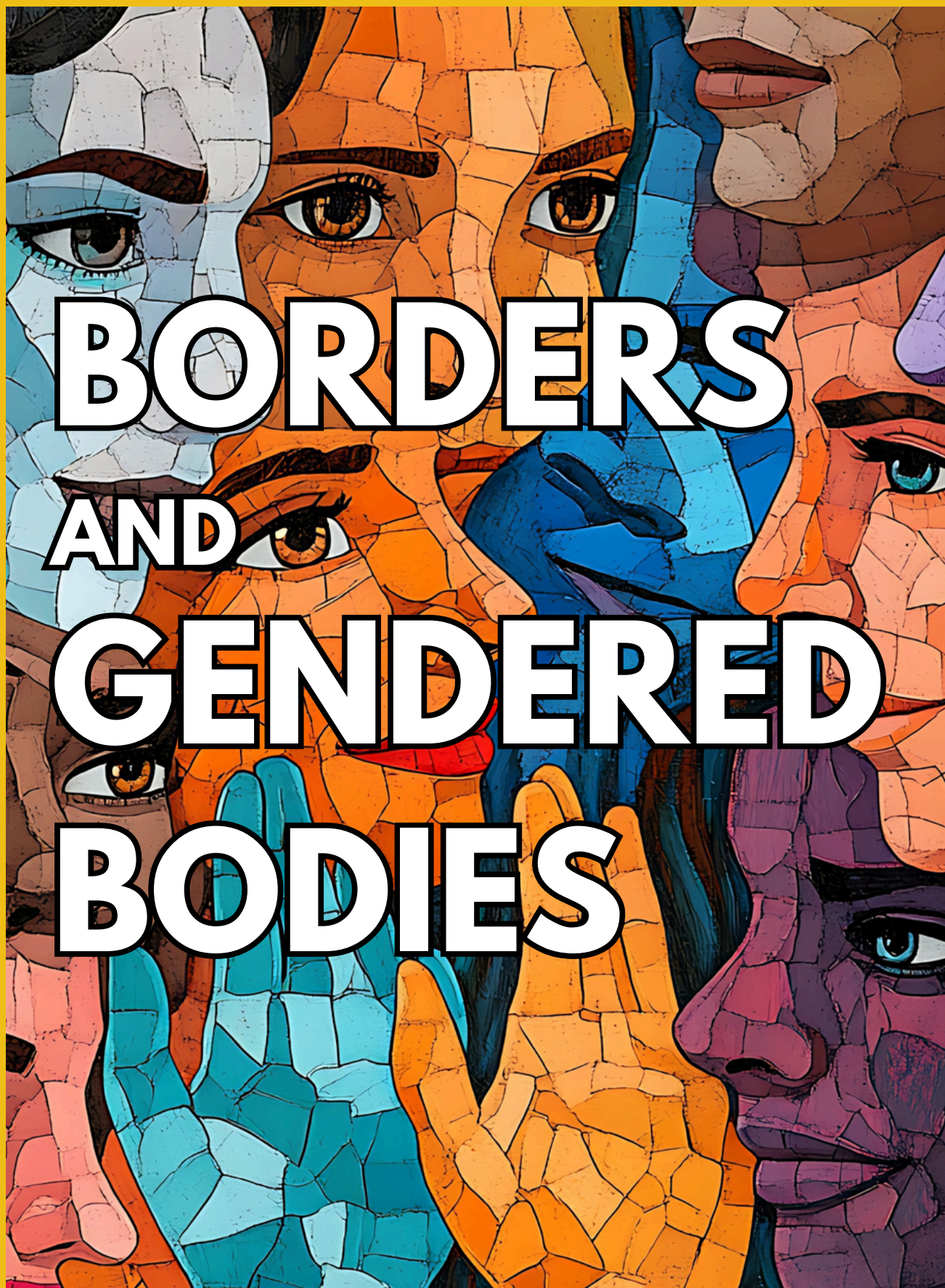




BORDERS AND GENDERED BODIES

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ACCESS, AUTONOMY AND AGENCY

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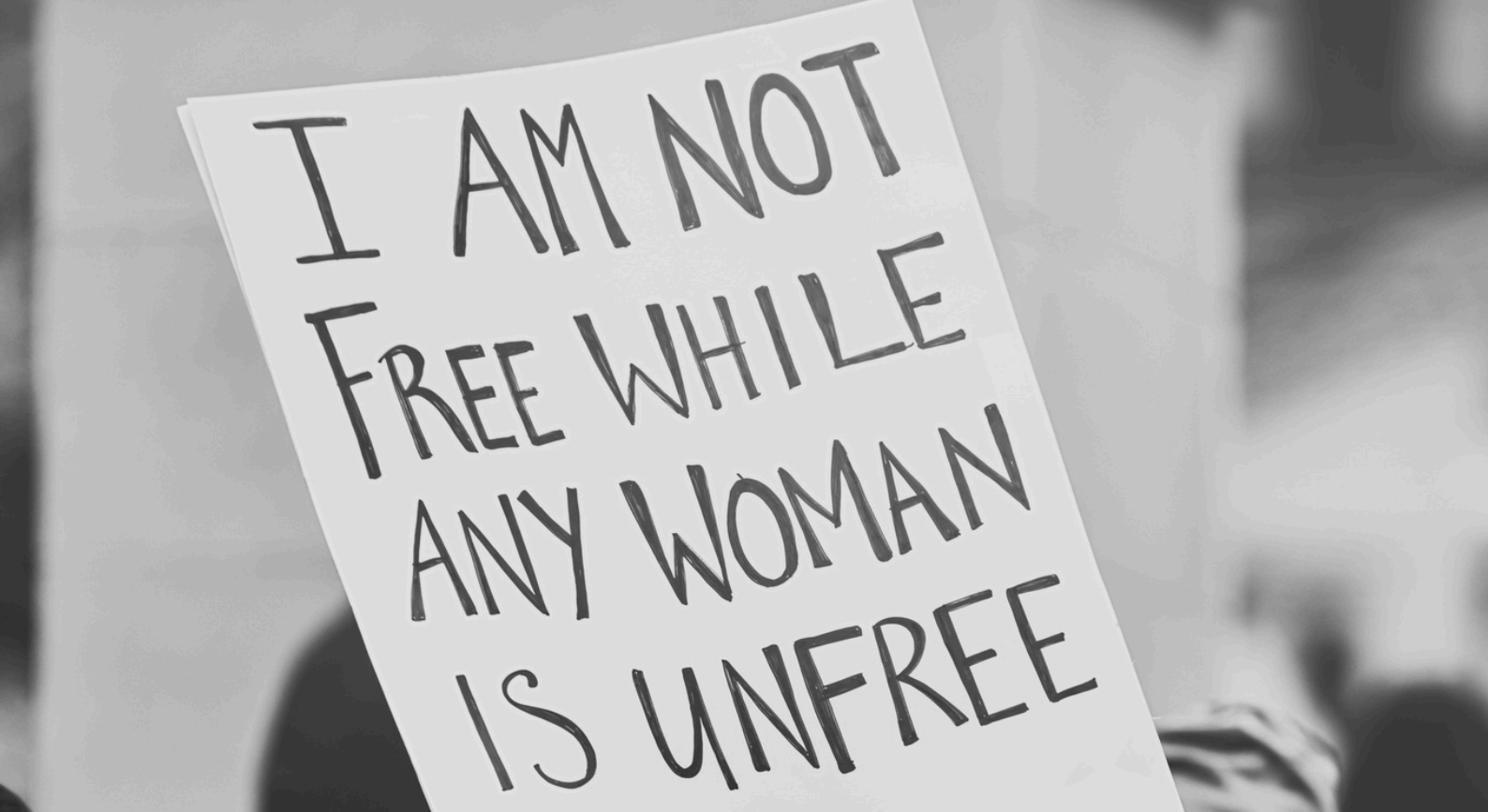
A black and white photograph of a person holding a large, white protest sign. The sign has the text "I AM NOT FREE WHILE ANY WOMAN IS UNFREE" written in bold, black, hand-painted capital letters. The person holding the sign is partially visible in the background, and the background is blurred.

Image: [shaunl](#)

INTRODUCTION

Migration and displacement are often framed as predominantly male experiences, yet a considerable proportion of people on the move are women. This population faces most of the same hardships and marginalisation as their male counterparts, compounded by the effects of migration on health, while also confronting specific health issues that are frequently overlooked, not only by policymakers but also by NGOs providing support along migration routes and at places of arrival.

