

Women's sexual and reproductive health and rights in Europe



Issue paper



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Women's sexual and reproductive health and rights in Europe

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Summary

Sexual and reproductive rights, including the right to sexual and reproductive health, are intrinsic elements of the human rights framework and effective state action to guarantee sexual and reproductive health and rights is imperative. Without it, some of the most significant and intimate aspects of our lives as human beings are at risk. Our ability to make autonomous and informed decisions about our bodies, our health, our sexuality, and whether or not to reproduce, is undermined.

In recent decades, considerable global progress has been made in the sphere of women's sexual and reproductive health and rights and towards the elimination of related forms of discrimination and Council of Europe member states have long been at the vanguard of these efforts. However, notwithstanding important progress, women in Europe continue to face widespread denials and infringements of their sexual and reproductive health and rights. Laws, policies and practices in Europe still curtail and undermine women's sexual and reproductive health, autonomy, dignity, integrity and decision-making in serious ways.

Moreover, in recent years, resurgent threats to women's sexual and reproductive health and rights have emerged in some parts of the region. These have sought to call into question and erode longstanding commitments to gender equality and the universality of women's rights. In some member states, laws and policies have sought to roll back existing protections for women's sexual and reproductive health and rights, in particular through the introduction of retrogressive restrictions on access to abortion and contraception. Courts in a number of countries have also been confronted with legal challenges threatening women's sexual and reproductive health and rights. The backlash has also affected the work of many human rights defenders and health care providers working to advance women's rights.

Meanwhile, harmful gender stereotypes, stigma and social norms regarding women's sexuality and reproductive capacities continue to apply to many aspects of women's lives. Violence against women and coercive practices in sexual and reproductive health care settings continue throughout Europe. Social opprobrium, shame and taboo are persistently associated with many facets of women's sexual and reproductive lives and with certain forms of sexual and reproductive health care.

Although several European countries have now established sexuality education programmes of some kind, many of these programmes fall short of international human rights requirements regarding comprehensive sexuality education and the World Health Organization (WHO) Standards for Sexuality Education in Europe. Furthermore, while many European health systems are relatively strong, deficits and shortcomings persist across the region in the manner in which health systems

are equipped to respond to women's sexual and reproductive health needs. Data collection and financing in the field of women's sexual and reproductive health remain insufficient. Women's access to effective methods of modern contraception continues to be impeded by a range of affordability and availability deficits, information shortfalls and discriminatory policy barriers.

Although almost all member states have now legalised abortion on a woman's request or on broad socio-economic grounds, a small number retain highly restrictive laws that prohibit abortion except in strictly defined, exceptional circumstances. These laws have severe and harmful implications for women's health and well-being. Most women in these countries who decide to end a pregnancy travel to another European country to obtain safe abortion services or undergo illegal clandestine abortion at home. Often in these countries even women who qualify under narrow exceptions for legal abortion care are confronted with serious obstacles when seeking access to legal abortion care.

Even in some of those European countries that have legalised abortion on a woman's request, women still face barriers in access to safe abortion care. A number of member states have failed to adopt adequate regulatory frameworks and enforcement measures to ensure that women can still access legal abortion services in practice when medical professionals refuse care on grounds of conscience. Meanwhile, procedural barriers that affect women's timely access to abortion care, such as third-party authorisation requirements, remain in place in a number of member states.

While many European countries now have the lowest rates of maternal death in the world, serious disparities remain with regard to access to maternal health care and failures to ensure adequate standards of care and respect for women's rights, dignity and autonomy in childbirth also endure in several areas of Europe.

Each of these concerns, challenges, deficits and barriers has exacerbated or distinct implications for marginalised groups of women in Europe, including women living in poverty, Roma women, adolescents, women with disabilities, refugees, asylum seekers and undocumented migrant women. These and many other groups of women in Europe face intersectional discrimination on the grounds of sex combined with other grounds in the realisation of their sexual and reproductive health and rights.

Additionally a range of barriers continues to undermine women's access to justice and effective remedies for violations of their sexual and reproductive rights. In some countries, women have yet to receive redress and reparations for serious and systematic past violations of their sexual and reproductive rights.

This issue paper considers each of these concerns and challenges from a human rights perspective, against the backdrop of member states' human rights obligations as enshrined in international and European human rights instruments and as elaborated and interpreted by human rights mechanisms. As widely recognised by human rights mechanisms, member states' obligations to advance and protect women's sexual and reproductive health and rights are core components of their obligation to respect and guarantee women's human rights and advance gender equality.

Although human rights mechanisms have repeatedly recognised that all human rights are relevant to women's sexual and reproductive health and rights they have also

identified certain human rights as having particular relevance, including the rights to health, to life, to freedom from torture and other ill-treatment, to privacy and to equality and non-discrimination. They have addressed the manner in which states are obliged to eliminate and reform relevant laws, policies and practices and take effective steps to respect and protect these rights, including by ensuring women's access to comprehensive sexuality education; modern contraception; safe and legal abortion and quality maternal health care.

This issue paper is preceded by the Commissioner's recommendations to all Council of Europe member states in the field of women's sexual and reproductive health and rights.

The Commissioner's recommendations

In order to ensure the human rights of all women and girls across Europe, the Commissioner for Human Rights calls on Council of Europe member states to:

I. Reaffirm commitments to women's human rights and gender equality and guard against retrogressive measures that undermine women's sexual and reproductive health and rights

- ▶ prevent erosion of existing protections, reject measures and initiatives that seek to roll back established entitlements, and repeal retrogressive measures that have already been enacted or introduced in the sphere of sexual and reproductive health and rights;
- ▶ refrain from rhetoric and discourse that is contrary to human rights principles and that challenges gender equality or undermines commitments to women's sexual and reproductive health and rights;
- ▶ reform laws and policies that undercut the operation of human rights defenders, civil society organisations and health care providers working to advance women's sexual and reproductive health and rights, and address, prevent and sanction violence, hate speech, smear campaigns and stigmatisation targeting these actors;
- ▶ refrain from censoring, obstructing, misrepresenting or prohibiting the provision of evidence-based information on sexual and reproductive health and rights.

II. Invest in women's sexual and reproductive health and establish a health system designed to advance women's sexual and reproductive health and rights

- ▶ guarantee sufficient budgetary provision for women's sexual and reproductive health and ensure the availability of adequate human resources across all levels of the health system, in both urban and rural areas;
- ▶ identify and address financial barriers that impede women's access to good quality sexual and reproductive health care and integrate sexual and reproductive health care needed by women, such as contraceptive goods and services, maternal health care and safe abortion services, into existing public health insurance, subsidisation or reimbursement schemes;
- ▶ end and reverse austerity measures and cutbacks that apply to gender equality programming or the provision of sexual and reproductive health care;

- ▶ adopt and implement comprehensive and inclusive national strategies and action plans for women's sexual and reproductive health and rights, structured around measurable targets and indicators;
- ▶ ensure that strategies and action plans are based on transparent consultation processes involving representatives of marginalised communities as well as a wide spectrum of human rights, gender equality and sexual and reproductive health experts;
- ▶ establish effective mechanisms to co-ordinate the implementation of strategies and action plans;
- ▶ establish effective oversight mechanisms and systems for evaluation, monitoring and periodic revision of strategies and action plans.

III. Ensure the provision of comprehensive sexuality education

- ▶ mainstream mandatory, age-appropriate, standardised, evidence-based and scientifically accurate comprehensive sexuality education (CSE) curricula across the education system including into ordinary school curricula;
- ▶ ensure that domestic legislation does not permit children to be withdrawn from age-appropriate CSE that meets the standards of objectivity and impartiality set by human rights law;
- ▶ guarantee that CSE curricula take a holistic approach to sexual and reproductive health and rights and address a wide range of issues including gender equality, sexual diversity and sexual violence, as well as prevention of early pregnancy and sexually transmitted infections;
- ▶ ensure that CSE curricula and teaching methodologies take account of the evolving capacity of the child, in accordance with human rights standards;
- ▶ provide teachers and education professionals with continuing specialised training to support and facilitate the provision of good quality CSE;
- ▶ establish CSE programmes for out-of-school adolescents.

IV. Guarantee the affordability, availability and accessibility of modern contraception

- ▶ ensure the affordability of effective contraceptive methods and address financial barriers that continue to undermine and impede women's access;
- ▶ reform laws and policies that exclude contraceptive goods and services from coverage under public health insurance or subsidisation schemes, and ensure that coverage extends to all age groups and all brands and methods of modern contraception;
- ▶ guarantee the practical availability of a wide range of effective contraceptive methods, across rural and urban areas, and include all modern contraceptive goods and medicines in national lists of essential medicines;
- ▶ ensure the provision of evidence-based, accurate information about contraception and establish awareness-raising programmes and strategies to tackle and dispel myths and misconceptions;

- ▶ address residual legal and policy barriers, such as third-party authorisation requirements, that impede access to contraceptive services and information for certain groups of women, including adolescents and women with disabilities, and remove barriers that obstruct timely access to emergency contraception;
- ▶ provide regular, specialised and evidence-based training on effective contraceptive methods for relevant medical practitioners.

V. Ensure all women's access to safe and legal abortion care

- ▶ reform highly restrictive laws that prohibit abortion except in a small number of strictly defined, exceptional circumstances and bring them into line with international human rights standards and regional best practices by ensuring that abortion is legal on a woman's request in early pregnancy, and thereafter throughout pregnancy to protect women's health and lives and ensure freedom from ill-treatment;
- ▶ ensure the accessibility and availability of legal abortion services in practice, including by establishing effective procedures and processes by which women can enforce existing legal entitlements to abortion services;
- ▶ decriminalise abortion and remove residual procedural requirements applicable to legal abortion services that contravene public health guidelines, such as mandatory waiting periods or third-party authorisation requirements;
- ▶ reform laws and policies requiring biased counselling prior to abortion and ensure that abortion counselling is never mandatory, biased or directive;
- ▶ ensure that the principle of non-retrogression is respected by repealing and rejecting laws and policy proposals that seek to introduce new barriers to women's access to safe abortion services.

VI. Ensure that refusals of care by health care workers do not jeopardise women's timely access to sexual and reproductive health care

- ▶ where domestic laws or policies allow health care workers to refuse certain forms of sexual and reproductive health care on grounds of conscience or religion, implement effective regulatory and enforcement measures to ensure that such refusals of care do not jeopardise women's timely access to sexual and reproductive health care;
- ▶ ensure that at a minimum such measures guarantee:
 - that refusals are not permitted in emergency and urgent situations;
 - that an explicit duty is imposed on all health care workers to provide timely referral to an alternative willing and capable provider;
 - that refusals are allowed only in relation to the direct provision of care;
 - that only refusals of care by individual practitioners are permitted and that they are not allowed as a matter of institutional policy or practice;
- ▶ ensure the dispersal and availability of adequate numbers of health professionals,

across public and private health facilities as well as in urban and rural areas, who are willing and able to provide sexual and reproductive care;

- ▶ establish systems throughout the country and in all health facilities to monitor the number of health professionals who refuse to perform sexual and reproductive health services on grounds of conscience or religion.

VII. Respect and safeguard women's human rights in childbirth and guarantee all women's access to quality maternal health care

- ▶ adopt measures to ensure that all women can access affordable, good quality maternal health care, including prenatal and postnatal care;
- ▶ reform laws and policies that exclude certain groups of women from access to maternal health care, including by removing legal and policy restrictions that apply on grounds of nationality or migration status;
- ▶ establish effective programmes and strategies to address financial, practical and social barriers to equal access to quality maternal health care for marginalised groups of women;
- ▶ collect and analyse disaggregated data on maternal health outcomes and ensure that maternal death audits are systematic and in line with international best practice and guidelines;
- ▶ take effective measures to safeguard women's mental health and emotional well-being in the context of pregnancy and childbirth;
- ▶ effectively prohibit, investigate and sanction physical and verbal abuse against women, as well as practices of informal payments or bribery, in maternal health care;
- ▶ guarantee the primacy of respect for women's informed consent, and prioritise women's informed decision making, at all stages of childbirth;
- ▶ ensure that every woman is able to benefit from the presence of a skilled birth attendant during childbirth.

VIII. Eliminate coercive practices and guarantee women's informed consent and decision making in sexual and reproductive health care contexts

- ▶ ensure that women's informed consent is guaranteed in all sexual and reproductive health care contexts by reforming patient consent laws, policies and practices that undermine women's informed decision making, that allow other considerations to take precedence, or that discriminate against certain groups of women, including on grounds of age or disability;
- ▶ prevent, redress and sanction all coercive sexual and reproductive health care practices, such as the forcible restraint of women in labour or during gynaecological examinations, forced sterilisation, forced contraception, forced abortion, non-consensual interventions during childbirth and the suturing of related injuries without adequate pain relief.

IX. Ensure all women's access to effective remedies for violations of their sexual and reproductive health and rights

- ▶ take action without delay to remedy past and systemic violations of women's sexual and reproductive rights, acknowledge state responsibility and establish human rights-compliant reparation schemes for all victims;
- ▶ investigate all violations of women's sexual and reproductive health and rights effectively, promptly, thoroughly and impartially and ensure the accountability of the perpetrators and that all victims have access to effective remedies commensurate with the gravity of the violations, including reparation, compensation and guarantees of non-repetition;
- ▶ provide all necessary rehabilitation services and support mechanisms, including requisite mental and physical health care, to all women who face violations of their sexual and reproductive health and rights;
- ▶ ensure that relevant justice and redress procedures do not re-victimise or re-traumatise women and that women seeking justice are treated with respect for their dignity and human rights;
- ▶ guarantee that statutes of limitation and other procedural barriers do not prevent women from obtaining redress for serious or systemic violations of their sexual and reproductive health and rights;
- ▶ provide training on gender equality and women's sexual and reproductive health and rights for members of the judiciary, law enforcement authorities and health care professionals, including to ensure that stereotypes, prejudices and assumptions about women's sexuality and their reproductive functions do not affect decision making.

