

Current status and directions for advancement of sexual and reproductive health and rights in Central and Eastern Europe

ASTRA – Central and Eastern European Women's Network
for Sexual and Reproductive Health and Rights



A S T R A N E T W O R K



Background

The publication prepared as a follow-up of the workshop for sexual and reproductive rights and health advocates “How to address threats to sexual and reproductive health and rights (SRHR) in Central and Eastern Europe” that took place in April, 2011 in Warsaw. The aim of the publication is twofold: it summarizes the experience of workshop participants and presents the current situation regarding observance of sexual and reproductive rights in Central and Eastern Europe (CEE). Further, it provides SRHR advocates with up-to-date information on the European Union’s (EU) commitments. Finally, the publication calls for renewed attention to reproductive and sexual health of Europeans and for strengthening the EU’s commitment. The current publication provides information on legal status of SRHR in CEE, data on the status of implementation of international agreements into the national legal and health systems, and identifies the legal challenges faced by reproductive health advocates in CEE.

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Comprehensive sexual and reproductive health: What it means

Reproductive and sexual health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and its functions and processes¹.

The right to sexual and reproductive health includes the right to have control over and to decide freely and responsibly about matters related to sexuality and whether or not to have children, and the information and means to do so, free of coercion, discrimination and violence. It also includes access to the following comprehensive services: safe motherhood, including basic and emergency obstetric services, including post abortion care, and, where legal, comprehensive abortion care; comprehensive family planning, including long-term, permanent and emergency contraception; prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS; prevention and medical response to sexual and gender-based violence, including the referral to psychosocial and legal services.

A lack of quality sexual and reproductive health services can lead to high infant and maternal mortality rates, an increase in the spread of STIs, including HIV/AIDS, an increase in unwanted pregnancies and unsafe abortions, and increased premature women's mortality and morbidity rates. The WHO's working definition of sexual rights includes a right to achieve „the highest attainable standard of sexual health, including access to sexual and reproductive health care services“. Other rights listed under sexual rights include rights to sexuality education and bodily integrity, and the right to „pursue a satisfying, safe and pleasurable sexual life“(2011).

Reproductive and sexual rights are firmly rooted in the most basic human rights principles guaranteed by international law. United Nations, the Council of Europe, and the EU institutions address the panoply of issues that are included in the reproductive and sexual rights framework.

Sexual and Reproductive Rights and Health in Central and Eastern Europe

Generally speaking, the atmosphere around the reproductive and sexual rights and health (SRHR) in Central and Eastern European (CEE) can be characterized by:

- the growing influence coming from the religious forces (esp. Catholic, Orthodox, Muslim),
- demographic policies fuelled by nationalist discourse,
- financial crisis influencing the state of public health care,

- novelty of the concept of sexual and reproductive rights as well the idea of human rights,
- lack of sexuality education and family planning infrastructure.

The prevailing outcomes of the situation resulting from intermingling of the above mentioned factors are low awareness of the sexual and reproductive rights in society, low prevalence of modern contraception, growing number of sexually transmitted infections (STIs), and growing number of heterosexual HIV infection.

1. International Conference on Population and Development – Cairo 1994: Programme of Action, para 7.2.

Addressing SRHR in the EU and CEE

While, within the EU, the principal responsibility for health policy rests with Member States, not all of them have the same available resources, tools or pools of expertise to address the different causes to health inequalities. Moreover, although not all the countries from the region belong to the EU, the EU has enormous

influence on policies at the global, regional and national levels. It is also important to note that, as a result of large-scale economic decline in the former communist states of CEE and the former Soviet Union, major indicators of the health status of their populations and of their health care systems have shown dramatic deterioration.