It's worth saying migration isn't only a story of harm. Research shows it can actually bring health benefits for women, for example better access to preventive

screenings than they had at home, but only under certain conditions: having a job, speaking the local language, living somewhere with functioning healthcare infrastructure. Without those, the same journey can just as easily mean losing access rather than gaining it¹.

In this report we look more in depth at some of these aspects. We cover restricted access to abortion for Ukrainian women in Poland, menstrual health on the move, access to care related to pregnancy, a study on determinants of mental health among Ukrainian women, and the difficulties and opportunities around menopause.

¹ Sheikh, A. H., Hamid, S., Lone, B. A., Muzaffar, F., & Hussain, M. (2025). Migration and Women's Health Research (2000-2023): A bibliometric analysis of trends and gaps. *Dialogues in health*, 6, 100210. <https://doi.org/10.1016/j.dialog.2025.100210>

ABORTION AS HEALTHCARE: A DIVE INTO THE GENDERED FAILURE OF THE TPD

Imagine stepping across a border and discovering that reproductive rights you once took for granted are now a crime. For millions of Ukrainians, that discovery happened when they fled the war in their home country in 2022 and set foot in Poland. Ukraine has very liberal abortion laws. In Poland, it's almost entirely illegal.

The war in Ukraine saw Europe's largest refugee crisis since the Second World War. More than 6.03 million have fled to other countries, resulting in the activation of the Temporary Protection Directive, a measure used to ensure swift international protection. Under the TPD, Ukrainian refugees don't face some of the issues a typical asylum seeker would face – guaranteed access to healthcare is a notable example².

However, there is a caveat – 60% of Ukrainian refugees entering Europe are women and girls. The gender composition has played a part at every turn of the response. It emphasises the need for not only access to basic services, but for a gender conscious approach to policy that caters for women's needs. This is especially relevant considering Ukrainian women are at a heightened risk of sexual violence.³

In Poland particularly, abortion rights have been a fervent source of debate for many years. A woman is only able to abort in case of life danger, incest, or rape criminally acclaimed. Providing police reports for sexual violence is also difficult in any situation, let alone for women raped during wartime in another country⁴. Many women resorted to doing the difficult journey back to the most Western parts of Ukraine to access the care they were used to⁵.



Image: Tanya Shyika for IPPF x Fine Acts

² Council of the European Union. (2001). Council Directive 2001/55/EC on temporary protection in the event of a mass influx of displaced persons. EUR-Lex.

³ European Union Agency for Fundamental Rights. (2026). Seeking safety from war: Violence and rights abuses against women from Ukraine. Publications Office of the European Union.

⁴ Andrea Cioffi et al. (2022). Violation of the right to abortion at the time of the war in Ukraine. Sexual & Reproductive Healthcare.

⁵ Maya Oppenheim. (2023). Ukrainian refugees living in EU forced to travel back for abortions, study warns. The Independent.

And now, 5 years after Poland's de facto abortion ban, we see a number of grassroots movements to provide both refugees and nationals the healthcare they need. In March 2025, the NGO named 'Abortion Dream Team' opened a centre in Warsaw, which provides counselling, pregnancy tests, and assistance for people considering an abortion⁶. A lot of these organisations have noticed a significant uptick in demand since the start of the current war⁷.

Five years after the activation of the TPD, its legacy remains mixed. While Art. 13(4) mentions healthcare provisions should cater to those with "special needs" - specifically mentioning victims of sexual violence⁸ - this does not guarantee access to contraception or safe abortion. Instead of ensuring a directive covering the full range of sexual and reproductive services as a basic standard, civil society organisations were left to fill the gaps. And with the termination of the TPD on the horizon in March 2027⁹, we can indeed say the directive ensured considerable protection to Ukrainians as refugees. But crucially, not always as women.



Image: @Karola G, Photo from 2022 women's rights protest in Poland. Translation: Piekło kobiet - Women's Hell

⁶ Claudia Ciobanu. (2025). Activists Open Abortion Clinic Opposite Polish Parliament. Balkan Insight.

⁷ Amie Ferris-Rotman. (2022). Ukraine's women refugees face the harsh reality of Poland's abortion restrictions. TIME.

⁸ Council of the European Union. (2001). Council Directive 2001/55/EC on temporary protection in the event of a mass influx of displaced persons. EUR-Lex.