X. Eliminate discrimination in law and practice including intersectional and multiple forms of discrimination and guarantee equality for all women in the enjoyment of sexual and reproductive health and rights

- ▶ take effective and positive action, including through public information, awareness-raising and training programmes, to address discrimination on the basis of sex, gender and other grounds, including by combating harmful gender norms, stereotypes, assumptions and stigma that undermine women's sexual and reproductive rights;
- ▶ design and implement targeted strategies, policies and programmes to advance the sexual and reproductive health and rights of marginalised groups of women and eradicate the specific or exacerbated financial, practical and social barriers they face in access to good quality sexual and reproductive health care;
- ▶ establish effective human rights-compliant systems for the collection of disaggregated data on women's sexual and reproductive health, not only on grounds of sex, but also, at a minimum, on grounds of age, disability, ethnicity, nationality and socio-economic status;
- ▶ repeal discriminatory laws and policies that curtail access to sexual and

reproductive health care for certain groups of women, including on grounds of age, disability, gender identity, marital status, migration status, nationality or sexual orientation;

- ▶ ensure that all marginalised women can access sexual and reproductive health care that responds to their specific health needs and personal circumstances, including women affected by conflict and crisis, internally displaced persons (IDPs), refugees, migrants, adolescents, older women and HIV-positive women;
- ▶ ensure that all survivors of sexual violence, including women in conflict zones or detention centres, victims of trafficking in human beings, asylum seekers and refugees, can access comprehensive sexual and reproductive health services, including emergency contraception, safe abortion services and HIV post-exposure prophylaxis.

Introduction

Effective state action to guarantee sexual and reproductive health and rights is imperative. Without it, some of the most significant and intimate aspects of our lives as human beings are at risk. Our physical, emotional and mental health and well-being is jeopardised. Our freedom to determine key facets of our lives and our relationships is curtailed. Our ability to make autonomous and informed decisions about our bodies, our health, our sexuality, and whether or not to reproduce, is undermined.

This Issue Paper addresses the sexual and reproductive health and rights of women in Europe. Despite progress, pervasive gender inequalities continue to affect women in Europe in all areas of life and often have profound effects on their sexual and reproductive health and rights. Laws, policies and practices in Europe still curtail and undermine women's sexual and reproductive health, autonomy, dignity, integrity and decision making in serious ways. Myriad forms of discrimination, violence and coercion persist across the continuum of women's sexual and reproductive lives, including in health care settings.

By "sexual and reproductive rights", this Issue Paper refers to a body of civil, political, economic, social and cultural rights that are protected by international human rights law and standards and that apply throughout human beings' sexual and reproductive lives. These rights include – but are not limited to – the right to health, the right to life, the right to freedom from torture and ill-treatment and the right to privacy. Crucially, they also include the right to gender equality and freedom from discrimination in the enjoyment of rights, which obliges member states to respect and ensure the enjoyment of all rights by women and girls on the basis of equality. These standards also embody the principle of non-retrogression, which prohibits member states from taking steps that undermine, restrict or remove existing rights or entitlements in the area of sexual and reproductive health and rights.

Consequently, women's sexual and reproductive rights, including the right to sexual and reproductive health, are not separate or distinct from human rights. On the contrary, as widely recognised by human rights mechanisms, they are intrinsic elements of the human rights framework. Likewise, member states' obligations to advance and protect women's sexual and reproductive health and rights are core components of their obligation to respect and guarantee women's human rights and advance gender equality.

In recent decades European countries have made significant progress in their efforts to eliminate the restrictions, discrimination, coercion and violence that women face throughout their sexual and reproductive lives. Laws and policies prohibiting

contraception have been eradicated. Restrictive abortion laws have been liberalised. Frameworks criminalising violence against women have been enacted. Regulations specifying differing ages of sexual consent for women and men have been eradicated. Provisions criminalising sex between men and women outside of marriage and between same-sex adults have been repealed. Divorce has been legalised. Child maintenance protections have been adopted and employment protections for pregnancy and maternity have been put in place.

Simultaneously, vast improvements have been made across Europe in the delivery, quality and accessibility of the many forms of sexual and reproductive health care that women need. To take a global perspective, several European countries have some of the lowest rates of maternal mortality in the world, modern contraception is more generally available than in other regions, unintended pregnancies are falling, and incidents of unsafe abortion are negligible in many parts of the region and continuously decreasing in others.

Yet despite these important achievements, in many parts of Europe women's sexual and reproductive health, autonomy, integrity and decision making remains threatened and violations of women's sexual and reproductive rights continue. In some countries, laws and policies still violate, restrict or undermine women's sexual and reproductive health and rights. A spectrum of financial, practical and social barriers jeopardise women's sexual and reproductive health and hinder their ability to obtain good quality sexual and reproductive health care. Violence against women persists in all European societies and coercive sexual and reproductive health care practices remain a concern in a number of countries. Social norms and expectations, harmful stereotypes and stigma concerning women's roles in society, their sexuality and reproductive capacities endure. At times these restrictions, barriers, biases and abuses affect all women in a particular European country; often they give rise to multiple forms of discrimination and target, or have worsened impacts on, particular groups of women.

Moreover, a worrying trend in which protections for women's sexual and reproductive health and rights are being rolled-back is currently underway in some parts of Europe and globally. This trend, and the resulting human rights violations it gives rise to, are among the reasons that prompted the preparation of this Issue Paper. Efforts to reverse progress painstakingly achieved in the field of women's sexual and reproductive health and rights are deeply troubling.

Advancing gender equality in Europe is a key component of member states' human rights obligations, public health commitments and sustainable development objectives. Attaining gender equality is not only imperative for states' delivery of their obligations under international human rights law; gender equality fuels sustainable economies and benefits societies and humanity at large. Yet failures to respect and ensure women's sexual and reproductive health and rights are at once both a cause and a consequence of gender inequality and discrimination – and women's equality across the region will remain illusory until their sexual and reproductive health and rights are guaranteed. Moreover, as resurgent threats to gender equality emerge across the region, concerted efforts to reaffirm the importance of women's human

rights are crucial if European progress towards the realisation of women's sexual and reproductive health and rights is to be maintained.

This Issue Paper is designed to contribute to region-wide efforts to advance gender equality and address some of the main sexual and reproductive health and rights deficits and violations that continue to confront women in Europe. To that end it considers women's sexual and reproductive health and rights in Europe from a human rights perspective, against the backdrop of member states' international human rights obligations as enshrined in international and European human rights instruments and as elaborated and interpreted by human rights mechanisms. This focus on women and girls does not detract from the serious and important sexual and reproductive health and rights issues facing men and boys across the European region; rather, it reflects the fact that addressing the serious sexual and reproductive health and rights concerns that continue to affect women and girls across Europe remains a vital component of efforts to promote gender equality.

This Issue Paper seeks to provide a concise overview of a wide range of issues rather than analyse any one aspect in depth. It will not attempt to provide an exhaustive catalogue of the sexual and reproductive health and rights concerns that affect women in Europe. Although it emphasises certain priority issues of concern in the region, a number of problems are not addressed. Moreover, where the Commissioner has previously dealt with relevant matters in some depth the Issue Paper does not address them in detail. As a result, for example, the Issue Paper does not include a focus on violence against women or the rights of lesbian, bisexual, transgender or intersex people.

Section 1 of the Issue Paper provides an overview of some of the central sexual and reproductive health and rights deficits that continue to affect women across Europe. To this end it outlines prominent concerns, inequalities and failures across nine key aspects of women's sexual and reproductive health and rights: (1) retrogression and backlash; (2) harmful gender stereotypes, social norms and stigma; (3) lack of comprehensive sexuality education (CSE); (4) deficits in health systems, data collection and financing; (5) barriers in access to modern contraception; (6) restrictions on access to safe and legal abortion; (7) concerns in the field of maternal health care; (8) intersectional discrimination; (9) and shortcomings regarding effective remedies and access to justice.

Section 2 addresses the manner in which Council of Europe member states' obligations under certain international human rights standards apply to women's sexual and reproductive health and rights. With reference to the pronouncements and analysis of human rights mechanisms, this section provides a general synthesis of the manner in which the rights to health, life, freedom from torture and ill-treatment, privacy and equality and non-discrimination impose obligations on member states vis-à-vis women's sexual and reproductive health and rights. It also addresses claims that women's sexual and reproductive rights may be legitimately curtailed for religious, moral or social reasons, or to protect the rights of others.

Section 3 draws on the analysis in Section 2 and highlights the manner in which specific obligations on member states' under international human rights standards apply to five core aspects of women's sexual and reproductive health and rights: CSE;

modern contraception; safe and legal abortion; refusals by medical professionals to provide sexual and reproductive health care on grounds of conscience; and quality maternal health care.

Section 1

Women's sexual and reproductive health and rights in Europe – concerns, challenges and deficits

In recent decades, considerable global progress has been made in the sphere of women's sexual and reproductive health and rights and towards the elimination of related forms of discrimination. Council of Europe member states have long been at the vanguard of these efforts and have taken serious action to advance and protect women's sexual and reproductive health and rights in their domestic laws, policies and practices.

Notwithstanding this important progress, women in Europe continue to face widespread denials and infringements of their sexual and reproductive health and rights. Indeed, as highlighted in the introduction, Europe's global position vis-à-vis women's sexual and reproductive health outcomes masks a number of substantial and troubling variations within the region. Although the nature and severity of prevailing human rights concerns differ across countries, no Council of Europe member state has fully discharged its obligations to ensure the realisation of women's sexual and reproductive health and rights.

1.1 RETROGRESSION AND BACKLASH

The universality of human rights is the cornerstone of international human rights law, and the sexual and reproductive health and rights of women are integral components of that legal framework. In this context sustained progress towards gender equality and the eradication of all forms of discrimination against women is imperative. Yet in recent years, resurgent threats to women's sexual and reproductive health and rights have emerged in Europe, with serious implications for women's human rights and for domestic, regional and international policy development.¹

Although to some extent these threats have taken on distinct forms across different European political and social contexts, they have consistently involved attempts to undermine or restrict women's access to certain types of health services and have

sought to call into question and erode longstanding commitments to gender equality and the universality of women's rights.

1.1.1 Harmful rhetoric

In some countries damaging rhetoric regarding gender equality and sexual and reproductive health and rights has been used by elected representatives and other policy makers, including those at the highest levels of government. In public statements, officials and public representatives have maligned the concept of gender equality, describing it and relevant human rights protections as a form of “gender ideology”. They have also co-opted language around “human rights”, “traditional values” or “protection of the family”, to reinforce harmful gender stereotypes and assumptions about women's roles in society, while encouraging discrimination on grounds of sex and also sexual orientation or gender identity. At times, public representatives have also wrongly identified gender equality and increased protection for women's sexual and reproductive health and rights as a prominent cause of declining birth rates and demographic concerns.²

1.1.2 Legislative retrogression

In some member states, threats have extended beyond rhetoric and discourse, with the adoption of laws and policies rolling back existing protection for women's sexual and reproductive health and rights. For example, in recent years governments in Armenia, “the former Yugoslav Republic of Macedonia”, Georgia, the Russian Federation and Slovakia have adopted laws and policies introducing a range of new preconditions that women must fulfil before they can obtain legal abortion services.³ Mandatory waiting periods and biased counselling requirements prior to abortion are particularly common examples of these newly imposed, retrogressive procedural barriers that undermine women's health and human rights. Additionally, although they were ultimately unsuccessful, retrogressive proposals to introduce similar procedural requirements were also promoted in other European countries such as Latvia, Lithuania and Romania.⁴

Proposals for near-total bans on abortion have also been tabled in recent years in Lithuania, Slovakia, Spain, Poland and the Russian Federation. Although these initiatives were eventually rejected, often following extensive public outcry and large-scale protests and demonstrations, they provide a powerful illustration of the extent and nature of the backlash to the advancement of women's rights and gender equality in some parts of Europe.

Moreover, although legislative rollbacks have specifically targeted women's access to legal abortion services in many European contexts, other aspects of women's sexual and reproductive health and rights have also been affected. For example, recent legislation in Poland reintroduced a requirement that all women obtain medical prescriptions for emergency contraception, abolishing previous policies that had allowed the purchase of some forms of emergency contraception over the counter (without a prescription) in pharmacies.⁵ Additionally, a series of retrogressive laws and policies with a broad range of harmful implications for women's sexual and

reproductive health and rights have entered into force in the Russian Federation. These include laws the effect of which prevents in practice the dissemination of information about sexual diversity and homosexuality, including for education purposes,⁶ as well as legislation decriminalising certain forms of domestic violence.⁷

1.1.3 Court challenges

Courts in a number of European jurisdictions have also been confronted with legal challenges threatening women's sexual and reproductive health and rights. In most instances they have rejected such claims, with courts in Croatia, Portugal and Slovakia overruling legal petitions contesting the constitutionality of women's access to abortion on request, and courts in Sweden and the United Kingdom dismissing claims seeking to expand medical professionals' entitlements to refuse to provide legal abortion care on grounds of conscience or religion.⁸

However, in a small number of cases, court decisions and jurisprudence have resulted in retrogression. For example, the Polish Constitutional Tribunal recently struck down important safeguards that previously applied in cases of medical professionals who refuse to provide certain health services on grounds of conscience or religion.⁹ In particular, the court abolished a requirement that medical professionals who refuse to provide health services refer patients to an alternate medical provider. This has serious implications for women in Poland, who routinely face repeated refusals of care when seeking access to legal abortion services or other forms of sexual and reproductive health care.