Health care systems in CEE – general characteristics

Although fleshing out the patterns of health care reform across the CEE is a complicated endeavor, it is important to note that the health systems of the CEE countries are still in transition, and they have undergone a number of reforms. The level of offered services is low, the access to reproductive health (RH) supplies and services is unevenly distributed among men/women and rural/urban areas. It seems that decentralization in financing and the introduction of two new sources of funding: social health insurance contributions and out-of-pocket payments are still major challenges faced by CEE health

systems. Lack of resources haunting health care sector often obstructs the establishment of effective mechanism monitoring the implementation of international regulations regarding reproductive health. However, it is essential to note that the RH deficiency is not due exclusively to reforms and financial shortages. Very often not enough attention is paid to the issue of reproductive health and health of women. The concept of sexual and reproductive health and rights in the EU and neighboring countries needs to be reinforced.

Need of further research and action

Taking into consideration that the existing data are incomplete and may not actually reflect the real situation due to the lack of the official data and underreporting, there is a need for a clearer picture of the state of sexual and reproductive health and rights and an overview of best practices. In order to best address the challenges facing women's health and to advance human rights in the expanding European Union, sexual and reproductive health and rights must be recognized as part of the mandate of the EU. The EU should use to that extent the

mechanisms and tools available in the most efficient way. For instance it can play an important role in raising awareness, promoting and assisting in the exchange of information and knowledge between the concerned Member States, identifying and spreading good practices and in facilitating the design of tailored made policies for the specific issues prevailing in Member States and/or special social groups. It shall also monitor and evaluate the progress in the application of such policies.

Discrepancies between Western Europe and the CEE

The SRHR situation in CEE stands in a notable contrast to the situation of women in Western Europe. The countries of Western Europe rapidly progressed in securing women's right to reproductive health care in the 1990s. The Netherlands, for example, have a very liberal abortion law and at the same time one of the lowest reported abortion rates in the world. This is due to a comprehensive reproductive health program that includes universal, accurate sex education in schools, and easily accessible family planning services. In addition, overall HIV/AIDS prevalence has risen only slightly in the countries of Western Europe and the availability and accessibility of antiretroviral treatment has decreased morbidity

and mortality. At a time when the European continent is unifying after the accession of new member states from Eastern and Central Europe to the European Union, the division between the East and the West on women's health is increasing. To narrow this widening gap, the EU must take a more active and intersectoral approach in ensuring that the sexual and reproductive health and rights of all of its citizens are promoted and respected. The EU has the authority through its various institutions and laws to ensure that all EU member states guarantee through laws, policies and practices the sexual and reproductive health and rights of their citizens.

ABORTION

International human rights law and relevant jurisprudence support the conclusion that decisions about abortion belong to a pregnant woman alone, without interference by the state or third parties. Any restrictions on abortion that unreasonably interfere with a woman's exercise of her full range of human rights should be rejected. UN bodies and conferences have recognized that firmly established human rights are jeopardized and prejudiced by restrictive and punitive abortion laws and practices².

Abortion trends in the EU

Across the EU-countries in 2005, the highest abortion rates (abortions per 1,000 live births) were observed in Hungary, Latvia, Bulgaria, and Estonia (ranging from 499 – 670/1,000 live births); the Netherlands, Germany, and Finland report substantially fewer abortions. Average rates of abortion in countries in Eastern and Central Europe are higher than in Western Europe³.

However, from 1995 to 2005, in these countries (the Czech Republic, Estonia, Lithuania, Latvia, Bulgaria, Hungary, Slovenia and Romania) a significant decline in abortions per 1,000 live births was observed (WHO 2009). Abortions among adolescents and young women less than 20 years of age remain high, having increased during the period 1995-2005.

Restrictions on access to abortion in EU

Abortion is prohibited in three of the EU's 27 member countries: Ireland, Malta and Poland. In theory in Ireland and Poland, it is possible to be granted an abortion under specific circumstances, for example, if the pregnancy is likely to cause the woman's death. But this has proven very difficult in reality. In all countries abortions are performed whether legal or not, but many are illegal and unsafe. Women often risk illness, sterility and even death. In Poland alone, about 200 000 illegal abortions are estimated to be performed each year. Every year a number of women die as a result of the procedure. Furthermore, the legal principles are applied with great rigidity. One case which upset many of the general public concerned an eleven-year-old girl in Romania who was refused an abortion despite having been raped. The reason was that the pregnancy was two weeks over the legal limit.