⁹ Government of the Netherlands. (2025). *Extension of the Temporary Protection Directive until 4 March 2027 for refugees from Ukraine and recommendations for an exit-strategy*. Government.nl.

WHY EVERYONE DESERVES TO MENSTRUATE WITH DIGNITY AND IN SAFETY



Image: Europe Must Act

MENSTRUATION IN TRANSIT AND DETENTION

The [UNFPA](#) defines menstrual health as a state of complete physical, mental, and social well-being, implying access to accurate information, menstrual products, water and sanitation facilities, treatment for menstrual-related discomforts, and the ability to participate in all spheres of life. However, with approximately 800 million people menstruating every day worldwide¹⁰. This normal biological process is far from a universally shared embodied experience, and in many instances, continues to be a taboo topic, surrounded by stigma, shame, and discrimination, particularly for vulnerable populations.

Migration as a social determinant of menstrual health introduces further layers of risk and marginalisation. The associated challenges with displacement – including extended migration routes and detention settings – may exacerbate physical and mental health consequences and increase susceptibility to gender-based violence. Consequently, meeting menstrual health needs safely and with dignity often becomes particularly difficult throughout the migration journey.

¹⁰ UNFPA. (n.d.). Menstrual Health. United Nations Population Fund. – [Menstrual health](#) | [United Nations Population Fund](#)

Pre-existing period poverty is frequently intensified during migration, as access to menstrual products and adequate water and sanitation facilities is often limited or inconsistent. Inadequate menstrual hygiene management can worsen existing health conditions or create new ones, including infections and long-term reproductive health issues. Furthermore, the absence of private and gender-segregated WASH facilities may expose individuals to a greater risk of Sexual and Gender-Based Violence (SGBV)¹¹. Sea crossings present additional health risks, often lasting several days in overcrowded and unsafe conditions that make managing menstruation hygienically extremely difficult¹².

Similarly, in reception and detention settings, the promotion of menstrual health is hardly considered a top priority for aid organizations or governments.

Overcrowding, lack of healthcare, and proper menstrual health management infrastructure make people who menstruate even more vulnerable to intersecting forms of discrimination. Certain groups, including people with disabilities, transgender or non-binary individuals, face heightened difficulties in meeting their unique menstrual needs.

Even though hygiene or dignity kits, containing menstrual supplies, are often distributed in humanitarian settings, they do not always reflect users' needs, preferences, and socio-cultural norms. Research has shown that in some cases, individuals have had to pay for sanitary napkins or undergo humiliating practices such as proving that they are menstruating, in order to receive them¹³.



Image: [pixelshot](#)

¹¹ UNFPA ESARO. (2025). Menstrual Health in Humanitarian Settings (Triple Nexus). UNFPA ESARO. – [UNFPA ESARO | Menstrual Health in Humanitarian Settings \(Triple Nexus\)](#)

¹² SOS MEDITERRANEE. (2024). Menstrual Health Challenges and Migration. SOS MEDITERRANEE. – [Menstrual health challenges and migration – SOS MEDITERRANEE](#)

¹³ Women for Refugee Women. (2015). I Am Human: Refugee Women's Experiences of Detention in the UK. London: Women for Refugee Women. – [women-for-refugee-women-reports-i-am-human.pdf](#)



Image: [GOd4ather](#)

Moreover, maintaining bodily care becomes very difficult both during transit and in detention. Being on the move and the constant fear of violence or deportation can significantly undermine the opportunities for rest and self-care. Additionally, menstrual stigma, internalised shame, or self-silencing may make it difficult for people to make informed decisions on their menstrual health, state their actual needs, and access sexual and reproductive health services.

Even though menstruation has increasingly been recognised as a public health, human rights, and gender equality issue, migration policies and humanitarian responses often overlook gender-specific needs, as migration has historically been studied and framed as a predominantly male experience¹⁴.

Addressing these gaps requires comprehensive, multi-sectoral, and gender-sensitive approaches, with inclusive migration policies that take into consideration the different needs and realities of all menstruating people¹⁵. It is thus crucial to implement programs and create spaces of care that specifically target everyone who is menstruating to provide them with materials, information, and possibilities to report incidents without fear. It is essential to understand that ensuring menstrual health throughout the whole migration journey is not only a hygiene issue, but is closely tied to bodily autonomy, the achievement of human rights, and gender equality.

