPF) on Population and Development, an estimated 69 percent of European women who are of reproductive age and married or living with a partner are using some for a contraception: less than women in comparable countries in the Americas (EPF

2018, 3). In addition, rates of unplanned pregnancies in Europe remain high, with approximately 43 percent of pregnancies in 2018 considered unplanned (EPF 2018, 3). Throughout the region, the availability of good quality government-supported online resources related to contraceptive supplies and services also varies, with only 11 countries providing such online resources (EPF 2018, 3-4). In terms of adolescent health, there are additional concerns about risk of unplanned pregnancy and sexually transmitted diseases and infections. The rate of pregnancy among adolescent girls ranges from just 0.8 percent in Switzerland to 4.6 percent in the UK (Michaud et al. 2020, 40). A recent study by Michaud et al. (2020) assessed the delivery of SRH care and services to adolescents in all EU countries plus Iceland, Norway, Switzerland, and the UK. It found that in most of the countries surveyed, oral contraceptive is only available by prescription, and in only 11 countries is it available free of charge or at a reduced price (Michaud et al. 2020, 42). Moreover, while emergency contraception (EC) is largely available across the region (with few exceptions), the number of healthcare providers who can provide it varies from country to country. In addition, certain countries (such as Croatia, Czech Republic, Hungary, and Latvia) require prescriptions for EC, while others (such as Spain, Sweden, and Switzerland) do not (Michaud et al. 2020, 42). In many EU countries, the lack of sufficient reimbursement schemes for contraceptives also poses a challenge to accessing SRH care, particularly for lower-income women and refugees (EPF 2018, 3). These variations in access to SRH care indicate that many member states have more work to do to prevent discrimination in healthcare and strengthen the provision of SRH services to adolescents and adults.

Notably, the recognition of SRHR has vital implications not only for the health of women and gender diverse people, but also for their social and economic wellbeing. Failures to meet the SRH needs of all persons is largely what prompted the recent (2021) resolution from the European

Parliament on sexual and reproductive health and rights, which identifies SRHR as fundamental human rights and explicitly calls upon all member states to uphold them. The protection of SRHR entails the removal of barriers to SRH care and services, including contraceptives, abortion, comprehensive sexuality education (CSE), and maternal healthcare. It also outlines the importance of strengthening access to SRH care for vulnerable populations, including LGTBQI people, migrants, and racial/ethnic minorities, who often face discrimination which limits their access to care. With this recognition of SRHR in mind, questions are thus raised about the exact nature of the influence of SRH care access on economic opportunities, including labour force participation and earnings potential, for women and other marginalized populations.

A 2017 study from the US reveals a correlation between stronger protections for reproductive health rights and access to SRH care and certain economic opportunities for women. According to the study by Bahn et al., US states with greater protections for women to make reproductive decisions also show higher labour force participation, earnings, and labour mobility among women (Bahn et al. 2017). More specifically, women living in states with better reproductive health climates – e.g., states with accessible abortion and insurance coverage for contraceptives and other family planning services – had higher earnings, greater promotion opportunities, and better labour mobility between jobs than women living in states with less robust reproductive health climates. Regarding abortion access in particular, women in states with targeted regulation of abortion providers (TRAP) laws[2] were found to be less likely to move between occupations or transition from unemployment to employment (Bahn et al. 2017). Significantly, women living in rural counties face barriers to accessing care due to geographic location. Almost 50 percent of US counties – most of them rural – do not have an obstetrician or

[2] TRAP laws are costly and medically unnecessary restrictions imposed upon abortion providers in an effort to create more barriers to abortion access.

gynecologist (OBGYN), forcing women in these areas to travel longer distances to access SRH care and services (Bahn et al. 2017). Marginalized populations, especially non-white women and LGBTQI people, also face significant barriers to fulfilling SRHR due to structural inequalities. Such inequalities are not unique to the US, as studies across Europe (Takács 2018; Skuban et al. 2022; Båge and Datt 2021) have shown similar limitations in accessing SRH care and services among immigrant and non-white women, transgender people, and other marginalized groups.

The literature presented here encompasses multiple disciplines to analyze the ways in which SRHR, labour market participation, and educational attainment interact. Questions remain, however, as to what effect access to SRH care and services has on labour market outcomes of European women. Notably, largely absent from previous studies are additional considerations for marginalized communities, especially LGBTQI people. For example, in American literature especially, there is substantial scholarship on racial differences in SRHR, educational attainment, and economic conditions, but the layered effects of mutually constitutive inequalities are often ignored when it comes to analyzing reproductive choice and labour market outcomes. Granted, fertility decisions among women are intimate choices often difficult for scholars to fully capture, but access to SRH care and information serves as a measurement of the availability of resources to make those decisions. Through this frame, restrictive and coercive measures to limit reproductive choice can therefore be identified. It is alarming that countries such as the US, Hungary, and Poland have recently taken ambitious action to do just that. Poland has banned abortion in nearly all cases of pregnancy, while a growing number of state-level policies in the US are currently attempting to do the same. In Hungary, a targeted campaign against the LGBTQI community has led to significant restrictions in access to SRH care and services. Policy decisions which limit SRHR threaten to negatively impact labour market outcomes of all people, especially

lower-income and non-white women and the LGQBTI population. It is precisely because of the interconnectedness of SRHR and social and economic inequality that policymaking cannot fulfill the rights of all women unless marginalized experiences are considered. Gender mainstreaming does serve as a promising method for the advancement of equality, as progress through the second half of the 20th century has shown that gender expertise can influence policymaking. However, the current rise in policies limiting reproductive choice in select countries and the disconnect among experts in addressing multiple oppression should be cause for concern in the (perhaps not-so-global) effort to protect women's rights, including SRHR.

2.2. Trends in Education, Fertility, and Labour Market Participation of Women

To better connect SRHR to labour market outcomes, this chapter examines trends in labour market participation among women in Europe, as well as the relationship between reproductive choice and economic empowerment. Across the region, there are similarities and differences in these patterns of SRH and labour market participation over the last few decades. In CEE, women's employment and access to SRH care as well as childcare services has fluctuated since the end of the socialist era, with more recent neoliberal policies affecting the provision of family benefits and, consequently, labour market opportunities for mothers and care workers. In Western Europe, advancements in labour force participation of women have not necessarily resulted in overcoming gender inequalities in employment or care responsibilities in the home. The following sections therefore examine SRH and childcare, education, and labour market policies in greater detail to identify how they interconnect and influence one another.