According to a medical-ethic committee there were insufficient reasons for overruling the legal limit – according to the law, all abortions after week twelve of the pregnancy are illegal, unless the fetus is badly deformed or the mother's life is endangered. This, however, was not the case of the eleven-year-old.

Women in these countries who need to have an abortion and who have the financial means have the not-ideal option of seeking help abroad. Others are subjected to the illegal alternative. This not only puts their lives and health at risk but can also impose criminal penalties. For example, in Malta a woman risks three years imprisonment after an illegal abortion. Due to the risk of prison sentences or other legal punishments, no one wants to be held responsible if an operation fails.

2. "In no case should abortion be promoted as a method of family planning. All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services... Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling... In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion" (ICPD Programme of Action).

3. In Central and Eastern European countries, abortion rates are much higher than in the EU. The sexual and reproductive rights (SRR) of women living in so called "new Member States" are being constantly challenged. This includes effective negating of women's right to reproductive health and self-determination. For example, while due to limited contraception options abortion is being used extensively by women from the region to control their fertility, there are continuing efforts to erode their right to legal abortion. This endangers the health and lives of the women. The lowest official abortion rates are to be found in the Czech Republic (17/1000), Lithuania, Slovakia and Slovenia (21/1000 women); the middle group consists of Bulgaria, Latvia, Estonia, Hungary, (around 40/1000 women), the highest abortion rate is to be found in Romania (52/1000 women).

Positive developments – change of legislation in Portugal and Spain

One of the few bright spots regarding this issue is the Iberian Peninsula with Spain and Portugal. For a long time abortion was criminalized there, but a positive development took place in Portugal 2007 when a major

change of society, nearly sixty per cent, decided through a referendum to decriminalize abortion. A new law allowing abortion without restrictions in the first 14 weeks of pregnancy came into effect in 2010 in Spain.

Negative trend - growing anti-choice opposition in the CEE

Countries where the development unfortunately goes in the opposite direction are Hungary and Russia. Hungary has recently adopted the new constitution granting fetus' protection from the moment of conception⁴, while Russian Parliament is currently working on legislation that they hope will cut the more than 1 million officially counted abortions taking place annually in Russia⁵. Also Ukrainian government has worked on amendments restricting the current abortion legislation. Further alar-

ming examples of attempts to restrict women's right to choose come from Moldova, where the government attempts to limit a number of social reasons for abortion in 2nd term, and from Macedonia, where the government has initiated aggressive anti-abortion campaign. Given the lack of access to contraception in the region, these restrictions would effectively deny women's reproductive self-determination and their basic human rights.

Induced abortion as a method of fertility control

While abortion is available without restriction during the first 12 weeks of gestation in Caucasus countries, the high rate of induced abortion (i.e. 2,3 abortions per

woman in Azerbaijan; 3,1 – in Georgia⁶) may indicate that abortion is a commonly used method of fertility control due to the limited access to modern family planning.

Quality and methods of abortion services in CEE

Another important trend common for CEE is the low quality of abortion services and the lack of access to medical abortion (Bulgaria, Poland). Although most countries are characterized by high abortion rates, dilatation and curettage continue to be the most widespread methods. Furthermore, the services provided in

public hospitals are generally of low quality (no choice of method, no counseling, no post-abortion contraceptive services, poor infection control and the use of general anesthesia as only method of pain relief, practices of exposure of women seeking abortions to anti-choice images).

Abuse of conscientious objection as a method of restricting access to abortion

Finally, it is important to note the practice of applying conscientious objection. Cases of conscientious objection's abuse were reported in Poland and Slovakia. According to the Polish law, physicians can refuse to perform abortion or dispense contraceptives on the

grounds of conscientious objection. The conscientious objection clause and the way it is exercised in Poland have become a significant barrier to accessing services by women to which they are entitled. It also happens quite often in Poland that conscientious objection is

4. The change of the constitution was followed by aggressive anti-abortion campaign. It is also expected that after entering to force of the new Constitution, the current abortion law will be applied more restrictively and some serious restrictions on the women's right to abortion will be imposed within a year.