¹⁴ Office of the United Nations High Commissioner for Human Rights (OHCHR). (2022). High Commissioner for Human Rights statement on menstrual health. OHCHR Statements and Speeches. – [High Commissioner for Human Rights statement on menstrual health | OHCHR](#)

¹⁵ UN Women. (2025). Women on the move: FAQs on migration and gender. UN Women FAQs. – [Women on the move: FAQs on migration and gender | UN Women – Headquarters](#)

MATERNITY IN THE BORDERLANDS

BARRIERS TO MATERNITY CARE FOR WOMEN ON THE MOVE

Pregnancy does not stop at borders; women continue to bear children throughout their migration journeys and upon arrival in Europe. However, migrant women underuse health services and experience higher pregnancy mortality rates than the rest of the population¹⁶. Why? While maternity care is classified as ‘urgent care’ under humanitarian clauses in many European countries¹⁷, and is often legally accessible regardless of administrative status, women continue to face multiple barriers, including language difficulties, lack of information, poverty, trauma, racial discrimination, administrative obstacles, and violations of their rights.

At Europe’s borders, access to maternal care can become complicated. At Paris CDG-Airport, studies show that pregnant women are not protected from pushbacks, detention, or deportation, even during later stages of pregnancy when air travel is not recommended for health reasons. Border police officers have stated: “if they came by plane, they can leave by plane” and “some come pregnant, it’s a strategy”¹⁸.

Pregnant women or with children, are subjected to multiple racialised and gendered stereotypes, including of being “irresponsible” to travel while pregnant, or of becoming pregnant deliberately, obscuring the realities of their lives and experiences. Studies have also shown that health professionals often view these women as “victims” of their partners, incapable of making their own reproductive choices or exercising agency over pregnancy.

In some contexts, the victimisation of pregnant women stems from a widespread narrative that African women migrating to Europe have experienced gender-based or sexual exploitation during their journeys. In Lampedusa, health professionals often perform additional tests instead of routine pregnancy ultrasounds and consultations. This extra care may reflect these assumptions, sometimes rightfully, particularly regarding women arriving from Libya. On the island, a protocol has been set to transfer by boat or helicopter women in labour or those requesting a voluntary termination of pregnancy (VTP)¹⁹.

¹⁶ Pérez-Sánchez, M., Immordino, P., Romano, G., Giordano, A., García-Gil, C., & Morales, F. (2024). Access of migrant women to sexual and reproductive health services: A systematic review. *Midwifery*, 139, 104167.

¹⁷ Grotti, V., Malakasis, C., Quagliariello, C., & Sahraoui, N. (2018). Shifting vulnerabilities: gender and reproductive care on the migrant trail to Europe. *Comparative migration studies*, 6(1), 23.

¹⁸ Freedman, J., Sahraoui, N., & Tyszler, E. (2025). The racialized sexism of migration and asylum regimes pregnancy, migration, and borders in France. *Social Politics: International Studies in Gender, State & Society*, 32(3), 513–536.

¹⁹ Sansosti, A. A., Macaluso, T., Saint, S., Greene, M. T., Genco, F., Diodati, A., ... & Canzone, G. (2025). Delivering obstetric care to maritime migrants: The Lampedusa protocol. *Journal of Migration and Health*, 100362.

²⁰ Grotti, V., Malakasis, C., Quagliariello, C., & Sahraoui, N. (2018). Shifting vulnerabilities: gender and reproductive care on the migrant trail to Europe. *Comparative migration studies*, 6(1), 23.

Although VTP is permitted in Italy during the first three months of pregnancy, bureaucratic procedures and delays in transfers frequently jeopardise timely access²⁰. Moreover, access to abortion is generally difficult throughout Sicily, where 87.6% of doctors are conscientious objectors, even for the local population.

In the Spanish enclaves of Ceuta and Melilla, administrative requirements to maternal care creates a vicious circle defined as “internal externalisation”; “since 2015, the Spanish borderlands require that undocumented residents of Moroccan origin possess a visa as prerequisite for being registered by the municipality, while such registration represents an administrative proof of residency that is key to any regularisation procedure”²¹. With municipal registration (which itself requires proof of address) women can access healthcare until 40 days after giving birth; without it, they must pay hospital bills themselves, which is often impossible. The police are responsible both for verifying the addresses provided for registration and for pursuing payment of unpaid invoices. This system directly affects maternal and postnatal care usage. The pregnancies are not monitored apart from emergency consultations, and women go to the hospital only once labour has begun²².