1.1.4 Threats to human rights defenders

The backlash has also affected the efforts and operations of many human rights defenders, civil society organisations and health care providers working to advance women's sexual and reproductive health and rights in Europe. Violence, threats, hate speech and smear campaigns, including by far-right or extremist religious groups, continue to be perpetrated both against human rights defenders who seek to advance gender equality and women's sexual and reproductive health and rights and against medical professionals who provide relevant health services to women. Meanwhile, the recent introduction in some member states of restrictive regulations and policies affecting civil society in general, such as those now in place in Hungary and the Russian Federation, have had direct and concrete implications for human rights defenders and civil society organisations working to advance women's sexual and reproductive health and rights.¹⁰

1.2 HARMFUL GENDER STEREOTYPES, SOCIAL NORMS AND STIGMA

In recent decades, extensive social change and critical shifts in attitudes to sex and reproduction have taken place across Europe. Gender norms have evolved and social mores about the role of women in society have advanced considerably. Yet discrimination, harmful gender stereotypes and social norms regarding women's

sexuality and reproductive capacities still prevail across member states, and stigma attaches to many aspects of women's sexual and reproductive lives.¹¹ These have a myriad of pervasive and harmful implications for women's sexual and reproductive health and rights in Europe and underlie many of the violations and abuses that are highlighted throughout this Issue Paper.

1.2.1 Violence against women

Women in Europe face widespread and varied forms of violence and abuse because they are women, including sexual assault and harassment in the context of intimate partnerships, public life and in the workplace. It is estimated that at least one in every four women in Europe will face gender-based violence in her lifetime. Harmful gender stereotypes and social norms play a key role in this regard. Not only are they among the root causes of violence against women, they also undermine member states' efforts to prevent violence and ensure accountability.

Across Europe, women's sexuality remains subject to a wide range of social mores and presumptions, which in many contexts direct blame towards women for rape and other forms of sexual violence, particularly when a woman is seen as contravening social mores or expectations. Such attitudes focus attention on women's appearance, behaviour or sexual history rather than on the actions of perpetrators. Even in countries with strong laws and policies, domestic and intimate partner violence against women is still widely considered to be a "private" or "family" matter, rather than a criminal justice concern. These and other harmful assumptions and attitudes can have drastic consequences for the prevention, prosecution and punishment of violence against women, often leading to impunity. They influence women's ability and willingness to report violence as well as the extent to which law enforcement and criminal justice officials pursue effective investigations and prosecutions.¹²

Gender stereotypes regarding sexuality

In 2017, the European Court of Human Rights addressed the harmful nature of widespread stereotypes and beliefs that women's sexuality is inherently linked with reproduction, and that as such it diminishes and becomes less important as women age.

In *Carvalho Pinto de Sousa Morais v. Portugal*,¹³ the applicant had suffered severe vaginal pain and loss of sensation and urinary incontinence as a result of medical negligence during a surgical procedure. This negatively affected her mobility and her ability to have sex and she became depressed. Following a legal claim against the hospital, she was awarded €172 000 in compensation by the Lisbon Administrative Court. However, on appeal the award of compensation was significantly reduced by the appellate court, notably on the grounds that "at the time of the operation the plaintiff was already 50 years old and had

two children, that is, an age when sex is not as important as in younger years, its significance diminishing with age.”

In her subsequent complaint to the European Court of Human Rights, the applicant argued that the appellate court decision had discriminated against her on grounds of sex and age. She claimed that by disregarding her right to a sex life, the appellate court had breached one of the most basic principles of human dignity and had violated her right to a private life and to enjoy this right free from discrimination on grounds of sex or age, under Articles 8 and 14 of the European Convention on Human Rights.

The European Court upheld her claims, recognising that:

the question at issue here is not considerations of age or sex as such, but rather the assumption that sexuality is not as important for a fifty-year-old woman and mother of two children as for someone of a younger age. That assumption reflects a traditional idea of female sexuality as being essentially linked to child-bearing purposes and thus ignores its physical and psychological relevance for the self-fulfillment of women as people.

1.2.2 Coercive sexual and reproductive health care practices

Harmful gender stereotypes and prejudices also underlie coercive sexual and reproductive health care practices in health care settings across Europe, in particular stereotypes about women’s reproductive capacities, roles in society and competence to make informed decisions.

As outlined in more detail in sub-section 1.7 below, allegations that women in many European countries still face various forms of forced and coercive medical interventions during childbirth, without appropriate efforts being made to ensure their full and informed consent, point to discriminatory assumptions regarding women’s decision-making capacity. These include wrongful beliefs that women, and specifically pregnant women in labour, are not capable of rational thought or of considered and responsible decision making: that they will make rash, imprudent decisions unless protected from their allegedly impulsive and emotional responses. Coercive practices during childbirth also reflect biases that prioritise women’s reproductive capacities over and above their entitlement to make autonomous decisions about their bodies and reproductive health.

Harmful stereotypes and ingrained biases also underlie many historical examples of coercive practices in Europe, such as the widespread and systematic practice of forced and coercive sterilisation of Roma women in countries such as the Czech Republic and Slovakia,¹⁴ and of women with disabilities in countries such as France and Switzerland.¹⁵ In these cases, presumptions about women’s abilities to make informed decisions intersected with deeply entrenched prejudices regarding who

should or should not reproduce, resulting in serious and systemic violations of women's rights.

1.2.3 Barriers in access to sexual and reproductive health care

A spectrum of harmful gender biases, norms and assumptions also underlies many of the legal and policy barriers that impede women's access to certain sexual and reproductive health services in parts of Europe.

For example, a number of member states retain laws and policies regarding abortion and contraception that are founded upon the harmful presumption that motherhood is, or should be, women's predominant social role and function. For instance, it is commonplace in Europe for legal abortion and contraception services to be excluded from coverage under public health insurance, subsidisation or reimbursement schemes. At times such regulations also expose persisting social mores that favour sex for reproductive purposes as well as beliefs that women should bear the financial and social costs and consequences of sexual activity that is not intended for reproduction. For example, in Slovakia legal provisions explicitly prohibit the coverage of contraceptive methods under public health insurance when used for the purpose of preventing unintended pregnancy, thereby contravening World Health Organization standards that define contraceptives as essential medicines.¹⁶

1.2.4 Stigma

Additionally, throughout Europe, pervasive forms of social opprobrium, shame and taboo are persistently associated with many facets of women's sexual and reproductive lives and with certain forms of sexual and reproductive health care.

For example, sex outside marriage has historically attracted significant levels of stigma and moral censure, with particular consequences for unmarried women who became pregnant. In many European countries these attitudes permeated discriminatory laws and policies concerning the rights and legal status of unmarried mothers and children born outside of marriage; in some member states, they gave rise to a range of coercive practices and ill-treatment, such as forced adoption, compulsory placement in "mother and baby" homes, and other forms of coercive institutionalisation and detention. Although today high numbers of children in Europe are born outside of marriage – and in several European countries, such as Bulgaria, Belgium, Denmark, Estonia, France, Slovenia and Sweden, represent a majority of births¹⁷ – in some European contexts social norms and state policies still reflect underlying disapproval of reproduction outside of marital relationships.

Stigma also continues to attach to women's sexuality and sexual expression throughout Europe, with negative implications for women's sexual autonomy, agency and freedom. For example, common presumptions that women's sexuality is inextricably related to reproduction persist in many settings, as do expectations that women are sexually passive. Such harmful stereotypes and assumptions are often particularly pronounced for certain groups of women. For example, women with disabilities, adolescents, older women, unmarried women and lesbian, bisexual and transgender women may face particular discriminatory presumptions in favour

of asexuality, residual social opprobrium attached to sex outside of marriage, related expectations that young women should “protect their virginity”, and prevailing homophobia and transphobia.

Similarly, stigma surrounding sexually transmitted diseases and infections, including HIV/Aids, endures in many parts of Europe and often undermines women’s access to relevant information, means of prevention, testing and treatment. Eastern Europe, for example, has the fastest-growing numbers of HIV-infection in the world, with women comprising up to 50% of new infections in some of these countries. There are also serious concerns that high numbers of women in the sub-region remain unaware of their status due to low testing prevalence.¹⁸

Meanwhile in some countries in the region there are concerns that deeply ingrained forms of social discrimination and gender inequality continue to give rise to son-preference. Likewise, stigma surrounding abortion and menstruation persist in parts of Europe.

Abortion stigma

In the case *P. and S. v. Poland*, the European Court of Human Rights considered the harmful health implications and serious human rights violations caused by abortion stigma in a country with a restrictive abortion law.¹⁹ The Court held that the rights to privacy and bodily integrity under Articles 3 and 8 of the European Convention on Human Rights were violated as a result of repeated failures by the Polish authorities to ensure that the first applicant could access legal abortion services to which she was entitled under domestic law.

The experiences of the applicants in *P. and S. v. Poland* illustrate the very grave consequences that such failures can have for women and girls. In the case, the first applicant had been raped by a school classmate and as a result became pregnant at 14 years of age. She and the second applicant, her mother, reported the rape to the police. Subsequently, upon finding out that she was pregnant, and with the support of her mother, the first applicant decided to end the pregnancy. As Poland’s prohibition on abortion makes an exception for pregnancies resulting from criminal actions, she was legally entitled to an abortion and obtained a prosecutorial certificate confirming that the pregnancy had resulted from a crime.

However, when the applicants contacted doctors and hospitals in Lublin seeking abortion care for the first applicant, they faced a myriad of extreme obstacles. At one hospital, instead of providing a referral for abortion services, the chief physician suggested the applicants meet with a Catholic priest. Another doctor who refused to issue a referral instead advised the second applicant “to get her daughter married”, while yet another physician asked the second applicant to sign a statement that read: “I am agreeing to the procedure of abortion and

I understand that this procedure could lead to my daughter's death." Hospital officials also disclosed confidential information regarding the pregnancy to a Catholic priest and had the first applicant meet with him. One hospital released a press release stating that it would not perform an abortion for the applicant and gave information about the applicants to the media.

Later, in Warsaw, hospital staff gave the same priest and an anti-abortion activist personal access to the first applicant in her mother's absence, whereupon they tried to persuade her not to have an abortion. The first applicant and her parents were also taken to a police station, where they were questioned for six hours without food. Following a court order, the first applicant was removed from her parents' custody and placed in a residential facility for juveniles for a period of 10 days. Eventually the second applicant filed a complaint with the Office for Patients' Rights of the Ministry of Health, and the Ministry of Health arranged for the first applicant to obtain an abortion in Gdansk.

1.3 LACK OF COMPREHENSIVE SEXUALITY EDUCATION

Young women and adolescents across Europe face a wide range of specific challenges in relation to the enjoyment of their sexual and reproductive health and rights. For example, data indicates that although many adolescents are sexually active, high numbers still do not use condoms or other effective methods of contraception to offset the risks of early pregnancy and exposure to sexually transmitted infections, including HIV.²⁰

Ensuring that young women and adolescents across Europe have access to age-appropriate, evidence-based comprehensive sexuality education (CSE) and information is a critical component of the measures that are necessary to effectively address these and other challenges. However, although several European countries have now established sexuality education programmes of some kind, many of these programmes fall short of international human rights requirements and the WHO Standards for Sexuality Education in Europe.²¹

1.3.1 Dedicated comprehensive and mandatory curricula

Although it is critical that comprehensive sexuality education be provided as part of mandatory school curricula, in some member states, such as Bulgaria, Lithuania, Poland and Romania, sexuality education either remains voluntary or policies allow children to be withdrawn from classes.²²

Moreover, in some parts of Europe, dedicated and comprehensive curricula or guidelines for the provision of holistic sexuality education are lacking. Where this is the case, although some aspects of relevant information may at times be provided in the context of biology, health or social science classes, this does not always ensure

the provision of comprehensive and holistic education and information regarding sexuality, reproduction and relationships.

1.3.2 Content, quality and teacher training

Programmes in a number of member states are failing to meet the crucial requirement that sexuality education provide accurate, scientific and age-appropriate information, and that relevant curricula be holistic and non-discriminatory. In some parts of Europe, curricula include scientifically and medically inaccurate information or reinforce discriminatory gender assumptions, roles and norms.²³

For example, in a number of countries, relevant materials or teaching practices portray women only as mothers who are responsible for raising children, stigmatise homosexuality and gender non-conformity, and reinforce gender stereotypes and expectations regarding male and female sexualities. Some countries' curricula remain focused on "preparation for family life" and emphasise heterosexual marriage and parenthood, while shunning topics like gender equality and sexual diversity. Similarly, some curricula still promote abstinence from sex outside of marriage or focus primarily on natural methods of family planning, and do not provide sufficient information about how to use effective, modern methods of contraception.

In many European contexts the content and quality of sexuality education is highly dependent on the knowledge and competence of individual teachers. Yet at the same time, the educational background of teachers providing sexuality education varies widely, and many countries do not provide adequate training programmes, continuing education, or support mechanisms and resources for sexuality education teachers.

1.4 DEFICITS IN HEALTH SYSTEMS, DATA COLLECTION AND FINANCING

A well-functioning health system that effectively addresses and meets women's sexual and reproductive health needs is imperative for the realisation of women's sexual and reproductive health and rights. Yet, although many European health systems are relatively strong, the degree to which they are equipped to respond effectively to the wide range of sexual and reproductive health and rights issues facing women varies considerably, and deficits and shortcomings persist across the region.²⁴

1.4.1 Action plans, oversight and training

Many European governments have yet to adopt national strategies and action plans that prioritise the advancement of women's sexual and reproductive health and rights throughout the life cycle. Where these plans and strategies do exist, they are sometimes drawn up outside of a transparent and participatory consultative process. They do not always include targeted and measurable indicators and benchmarks, nor do they consistently provide for appropriate mechanisms of oversight and monitoring of implementation.

Additionally, a number of member states do not provide specialised training programmes for health care workers providing sexual and reproductive health care to women, or training curricula lack strong components on gender equality and human rights. Some fail to ensure effective regulation, monitoring and oversight of sexual and reproductive health care, particularly in relation to private health care providers.