5. According to the draft, abortion would no longer be qualified as a medical service under the nation's government-run health system, thus allowing physicians to opt out of doing them. The measure would also increase the monthly payments to pregnant women from the current 2,000 rubles (\$70) a month until birth. Furthermore the proposed legislation seeks to make it illegal to do abortions in the second half of pregnancy.

6. ASTRA Youth: Sexual and Reproductive Health and Rights of Adolescents in Central and Eastern Europe and Balkan Countries (Report 2011) at http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf

“practiced” by the entire hospital, not by individual doctors, which opposes the individuality-based concept of the conscience clause. The newest anti-choice initiative calls on the pharmacists to refuse to sell the

contraceptives in pharmacies, and was inspired by the PACE’s recent unfortunate resolution “The right to conscientious objection clause in the legal care”.

CONTRACEPTION

ICPD stated that all countries should, by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods. In addition, the Outcome Document of FWCW+5 set the target of 2015 for achieving universal access to high quality primary health care, including sexual and reproductive health care.

Family Planning services in the EU

No national governments in the EU have a clear and separate policy on sexual and reproductive health, but the majority of countries support family planning

services, which are, on the whole, widely available through health systems, mostly through general practitioners.

Modern contraceptives’ prevalence

While the average EU rate of modern methods of contraceptive use is around 65%, the average rate of contraceptive use in the Eastern and Central Europe is much lower with an average of around 31%, with the lowest

rates in Romania and Lithuania (around 13, 5%) and the highest rates in the Czech Republic, the Slovak Republic (22, 3%), Hungary and Slovenia (around 47%).

Main challenges – financial barrier

SRHR surveys record limited availability and the high cost of appropriate contraceptives as well as the lack of counseling services in Central and Eastern Europe. Financial accessibility is crucial in increasing contraceptive use and preventing unintended pregnancies and all their consequences. Safe motherhood programs tend to ignore the specific needs of rural women and women from ethnic minority groups, this in some cases leads to discriminatory practices. In most of the Central and Eastern European countries (Bulgaria, Croatia, Hungary,

Poland, Romania, and Slovakia) contraceptives are not covered by public health insurance making them inaccessible to many women and adolescent girls. Without appropriate education and counseling on the full range of contraceptive methods and pregnancy risks, women cannot make informed decisions regarding their use. The lack of accurate, unbiased and comprehensive information on modern contraceptives further inhibits their access.

Politics of disinformation

The Catholic and Orthodox Church hierarchies, which play an important role in politics and communities in many CEE countries, actively advocate against the use of modern contraceptives and promote traditional methods of family planning, such as periodic abstinence,

which are often ineffective. Gynecologists frequently lack the time or will to appropriately discuss contraceptives with their patients. As a result, misinformation and myths about the side effects of contraceptives abound, undermining their use.

7. Resolution 1763 on the right to conscientious objection clause in the legal care at <http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950>

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH – SEXUALITY EDUCATION

The lack of accurate, unbiased, and comprehensive information on family planning methods further inhibits women’s and adolescent girls’ access to modern contraceptives. In none of CEE countries young people receive reliable and science based sex education in schools. Although there are often many classes, which are meant to teach young people some issues regarding reproductive health (for example during biology classes or other “life skills” or “health basics” courses) none of them are entirely devoted to sex education and are usually voluntary. Sometimes even the word “sex” is especially avoided. Often the classes are influenced by ideology and/or religion (in Poland “Preparation for Family Life” classes are strongly influenced by the Catholic teachings). Various initiatives are however being implemented by Ministries of Health or Education and the NGO sector (i.e. in Croatia, Armenia, Azerbaijan). As the youth is not educated sufficiently on reproductive and sexual health they often turn for information to peers and the media. This often causes misunderstandings, produces and reiterates myths which can be harming to young people.