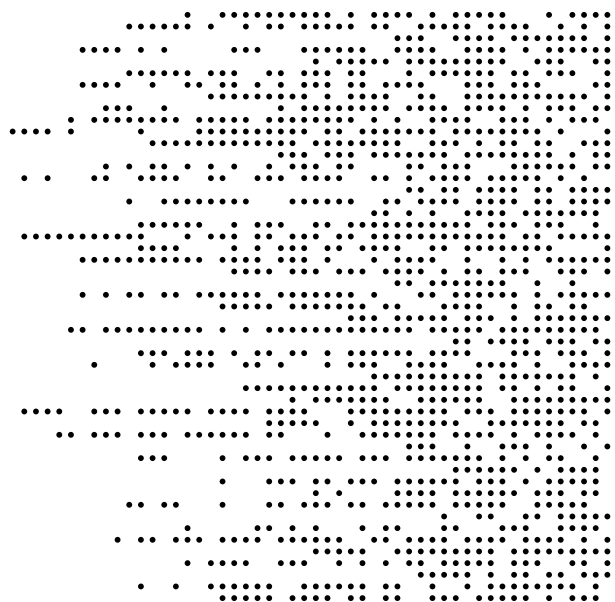


Image: Natrot. Digital technology in healthcare and the collection of personal data presents risks to people in exile.

INGESA (Instituto de Gestión Sanitaria) has announced plans to use facial recognition technology to improve patient identification and ensure the payment of health-related invoices²³. The sharing of personal data between hospital administrations and the police is a key mechanism in the criminalisation of exiled people, the violation of their rights and the restriction of access to healthcare. This trend is likely to intensify, as the new European Return Regulation seeks to facilitate the collection and transfer of personal vulnerability and medical data to national authorities or Frontex (Article 38)²⁴. Such breaches of doctor-patient confidentiality in the service of reporting undocumented individuals will have direct consequences on women’s health. The fear of being reported to authorities already prevents many from seeking maternity care.

²¹ Sahraoui, N. (2023) Externalized Within, Everyday Bordering Processes Affecting Undocumented Moroccans in the Borderlands of Ceuta and Melilla, Spain. *Journal of Borderlands Studies*, 1-20.

²² Sahraoui, N. (2026). Perinatal and maternal healthcare faced with borders. *Rhizome*, 96(1), 14-14.

²³ Spain’s national health service will use facial recognition on 170,000 patients in Ceuta and Melilla, August 7, 2025.

<https://civio.es/sanidad/2025/08/07/spains-national-health-service-will-use-facial-recognition-on-170-000-patients-in-ceuta-and-melilla/>

²⁴ Médecins du Monde and PICUM warn new EU migration regulation puts healthcare at serious risk, October 21, 2025

<https://picum.org/blog/medecins-du-monde-and-picum-warn-new-eu-migration-regulation-puts-healthcare-at-serious-risk/>

A 2024 study revealed that maternal suicide (occurring between the beginning of pregnancy and one year postpartum) is the leading cause of maternal mortality in France²⁵. The same study also found that migrant women experience higher mortality rates than others. Trauma, isolation, poor living conditions, and insecure residence status directly affect women's mental health and their use of antenatal and postnatal care. The loss of social support networks and persistent instability may also increase the risk of postpartum depression and affect postnatal practices such as breastfeeding. Indeed, studies have shown that peer-to-peer breastfeeding support prolongs breastfeeding more effectively than programmes led by healthcare professionals²⁶.

The experiences of exiled pregnant women show that maternal health is shaped by more than healthcare access alone. Housing, legal status, continuity of care, and social support are all essential determinants of safe and dignified maternity.



Image: [Kristina Paukshtite](#)

²⁵ Maggi-Perpoint, C. (2026). Vulnérabilité psychique périnatale et migration. *Rhizome*, 96(1), 5-6.

²⁶ Pérez-Sánchez, M., Immordino, P., Romano, G., Giordano, A., García-Gil, C., & Morales, F. (2024). Access of migrant women to sexual and reproductive health services: A systematic review. *Midwifery*, 139, 104167.