Under state socialism in CEE, women's labour force participation rates and levels of educational attainment largely grew. Labour participation among CEE women exceeded 80 percent in some countries, and their participation in education increased to equal or higher levels

than that of men by the early 1990s (Fodor 2002, 371). Although gender inequality remained prevalent in the labour market, with women often working lower paid, white-collar jobs with limited opportunity for promotion, state welfare helped compensate for wage inequalities. As a result, "gender inequality in paid work was overall smaller in state socialist than in comparable capitalist societies at the same time" (Fodor 2002, 371). However, gender divisions in reproductive labour and household duties also persisted during state socialism. As a result, women performed the majority of household work, having to deal, for example, with the insufficiencies of state-provided childcare facilities as well as food shortages (Fodor 2002, 371). Following the collapse of socialism in the region in the early 1990s, former socialist countries underwent drastic social and economic transition. The labour market took a significant hit during this time and women were often the first workers to be targeted for layoffs, regardless of their qualifications (Brzozowska 2015, 692; Fodor 2002, 372). In many countries, women's unemployment rates exceeded that of men, including in Poland, Romania, and Bulgaria, and they often experienced unemployment for longer periods of time (Fodor 2002, 372). At the same time, new welfare policies largely restricted access to family assistance and maternity benefits, as well as education and healthcare (Fodor 2002, 373). This period therefore marks a decline in the employment of women and the creation of new barriers, including the inaccessibility of childcare and family benefits, which limit a mother's ability to participate fully in the labour market.

Women tend to be less included in the labour force in some countries compared to others. For instance, women are more often excluded from the labour force in Poland and Romania than they are in Hungary and Bulgaria (Fodor 2002, 378). On average, women still spend more time in unpaid work – especially care work – than men do in the EU (OECD, 2021). There are notable differences between CEE and Western Europe, however, as women taking care of children and

other relatives in CEE are more likely to have full-time care responsibilities as well as limited institutional support, which prevents them from fully participating in the labour force. Despite general increases in women's labour force participation across the globe, women are still underrepresented in executive positions, mid- and high-level management positions, and top academic positions in most countries (Kunze 2016, 2). Moreover, women with children – especially children under the age of two – have lower employment rates than women without children (Kunze 2016, 2). These trends indicate not only continued gender inequalities within the labour market, but more specifically, the prevalence of obstacles to flexible employment and labour mobility for mothers in particular.

The connection between motherhood and employment rates can also be examined through the lens of SRH care access by looking at the effects of contraceptive use and reproductive control. In their 2018 study, Finlay and Lee claim that "contraceptive access and use increase women's decision-making power over the timing and number of children, education attainment, labour force participation, and job quality" (Finlay & Lee 2018, 304). In addition, higher maternal age at first birth and having fewer children both increase labour force participation among women (Finlay & Lee 2018, 304; Bratti 2015, 2-3). Moreover, previous work by Goldin and Katz (2002) links contraceptive use – specifically the birth control pill – to delayed marriage and college completion. The ability to plan their educational and professional careers without fear of unintended pregnancies is the main factor at work here. Delaying first birth can therefore lead to an overall increase in a woman's economic empowerment through subsequent increases in educational attainment, labour force participation, and wages (Finlay & Lee 2018, 308). Continued use of contraceptives to plan the timing, spacing, and number of children can have similar effects on

economic empowerment among women due to greater control over their educational and professional careers.

However, it is notable that this relationship between family planning and educational and professional outcomes only holds when contraceptives are accessible and reliable, meaning that lower-income and marginalized women – such as non-white or immigrant women – might not experience the same outcomes due to limited access to reliable birth control. In addition, the expectation of economic empowerment, such as increased labour force participation and higher wages, as a result of delaying first birth is based on the assumption that the period of delayed birth is spent investing in human capital, such as education or skills building (Finlay & Lee 2018, 318). It is also important to consider the role of childcare policies in encouraging women's labour force participation, as well as economic necessity. Many women who participate in the labour force do so because a single income is not enough to support the household. Such participation in the labour force (e.g., out of economic necessity) should not be automatically viewed as a means of female empowerment. The threat of poverty as a negative incentive to work – as has been observed among Estonia's older populations of both men and women (European Commission, 2020) – can play an important role in labour market decisions.

The relationships between educational attainment, economic inequalities, and labour force participation are thus more intricate than one may assume. While both educational attainment and labour force participation for women have increased across many EU countries, differences in access to educational and economic opportunities among different groups of women still remain and largely stem from structural barriers. In Western countries, women generally have higher levels of educational attainment than men (Piccoli 2017, 5), and in general, higher educational attainment can be linked to better job prospects and greater opportunity for social mobility. Higher

levels of educational attainment can also help women strengthen their bargaining power within the home, potentially shifting unequal distributions of resources (Piccoli 2017, 5; Winters 2015; Moretti 2004). Under state socialism in Europe, many men and women alike had access to universal public education. However, restrictions to state budgets following the socialist era have resulted in less access to higher education, particularly in countries "characterized by strong patriarchal family values," where women and girls might be more likely not to enroll in higher education (Piccoli 2017, 5). These limitations in access to educational attainment therefore have the potential to impact a woman's reproductive decisions as well as professional and economic opportunities throughout her life.

The economic wellbeing of women is therefore not a uniform, sweeping phenomenon, but rather differs based on social, cultural, and political contexts. Female immigrants and single mothers constitute particularly vulnerable groups in terms of poverty risk, especially in Western Europe (Piccoli 2017, 3; Fodor 2002, 375). Compared to other parts of Europe and the US, there are very few women who live in single parent households in CEE (Fodor 2002, 375). The same is true for households composed of a single older person, which are also scarce in CEE as many people live in extended households (Fodor 2002, 376). While wages for women have increased throughout the second half of the 20th century and in recent decades – largely as a reflection of their increased skill and educational attainment – the concurring increase in female-headed families has also helped to strengthen the so-called feminization of poverty (Smith & Ward 1989, 20; Kim & Choi 2013, 348). This phenomenon has been linked to structural gender inequalities that result in lower salaries, pensions, and benefits for women in the labour force, especially those with less education and skills. Notably, the feminization of poverty takes different forms in different countries. Kim and Choi (2013) identify that variations in welfare schemes contribute to

these differences, indicating that family benefits can play a role in reducing poverty among female-headed households, in particular (Kim and Choi 2013, 357). Such policies are therefore likely to increase in importance as the number of female-headed families grows.

In two-parent families, scholars such as Fodor (2002) and Piccoli (2017) have shown that traditional measures of female poverty rely on the unitary model of the household, thereby ignoring inequalities in the sharing of resources within the home and underestimating the severity of poverty risks among women. In considering the distribution of resources within a household and differences in bargaining power between men and women, the true extent of intrahousehold inequality and subsequent risk of poverty for women is more evident (Piccoli 2017, 2). Notably, non-unitary models to assess female poverty also account for unpaid work within the home, such as care work and other domestic duties (Piccoli 2017, 3), which helps build a stronger understanding of inequalities between men and women. According to the Harmonized European Time Use Survey, women participate in less paid work than men on average, but substantially more household work and childcare – 82 percent and 154 percent more, respectively. Many researchers have argued that because women bear more responsibility than men for taking care of children (and sometimes other relatives or dependents) they are more dependent on the state for welfare provisions (Fodor 2002, 380). The provision of such benefits differs significantly throughout the region, with notable distinctions often existing between countries in CEE, Western Europe, and Southern Europe.