Sexual health of adolescents in the EU

The rate of teenage pregnancies is generally increasing in the EU (actual rate between 12 and 25 per 1000 girls aged 15-19 years), with the lowest rates to be found in Netherlands, and Belgium, the middle group is formed by Germany, France, Finland and Denmark and the highest rates are to be found in Sweden, Italy and England and Wales⁸. Within the EU, young people still do not have the same level of knowledge and skills in regard to sexuality. The differences in teenage pregnancy rates,

e.g. the UK 28 per 1000 girls aged 15-19 years and the Netherlands, 7 per 1000, are striking. In Eastern Europe, the lack of sexuality education contributes to the insufficient use of contraceptives. Overall, more adolescent health programmes are needed. In some countries like Latvia, Bulgaria and Poland parental authorization is needed for family planning services. In Poland, no sexuality education whatsoever exists.

HIV/AIDS PREVALENCE IN THE EU

HIV and the development of AIDS is a major health issue in the EU population. Between 2000 and 2007, newly diagnosed cases of HIV infections increased from 44 per million (14,483 cases) to 58 per million (19,435 cases) in 28 EU countries. In 2007, the EU (excluding Italy and Austria) reported 26,279 newly diagnosed cases of HIV infection (64.1/million), with the highest rates recorded in Estonia (472/million, 633 cases total), Portugal (217/million, 2,302 cases total), and Latvia (149/million, 338 cases total). Romania (7/million, 158 cases total) and Slovakia (7/million, 39 cases total) reported the lowest infection rates. Among women the predominant routes of transmission are heterosexual contact and injection drug use. Between 2003 and 2005 newly diagnosed HIV infections among female injection drug users declined from 623 to 496. However, newly diagnosed cases as a result of heterosexual contact increased from 6,231 to 7,377. In 2007, mother-to-child transmission resulted in 270 cases of HIV infections. Despite the increase in newly diagnosed cases of HIV, between 2000 and 2007 the number of AIDS cases in EU Member States continued to decline, dropping from 20.8/million to 9.3 /million, with the highest rates in Estonia (42.4/million), Portugal (30.2/million), and Latvia (23.7/million).

8. ASTRA Youth: Sexual and Reproductive Health and Rights of Adolescents in Central and Eastern Europe and Balkan Countries (Report 2011) at http://www.astra.org.pl/SRHR_of_adolescents_in_CEE_and_Balkan_countries_AY_2011.pdf

HIV/AIDS on a rise in CEE⁹

Eastern Europe and Central Asia is the only region in the world where HIV prevalence clearly remains on the rise. An estimated 110,000 [100,000–130,000] people were newly infected with HIV in 2008, bringing the number of people living with HIV in Eastern Europe and Central Asia to 1.5 million [1.4 million–1.7 million], compared to 900,000 [800,000–1,000,000] in 2001, a 66% increase over that time period. Ukraine and the Russian Federation are experiencing particularly severe and growing national epidemics. With adult HIV prevalence higher than 1.6%, Ukraine has the highest infection level reported in Europe. A number of countries in the region have expanded access to antiretroviral therapy,

although treatment coverage remains relative low. By December 2008, 22% of adults in need of antiretroviral therapy were receiving it - a level less than half the global average for low and middle-income countries (42%). Intravenous drug use remains the primary means of transmission in the region. In many countries, drug users frequently engage in sex work, magnifying the risk of transmission. With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among drug users to one that is increasingly characterized by significant sexual transmission.