BEYOND SAFETY: WHAT UKRAINIAN REFUGEE WOMEN IN POLAND REVEAL ABOUT MENTAL HEALTH AFTER DISPLACEMENT

When discussions about refugee mental health take place, the focus is often placed on the trauma of war, displacement, and loss. While these experiences undoubtedly shape wellbeing, recent research among Ukrainian refugee women in Poland suggests that what happens after arrival may be just as important.

A recent study²⁷ of 290 Ukrainian refugees living in Poland, over 90% of whom were women, examined mental health, wellbeing and coping mechanisms during prolonged displacement. The findings revealed persistent symptoms of depression and anxiety among participants. However, some of the most interesting findings were not related to experiences of war itself, but to conditions encountered after arrival in Poland.

Women who had access to information about their rights and available services reported better well-being and were more likely to engage in adaptive coping strategies. Similarly, participants who had access to psychological support demonstrated healthier ways of managing stress. Employment also emerged as an important factor.

Refugees who were working in positions that matched their education and professional qualifications reported higher levels of wellbeing and lower levels of depression. Yet despite the sample being highly educated, only a minority of participants were employed in roles corresponding to their previous skills and experience.

These findings suggest that mental health among refugee women cannot be understood solely through the lens of trauma. While exposure to conflict, displacement and family separation undoubtedly shape psychological wellbeing, the study highlights the importance of post-migration factors that are often shaped by policy decisions. Access to information, labour market integration, social support and mental health services all appear to influence how individuals adapt to life in displacement.

²⁷ Chudzicka-Czupala, A. et al. (2026). Mental health, psychological wellbeing, and coping with stress by Ukrainian war refugees staying in Poland. *Frontiers in Public Health*.

The relationship between employment and wellbeing is particularly noteworthy. Discussions surrounding refugee employment are often framed in economic terms, focusing on labour shortages or financial self-sufficiency. However, the Polish case suggests that employment may also function as a determinant of health. The ability to utilise existing skills, maintain professional identity and work towards meaningful goals appears to influence wellbeing beyond income alone.

For European policymakers, the implications extend beyond the Ukrainian context. As displacement increasingly becomes a long-term reality rather than a temporary emergency, integration policies should also be viewed as health policies. Reception systems do not simply provide accommodation and legal status; they shape access to information, employment opportunities, social networks and support services that influence long-term wellbeing.

The experience of Ukrainian refugee women in Poland highlights an important lesson for European migration systems. Providing safety is an essential first step, but it is not the final objective. Long-term wellbeing is influenced by the opportunities available after arrival. Ensuring access to information, meaningful employment and appropriate support services may therefore be understood not only as measures of integration, but as investments in health and dignity.



[Image: brand308162641](#)

SILENT BODIES: MENOPAUSE AT THE CROSSROADS OF AGE, GENDER, AND DISPLACEMENT

When we talk about the health of migrant and refugee women, the conversation almost always circles back to pregnancy, childbirth, or contraception. These issues are critical. Yet one important aspect of women's health remains largely absent from policy discussions, research, and service provision: menopause²⁸.

This silence is striking because menopause is not an unusual or marginal experience. Despite affecting millions of women worldwide, it remains under-recognised and under-treated, even in well-resourced healthcare systems. For women who have been displaced, the challenges associated with menopause may be compounded by displacement, disrupted healthcare access, language barriers, social isolation, and prolonged uncertainty regarding their legal and economic circumstances²⁹.

The problem is not just that menopause gets overlooked. It is that menopause becomes even more invisible once displacement enters the picture.

The two kinds of invisibility feed each other. Navigating an asylum process, or simply trying to settle into a new country, already takes an enormous amount of emotional and practical energy. Medical concerns that are not considered urgent often fall through the cracks. Symptoms may be misunderstood, attributed to stress, or simply never discussed. In many cases, there is no regular doctor, no continuity of care, and little opportunity to build the kind of trust that encourages women to talk about what they are experiencing³⁰.

At the same time, migrant and refugee women should not be viewed solely through the lens of vulnerability. Women frequently draw upon family networks, community support, cultural knowledge, and personal resilience to navigate both migration and health challenges³¹. An effective response must therefore acknowledge both realities: the structural barriers that limit access to care and the agency that women exercise in managing their own health and wellbeing.