Furthermore, when looking at the intergenerational transmission of income and education, it is evident that the children of richer parents are often advantaged compared to children of poorer parents. Parents who earn higher incomes can invest more in their child's human capital, as well as devote more financial resources to their child's education and skill development (Cappellari

2021, 2). Moreover, more highly educated parents may be able to better assist their children in their educational endeavors or, if a single income produces enough financial resources, one parent may decide to stay home to care for their child and guide their studies (Cappellari 2021, 2; Kim 2016, 6). These kinds of investments within the home can produce positive effects on a child's educational attainment and labour market outcomes in the future. From the perspective of gender, intergenerational effects of education and income are uniquely significant because of the relationships between mothers and daughters, as well as grandmothers and granddaughters. Multiple studies by Esther Duflo (2003; 2004; 2012) have shown that mothers and grandmothers in developing countries are more likely to invest financial resources in their daughters and granddaughters than are fathers. The economic wellbeing of mothers can therefore impact daughters in a way that is unique from its impact on sons.

In general, better-educated women have fewer children than lower-educated women. However, there are multiple factors that influence fertility decisions both beyond and through education. For this reason, the causal relationship between education and lower fertility is still unclear. Though multiple studies have tried to explore this relationship in more detail, the intensely private nature of fertility decision-making makes it difficult to assess personal choices within the home. For example, Pronzato (2017) and Hazan and Zoabi (2015) found that the increased financial resources of better-educated women allow them more opportunity to supplement parenting with childcare assistance, thereby increasing their ability to participate in the labour force (Hazan & Zoabi 2015, 1194). In particular, the availability of immigrants who work as child caretakers and childminders[3] can influence better-educated women's fertility decisions given their

[3] Childminders are distinct from daycare providers and babysitters. They care for other people's children – often from their own home – while the parents are at work. Childminders typically also provide early education for children under their care. For these reasons, childminders generally demand higher wages and are therefore less accessible to lower-income parents.

ability to afford childcare, which may incentivize them to have more children. However, the overall proportion of women employing childminders is quite small in Europe, seemingly because of their high costs (Pronzato 2017, 6). Therefore, additional research is still needed on the availability of childminders and their influence on fertility decisions.

Still, evidence suggests that education influences fertility in a number of ways. For example, education can improve maternal and child health through empowering women with the knowledge to have healthier pregnancies, which increases child survival rates and potentially reduces the desire – or as may be the case in agricultural households, the economic need – for more children (Kim 2016, 9; Psaki et al. 2019, 2). Moreover, better-educated women are more likely to know more about modern contraceptives, including how to use them and where to get them. Higher education can also empower women in the home and provide them more bargaining power with their husbands, increasing their ability to make decisions about contraceptive use (Kim 2016, 6-7). However, evidence of causal linkages between education and sexual and reproductive health more broadly, such as the effect of grade attainment on fertility preferences, autonomy, and sexual behavior, is mixed across studies (Psaki et al. 2019, 16). It is difficult to identify precisely when these mechanisms are influencing a woman's fertility decisions, given that each can affect better-educated women in its own right, as well as collectively influence their reproductive health decisions.

In postsocialist Europe, Brzozowska (2015) argues that there is limited evidence for a single socialist fertility pattern in CEE, and that changes in fertility throughout the second half of the 20th century in this region are similar to changes experienced by the whole of industrialized Europe. There is evidence, however, that growing educational attainment in the region affected fertility among women of multiple educational groups (primary, basic vocational, secondary, and

tertiary). But the extent of this impact is varied, as data shows a declining rate of childlessness among women, a growing proportion of women with just two or three children, as well as increases in fertility among young women (born in the 1940s and 1950s) affected by the pronatalist policies of the 1970s and 1980s – especially in Ceaușescu's Romania (Brzozowska 2015, 708). While educational attainment can influence women's fertility decisions, there is no distinct relationship which can be identified in CEE, likely due to the influence of other factors, including access to contraception and abortion, bodily autonomy and bargaining power within intimate relationships, as well as personal desire for (or not for) having children.

Notably, there is still reason to believe that a parent's educational attainment can impact the number of children that they have, depending on public education schemes. In countries where education is highly subsidized, private spending of parental resources on children's education will have less of an impact than countries where government spending on education is lower. Additionally, the number of children that parents have will also have less impact on their children's education, since the spending of private resources for educational purposes is not necessarily needed as a substitute to government spending (Li & Liu 2022, 4). In this regard, the quality-quantity tradeoff theory – that the higher the number of children parents have, the lower their quality (e.g., educational attainment and future earnings) will be – does not hold as well in developed countries, given the greater government provisions for education. However, a study on the US found that for each additional child born in a family, the probability of the oldest child attending private school was reduced by 1.2 percent, as was the mother's labour force participation, indicating a reduction in the parents' abilities to financially invest in each additional child's education (Cáceres-Delpiano 2006, 749, 745). But according to Li and Liu (2022), such a reduction is not wholly indicative of a significant negative effect to educational quality among the children

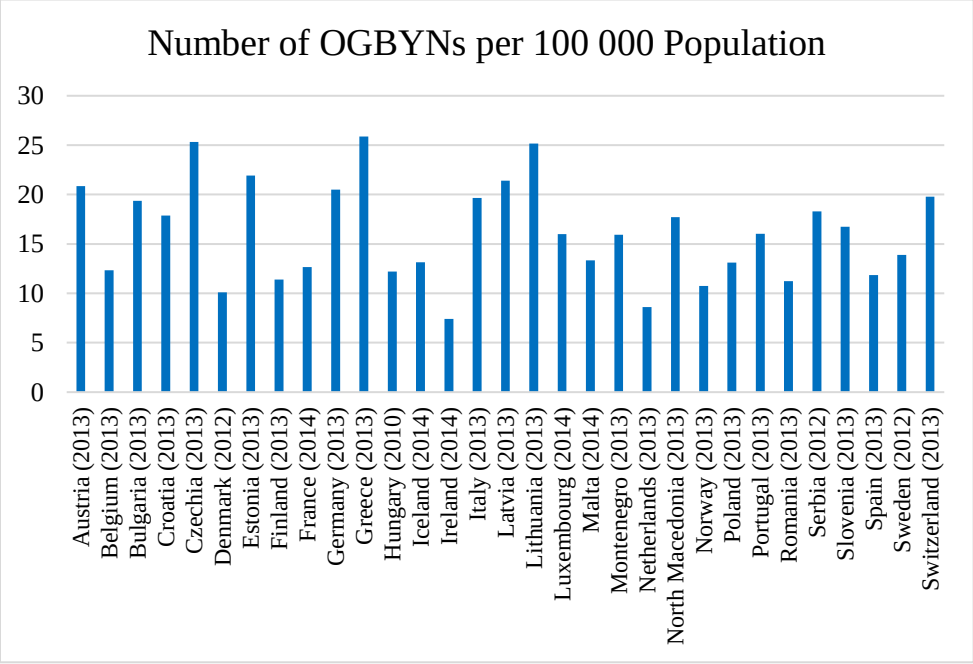
(Li & Liu 2022, 8). It may be true that certain parents make fertility decisions based on these assumptions, but it is difficult to capture that level of decision-making within research studies.