1.4.2 Disaggregated data

Failures to collect and analyse important forms of data and evidence on women's sexual and reproductive health, and in particular disaggregated data, remain a concern in a number of European countries.²⁵ Many health systems do not collect and analyse disaggregated data on sexual and reproductive health, not only with regard to sex, but also with regard to factors such as age, disability, ethnicity, nationality or socio-economic status. This lack of data collection hampers member states' ability to appropriately identify gaps and deficits in women's access to quality sexual and reproductive health care and design effective and responsive strategies. Data collection deficits in some countries also extend beyond disaggregation. Concerns have been raised regarding the absence of good quality indicators, as well as the need to measure rates of unintended pregnancies, abortion rates, and the prevalence of, and unmet need for, modern contraception.

1.4.3 Budgetary allocations, financing and costs

Financial barriers remain a key source of inequalities in the arena of women's sexual and reproductive health in Europe. Budgetary allocations for women's sexual and reproductive health, while strong in some European countries, remain insufficient in others, and the human and financial resources necessary to advance women's sexual and reproductive health and rights are often lacking. The provision of sexual and reproductive health services frequently varies across communities, and deficits can be especially marked for women living in rural areas. In addition, some health systems are failing to ensure a life cycle-based approach to women's sexual and reproductive health. For example, adequate resources may not be assigned to youth-friendly sexual and reproductive health services for adolescents, or to screening, early diagnosis and treatment programmes for reproductive cancers affecting women, in particular older women.

Additionally, and as outlined in more detail in sub-sections 1.5, 1.6 and 1.7 below, some member states continue to exclude particular aspects of sexual and reproductive health care that women need, such as contraception and abortion, from existing health insurance, subsidisation and reimbursement schemes. Certain countries also bar undocumented migrant women from subsidised or free access to maternal health care or prevent them from purchasing health insurance or contributing to relevant schemes.

The recent economic crisis and resulting cutbacks in public expenditure have exacerbated many of these issues. There are concerns that growing income inequality across the region, combined with reductions in resources for gender equality programming and sexual and reproductive health services, means that women

of low socio-economic status face increasing barriers to accessing quality sexual and reproductive health care.²⁶ Efforts to reduce costs can also affect the quality and acceptability of sexual and reproductive health care for women in general. For example, in some countries concerns have been raised regarding the use of medication or procedures to speed up childbirth and thus reduce the associated costs for human resources and hospital infrastructure.²⁷

1.5 BARRIERS IN ACCESS TO MODERN CONTRACEPTION

Across the European region, women's access to effective methods of modern contraception continues to be impeded by a range of affordability and availability deficits, information shortfalls and discriminatory policy barriers.

Indeed, although more women in parts of Europe are now using effective, evidence-based methods of contraception than in any other region of the world, there are important exceptions to this and considerable variations within the region. For example, in some European countries, such as Albania, Armenia, Azerbaijan and Bosnia and Herzegovina, the rates of women using modern contraceptives are among the lowest in the world.²⁸

Moreover, even in those member states where the use of modern contraceptives is relatively high, women face a range of serious challenges in accessing good quality and affordable contraceptive services and their unmet need for contraception is a significant concern.

1.5.1 Discriminatory and inadequate reimbursement and insurance policies

Many European countries have established strong national health systems and public health insurance, subsidisation and reimbursement schemes. As a result, in several member states the cost of most medicines and medical goods are not paid out of pocket, or are at least partially reimbursed. However, the cost of modern contraception is a notable exception to this rule and in numerous countries it is excluded, wholly or in part, from relevant schemes.²⁹

For example, some member states, including Austria, the Czech Republic, Denmark, Hungary, Latvia, Lithuania, and Slovakia, offer no coverage or reimbursement for any women or for any methods of contraception, when contraceptives are used to prevent unplanned pregnancy. Others, such as Germany, the Netherlands and Sweden, cover the costs of contraception for adolescent girls and young women but not for older women. Some, such as Italy and Poland, cover only specific, very limited contraceptive methods.

Although there are exceptions to this approach, many member states thus distinguish contraception from other medicines and medical goods and exclude it from insurance, subsidisation or reimbursement schemes, at least in part. In practice, this means that the financial burden of preventing unplanned pregnancy is placed almost entirely

on women, thereby illustrating continuing failures to recognise access to modern contraception as a human rights issue and a health care imperative.

These exclusions have clear implications for certain groups of women in Europe who cannot afford to cover the cost of modern contraception themselves. Moreover, these barriers increase in central and eastern European jurisdictions where the cost of contraception remains high relative to median monthly incomes. However, even in countries where the costs of contraception are lower in relative terms, they often remain prohibitive for certain groups of women, especially those living in poverty and adolescents.

1.5.2 Poor quality information and misconceptions

Member state failures to take effective measures to guarantee women's access to good quality, evidence-based and scientifically accurate information about modern contraception also remain a critical concern in some parts of Europe.³⁰

In some European countries standardised guidelines on the provision of modern contraception services still do not exist or are not implemented in practice. At times, good quality training for medical professionals on modern contraceptive methods is non-existent or insufficient. As a result, women receive poor quality or erroneous information from medical professionals. This situation is often compounded by a lack of public information campaigns and other targeted communication measures to disseminate evidence-based information to the public.

Such failures allow a range of misconceptions about modern methods of contraception to go unchallenged. These include misconceptions regarding the risks and side effects of hormonal contraception that can often dissuade women from using modern contraceptives.

1.5.3 Policy barriers and availability shortcomings

In a small number of countries, women's access to modern contraceptive services is further hindered by policies requiring third-party approvals prior to access. For example, although most member states have abolished third-party authorisation requirements for adolescents' access to contraceptive goods and services, some countries still impose a requirement of parental consent on some age groups.³¹

In some countries the practical scarcity of modern contraception, or certain forms of contraceptives, also gives rise to significant barriers for women, particularly in economically disadvantaged or rural areas. In addition, there have been worrying reports in some member states of refusals by gynaecologists or pharmacists to prescribe or sell contraception on grounds of conscience or religion.

1.6 RESTRICTIONS ON ACCESS TO SAFE AND LEGAL ABORTION

In some parts of the world abortion is regulated by highly restrictive laws that do not allow women's access to abortion on request or on broad socio-economic grounds.³² These laws prohibit abortion entirely or limit its legality to a small number of very strictly defined exceptional circumstances. They also often prescribe severe criminal penalties for abortion outside the legal framework.³³ In these countries, the rates of unsafe abortion are often high, as are resulting rates of maternal mortality and morbidity.³⁴

In contrast, almost all Council of Europe member states have now legalised abortion on a woman's request, for reasons of distress or on broad socio-economic grounds. Simultaneously, unsafe abortion in Europe has fallen significantly, with rates negligible in many countries and decreasing in others.³⁵

Although this trajectory is a critically important achievement, further progress is needed. As outlined below, many women in Europe face a range of serious barriers in access to safe and legal abortion care. Although these difficulties are the most severe in the small number of European countries that retain highly restrictive laws on abortion, challenges and concerns persist in other parts of the region as well.

1.6.1 Highly restrictive laws

Over four fifths of all Council of Europe member states have legalised abortion on a woman's request, for reasons of distress or on broad socio-economic grounds.³⁶ Of these 40 countries, 36 allow abortion on a woman's request without restriction as to reason or for reasons of distress, with time limits ranging from 10 to 24 weeks, while the remaining four have legalised abortion on socio-economic grounds. In most of these countries, once the relevant time limit for abortion on request or socio-economic grounds has passed, abortion remains legal later in pregnancy when performed to protect a woman's physical or mental health or where there is a severe or fatal foetal impairment.

In eight cases in Europe, laws on abortion have yet to be reformed in a manner that corresponds to this approach. Andorra, Ireland, Liechtenstein, Malta, Monaco, Northern Ireland in the United Kingdom, Poland and San Marino all retain highly restrictive laws that forbid women's access to abortion except in extremely limited circumstances. Andorra and Malta prohibit abortion in all situations. In Ireland, abortion is legal only to avert a substantial risk to a woman's life and in San Marino life saving care is permitted as criminal law exception. In Northern Ireland, the sole exceptions are for risks to a woman's life or health. Laws in Poland and Monaco allow abortion only when there is a risk to a woman's health or life, a severe foetal impairment, or the pregnancy is the result of sexual assault. In Liechtenstein, abortion is legal only in cases of serious risks to a woman's life or health, if the pregnant woman is under the age of 14, or if the pregnancy is the result of rape, sexual coercion or sexual abuse of a defenceless or mentally impaired person. Most of these countries' laws also prescribe criminal sanctions, including imprisonment, for women who undergo abortion outside the above-mentioned criteria or for those who assist

them. In many cases the sanctions outlined are severe: in Ireland, for example, the prescribed penalty for women can amount to 14 years in prison, while in Northern Ireland it can extend to life imprisonment.

The health and human rights implications of these laws are acute. Most women in these member states who decide to end a pregnancy fall outside of any relevant exceptions and are therefore prohibited from obtaining safe abortion care in their home jurisdictions. As a result, many travel to other member states in order to access safe and legal services. Others undergo illegal and clandestine abortions in their home countries – increasingly, by obtaining and taking the abortion pill. Where a woman is unable to travel to another country to obtain safe abortion care, or is reluctant to undergo clandestine abortion, she may be left with no choice but to carry a pregnancy to term against her will.

Because of the legal consequences, women in these countries who resort to clandestine abortion are often afraid to seek post-abortion care if complications arise, with potentially severe consequences for their health. This fear is often well founded – in some of these jurisdictions women who have had illegal abortions, or family members who assisted them, have subsequently faced criminal prosecution and penalties. Recently, for example, a young woman in Northern Ireland was prosecuted and convicted after she became pregnant at nineteen and induced an abortion by taking the abortion pill, which she ordered online.³⁷ The trial of a woman who helped her teenage daughter obtain the abortion pill, and who was subsequently reported to law enforcement authorities by a medical practitioner working at a clinic her daughter attended, is also pending before the courts in Northern Ireland.³⁸

This continuum of consequences, and the feelings of isolation, fear, humiliation and stigmatisation that these laws often produce, can have a broad range of physical, psychological, financial and social impacts on women, with implications for their health and well-being. These effects are often intensified for certain groups of women, including adolescents, asylum seekers and undocumented migrants, women at risk of domestic violence, and women living in rural areas. These women frequently face particular financial barriers and restrictions on freedom of movement that further hinder access to abortion services. In addition, these laws perpetuate and magnify existing social inequalities, as women with financial means may often be able to afford the expense involved in obtaining legal abortion services in another country or clandestine abortion care at home, while women living in poverty will often be unable to afford or manage these costs.

The harmful effect of highly restrictive laws

In two recent decisions, *Mellet v. Ireland* and *Whelan v. Ireland*,³⁹ the Human Rights Committee (HRC) addressed the harmful impact that highly restrictive abortion laws can have on women. Both applicants were women in Ireland who had received diagnoses of fatal foetal impairment from their doctors in the course of their pregnancies. Following routine tests they were each informed that the foetus they

were carrying would die in utero or would not survive long after birth. On receiving this news, each woman found the prospect of continuing her pregnancy unbearable. However, because Irish law prohibits abortion in all situations except when a pregnant woman's life is at "real and substantial" risk, they were informed by their doctors that in Ireland carrying the pregnancy to term was their only option; to end the pregnancy, they would have to seek abortion care in another country. Both women thus arranged to travel with their husbands at their own expense to hospitals in the United Kingdom, where they received abortion care. They were not given any further information, advice or assistance from medical professionals in Ireland. In both cases, they had to leave the remains of their stillborn babies behind them for cremation and later received the ashes in the post.

Both women subsequently filed separate complaints with the HRC, alleging violations of their human rights under the International Covenant on Civil and Political Rights (ICCPR), including their right to freedom from ill-treatment (Article 7) and their right to privacy (Article 17). The HRC upheld their complaints and found that as a result of Ireland's legal prohibition and criminalisation of abortion both women had been subjected to high levels of mental anguish and "conditions of intense mental and physical suffering." The HRC specified that in each case, the suffering could have been avoided if the woman had not been prohibited from terminating her pregnancy in the familiar environment of their own country and under the care of health professionals whom they knew and trusted. It recognised that Ireland's laws compelled each woman to choose between continuing a non-viable pregnancy or traveling to another country at personal expense and separated from the support of her family and that this forced them to bear significant financial, psychological and physical burdens that intensified their suffering. It found that "the shame and stigma associated with the criminalization of abortion" exacerbated the women's suffering.

In addition to the serious implications that restrictive abortion laws have for women who do not qualify for legal abortion services in their home countries, these laws also often have a severe chilling effect on medical practitioners. Although in most cases these laws specify limited legal exceptions to the general prohibition on abortion, women whose circumstances fall within those exceptions often face considerable obstacles in access to legal care. At times, they may be unable to obtain abortion services even when they are legally entitled to do so.

Indeed, highly restrictive laws, the stigma generated by such laws, and the related fear of criminal sanction combine to suppress medical practice and decision making in these jurisdictions. In most of these countries guidelines, protocols and procedures relating to legal abortion do not exist, or are unclear or highly restrictive. Furthermore,

medical professionals are frequently unsure of when it is legal to perform abortion, afraid to certify that the grounds for legal abortion exist, or unwilling to perform legal abortions.

As a result, women are often unable to obtain accurate information about the circumstances in which abortion is legal or the processes that they should follow to obtain legal services. Even where women do seek to enforce entitlements to legal abortion, the requisite timely and effective procedures and complaints mechanisms are often lacking. At times, medical practitioners have actively sought to prevent women who qualify for legal abortion from accessing services.

1.6.2 Refusals of care

At times obstacles in accessing safe and legal abortion services derive from regulatory failures to ensure that these services are accessible and available in practice. In particular, some member states are failing to ensure that women can practicably access legal abortion services in situations where medical professionals refuse to provide legal abortion services on grounds of conscience or religion.