Heterosexual transmission route

In Eastern Europe, heterosexual transmission was the source of 42% of newly diagnosed HIV infections in 2007¹⁰. According to a recent study in the Russian Federation, having sex with an intravenous drug user increased the odds of acquiring HIV by 360%. As the rate of heterosexual transmission has increased, gender disparities in HIV prevalence are narrowing. In Ukraine, women now represent 45% of all adults living with HIV. Heterosexual contact causes nearly two thirds of infections in women in Russia and accounts for an ever-growing proportion of new infections. In 2000, women

comprised 20.6% of new infections; in 2003, this figure was 38.5%; and in 2007, the proportion had grown to 44% or 135,000 cases. In Ukraine, the growth of heterosexual transmission as a proportion of total HIV incidences between 2001 and 2006 (28% to 35%) is largely attributable to unprotected sex. Regionally, half of HIV-positive women became infected by partners. Women living with HIV/AIDS face double stigma and discrimination, and regionally implemented harm-reduction programmes lack gender sensitivity.

INTERNATIONAL AND REGIONAL AGREEMENTS, STANDARDS AND POLICIES REGARDING SRHR

The UN and International Treaty Monitoring Bodies have addressed various reproductive and sexual health issues by issuing and reviewing their relevant Concluding Observations and General Comments or General Recommendations.

United Nations - key policy documents¹¹:

- Programme of Action (PoA) of the UN International Conference on Population and Development (ICPD)¹², Cairo, 1994 and its follow up session in 1999;
- Beijing Platform for Action¹³ (1995) and The Beijing Five-year Review (2000)¹⁴;
- The MDGs framework that promotes gender equality (MDG3), reduction of child mortality (MDG4) and improvement of maternal health (MDG5), with a specific target on universal access to reproductive health, and combating HIV/AIDS and other diseases (MDG6);

Council of Europe – key policy documents¹⁵:

- Resolution 1607 (2008) of Parliamentary Assembly of the Council of Europe (PACE) stating that the *“ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising the right in an effective way”*¹⁶;

EU – key policy documents¹⁷:

- The European Parliament’s (EP) resolution on the state of women’s health in the European Community (1997)¹⁸, where the European Parliament acknowledges that the conditions in which women can enjoy sexual and reproductive health vary significantly throughout the EU. The resolution appeals to the Member States to legalize induced abortion and to ensure that voluntary abortions are carried out in

11. The Declarations and the Programmes and Platforms for Action of international conferences are considered soft law, i.e. they are not legally binding like human rights treaties and conventions. They are, in fact, moral commitments made by signatory states and do not imply automatic integration into domestic law. These commitments result in external pressure to comply with a given agreement and, ultimately, political embarrassment for states that fail to comply. They are intended, therefore, while offering no guarantees, to promote enforcement inside national borders of the provisions of the international consensus.

12. Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant consensus documents. The rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (paragraph 7.3 Programme of Action)

13. The human right of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (paragraph 96, Platform for Action).

14. The Declarations and Programmes of Action of both the UN International Conference on Population and Development (Cairo, 1994) and the United Nations Fourth World Conference on Women (Beijing, 1995) mark a turning point in ways of thinking about sexuality and reproductive matters. In ICPD and FWCW, sexuality and reproductive health were for the first time considered from a human rights perspective. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) provides that states shall ensure men and women „...the same rights to decide freely and responsibly on the number and spacing of their children...”, guarantees access to necessary information and education, and entitles women and men to the means to control their family size. According to CEDAW Recommendation 21, family planning is understood as: guaranteed sex education, availability of family planning services, availability of safe and reliable methods of contraception, freely available and appropriate measures for the voluntary regulation of fertility for the health and well-being of all members of the family. In its General Comment (no.14, 2000) on article 12 of the UN International Covenant on Economic, Social and Cultural Rights dealing with the Right to the Highest Attainable Standard of Health, the Committee on Economic, Social and Cultural Rights recognizes the right to sexual and reproductive freedom, the right to access to education and information on sexual and reproductive health, and the availability, accessibility, acceptability and quality of health care facilities, goods and services.

15. The PACE’s resolutions are ultimately non-binding, they serve as an official viewpoint of PACE, and can be seen as a recommendation to member states and other European governmental bodies.