In order to gain a clearer understanding of the relationship between access to SRH and labour market outcomes among European women, this study deemphasizes the role of educational attainment in an effort to focus more on the availability of healthcare and services as opposed to individual decision-making regarding reproduction and sexual health. Given the mixed studies on the role of education in influencing SRH, it remains unclear how educational attainment effects fertility decisions at the individual level. Moreover, it is possible that the use of SRH services has an impact on labour market outcomes through its effect on educational attainment, but this too is difficult to capture in this study. The following section details the research design, including the sources of data and methodology used, and conceptualizes more concrete measures of SRH care access and labour market outcomes among women.

3. Research Design and Methodology

This study uses two different sources of data to examine the relationship between SRH care access and labour market outcomes for women in Europe. The first data set has been obtained from the World Health Organization's European Health Information Gateway. Using the European database on human and technical resources for health (HlthRes-DB), the indicator for the number of OBGYNs (per 100 000 population) was selected to represent the explanatory variable of access to SRH care and services (Figure 3.1). Since the use of SRH services is likely to be influenced by many factors which are difficult to include in this study – including bargaining power within intimate partner relationships and personal choice – this variable was intentionally chosen to separate access to SRH care from individual decisions regarding the actual use of services. Within this data set, the number of OBGYNs is available at the country level across the region and spans the years 1980 to 2014.

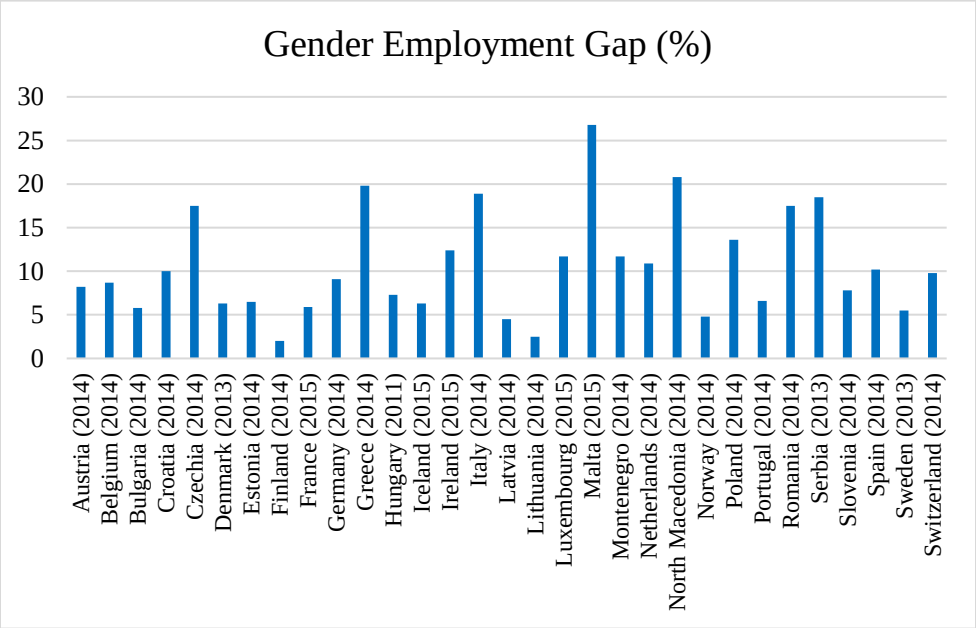
Figure 3.1



Source: WHO, 2016

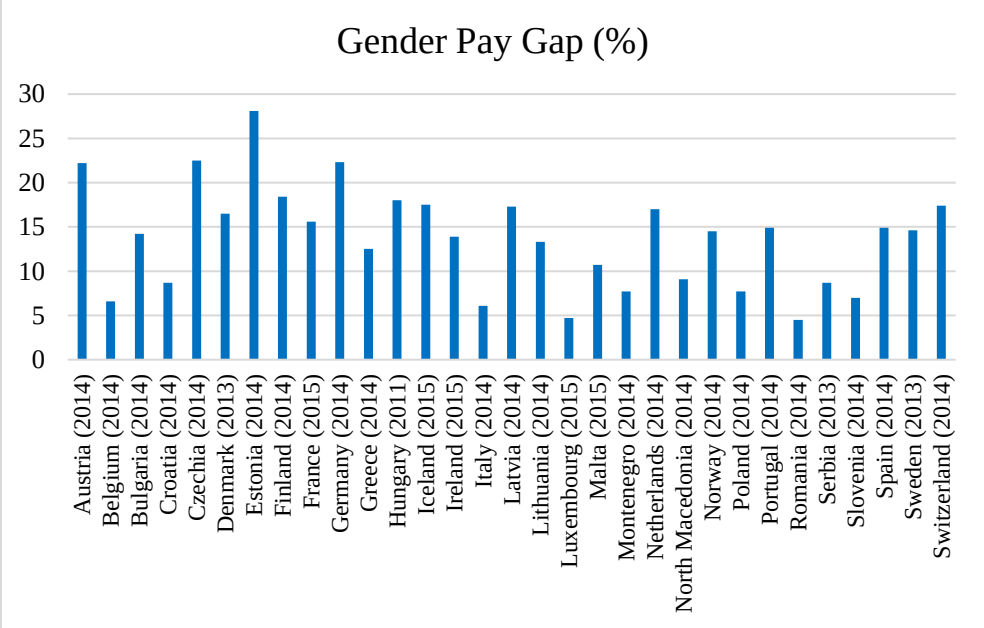
The second source of data is the statistical office of the European Union (Eurostat). From this data source, two separate dependent variables were drawn to represent labour market outcomes among women. First, the indicator for the gender employment gap was used from the European Labour Force Survey (EU-LFS). This variable is defined as the difference between the employment rates of men and women between the ages of 20 and 64 (Figure 3.2). Second, the indicator for the gender pay gap was used, which shows the difference between average gross hourly earnings of employed men and employed women as a percentage of average gross hourly earnings of employed men (Figure 3.3). The data includes all employed persons who are working at firms with at least ten employees and does not distinguish by age or number of hours worked. The year of the data sample for these two variables was dependent upon the most recent year of data for the variable on SRH care access. For both the gender employment and pay gaps, data from the year following the most recent reported number for OGBYNs in each country was used. Due to the unavailability of data in the relevant years of study, both Cyprus and Slovakia were dropped from the sample. The countries included are the remaining EU member states plus Norway, Switzerland, Iceland, Serbia, Montenegro, and North Macedonia.