Usually such failures occur when laws and policies allow medical practitioners to refuse to provide legal abortion care but do not also set up and enforce corresponding regulatory and oversight mechanisms to guarantee women's access to legal services.⁴⁰ For example, in some member states medical practitioners are legally permitted to refuse to provide abortion care without referring patients to another provider. In others, referral obligations are enshrined in law or policy but are not reliably enforced. At times, regulations allow, or do not clearly prohibit, refusals of care by a whole health care institution (and not just refusals by individuals) or do not specify that medical practitioners must provide written confirmation of their refusal to patients. Sometimes refusals of care are not limited to the direct provision of abortion services and instead are allowed to apply in relation to pre-abortion or post-abortion care. Sometimes state authorities fail to enforce requirements prohibiting refusals to provide abortion care in emergency situations. Health systems at times lack effective procedures or oversight mechanisms to monitor the numbers of practitioners who are refusing to provide abortion care, and are not always organised so as to guarantee adequate numbers and distribution of personnel who agree to do so. In some contexts there have been worrying reports of medical practitioners refusing to provide abortion services in public facilities but agreeing to do so in private practice.

Such regulatory and enforcement shortfalls can have serious impacts on women's timely access to safe and legal abortion in countries where the numbers of refusals are high. Even where available, access to services may only be possible far away from their local community and at considerable financial and practical cost to women, who must travel long distances to find practitioners willing to provide abortion care.

Refusal of abortion care and women's access to safe and legal abortion

In Italy many women are unable to find a medical practitioner or hospital willing to provide the legal abortion services to which they are entitled. Others face such serious delays in access to services that they fall outside the legal time limits for legal abortion services. Reports indicate that approximately 70% of medical professionals refuse to provide abortion care. In a 2016 decision, the European Committee of Social Rights (ECSR) examined a complaint claiming that Italy had failed to guarantee women's right to health due to its failure to ensure that refusals of care by medical practitioners did not jeopardise women's access to legal abortion procedures. The ECSR concluded that women who sought access to legal abortion services faced substantial difficulties in obtaining access to such services in practice. It noted that Italy's failure to effectively regulate and oversee conscience-based refusals meant that women seeking abortion care were often forced to travel to other health facilities, in another part of the country or abroad. It therefore held that there was a violation of Article 11, paragraph 1 (right to health) of the Revised European Social Charter.⁴¹

1.6.3 Procedural barriers

Procedural requirements that must be fulfilled prior to abortion are a common feature of European laws and policies concerning abortion. In many instances these involve routine, appropriate steps, as would be required prior to any medical procedure, but in some instances they impose distinct and medically unnecessary preconditions on women's access to abortion.

For example, some European countries require an obligatory waiting period, which must elapse between a woman's request for an abortion and before the procedure can be legally carried out. Yet WHO guidelines on safe abortion state that such "mandatory waiting periods" do not fulfil a medical purpose, undermine women's decision-making autonomy, and delay women's access to timely, legal abortion care.⁴² They can also increase the financial and practical costs involved in obtaining abortion services, as they often mean that women must make at least two separate trips to a health facility. This can have a heightened and disparate impact on some groups of women, including women from rural areas, women living in poverty, or women or adolescents at risk of domestic violence.

Mandatory counselling and third-party authorisation requirements are other common examples of procedural barriers that remain in place in some European countries and may jeopardise women's access to legal abortion services. For example, in Turkey married women may not access abortion services unless their spouse consents. WHO guidelines state that third-party authorisation requirements can undermine

women's access to safe abortion services, in particular for certain groups of women, including adolescents, women living in poverty, and those at risk of domestic violence. The guidelines therefore advise against such authorisation requirements. They also specify that counselling about abortion should not be mandatory and that women's decisions to seek abortion care should be respected.

As highlighted in sub-section 1.1, recent trends in central and eastern Europe towards the retrogressive introduction of procedural barriers are of serious concern. In recent years Armenia, the Russian Federation, Slovakia and "the former Yugoslav Republic of Macedonia" have all enacted retrogressive laws and policies that newly impose mandatory waiting periods and/or biased counselling requirements prior to abortion on request.⁴³ Although the new preconditions vary by jurisdiction, many of the relevant provisions or explanatory reports indicate that they are intended to limit women's access to abortion. As a result of these developments, new biased counselling requirements are now being imposed on women in some of these jurisdictions with medical professionals mandated to provide directive, medically inaccurate or misleading information about abortion to women who request abortion services. This directly contravenes WHO guidelines, which specify that information given to women seeking abortion services must be unbiased, non-directive, respectful of women's dignity, needs and perspectives, and provided only on the basis of informed consent. The guidelines emphasise that intentionally misrepresenting information about abortion services can impede women's access to services or cause delays, which may increase health risks for women.

Biased counselling

Abortion counselling and information requirements are biased where their purpose is to persuade women not to obtain an abortion. As such, biased counselling and information requirements are directive in nature and require women to undergo counselling or receive information that is designed to dissuade them from obtaining abortion services and encourage them to continue their pregnancy. They often involve the provision of stigmatising or medically inaccurate or misleading information about abortion. Examples of biased counselling and information include where health professionals overemphasise the risks involved in abortion procedures, counsellors describe abortion as murder or killing of an "unborn child", or women are compelled to look at pictures of a foetus and receive information on its stage of development. For example, in 2010, the Russian Ministry of Health and Social Development issued Guidelines on Psychological Pre-Abortion Counseling describing abortion as "murder of a living child" and portraying women with unwanted pregnancies as irresponsible.⁴⁴

1.7 CONCERNS IN THE FIELD OF MATERNAL HEALTH CARE

Compared to other regions, Europe now has the lowest rates of maternal mortality and morbidity in the world and global statistics identify many European jurisdictions as among the safest places in the world for women to give birth. However, despite these considerable achievements, serious problems persist and cross-regional data masks considerable variations in maternal health outcomes, both between and within European countries.⁴⁵

In fact, important public health, human rights and equality concerns remain at play across Europe, even in those countries where overall rates of maternal death are very low. In a number of member states, certain groups of women still face serious forms of discrimination in access to maternal health care, and across the region there are reports of continuing failures to observe adequate standards of care and ensure respect for women's rights, dignity and autonomy during childbirth.

1.7.1 Maternal mortality and morbidity

Between 2000 and 2015, the average estimated maternal mortality ratio in Europe decreased by more than half, from 33 to 16 maternal deaths per 100 000 live births, and many European countries now have the lowest rates of maternal death in the world. Yet more progress is needed to eradicate preventable maternal mortality and morbidity in Europe. For example, in some member states the estimated maternal mortality ratio is 25 times greater than in other parts of the region. Relatively high rates of maternal death persist in Azerbaijan, Albania, Armenia, Georgia, Romania, the Russian Federation and Ukraine.⁴⁶

Moreover, even in countries with very low overall rates of maternal death there can be considerable disparities in rural areas, among women of low socio-economic status, and among ethnic minorities. As highlighted in sub-section 1.4, many European countries still do not collect adequate disaggregated data on maternal health outcomes; however, in countries with low overall maternal mortality, available research indicates that, there were significant variations in maternal death ratios between different groups of women and a much higher relative risk of maternal mortality in women belonging to ethnic minorities or of “non-Western” origin.⁴⁷

1.7.2 Exclusions and barriers in access to quality care

For some women living in Europe, including in high-income countries with highly developed health systems, accessing maternal health care, including prenatal and postnatal care, remains very difficult. Legal and policy exclusions or financial and practical barriers severely curtail these women's ability to access maternal health care throughout pregnancy.

Particularly harmful restrictions and obstacles confront undocumented migrant women in Europe.⁴⁸ Laws and policies in some member states exclude these women from access to quality maternity care at many stages of pregnancy. In Denmark, Hungary and Sweden, for example, they are not entitled to access any health care that is not emergency care. As a result, pregnant women are prevented from obtaining ordinary

prenatal care and frequently are only able to obtain medical assistance once labour has begun. Financial barriers and exclusions in health insurance schemes give rise to additional barriers. For example, in some countries, such as the United Kingdom, undocumented women must often pay high out-of-pocket charges for maternal health care; at times, these charges result in undocumented migrant women not seeking medical attention even during labour. In some member states, although regulations specify that emergency care can be provided free of charge, definitions of what constitutes an emergency may be either absent or very restrictive, resulting in the imposition of charges for hospital care during labour. A lack of firewalls separating the provision of basic services from immigration control as well as administrative barriers, language barriers and social exclusion also often dissuade undocumented migrant women from seeking medical assistance during pregnancy.

As highlighted in more detail in sub-section 1.8 below, women affected by conflict and crisis and asylum-seeking women in Europe also face a range of specific and exacerbated barriers in access to quality maternal health care.

Failures to ensure women's access to maternal health care and restrictions on women's legal entitlements to certain forms of maternal health care have serious implications for their health and lives. When women are unable to obtain good quality prenatal care they face elevated risks of severe adverse pregnancy outcomes, including maternal death. Moreover, the dangers of restrictions or circumstances that may drive women to give birth in the absence of skilled birth attendants cannot be overstated.

1.7.3 Abusive and coercive practices

Failures to ensure adequate standards of care and respect for women's rights, dignity and autonomy in childbirth affect women from all backgrounds in a range of European countries.⁴⁹

For example, worrying reports have emerged of physical and verbal abuse by health care staff, suturing of birth injuries without adequate pain relief, failures to safeguard women's privacy during labour, and deprivation of food and water during childbirth in a number of member states. In addition, allegations of disregard for women's decisions during labour are also commonplace, as are failures to ensure women's full and informed consent and ability to make informed decisions prior to medical interventions and procedures during childbirth. These interventions may often be highly invasive and regularly include fundal pressure (a practice involving the use of manual or instrumental pressure on the maternal abdomen), episiotomy (a surgical cut to the perineum) or caesarean section. There are also indications that systems of informal payments or bribes exist in maternal health care contexts in some member states.

The impact of these practices on pregnant women's emotional and mental well-being can at times be severe. Women across Europe have reported feelings of humiliation, degradation and diminished autonomy in the course of medical care during childbirth. The failure of many member states to address these issues and ensure adequate responses and changes in policy and practice may reveal a tendency by European health systems and policy makers to dismiss concerns regarding respect for women's personal and bodily integrity and autonomy during childbirth, and to underestimate the implications of emotional trauma and postpartum mental health issues.

The case of Konovalova v. Russia

In a 2014 decision, the European Court of Human Rights addressed the importance of guaranteeing women's informed consent and decision making during childbirth and related procedures. The Court held that the lack of sufficient safeguards to ensure women's informed decision making in relation to medical interventions, including in the course of childbirth, gave rise to a violation of the right to private life under Article 8 of the European Convention on Human Rights.

In *Konovalova v. Russia*,⁵⁰ the applicant, who was pregnant, went into labour and was urgently transferred to hospital. Upon arrival, she was given a booklet that asked patients "to respect the fact that medical treatment in our hospital is combined with teaching for students studying obstetrics and gynaecology" and informed them that therefore, "all patients are involved in the study process." On being admitted to the hospital, due to complications, the applicant was put into a drug-induced sleep twice in an effort to postpone labour. Delivery was scheduled the next day. Despite the applicant's objections in the delivery room, a group of medical students observed the birth and related interventions, including an episiotomy, and were given information about her health and medical treatment.

The applicant later filed claims against the hospital in the Russian courts, seeking compensation as well as a public apology for the presence of third parties during the birth, among other things. These claims were rejected and the domestic court held that although written consent was not necessary under domestic law the applicant had given implied consent to the presence of the medical students. During the proceedings an expert for the hospital outlined to the court that, "Childbirth is stressful for every woman ... During the bearing down phase, a pregnant woman is usually focused on her physical activity. The presence of the public could not adversely affect her labour."

Subsequently, the applicant filed a complaint with the European Court of Human Rights, and the Court upheld her claim that her right to private life had been violated. The Court held that the concept of private life encompasses "the right of choosing the circumstances of becoming a parent ... [and] the physical integrity of a person, since a person's body is the most intimate aspect of private life, and medical intervention, even if it is of minor importance, constitutes an interference with this right".

It recognised that "the absence of any safeguards against arbitrary interference with patients' rights in the relevant domestic law at the time constituted a serious shortcoming". It emphasised that it was "unclear whether the applicant was given any choice regarding the participation of students on this occasion", and noted that as the applicant learned about the planned presence of the medical students between

two sessions of drug-induced sleep, and at a time when the applicant was in a condition of “extreme stress and fatigue”, she was not given an opportunity to make an informed decision as to their presence.

The Court also found that domestic courts had failed to take account of the “alleged insufficiency of the information contained in the hospital’s notice, the applicant’s vulnerable condition during notification ... and the availability of any alternative arrangements in case the applicant decided to refuse the presence of the students during the birth”.

1.7.4 Segregated maternity care

The risk of exposure to abusive and discriminatory treatment in the context of maternal health care is exacerbated for certain groups of women in Europe, and for Roma women in a number of central and eastern European countries, it can be extreme. Reports indicate that the ethnic segregation of Roma women in maternal health facilities remains a reality in certain parts of Europe in 2017. Roma women are sometimes assigned to separate rooms, bathroom facilities and eating areas within maternity hospitals or departments. In these separate facilities, overcrowding and inadequate sanitation services frequently prevail. There are reports of two Roma women being placed in the same bed after giving birth, of patients being given beds in corridors when segregated rooms became full, and of failures to change soiled bedclothes and to ensure clean toilet facilities. Allegations of pervasive racial harassment and discrimination against Roma women by medical professionals in the context of childbirth and provision of reproductive health care are also common in several central and eastern European countries and affected Roma women describe intense feelings of humiliation, discrimination and debasement as a result of these practices.⁵¹

1.8 INTERSECTIONAL DISCRIMINATION

Each of the concerns, challenges, deficits and barriers identified in the preceding sub-sections has exacerbated or distinct implications for marginalised groups of women in Europe. Women living in poverty, rural women, unmarried and single women, women living with HIV, sex workers, ethnic minorities including Roma women, older women, adolescents, women with disabilities, women affected by conflict situations, victims of trafficking, refugees, asylum seekers and undocumented migrant women, and lesbian, bisexual and transgender women are some examples of marginalised groups of women in Europe who face intersectional discrimination in the realisation of their sexual and reproductive health and rights. In all cases, discrimination based on their status as women combines with discrimination on other grounds to give rise to distinct and disproportionate impacts, often with serious consequences.