16. Parliamentary Assembly of the Council of Europe, Resolution 1607, April 16, 2008 (15th sitting). The resolution calls for specific changes including decriminalizing abortion, lifting other restrictions that block access to safe abortion, providing access to affordable contraception for men and women, and providing comprehensive sexuality education for young people.

17. The inclusion of SRHR in European policies is not systematic. The EP directives are legally binding documents that provide the Member States with a timetable for the implementation of the intended outcome. Non-legislative resolutions and reports provide recommendations for Member States.

18. Report on the state of women’s health in the European Community (COM(97)0224 - C4-0333/97). Rapporteur: Nel van Dijk at: <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+REPORT+A4-1998-0260+0+DOC+XML+V0//EN>

9. UNAIDS: Women, Girls and HIV, UNAIDS Factsheet, http://data.unaids.org/pub/Factsheet/2010/20100302_fs_womenhiv_en.pdf; AIDS Epidemic Update, December 2010; <http://www.unaids.org/en/Knowledge-Centre/HIVData/Epidupdate/EpiUpdarchive/2010/default.asp>

10. UNAIDS Global Report: http://www.unaids.org/globalreport/Global_report.htm

- a medically safe way and that psychological and social support is provided;
- The Charter of Fundamental Rights¹⁹ (2000) recognizes citizens' right to access preventive healthcare and the right to benefit from medical treatment;
- The EP's Report on Sexual and Reproductive Health and Rights (2002)²⁰ recommends that in order to safeguard women's reproductive health and rights, abortion "should be made legal, safe and accessible to all"²¹;
- The Council conclusions (2004)²² reaffirming commitment to the PoA, following the 10-year review of the programme in 2004. The conclusions called for more financing and support for sexual and reproductive health; urged specific attention to be paid to the right to reproductive health, and called especially for actions to prevent the increasing number of teenage pregnancies by making contraceptives more widely available for young people, making more use of information campaigns and improving the quality and accessibility of sex education;
- The Council conclusions (2005)²³ recognizing that sexual health issues, in particular maternal and child health, gender equality and HIV are key to meeting MDGs;
- EU Health Strategy (2008-2013)²⁴ including the objective of "promoting sexual health and encouraging the development of a healthy lifestyle regarding sexual behaviours".
- The EP's Annual Report on Human Rights in the World in 2009 and European Union's policy on the matter (2010)²⁵ insists "that women's rights be explicitly addressed in all human rights dialogues"²⁶; recalls "the Millennium Development Goals, and stresses that access to education and health are basic human rights; believes that health programmes, including sexual and reproductive health, promotion of gender equality, empowerment of women and rights of the child should be prominent in the EU's development and human rights policy, in particular where gender-based violence is pervasive and women and children are put at risk of HIV/AIDS, or denied access to information, prevention and/or treatment"²⁷; and welcomes the UN Human Rights Council resolution of 16 June 2009 on preventable maternal mortality and morbidity and human rights, which calls for urgent action in line with the Millennium Development Goals to prevent women from dying needlessly in pregnancy and childbirth; notes that the resolution was supported by the EU Member States, and calls on them effectively to promote the protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health²⁸;
- The Commission's report Data and Information on Women's Health in the European Union (2009)²⁹ notes that "abortion services are limited in some Eastern European countries";
- The EP's Report on equality between women and men in the European Union – 2009 (2010)³⁰ "emphasizes that women must have control over their sexual and reproductive rights, notably through easy access to contraception and abortion; emphasizes that women must have access free of charge to consultation on abortion; supports measures and actions to improve women's access to sexual and reproductive health services and to raise their awareness of their rights and of available services; invites the Member States and the Commission to implement measures and actions to make men more aware of their responsibilities in relation to sexual and reproductive matters";
- The EP's resolution on Beijing +15 - UN Platform for Action for Gender Equality (2010)³¹ stating that "efforts must be made to strengthen sexual and reproductive health and rights in Europe and globally, as an integral part of the women's rights agenda";
- Women's Charter (2010)³² strengthening and deepening the European Commission's commitment to equality between women and men³³. This political declaration sets out five key areas for action³⁴ and commits the Commission to building a gender perspective into all its policies for the next five years while taking specific measures to promote equality. The full access to SRHR is crucial for achieving all fields for action delineated by the Charter (economic independence, equal pay, representation of women in decision-making and positions of power, respect for women's dignity and integrity, ending gender-based violence). Furthermore, the Charter reiterates the Commission's commitment to fundamental rights. The Commission's action is specifically aimed at eliminating inequality in access to healthcare and eradicating all forms of gender-based violence.
- Strategy for equality between women and men 2010-2015 (2010)³⁵ outlining the key actions planned for the period 2010-2015: economic independence of women; equal pay; equality in decision-making; dignity, integrity and ending gender-based violence; promotion of gender equality in external relations and horizontal issues³⁶.
- The EP's Report on equality between women and men in the European Union – 2010 (2011)³⁷ "advocates access for women and men to adequate information and support on reproductive health, and stresses that women should have the same rights and