Figure 3.2



Source: Eurostat, 2022 (LFSI_EMP_A)

Figure 3.3



Source: Eurostat, 2022 (EARN_GR_GPGR2)

The dependent variables were intended to represent gender inequalities in the labour market, and the subsequent data analysis looked for a relationship between access to SRH care and

those labour market outcomes. STATA was used to run a simple regression on both dependent variables in an effort to estimate the association between access to SRH care (*SRH*) and the gender employment gap (*empgap*) and gender pay gap (*paygap*). The regression equations were as follows:

$$empgap = \beta_0 + \beta_1 SRH + u \qquad paygap = \beta_0 + \beta_1 SRH + u$$

Given the variation in access to SRH across the countries under observation, the regression is used to assess if this variation influences the width of the gender gaps in both employment rates and hourly earnings. The underlying assumption is that access to SRH care and services will help increase the labour force participation and earnings potential of women, thereby reducing gender inequalities in the labour market.

Notably, the data could only be obtained at the country level, meaning that additional variation by geographic location (e.g., rural compared to urban areas) is not accounted for in this model. This poses some limitations to the interpretation of results given that rural areas typically have less access to healthcare resources in general. In addition, it is difficult to account for alternative influencing factors on both the employment and earnings gap between genders using the macro level data. For example, variations in access to SRH care on the basis of race/ethnicity, immigration status, sexual and gender identity, and educational attainment can influence labour market outcomes in ways that are not captured here. Currently absent from the data used here is any distinction based on educational attainment. A woman's level of education can influence her knowledge of sexual health, contraceptives, and other family planning services, and therefore impact her decisions on how to use SRH services. Educational attainment can also affect earnings and mobility in the labour force. However, at the country level, educational attainment should not have an effect on the available number of OBGYNs.

In order to obtain more information about the relationship between access to SRH care and labour market outcomes among women, more precise micro data would be necessary to make stronger statistical inferences. Ideally through multivariate regression, a data set including variables for gender, educational attainment, professional experience, race/ethnicity, geographical location, labour mobility, and hourly wages could allow for further analysis of a causal relationship. Using the variables for wages and labour mobility as proxies for labour market outcomes would necessitate the inclusion of control variables, such as race/ethnicity, education, and experience. More research is also needed still on the effect of access to sexual and reproductive health on labour market outcomes for vulnerable subpopulations, such as LGBTQI people, immigrants, and disabled persons. For example, given the unique sexual health needs of transgender people, more data is needed to assess how additional barriers to care – including discrimination, violence, and lack of trans-specific knowledge among healthcare providers – further influences labour market outcomes. Still, using the macro data available can offer insight into possible connections between access to SRH care – in the form of the number of OBGYNs available in each country – to broader indicators of gender inequality within the labour market.

4. Discussion

4.1. Results

The analysis of results begins with using scatter plots to identify any emerging patterns across the data, first between the number of available OGBYNs and gender employment gaps, then between the number of OGBYNs and gender pay gaps. The gender employment and pay gaps vary across countries even with similar numbers of OBGYNs available, suggesting the influence of alternative factors on labour market outcomes. Figures 4.1.1 and 4.1.2 below show the correlation (or lack thereof) between the gender gaps and number of OBGYNs for all countries under observation.

Figure 4.1.1

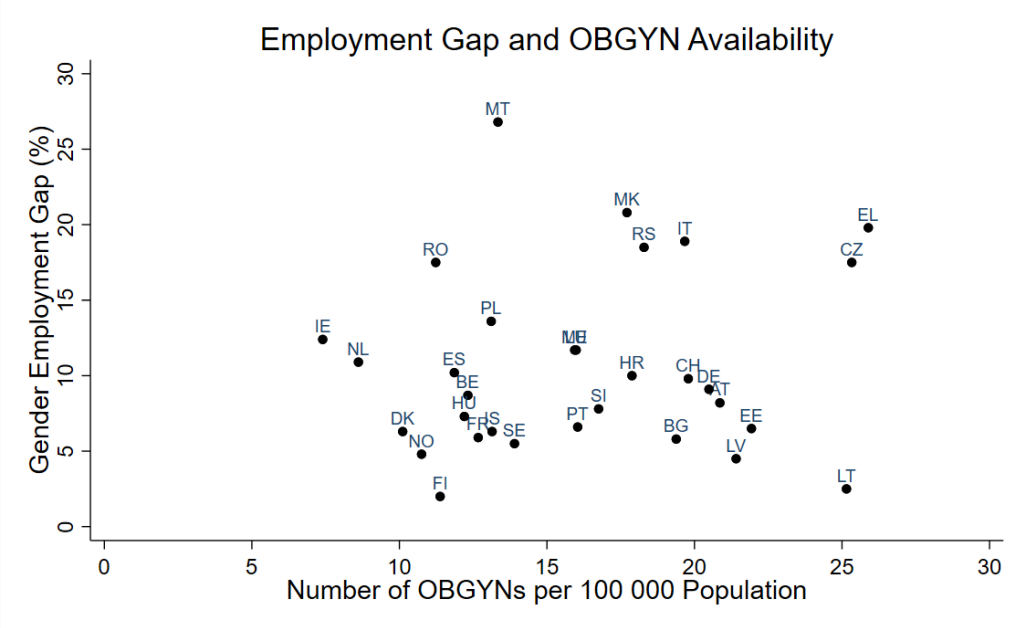
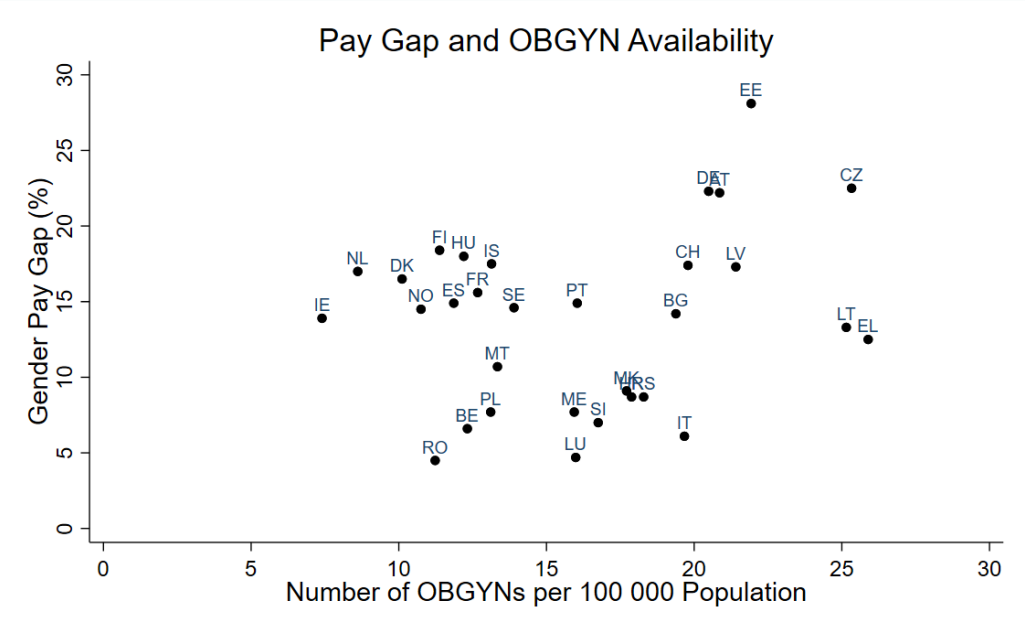


Figure 4.1.2



At first look, there is no distinct trend line among all observed countries in regard to the number of OBGYNs and gender gaps in employment and pay. When comparing scatter plots for the relationship between the gender pay gap and access to SRH care to the relationship between the gender employment gap and access to SRH care, there is movement of particular countries on the graphs. For example, in Lithuania there is higher access to care compared to the EU average, as well as a lower difference between male and female employment rates. However, the difference in male and female earnings is slightly above the EU average. In Romania, both access to care and the difference in the gender pay gap are lower than the EU average, but the gender difference in the employment rate is one of the highest in the region. While it is possible that the limited access to SRH care in Romania could be affecting the employment rates of women, one cannot assume a causal relationship based on the data presented here.