For example, both adolescent girls and older women face increased risks of violence and abuse and heightened levels of harmful gender stereotypes, assumptions and stigma in relation to their sexuality and sexual rights. Additionally, for adolescents a lack of adequate youth-friendly and affordable sexual and reproductive health care services remains a critical concern in many member states, including with regard to modern contraception. Their access to sexual and reproductive health services is often jeopardised as a result of parental consent or notification requirements. Meanwhile, some European health systems still do not ensure full provision for older women's specific sexual and reproductive health needs, and in some parts of Europe, older women in care settings may be especially vulnerable to sexual violence or related violations of their personal and bodily integrity.⁵²

Laws and policies in many member states continue to allow coercive sexual and reproductive health care practices on grounds of disability. Legal capacity and guardianship laws and arrangements may limit the ability of women with disabilities to make informed decisions in respect of their sexual and reproductive health; forced contraception, sterilisation and abortion are concerns for women with disabilities across the region. Violence, stigma and stereotypes in various settings undermine the sexual and reproductive rights of women with disabilities, and practical and financial barriers and failures to ensure reasonable accommodation obstruct their access to sexual and reproductive health care and information.⁵³

Female sex workers across Europe also face a range of coercive practices and confidentiality infringements that undermine their sexual and reproductive health and rights. Many member states are still failing to take effective measures to ensure that sex workers receive equal and unhindered access to sexual and reproductive health care. In addition, although they may frequently experience or witness sexual and other forms of gender-based violence, sex workers in many member states remain unable to report such crimes due to fear of prosecution, criminal sanction or deportation.

Sexual and reproductive health outcomes for Roma women in Europe are consistently poor. In addition to experiencing ethnic segregation and racial harassment and abuse in maternal health care settings, as mentioned above, Roma women also face racist and sexist verbal abuse and harassment in other sexual and reproductive health care settings in Europe. Financial, practical, social and policy barriers also have serious implications for their access to sexual and reproductive health care. Roma women are regularly denied access to relevant health services due to their perceived inability to pay medical bills or travelling lifestyle, a lack of health insurance or relevant identity documents. Roma girls experience disproportionately high teenage pregnancy rates and in some contexts face high rates of early or child marriage.⁵⁴

Conflict and crisis have disastrous consequences for women's sexual and reproductive rights, and women in Europe who are fleeing conflict or living in European conflict zones are often exposed to acute violations of these rights. In such settings, many women may not be able to access sexual and reproductive health care. They also face particular risks of gender-based violence, including rape, trafficking, high-risk and unintended pregnancy, unsafe abortion, early and forced marriage, and sexually transmitted infections, including HIV. Many member states have yet to adopt adequate and effective rehabilitation and response services for asylum-seeking women

in Europe who have endured violations of their sexual and reproductive health and rights. Furthermore, gendered forms of persecution are not always recognised as valid bases for refugee status claims in Europe, and women at risk of serious violations of their sexual and reproductive rights are often not granted international protection in Europe.⁵⁵

Undocumented migrant women in Europe also face extreme forms of discrimination and exclusion in relation to their enjoyment of sexual and reproductive health and rights. The situation of undocumented women living in transit camps, squats and informal settlements across Europe is particularly dire. Not only do many countries in Europe exclude undocumented migrant women from accessing most forms of sexual and reproductive health care, but these women often refrain from seeking health care or reporting violence due to fears that they will be reported to immigration authorities and detained or deported.⁵⁶

Meanwhile, discrimination based on marital or health status, sexuality or gender identity enables various forms of stigma, harmful gender stereotypes, biases and discrimination. These have significant and distinct implications for the sexual and reproductive health and rights of unmarried and single women, women living with HIV, and lesbian, bisexual and transgender women and intersex persons.⁵⁷

For example, laws and policies on assisted reproductive technologies in a number of member states effectively exclude single women or women in same-sex partnerships from access to IVF or sperm-donor insemination services.

1.9 SHORTCOMINGS REGARDING EFFECTIVE REMEDIES AND ACCESS TO JUSTICE

Although European justice systems have taken important steps to improve women's access to justice and the provision of effective remedies for violations of women's human rights, serious shortcomings persist in parts of the region that affect women's sexual and reproductive health and rights.

In some countries, women have yet to receive redress and reparations for serious and systematic past violations of their sexual and reproductive rights. For example, the widespread and systematic practice of forced and coercive sterilisation of Roma women in several central and eastern European countries is a well-documented past practice and has been the subject of repeated condemnation. Although a small number of individual women have obtained compensation following arduous litigation over many years, most Roma women who were forcibly sterilised have been unable to obtain redress. Over 25 years after these violations were first exposed, a number of member states are still failing to accept responsibility for these practices and establish comprehensive inquiries and reparation schemes. Similarly it is estimated that symphysiotomy operations (a surgical procedure that involves dividing a pregnant woman's pelvis to facilitate vaginal childbirth) were carried out on 1500 women in Ireland, without their informed consent, between the 1940s and the 1980s. However, Irish authorities have yet to investigate the practice in an impartial, independent

and thorough way, including by hearing the testimony of the alleged victims, and ensuring that victims receive prompt and adequate redress.⁵⁸

Ongoing failures to ensure effective remedies and reparation also affect other groups of women in the region, with particular challenges for survivors of gender-based violence, victims of sexual abuse in residential care or educational institutions, and women who have faced forced or coercive practices in childbirth.

Challenges include the lack of effective and impartial investigations, failures to prosecute and punish perpetrators, imposition of restrictive statutes of limitation and other procedural rules, unwillingness to acknowledge state responsibility, and failures to establish meaningful human rights-compliant compensation and reparation schemes. In addition, sometimes an appropriate legal basis for claims related to women's sexual and reproductive health and rights may be lacking, avenues for redress may be unavailable and relevant forms of harm may not be recognised as human rights violations. In some parts of Europe, legal processes and complaint procedures intended to prevent violations of women's sexual and reproductive health and rights are lacking. Where they do exist they are sometimes ineffective and cumbersome and thus fail to enable women's timely access to relevant forms of sexual and reproductive health care.

Section 2

International human rights standards and women's sexual and reproductive health and rights

Sexual and reproductive rights, including the right to sexual and reproductive health, derive from international human rights law and standards. Civil, political, economic, social and cultural rights enshrined in human rights instruments apply across the continuum of human beings' sexual and reproductive lives.

Human rights mechanisms have addressed many sexual and reproductive health and rights issues facing women and have outlined the manner in which international human rights standards oblige states to address these concerns. They recognise that a multiplicity of human rights are infringed by the barriers, restrictions, discrimination, coercion, violence and abuse that women face throughout their sexual and reproductive lives and in relevant health care settings. They have addressed claims of competing rights and have considered arguments that states may legitimately limit or curtail women's sexual and reproductive health and rights in certain contexts.

As with all other human rights issues and aspects of human rights law, the interpretation and application of international and European human rights standards to the lived experiences of women has developed and expanded over time. It is well established that the human rights framework is not static and that human rights treaties are living instruments, the interpretation of which necessarily continues to evolve. Undoubtedly, with the advancement of public health research and evidence concerning women's sexual and reproductive health as well as social progress related to women's roles in society, their sexuality and their reproductive lives, this interpretative trajectory and evolution will continue to deepen and expand.

With reference to the pronouncements of human rights mechanisms, this section summarises the general content and contours of member states' international human rights obligations to respect and ensure women's sexual and reproductive health and rights. Although human rights mechanisms have repeatedly recognised that all human rights are relevant to women's sexual and reproductive health and rights, they have often identified certain human rights as having particular relevance in this context. Consequently, sub-sections 2.1 to 2.5 focus on the manner in which specific human rights – namely the rights to health, to life, to freedom from torture and other ill-treatment, to privacy and to equality and non-discrimination – apply to women's sexual and reproductive health and rights and place corresponding obligations on member states.

2.1 THE RIGHT TO HEALTH, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

The right to enjoyment of the highest attainable standard of physical and mental health (hereinafter the right to health) is enshrined in Articles 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), both of which have been universally ratified by Council of Europe member states. It is also enshrined in Article 24 of the United Nations Convention on the Rights of the Child, Article 25 of the Convention on the Rights of Persons with Disabilities and Article 12 of the Revised European Social Charter. The right to health is also closely connected with the right to benefit from scientific progress enshrined in Article 15(b) of the ICESCR.

Women's right to sexual and reproductive health is an essential part of their right to health, and in a recent General Comment on the right to sexual and reproductive health, the Committee on Economic, Social and Cultural Rights (CESCR) delineated the content of this right:

[it] entails a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health.⁵⁹

Member states' obligations to guarantee women's equal enjoyment of these freedoms and entitlements encompass a broad spectrum of components.⁶⁰ For example, states must guarantee the availability, accessibility, acceptability and quality of all health facilities, goods, information and services related to women's sexual and reproductive health and must ensure they are evidence-based, scientifically and medically appropriate, and up to date. States must ensure the affordability of sexual and reproductive health services for women; they must remove discriminatory financial barriers and in some cases, may be required to make essential goods and services free of charge, at least for certain groups of women. They must also guarantee sufficient budgetary

allocations and ensure adequate financial, human and other resources to support women's sexual and reproductive health, including in rural areas.

Additionally, states must reform laws, policies and practices that restrict or deny women's access to sexual and reproductive health care or otherwise impede women's exercise of the right to sexual and reproductive health. For example, they must remove laws criminalising abortion and restrictive abortion laws;⁶¹ policies that exclude certain sexual and reproductive health services from public funding; third-party authorisation requirements such as parental, spousal and judicial authorisation requirements for access to health services, including for abortion and contraception; and medically unnecessary prerequisites to abortion, namely mandatory waiting periods and biased counselling requirements.

States must also take legal, policy and other measures to ensure that the enjoyment of the right to sexual and reproductive health is not undermined by the conduct of third parties, including private health care providers. For example, as outlined in more detail in sub-section 3.4, they must ensure that refusals of care by medical practitioners do not affect women's access to sexual and reproductive health care. They must also prevent private actors from impeding access to sexual and reproductive health services, such as by disseminating misinformation or seeking bribes or other informal payments.

Fulfilment of the right to sexual and reproductive health further requires states to provide universal access for all women, including marginalised groups of women, to the full range of sexual and reproductive health care that they need as women. This includes, but is not limited to, maternal health care, safe abortion care, modern contraceptive goods and services, youth-friendly sexual and reproductive health care, and services related to the prevention, diagnosis and treatment of infertility, reproductive cancers, sexually transmitted infections and HIV/Aids. Furthermore, governments must ensure, while fully respecting the principle of personal data protection, collection of disaggregated data on key aspects of women's sexual and reproductive health, with regard to sex as well as a range of additional indicators. Adequate training for health care workers has also been identified as imperative for quality of care.

In addition, states must adopt affirmative measures to eradicate the wide range of entrenched social norms and gender roles, attitudes and stereotypes that impede women's autonomy and equality in the sphere of sexual and reproductive health. These include social misconceptions, prejudices and taboos such as those surrounding menstruation, pregnancy, delivery and fertility.

Although some aspects of the right to sexual and reproductive health may be progressively realised over time, states must always use all available resources to discharge their obligations and move towards full realisation of the right.

Moreover, certain core obligations are of immediate effect.⁶² These include state duties to:⁶³

- repeal and eliminate laws, policies and practices that criminalise, obstruct or undermine women's access to sexual and reproductive health facilities, services, goods and information;

- ▶ adopt and implement a national strategy and action plan with adequate budget allocations for sexual and reproductive health that is devised, periodically reviewed and monitored through participatory and transparent processes and that targets, prioritises and advances women's sexual and reproductive health;⁶⁴
- ▶ guarantee universal and equitable access for all women, including marginalised groups of women, to affordable, acceptable and quality sexual and reproductive health services, goods, facilities and information;
- ▶ ensure women's privacy, confidentiality and free, informed and responsible decision making, without coercion, discrimination or fear of violence, in relation to sexual and reproductive health;
- ▶ provide equal access to medicines, equipment and technologies essential to women's sexual and reproductive health, including those provided for in the World Health Organization Model List of Essential Medicines;
- ▶ enable access to effective remedies and redress, including administrative and judicial remedies, for violations of the right to sexual and reproductive health;

In addition, the obligation to eliminate all forms of discrimination against women, including intersectional discrimination, in the enjoyment of sexual and reproductive health is also of immediate effect (further discussed in sub-section 2.5 below).⁶⁵ This critical array of states' obligations to guarantee women's right to sexual and reproductive health require urgent action towards compliance.

The principle of non-retrogression

The principle of non-retrogression prohibits steps that undermine, restrict or remove existing rights or entitlements. As a result, member states' introduction of retrogressive measures – deliberately backward steps in law or policy that directly or indirectly impede or restrict enjoyment of a right or entitlement – will almost never be permitted under international human rights law.⁶⁶

Attempts to weaken gender equality protections and safeguards for women's sexual and reproductive health and rights violate this principle and can rarely be justified.

Consequently, member states' adoption of measures that roll back protections for women's sexual and reproductive health and rights, introduce new barriers, or remove or scale back women's entitlements to sexual and reproductive health care will almost always give rise to violations of international human rights standards.

2.2 THE RIGHT TO LIFE

The right to life is enshrined in Article 2 of the European Convention on Human Rights and Article 6 of the ICCPR. Obligations to guarantee women's equal enjoyment of the right to life also derive from Articles 1 and 2 of CEDAW.

The right to life protects women from arbitrary and preventable loss of life. Human rights mechanisms have clearly stated that the right to life will be engaged when states fail to take effective measures to address sexual and reproductive health and rights deficits that expose women to life-threatening risks.