²⁸ Kirchengast, Sylvia. "Menopause in a globalized world-A systematic literature review focusing on the challenge of health problems associated with menopausal transition among women with a migration background." *Maturitas* 187 (2024): 108045.

²⁹ Ussher, Jane M., Alexandra J. Hawkey, and Janette Perz. "'Age of despair', or 'when life starts': migrant and refugee women negotiate constructions of menopause." *Culture, Health & Sexuality* 21, no. 7 (2019): 741-756.

³⁰ A systematic review of immigrant women's experiences confirmed that most women who did seek menopause-related healthcare came away disappointed, with family and friends remaining the primary source of information rather than health professionals, Stanzel, Karin A., Karin Hammarberg, and Jane Fisher. "Experiences of menopause, self-management strategies for menopausal symptoms and perceptions of health care among immigrant women: a systematic review." *Climacteric* 21, no. 2 (2018): 101-110.

³¹ Zou, Ping, Yan Luo, Michael Wyslobicky, Husna Shaikh, Ashar Alam, Weihong Wang, and Hailee Zhang. "Menopausal experiences of South Asian immigrant women: a scoping review." *Menopause* 29, no. 3 (2022): 360-371.

There is also an important physiological aspect to consider. For many refugees and migrants, displacement involves months or years of insecurity, financial hardship, social isolation, and fear about the future. This kind of stress does not remain purely psychological. It can influence physical health in profound ways. Some studies suggest that chronic stress may intensify menopausal symptoms and make the transition more difficult to manage. In this sense, menopause is not simply occurring alongside displacement³². Displacement can actually shape how menopause is experienced.

Addressing this gap requires moving beyond a narrow focus on reproductive and maternal health towards a more comprehensive, life-course approach to women's wellbeing. Policymakers, healthcare providers, and humanitarian actors should ensure that menopause and healthy ageing are incorporated into migrant and refugee health strategies, while improving professional training on the specific needs of culturally diverse populations.

Greater efforts are also needed to guarantee continuity of care for displaced women, develop multilingual information and support resources, and strengthen the evidence base through better data collection on menopausal health among migrant and refugee populations. Without these measures, a significant aspect of women's health will continue to remain overlooked within both healthcare and migration systems.

That, in the end, is the first step: simply seeing them. Once that silence is broken, everything else becomes possible to build.



Image: Ål Nik

³² Balic, Dragana, Mediha Rizvanovic, Maja Cizek-Sajko, et al. "Age at natural menopause in refugee and domicile women who lived in Tuzla Canton in Bosnia and Herzegovina during and after the war." *Menopause* 21, no. 7 (2014): 721-725.

CONCLUSION

In this report we highlighted some of the health-related challenges that women on the move face during their journey and after arrival.

Some of these challenges are structural: for example healthcare access is increasingly tied to surveillance and enforcement. In Ceuta and Melilla, access to maternal care depends on data shared with the police. Under the new EU Return Regulation, medical vulnerability could itself become information passed to authorities.

Others are more about what gets left out entirely. Menstrual health and menopause are heavily overlooked. As we saw, discussions of migrant women's health almost always circle back to pregnancy and childbirth, leaving other life stages out.

And sometimes migration doesn't just fail to add protection, it actively removes it. Abortion access for Ukrainian women in Poland is a clear case: moving means losing a health right.

On a more hopeful note, the study on Ukrainian refugee women showed that wellbeing improved not just through crisis-focused mental health support, but through access to information about their rights and to work that matched their skills. In other words, what helped wasn't only emergency care, but the everyday infrastructure around it. That's the point: **women's health can't be an afterthought in how protection systems are built.**



Image: Europe Must Act

About Europe Must Act

Europe Must Act (EMA) is a growing grassroots movement, bringing together volunteers and NGOs to campaign for the humane and dignified reception of refugees in Europe.

**We're volunteers and asylum and migration is a complex topic. This means we try to include a variety of opinions and approaches to a topic. We do our best to research and use our expertise accurately however, we also believe it's vital to encourage healthy discussion and stop misinformation. Therefore we encourage any feedback or constructive criticism of our work.*

Follow EMA to receive resources, tips and opportunities to support people on the move in Europe.



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About our research reports

By bringing together thoughts, cases, and ideas from across Europe, breaking down complex topics and sharing evidence-based insights, we connect the dots to promote a better understanding of the challenges people on the move face, and what can be done to support them.

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