To identify regional trends, the countries were divided into two categories: non-postsocialist and postsocialist. Figures 4.1.3 and 4.1.4 show the relationships for the non-postsocialist countries only, including Western, Northern, and Southern parts of Europe.

Figure 4.1.3

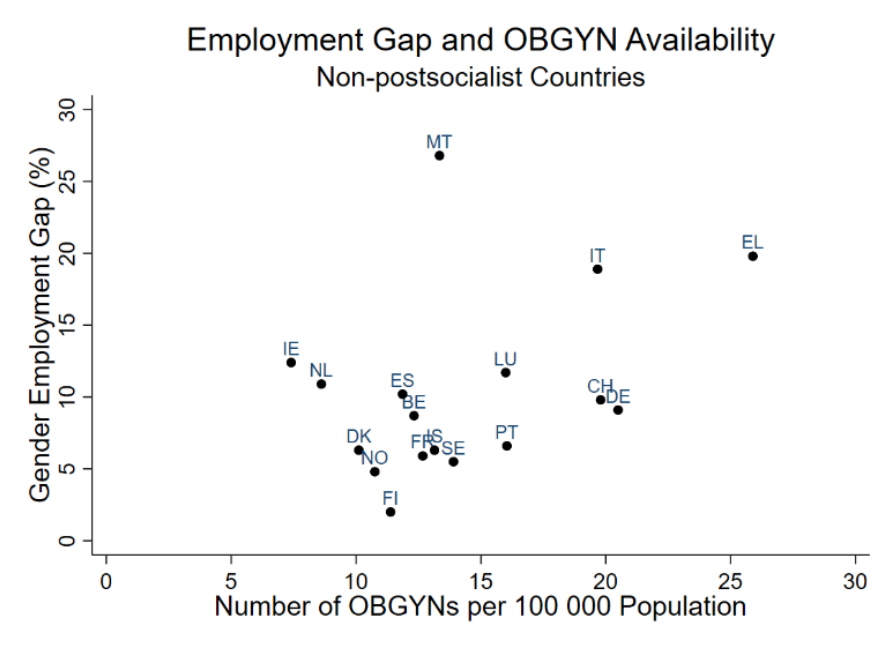
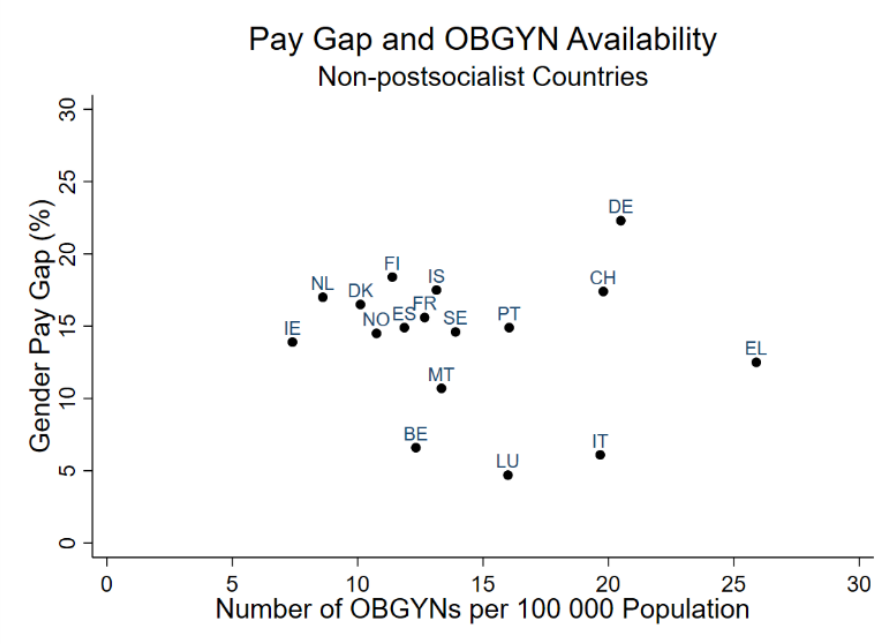


Figure 4.1.4



The observations are largely clustered around the same area in each plot, with some movement on the right side of the graph. The gender employment gaps in this region, on average, are generally low, with higher rates for Italy, Malta, and Greece. Greece also has the highest number of OBGYNs in this data set, but there is no indication of a negative correlation with the gender employment and pay gaps. Figures 4.1.5 and 4.1.6 then show the remaining post-socialist countries, including Central and Eastern Europe and the Baltic and Balkan regions.