For example, guaranteeing women's right to life requires states to take effective action to prevent maternal mortality, including by ensuring women's access to acceptable, affordable and good quality maternal health services such as emergency obstetric care and skilled birth attendants.⁶⁷

Furthermore, state action to help women prevent unintended pregnancy has also been identified as vital to ensuring women's right to life, not least as a result of the attendant risks of unsafe abortion and maternal mortality. Consequently, human rights mechanisms have expressed concern about obstacles women face in access to modern contraceptive goods and services when considering states' efforts to give effect to women's enjoyment of their right to life.⁶⁸

These mechanisms have also stated that barriers in accessing safe abortion services, which may cause women to undergo clandestine abortions or otherwise place their lives or physical and mental health at risk, violate the right to life. Therefore, they have identified the reform of highly restrictive abortion laws as an important component of states' obligations to respect and ensure this right.⁶⁹

The right to life accrues from birth

Although at times attempts have been made to justify restrictions on women's sexual and reproductive health and rights with reference to a purported "prenatal right to life", in fact the right to life as enshrined in core international human rights treaties does not apply prior to birth and international human rights law does not recognise a prenatal right to life.

Records of the drafting processes (*travaux préparatoires*) leading to the adoption of the core international human rights treaties clearly demonstrate that the drafters of these treaties rejected claims that the right to life enshrined in those instruments should apply prenatally. Additionally, no international human rights mechanism has found that the human right to life applies before birth.⁷⁰

Accordingly, where justifications or excuses for constraints on women's sexual and reproductive health and rights are premised on claims of a "prenatal" or "unborn" right to life, these arguments misconstrue the

content and application of the right to life as enshrined in international human rights instruments and standards. This remains true without regard to whether such claims are rooted in ideological or religious motivations.

2.3 THE RIGHT TO FREEDOM FROM TORTURE AND ILL-TREATMENT

The right to freedom from torture and other cruel, inhuman or degrading treatment or punishment (hereinafter torture and ill-treatment) is enshrined in Article 3 of the Convention, Article 7 of the ICCPR, and Articles 2 and 16 of the United Nations Convention against Torture (UNCAT). Women's equal right to freedom from torture and ill-treatment also derives from Articles 1 and 2 of CEDAW.

These provisions impose rigorous and absolute obligations on states across the continuum of women's sexual and reproductive lives and human rights mechanisms have repeatedly recognised that women face particular forms of torture and ill-treatment related to their sexuality, reproductive capacities and decisions, and in sexual and reproductive health care settings. They have underlined that these violations can cause tremendous and lasting physical and emotional suffering, with grave consequences for women's personal and bodily integrity, their physical and mental health, and their emotional well-being.⁷¹

The right to freedom from torture and ill-treatment not only requires states to refrain from such treatment, and to eliminate laws, policies and practices related to sexual and reproductive health that may expose women to intense physical or mental suffering, anguish, or feelings of humiliation or debasement. It also demands proactive action on the part of states, including through the adoption of laws, policies and programmes, to prevent torture and ill-treatment.

Human rights mechanisms have explained that these obligations require states to eliminate coercive sexual and reproductive health care practices that give rise to various forms of physical and psychological suffering. Examples of these practices include forced and coercive sterilisation, forced abortion and a wide range of coercive interventions often carried out in the course of childbirth without women's informed consent. The eradication of serious forms of verbal abuse and discriminatory treatment in sexual and reproductive health care settings, which can cause women intense feelings of humiliation or other forms of psychological suffering, is also crucial.

The right to freedom from ill-treatment also obliges states to guarantee women's access to sexual and reproductive health care, when failures to do so could place their health at risk or cause them considerable physical or mental suffering, anguish, or feelings of degradation. For example, human rights mechanisms have emphasised that states must ensure that all survivors of sexual violence are able to access a comprehensive range of relevant sexual and reproductive health services, including HIV post-exposure prophylaxis, emergency contraception and safe abortion services.

At times compliance with these obligations will require reform to abolish laws and policies that prevent certain groups of women from accessing services or that prohibit all women's access to certain forms of sexual and reproductive health care. For instance, highly restrictive abortion laws have repeatedly been found to engage the prohibition on ill-treatment. Specifically, human rights mechanisms have clarified that women's right to freedom from ill-treatment requires states to legalise abortion to protect women's lives or health, as well as in other situations in which carrying a pregnancy to term would cause women substantial physical or mental pain or suffering.⁷²

For example, as noted in sub-section 1.6, the Human Rights Committee found that Ireland had violated the rights of two women to freedom from cruel, inhuman or degrading treatment as a result of its far-reaching prohibition on abortion. Specifically, the HRC held that Irish laws prohibiting and criminalising abortion, which thereby prevented two women in Ireland who had received diagnoses of fatal foetal impairment during the course of their pregnancies, from accessing safe abortion services in their home country, resulted in a violation of their right to freedom from cruel, inhuman or degrading treatment, under Article 7 of the ICCPR. The HRC found that as a result of Ireland's legal prohibition and criminalisation of abortion both women had been subjected to high levels of mental anguish and conditions of intense mental and physical suffering. It held that Ireland was therefore obliged under the ICCPR to reform its laws on abortion so as to ensure non-repetition of the violations and to establish effective, timely and accessible procedures for pregnancy termination in Ireland.⁷³ In a series of judgments, the European Court of Human Rights also ruled that Poland's failures to ensure women's access in practice to abortion services that are legal under domestic law, as well as to prenatal testing services, violated the prohibition of ill-treatment under the European Convention on Human Rights.⁷⁴

The absolute nature of the prohibition on torture and ill-treatment

The international prohibition on torture and ill-treatment is an absolute proscription – no justification or extenuating circumstances of any kind may ever be invoked to excuse violations of women's rights to freedom from torture and ill-treatment.

As a result, where states' actions or omissions constrain women's sexual and reproductive health, autonomy or personal or bodily integrity in a manner leading to intense physical or mental suffering or anguish, there can be no validation or rationalisation for relevant laws, policies or practices.

No religious, moral or social considerations, political, economic or public health concerns, or interests in protecting the rights of others may be legitimately invoked to mitigate state responsibility. Women's rights to freedom from torture and ill-treatment must always be given precedence, and there can never be attempts to "balance" those rights with other rights or state interests.⁷⁵

2.4 THE RIGHT TO PRIVACY

The right to privacy or to respect for private and family life (hereinafter the right to privacy) is enshrined in Article 8 of the Convention and Article 17 of the ICCPR. It encompasses a broad constellation of elements that take on critical importance in relation to women's sexual and reproductive health and lives, including the rights to physical and psychological integrity, to personal autonomy and personal development, to establish and develop relationships with other human beings, to decide whether or not to have a child and to become a parent, and to choose the circumstances in which to become a parent.⁷⁶

Aspects of women's rights to privacy also find expression in Article 16 of CEDAW, which among other entitlements guarantees women's right "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".

States' obligations to respect and ensure women's right to privacy require them to refrain from arbitrary or disproportionate restrictions on, or intrusions into, women's personal and bodily integrity or their freedom to make decisions about their sexual and reproductive health and lives. In addition, states have positive obligations, that is they are obliged to adopt measures to guarantee women's enjoyment of the right to privacy, including by taking effective action to prevent its infringement by private actors.

Human rights mechanisms have found that a wide variety of constraints on women's sexual and reproductive health and autonomy violate women's rights to privacy. These have included severe legal restrictions on abortion,⁷⁷ failures to enable women's access in practice to legal abortion services,⁷⁸ barriers in access to prenatal testing,⁷⁹ forced and coercive sterilisation,⁸⁰ failures to safeguard women's confidentiality and personal and physical integrity and autonomy in the course of childbirth,⁸¹ deficits in legal certainty regarding women's ability to give birth at home,⁸² and judicial reliance on harmful stereotypes regarding women's sexuality.⁸³

At all times, human rights mechanisms have stressed that the principle of informed consent to medical procedures and interventions is an essential component of the right to privacy. Informed consent requires that women's medical decision making be free from threat or inducement, and that their consent to medical procedures be given freely and voluntarily, after they have been offered clear, adequate and evidence-based information on the proposed course of action, as well as on alternatives.⁸⁴

As highlighted in Section 1, laws, policies and practices that impede and undermine women's sexual and reproductive health, autonomy, personal integrity and decision making remain commonplace throughout Europe. Often states seek to justify these restrictions with reference to religious, moral or social considerations, political or economic necessities, security imperatives, or demographic and public health concerns. At times they claim that state obligations to protect the human rights of others must be afforded priority or be balanced against women's sexual and reproductive rights.

Unlike the prohibition on torture and ill-treatment, the nature of the protection afforded to the right to privacy under international human rights law and standards is not absolute; at times, states may be permitted to restrict women's right to privacy. However, human rights standards require that any such measures limiting women's sexual and reproductive rights must meet a number of strict and cumulative criteria: states must demonstrate that limitations are lawful, pursue a legitimate aim, and are necessary and proportionate.⁸⁵ Human rights mechanisms have frequently found that states' restrictions on women's sexual and reproductive rights have failed to strike the right balance and meet these benchmarks, and thus violated their right to privacy.

Though the European Court of Human Rights, in assessing the permissibility of limitations on the right to privacy, has at times afforded a certain margin of appreciation to member states, other international and regional human rights mechanisms have not applied the margin of appreciation doctrine.⁸⁶ For example, while the European Court has sometimes granted member states a wide margin of appreciation in the field of restrictions on women's sexual and reproductive health and rights,⁸⁷ other mechanisms have not used the same approach.⁸⁸ Moreover, as the European Court has repeatedly noted, the Convention is a living instrument. As a result, Court jurisprudence regarding women's sexual and reproductive health and rights will undoubtedly continue to evolve.⁸⁹

2.5 GENDER EQUALITY AND FREEDOM FROM DISCRIMINATION

Women's rights to equality and freedom from discrimination in the enjoyment of civil, political, economic, social and cultural rights are the focus of a dedicated international treaty, CEDAW. These rights are also afforded particular emphasis in Articles 3 of both the ICCPR and ICESCR and are enshrined in numerous additional provisions across multiple human rights instruments.⁹⁰

Together, these fundamental human rights standards give rise to an array of state obligations to ensure women's equality and freedom from discrimination in law and practice, including intersectional or multiple forms of discrimination.

These obligations apply throughout women's sexual and reproductive health and lives: human rights mechanisms have repeatedly recognised that the enjoyment of sexual and reproductive health and rights is indispensable to women's autonomy and their ability to make meaningful decisions about their lives and health.⁹¹ They have specified that obligations to guarantee gender equality and non-discrimination require states to "respect the right of women to make autonomous decisions about their sexual and reproductive health,"⁹² and ensure that "all health services are consistent with women's rights to autonomy, privacy, confidentiality, informed consent and choice".⁹³ To this end, states must not only ensure adequate standards of care and respect for women's rights, dignity and autonomy in the course of sexual and reproductive health care, but must also remove all barriers, including legal, practical, financial and social barriers, that jeopardise, obstruct or otherwise undermine women's enjoyment of sexual and reproductive health and rights.⁹⁴

Accordingly, states must repeal or reform laws and policies that nullify or impair women's ability to realise their right to sexual and reproductive health and laws that prohibit health services that only women need amount to a discrimination against women. These include laws and policies that criminalise or prohibit certain sexual and reproductive health services or exclude access for certain groups of women as well as procedural barriers, such as third-party authorisation requirements, that impede women's access to sexual and reproductive health care.⁹⁵

Human rights mechanisms have declared that states must eradicate both direct and indirect forms of discrimination against women and ensure both formal and substantive equality. This means that they must ensure that laws, policies, programmes and health system operations take account of the specific health needs of women, and biological as well as socially and culturally constructed differences between women and men. Furthermore, they must alleviate the inherent disadvantages that women face in exercising their sexual and reproductive rights.⁹⁶

Against this backdrop, guarantees of gender equality and non-discrimination also require states to take effective measures to eliminate the myriad of harmful gender stereotypes and assumptions that undermine women's sexual and reproductive health and rights. Human rights mechanisms have recognised that "gender stereotypes may affect women's capacity to make free and informed decisions and choices about their health care, sexuality and reproduction and, in turn, also affect their autonomy to determine their own roles in society".⁹⁷ They have held that where laws, policies, judicial reasoning or other state practices embody these stereotypes and assumptions, this can result in violations of Article 5 of CEDAW as well as other human rights provisions.⁹⁸

States must further provide timely access to the full range of sexual and reproductive health services, goods, facilities and information that women need. This requires them to confront regulation and enforcement failures in the sphere of sexual and reproductive health, including by ensuring that refusals of care do not jeopardise women's access to services.⁹⁹

These obligations also generate particular requirements in relation to the elimination of intersectional forms of discrimination against women. Human rights mechanisms have emphasised that states must take concrete and effective measures to address the distinct needs of marginalised groups of women and eliminate the specific or exacerbated barriers they face in the realisation of their sexual and reproductive health and rights.¹⁰⁰ In many instances, they have described the content of these requirements in detail.¹⁰¹

Section 3

Specific obligations to ensure women's sexual and reproductive health and rights

As outlined in Section 2, the manner in which international human rights standards apply in the context of women's sexual and reproductive lives has been articulated with increasing specificity by human rights mechanisms. Although in this regard human rights mechanisms have addressed a broad spectrum of sexual and reproductive health and rights concerns, certain issues have been the focus of repeated and particularly in-depth analysis.

Drawing on the analysis from the preceding section, sub-sections 3.1 to 3.5 below provide a concise snapshot of how human rights mechanisms have addressed five core aspects of women's sexual and reproductive health and rights: comprehensive sexuality education (CSE); modern contraception; safe and legal abortion; medical professionals' refusals to provide sexual and reproductive health care on grounds of conscience; and quality maternal health care.