Figure 4.1.5

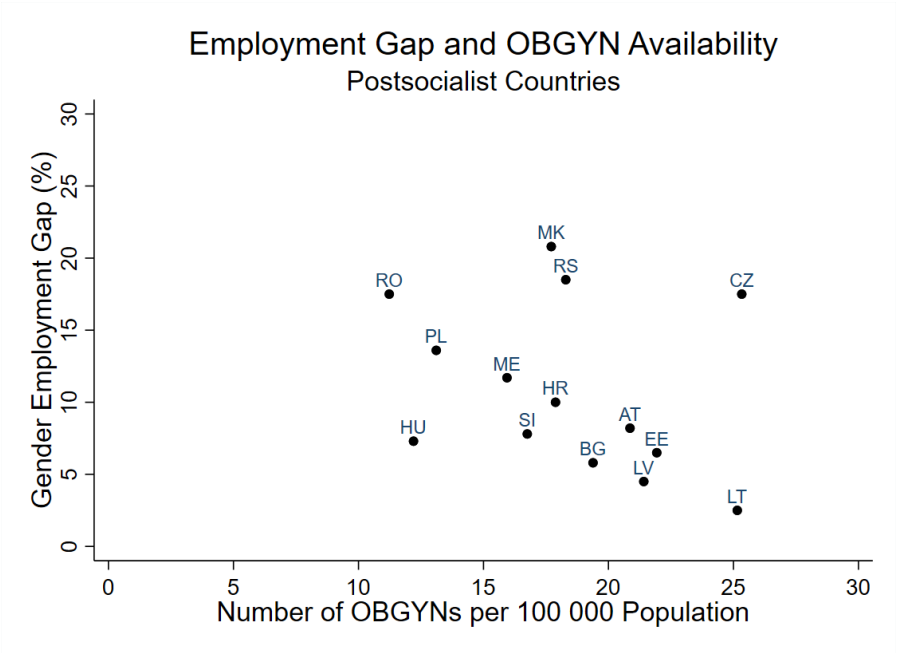
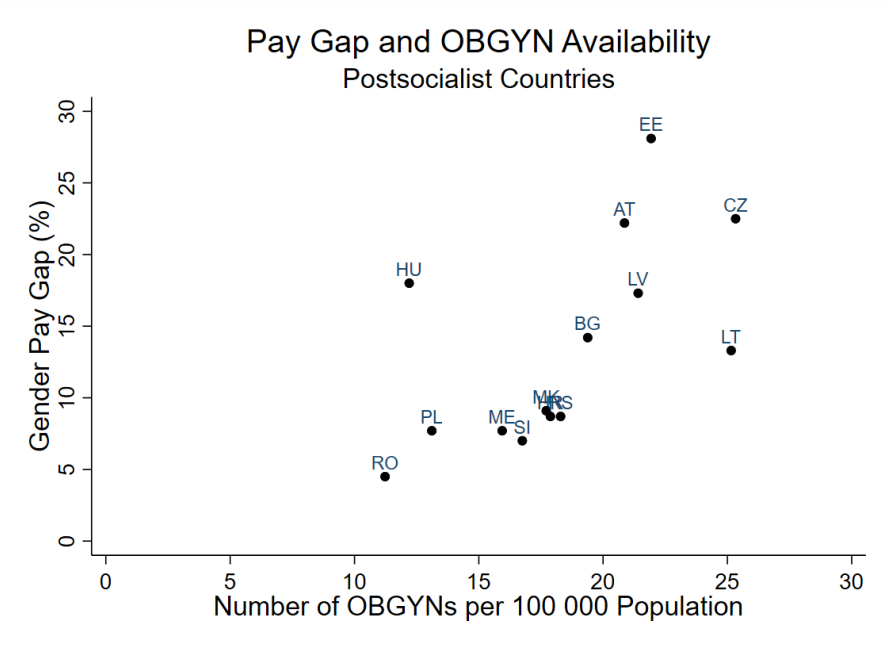


Figure 4.1.6



The trend lines are clearer in each of the plots for the postsocialist countries, but interesting enough, they move in opposite directions. The correlation is negative in Figure 4.1.5, with higher numbers of OGBYNs associated with lower gender gaps in employment. In Figure 4.1.6, however, the higher the number of OBGYNs, the higher the gender pay gap (with the exception of Hungary). While these plots do not indicate any conclusive relationship, they warrant further examination. Therefore, the regressions were run first for all countries observed, then for each grouping of non-postsocialist and postsocialist countries.

However, the regression model yielded similarly inconclusive results. Table 4.1.1 depicts the coefficients for both regression equations, first with the gender employment gap and second with the pay gap. Given that the higher the gaps between men and women for pay and employment the greater the gender inequality is in a given country's labour market, the expectation was that increased access to SRH care and services – as measured by the number of OBGYNs in a country – would decrease these gaps. However, the regression results for both models show positive

associations between the number of OBGYNs and the gender employment and pay gaps. Notably, the R-squared for each model is very low, with only approximately 0.01 percent of variance in gender employment gaps explained by the number of OBGYNs, and 0.05 percent of the variance in pay gaps explained by the number of OBGYNs. The results are also statistically insignificant at the 90 percent confidence level. These results presumably stem from the limited nature of the data used in the regression models. Using macro level data resulted in a more limited number of observations (31 countries in total). In addition, the regression models do not capture variations in access to SRH care *within* the countries themselves. Overall, the analysis presented here cannot be interpreted as a causal relationship between access to SRH care and the gender employment and pay gaps. This likely indicates alternative explanations for the variations in gender inequalities in the labour market across the region, but access to SRH care should not be ruled out entirely as a potentially influential factor.

Table 4.1.1: Regression Results for All Countries

	EmpGap b/se	PayGap b/se
Number of OBGYNs	**0.136**	**0.257**
	(0.23)	**(0.20)**
Constant	**8.374***	**9.626****
	(3.68)	**(3.16)**
R-sqr	**0.013**	**0.049**
dfres	**29**	**29**

* p<0.05, ** p<0.01, *** p<0.001

Table 4.1.2 below then shows the regressions run for each group of countries, first for the employment gap variable and second for the pay gap variable. The negative coefficients under the second and third columns reflect previous assumptions that more OBGYNs would be associated

with less wide gender gaps in employment and pay, but again the R-squared for each model is quite low, indicating limited explanatory power of the independent variable on the variance in the dependent variables. The results of the fourth regression model, which used the gender pay gap as the dependent variable for postsocialist countries only, is of particular interest because it shows a positive coefficient that is statistically significant (at the 95 percent confidence level) and has a relatively high R-squared of approximately 36 percent. This relationship was modeled in the previous plot (Figure 4.1.6) and raises questions about the causal forces behind the high gender pay gaps in the region. It is possible that these inequalities in the labour market are reflective of alternative explanations, such as gendered divisions within different sectors as well as the role of care leave policies and welfare schemes, which may influence the promotional opportunities and labour mobility of women with children or other dependent relatives.

Table 4.1.2: Regression Results by Region

	EmpGap, NPS b/se	EmpGap, PS b/se	PayGap, NPS b/se	PayGap, PS b/se
Number of OBGYNs	**0.501**	**-0.404**	**-0.099**	**0.980***
	(0.24)	**(0.40)**	**(0.22)**	**(0.41)**
Constant	**3.163**	**18.290***	**15.421*****	**-4.499**
	(3.85)	**(6.96)**	**(2.75)**	**(7.55)**
R-sqr	**0.147**	**0.093**	**0.010**	**0.362**
dfres	**15**	**12**	**15**	**12**

* p<0.05, ** p<0.01, *** p<0.001

Note: *NPS = Non-postsocialist Countries, PS = Postsocialist Countries*

It is very possible that, although on average the findings are insignificant, by social strata, there are important distinctions in access to SRH and labour market outcomes among women. As aforementioned, the impact of educational attainment is not present in the average statistics

gathered from the data sources. Education can influence the labour market outcomes of women – namely in terms of wages and labour mobility – in ways that are not affected by access to SRH care. At the same time, knowledge of SRH care, including family planning services and pre- and postnatal health, can also influence a woman's reproductive decisions and, subsequently, her participation in the labour force. As a result, existing barriers to education are important for understanding inequalities in labour market outcomes more broadly. For women and marginalized subpopulations – such as refugees, LGBTQI people, and racial/ethnic minorities – limitations in access to comprehensive sexuality education in particular might have a significant unobserved effect on their knowledge and use of SRH services. It is within these different social strata that the effects of access to SRH care on labour market outcomes could become more obvious.

It is also worth mentioning that the influence of childcare policies, parental leave schemes, and supportive measures for caretakers are also not observed here. The analyzed data is based strictly on access to SRH care rather than explicit support services for mothers, such as the availability of daycare and family friendly employment policies. As the literature presented in section 3 above showed, mothers of children under the age of two often have lower rates of employment compared to other women (including mothers of older children) and men. This indicates the impact of childrearing on labour force participation rates of new mothers. The prevalence of gender inequalities in the division of care responsibilities within the home is also important for consideration when examining the role of policies in influencing women's labour market outcomes, namely their labour force participation, earnings potential, and labour mobility. Variations in parental leave schemes across Europe, as well as in family benefits and care policies, can also account at least in part for some of these variations in the gender employment and pay gaps. For the postsocialist countries, the insufficiencies of current welfare systems and caretaker

support measures – which largely operate under neoliberal ideological constraints – may be particularly influential on the labour market outcomes of women and help explain the regression results in Table 4.1.2.

4.2 Policy Implications

4.2.1 Data Collection

Although it is not feasible to identify a causal relationship between access to SRH care and gender inequalities in the labour market – as measured by gaps in employment and earnings between men and women – based on the data presented here this analysis still yields important policy implications across the region, including the need for more SRH data. This is especially true in countries where the gaps between genders are high in terms of average earnings (e.g., Austria, Germany, Czechia, and Estonia) and rate of employment (e.g., Romania, Italy, North Macedonia, and Czechia). In particular, data disaggregated by gender identity, sexual orientation, race/ethnicity, nationality, immigration status, age, disability status, educational attainment, and socioeconomic status are important for identifying distinct trends in access to SRH care. The collection of disaggregated data is also necessary to understand how current policies and, in the cases of Hungary and Poland, restrictive measures in accessing LGBTQI-specific SRH care or abortion impact more vulnerable groups compared to the general population. Each country under observation could benefit from stronger data collection efforts in the realm of SRHR in order to better address the needs of women, especially those who belong to marginalized subpopulations.

Furthermore, the lack of distinction in age when it comes to the relationship between SRH care access and the gender gaps in employment rates and average wages raises questions about the long-term effects of SRH care access. It is worth examining how limited access to SRH care and services among adolescents might influence labour market outcomes later in life, possibly through

effects on educational attainment or social stigmatization among, for example, LGTBQI people or people living with HIV. The impact of accessible SRH during the adolescent and early adulthood stages is likely to have important ramifications for later life stages, thereby affecting labour market outcomes such as labour force participation and income. Additional data on the SRH needs of adolescents, as well as longitudinal studies on the long-term impact of access to sexual and reproductive healthcare during adolescence, could lead to more practical evidence-based policy models for SRH, including comprehensive sexuality education. The need for disaggregated data collection and more subpopulation-specific research also connects to the following policy implication regarding the identification of unmet needs for SRH care and services.

4.2.2 Identification of Unmet Need for Contraception

The collection of SRH data can help isolate populations currently unable to access the care and services that they need. Given the divide in access to healthcare between urban and rural communities, as well as the influence of factors such as socioeconomic status and immigrant status on access to SRH care, policymakers must consider the importance of targeted measures to address unmet needs among subpopulations. Identifying unmet needs for contraception and abortion is also important to ensure that women have control over their reproductive decisions. The ability to control the spacing and number of children can influence a woman's labour market decisions, including her number of hours worked and leaves of absence from employment. In addition, it is worth considering how the SRH needs of LGBTQI people, especially transgender people, might impact their labour market opportunities. More research is still needed on the ways in which discrimination in healthcare, lack of knowledge on trans-specific care among healthcare providers, and access to gender-affirming medicines and services might influence a transgender person's participation in the labour market and subsequent labour mobility and earnings potential. This is

one target population that could benefit from a more precise identification of unmet SRH needs, including insufficient access to family planning services. It is also necessary, however, for policymakers to recognize the role of mutually constitutive inequalities in limiting both access to SRH care and labour market outcomes among people who experience multiple oppression.

4.2.3 Reduction of Gender Inequalities in- and outside the Labour Market

Considering the limited ability to estimate the relationships between access to SRH care and labour market outcomes among European women based on the data used in this study, there is reason to believe that additional factors are influencing the gender gaps in employment and wages but are possibly still related to reproductive labour. For example, Czechia, Austria, and Estonia had some of the highest numbers of OBGYNs across the region, but also high gender gaps in average wages. It is worth considering how gender divisions in unpaid care work, as well as divisions within sectors of the labour market, might also affect the width of pay gaps between men and women in these countries. Given the disproportionate bearing of care responsibilities by women, it is plausible that their wages are being impacted by the need for caretaker leaves or the inability to work full time. This is especially relevant in countries in which women are less likely to participate in the labour force due to full-time caretaking responsibilities – either for their own children or another relative – such as in parts of CEE. It could therefore be beneficial to harmonize both SRH care access and childcare policies in order to firstly increase women's bodily autonomy and reproductive control and to secondly reduce the negative employment and wage effects of care work, especially among single mothers and people with lower socioeconomic statuses. Given the high rates of gender division in care work across the region, such policy measures are in need from the East to West, though differences in current care leave and job flexibility schemes imply the need for variations in reform from country to country.

5. Conclusion

This study has attempted to identify the association between access to SRH care, as measured by the number of OBGYNs in each observed country, and the gender gaps in employment and wages. Although the results of the data analysis are not statistically significant or particularly explanatory of variations in gender inequalities in the labour market, there is reason to believe that SRH care access is a key factor in the protection and promotion of the economic wellbeing of European women. The limited explanatory power of the macro data used here highlights the need for additional SRH data disaggregated by additional characteristics, including age, educational attainment, sexual orientation and gender identity, immigration status, and socioeconomic status. It is evident that more policy work needs to be done in order to address the inequalities between men and women in terms of labour force participation and average earnings. Improving access to SRH care and services by reevaluating the unmet needs of women – especially vulnerable subpopulations – could have a positive effect on labour market outcomes in the long term, but additional research is needed to identify these effects more precisely. Such research could lead to stronger evidence-based policymaking which targets populations most in need of SRH support.

Moreover, it is of key importance that access to SRH is considered alongside the influence of supportive measures for the provision of childcare. Reproductive justice is not only a matter of fertility control and bodily autonomy, but also of the right to raise children in safe and healthy environments. As such, SRHR, childcare policies, and family benefits are all interconnected. It is therefore necessary for policymakers involved in the fields of health, labour, education, and social welfare to collectively work towards more equitable policies that improve the labour market outcomes of women through greater protections for fertility control and sexual health, access to

childcare, and family-friendly benefits. For EU member states and candidate countries in particular, recognizing the guidelines laid out in the 2021 European resolution on sexual and reproductive health and rights requires greater effort to meet SRH needs as a means to promote the rights of women more generally. The SRHR of all women, including vulnerable subpopulations, must be approached with a universalist mentality that recognizes the interconnectedness of SRH and gender equality in the labour market and seeks to empower women through greater economic opportunities and reproductive health support.

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