3.1 GUARANTEEING THE PROVISION OF EVIDENCE-BASED INFORMATION AND COMPREHENSIVE SEXUALITY EDUCATION

International human rights standards guarantee women's right to receive and impart information related to their sexual and reproductive health and rights. Accordingly, human rights mechanisms have outlined that states must ensure women's access to evidence-based information on all aspects of sexual and reproductive health,

including their own health status, and must enable women to make informed decisions about their sexual and reproductive health.¹⁰² These obligations require that information on sexual and reproductive health be provided in a manner that takes account of women's personal circumstances, such as age, gender, language or disability. In addition, such information must be evidence-based, scientifically accurate, objective and up to date, and states must refrain from misrepresenting, censoring or criminalising such information and remove barriers to access.¹⁰³

Human rights mechanisms have also elaborated specific state obligations related to the provision of CSE,¹⁰⁴ which should be accurate, scientifically sound and culturally sensitive; respect the principle of non-discrimination and promote diversity; address gender norms; and promote tolerance and respect. Curricula should be tailored to developing young people's capacity to understand their sexuality in all its dimensions, and attention should be paid to gender equality, sexual diversity, human rights, responsible parenthood, sexual behaviour and violence prevention.

Importantly, human rights mechanisms have emphasised that age-appropriate CSE must be a mandatory part of ordinary school curricula. In particular, they have explained that international human rights standards on the right to freedom of religion or belief do not entitle parents to withdraw children from such classes where relevant information is conveyed in an objective and impartial manner. They have also specified that CSE should be provided in alternative¹⁰⁵ and accessible, age-appropriate formats, including for adolescents with disabilities.

3.2 SECURING THE AVAILABILITY AND AFFORDABILITY OF MODERN CONTRACEPTIVE SERVICES

Human rights mechanisms have repeatedly held that guaranteeing women's effective access to modern contraception is critical for the realisation of their sexual and reproductive health and rights. They have recognised that states violate obligations to fulfil women's right to sexual and reproductive health when they fail to ensure their access to a full range of contraceptive choices and prevent them from using appropriate methods that suit their individual situations and needs.

Moreover, these mechanisms have recognised that blanket prescription requirements may undermine women's timely access to emergency contraception and that failures to subsidise contraceptives, cover them under public health insurance or reimbursement schemes, or provide them free of charge may constitute discrimination against women. They have also recognised that cost barriers can have particular implications for adolescents' access to contraceptive services and have also stated that all adolescents should be provided with access to free, confidential, responsive and non-discriminatory sexual and reproductive health services, information and education, including on contraception and emergency contraception. Likewise, third-party authorisation requirements, such as parental consent requirements, should not be attached to contraceptive commodities, information and counselling.¹⁰⁶

3.3 ENSURING ACCESS TO SAFE AND LEGAL ABORTION SERVICES

Human rights mechanisms have repeatedly held that ensuring women's access to safe abortion care is a critical component of states' obligations to respect and guarantee women's human rights. They have stated that international human rights standards place requirements on states in relation to the provision of safe abortion care and specify a range of concrete measures.

Thus, states are obliged to ensure that laws and policies on abortion do not prevent or obstruct women's access to good quality abortion care. As noted in Section 2, laws that severely restrict access to abortion services contravene myriad international human rights standards, and a number of human rights mechanisms have underlined that states' obligations to respect and ensure women's human rights require reforming restrictive abortion laws and removing associated criminal penalties.¹⁰⁷

Human rights mechanisms have also pointed out that legalising the provision of safe abortion care will not be sufficient to ensure compliance with human rights obligations. States must also take concrete action to guarantee the quality of abortion care and ensure that it is available and accessible in practice. Measures to eliminate legal, policy, financial and other barriers that still impede women's access to abortion care, including mandatory waiting periods and restrictive third-party authorisation requirements, are critical. States should ensure the availability and quality of safe abortion services in line with World Health Organization safe abortion guidelines, including by guaranteeing women's access to evidence-based and scientifically accurate information about abortion. Counselling prior to abortion should not be compulsory and requirements that counselling prior to abortion be directive or biased should be urgently addressed.¹⁰⁸

3.4 SAFEGUARDING ACCESS TO HEALTH CARE IN LIGHT OF REFUSALS OF CARE

International human rights standards oblige states to take effective measures to ensure that medical professionals' refusals of care on grounds of conscience or religion do not jeopardise women's access to sexual and reproductive health care. The European Committee of Social Rights, the European Court of Human Rights, the Committee on the Elimination of All Forms of Discrimination against Women, the Committee on Economic, Social and Cultural Rights, and the Human Rights Committee have repeatedly articulated this requirement. Notably, they have emphasised that under international human rights law the right to freedom of religion or belief does not entail an absolute right to manifest one's religion or belief, and they have refused to recognise any entitlement for medical professionals to refuse sexual and reproductive health care under international human rights law.¹⁰⁹

Any manifestation of religion or belief can be lawfully restricted in situations where it is necessary to protect the rights and freedoms of others.¹¹⁰ The European Court of Human Rights has noted that the main scope of Article 9 of the Convention is that of personal convictions and religious beliefs, in other words what are sometimes referred

to as matters of individual conscience. The Court added that “in safeguarding this personal domain, Article 9 of the Convention does not always guarantee the right to behave in public in a manner governed by that belief. The word ‘practice’ used in Article 9 § 1 does not denote each and every act or form of behaviour motivated or inspired by a religion or a belief”. In a case concerning refusal from pharmacists to sell contraceptives, the European Court considered that “as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere.”¹¹¹ Thus any refusal of care on grounds of religion or belief by a medical professional may never be allowed to jeopardise women’s right to access sexual and reproductive health services.

Human rights mechanisms have underlined that where domestic laws or practices allow medical professionals to refuse to provide certain forms of health care, including abortion care, international human rights standards require them to ensure that access to the relevant health service is not undermined as a result. In particular, they have specified that states must effectively implement a range of measures, including, at a minimum: establishing a timely and effective referral system that ensures women are referred to alternative providers who are able and willing to provide care; guaranteeing the availability of an adequate number of health care providers willing and able to provide services at all times, in both public and private facilities and within reasonable geographical reach; prohibiting institutional refusals; ensuring that emergency or urgent procedures are not refused; and establishing adequate oversight and monitoring systems.¹¹²

While Resolution 1763 of the Parliamentary Assembly of the Council of Europe (2010) asserts that medical institutions should be allowed to refuse care, this view is contrary to the repeated recommendations of international human rights mechanisms that have consistently held that institutions may not be allowed to refuse to provide sexual and reproductive health care on grounds of conscience.

3.5 RESPECTING WOMEN’S RIGHTS IN CHILDBIRTH AND GUARANTEEING ACCESS TO QUALITY MATERNAL HEALTH CARE

Ensuring women’s access to quality maternal health care, free from intersectional discrimination, is a crucial component of states’ human rights obligations. International human rights standards require states to guarantee women’s access to quality care throughout pregnancy, including by ensuring access to ante-natal and post-natal care and emergency obstetric services.¹¹³ To discharge this obligation, states are specifically required to remove obstacles that impede access to maternal health care for certain groups of women, as well as those that exclude some groups of women from entitlements to certain forms of care.

Human rights mechanisms have also clarified that states must ensure adequate standards of care and respect for women's rights, dignity and autonomy during childbirth and in maternal health care settings. For example, cost-saving measures should never jeopardise the quality of care available to women and states must take steps to ensure that all women can benefit from the presence of skilled birth attendants during childbirth, including in cases where they are giving birth at home or otherwise outside of medical facilities. In addition, human rights mechanisms have established that women's informed consent and decision making at all stages of pregnancy and during childbirth must be guaranteed and have emphasised that medical interventions or procedures, such as episiotomies or fundal pressure, should not be performed without women's full and informed consent. Segregation on racial or ethnic grounds and abusive or discriminatory treatment, including verbal abuse and harassment of women in the context of maternal health care or during childbirth, must be eradicated.¹¹⁴

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30. IPPF-EN (2016), "Access to modern contraceptive choice in eastern Europe and central Asia"; IPPF-EN/UNFPA (2012), "Key factors influencing contraceptive use in eastern Europe and central Asia".
31. See, for example: Slovakia: Act No. 576/2004 Coll. of Laws on healthcare, healthcare-related services, and on amending and supplementing certain acts as amended, sec. 6.
32. In countries that have legalised access to abortion on a woman's request, without restriction as to

reason or for reasons of distress, laws provide for a time-period in which women can legally access abortion without requiring certification from a number of medical professionals. In countries that have legalised access to abortion on broad socio-economic grounds, a number of medical professionals must certify the existence of the relevant socio-economic reason.

33. For all relevant laws and policies see Center for Reproductive Rights: the World's Abortion Laws Map, at <http://worldabortionlaws.com/map> and WHO's Global Abortion Policies Database, at <http://srhr.org/abortion-policies>, both accessed 17 October 2017.
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63. CESCR, General Comment No. 22, paragraph 49.
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68. See for example HRC, "Concluding observations: Poland", CCPR/C/POL/CO/6, paragraph 12.
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- and 5(e)(iv); see also Council of Europe Convention on preventing and combating violence against women and domestic violence.
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 93. CEDAW, General Rec. No. 24, paragraph 31.
 94. CESCR: General Comment No. 22, paragraphs 2, 9, 25-9, 57, 59; General Comment No. 14, paragraph 21; General Comment No. 16, paragraph 29; CEDAW, General Rec. No. 24, paragraphs 2, 11, 12(a), 18, 23, 29, 31(b).
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 102. CEDAW Arts. 10(h) and 16(1)e; ICCPR Art. 19; CRC, Art. 17; CRPD Art. 4(h); European Convention on Human Rights Art. 10; CESCR, General Comment No. 22, paragraphs 6, 18; General Comment No. 14, paragraphs 11, 21, 34-6; CEDAW, General Rec. No. 24, paragraph 18; General Rec. No. 21, paragraph 22; CEDAW, *A.S. v. Hungary*, Communication No. 4/2004, paragraph 11.2 (2006).
 103. CESCR, General Comment No. 22, paragraphs 19-20, 38, 41; CEDAW, General Rec. No. 24, paragraph 31(e); HRC, "Concluding observations: Ireland", CCPR/C/IRL/CO/4, paragraph 9 (2014).
 104. See for this and preceding analysis Art. 13 ICESCR; Arts. 28, 29 CRC; CESCR, General Comment No. 22, paragraph 9, 24, 28, 47, 49(f), 63; CRC, General Comment No. 20, paragraph 61; Report of the United Nations Special Rapporteur on the right to education, A/65/162 (2010); (2006), paragraph 52; ESCR, *INTERIGHTS v. Croatia*, No. 45/2007 (2009), paragraph 43 ff.; European Court of Human Rights: *Kjeldsen et al. v. Denmark*, 1 EHRR 711 (1976) and *Hartikainen v. Finland*, No. 40/1978, CCPR/C/12/D/40/1978 (1978).
 105. For instance in the form of braille, audio formats, large print, captioned or signed films/videos.
 106. See for all of the above, HRC (2016), "Report of the Working Group on the issue of discrimination against women in law and in practice", A/HRC/32/448, April 2016 and CESCR (2016), General Comment No. 22, paragraph 62; CRC, General Comment No. 20, paragraph 60; CEDAW: "Concluding observations: Hungary", CEDAW/C/HUN/CO/7-8, paragraph 31(b) (2013), as well as Poland, CEDAW/C/POL/CO/7-8, paragraphs 36-7 (2014), Slovakia, CEDAW/C/SVK/CO/5-6, paragraph 31 (2015) and Croatia, CEDAW/C/HRV/CO/4-5, paragraphs 30-1 (2015).
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 110. European Convention on Human Rights, Art. 9(1); ICCPR Art. 18(3); HRC (1993), General Comment, No. 22, paragraph 8.
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 112. See ESCR, *IPPF-EN v. Italy*, No. 87/2012 (2014); European Court of Human Rights: *R. R. v. Poland*, Appl. No. 27617/04 (2011) and *P. and S. v. Poland*, Appl. No. 57375/0 (2013); CEDAW, General Rec. No. 24, paragraph 11; CESCR, General Comment No. 22, paragraphs 14, 43; CEDAW: "Concluding observations: Croatia", CEDAW/C/HRV/CO/4-5, paragraph 31 (2015) and Hungary, CEDAW/C/HUN/CO/7-8, paragraphs 30-1 (2013); CRC, "Concluding observations: Slovakia", CRC/C/SVK/CO/3-5, paragraph 41(f) (2016); CESCR, "Concluding observations: Poland", E/C.12/POL/CO/5, paragraph 28 (2009).
 113. CEDAW, *Alyne da Silva Pimentel v. Brazil*, Communication No. 17/2008 (2011).
 114. See, for example CEDAW: "Concluding observations: Slovakia", CEDAW/C/SVK/CO/5-6, paragraphs 30-1 (2015), as well as Croatia, CEDAW/C/HRV/CO/4-5, paragraphs 30-1 (2015) and the Czech Republic, CEDAW/C/CZE/CO/6, paragraph 31 (2016); CRC, "Concluding observations: Slovakia", CRC/C/SVK/CO/3-5, paragraphs 38(d), 39(c) (2016); HRC (2016), "Report of the Working Group on the issue of discrimination against women in law and in practice", A/HRC/32/448, April 2016.

Despite considerable progress, women in Europe continue to face widespread denials and infringements of their sexual and reproductive health and rights. Laws, policies and practices still curtail and undermine women's sexual and reproductive health, autonomy, dignity, and decision-making and pervasive gender inequality continues to have profound effects on their sexual and reproductive health and rights. Moreover, in recent years, resurgent threats to these rights have emerged jeopardising longstanding commitments to gender equality and women's rights.

This Issue Paper addresses these concerns against the backdrop of the human rights obligations of Council of Europe member states as enshrined in international and European human rights instruments and as elaborated and interpreted by human rights mechanisms. It provides an overview of states' obligations in the field of women's sexual and reproductive health and rights with a particular focus on comprehensive sexuality education; modern contraception; safe and legal abortion care and quality maternal health care.



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The Council of Europe is the continent's leading human rights organisation. It comprises 47 member states, 28 of which are members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.



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