19. The Charter of Fundamental Rights at http://www.europarl.europa.eu/charter/default_en.htm

20. Report on Sexual and Reproductive Health and Rights (2001/2128 (INI)) Committee on Women's Rights and Equal Opportunities Rapporteur: Anne E.M. Van Lancker. Non-legislative report and non-legislative resolution on sexual and reproductive health and rights. Parliament recommended that Member States and candidate countries develop a high quality national policy on sexual and reproductive health, in cooperation with plural civil society organisations. They must provide comprehensive information concerning effective and responsible methods of family planning, and ensuring equal access to all forms of high quality contraceptive methods as well as fertility awareness methods. Access to the morning-after pill should be facilitated. Parliament also urged research in the field of male contraception. Finally, it drew attention to the devastating impact of the Mexico City Policy of the Bush Administration, which denies funding to NGOs referring women to abortion clinics as a last resort. The effects are felt especially with regard to programmes for Central and Eastern Europe. The Commission is asked to fill in the budgetary gap provoked by the Mexico City Policy.

21. Despite a strong opposition fuelled by anti-choice activists, a clear majority of the European Parliament supported the report, (280 in favour, 240 against and 28 abstentions), sending a firm international signal that it intends to fight for the right of all people to have healthy and satisfying sex lives.

22. Council Conclusions on Renewed EU Commitment To ICPD in the Context of the Millennium Development Goals (MDGs) at <http://register.consilium.europa.eu/pdf/en/04/st15/st15157.en04.pdf>

23. Conclusions of the Council on Accelerating Progress Towards Attaining the Millennium Development Goals at <http://register.consilium.europa.eu/pdf/en/05/st09/st09266.en05.pdf>

24. The EU Health Strategy (2008-2013) at http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf

25. European Parliament resolution of 16 December 2010 on the Annual Report on Human Rights in the World 2009 and the European Union's policy on the matter (2010/2202(INI)) at

<http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2010-0489&language=EN>

26. *ibidem*, para 76.

27. *ibidem*, para 77.

28. *ibidem*, para 7

29. Data and Information on Women's Health in the European Union at http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf

30. Report on equality between women and men in the European Union – 2009. Rapporteur: Marc Tarabella at <http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&reference=A7-2010-0004&language=EN>

31. European Parliament resolution of 25 February 2010 on Beijing +15 – UN Platform for Action for Gender Equality at <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2010-0037+0+DOC+XML+V0//EN>

32. Women's Charter [COM(2010) 78 final - Not published in the Official Journal].

33. „This Charter represents the commitment of the Commission to making gender equality a reality in the EU. Women and men still face widespread inequalities, with serious repercussions for economic and social cohesion, sustainable growth and competitiveness, and the ageing of Europe's population. It is therefore important to include a strong gender dimension in the future Europe 2020 strategy that the Commission will develop in the next five years. Especially in times of crisis, we need to incorporate the gender dimension in all of our policies, for the benefit of both women and men,” President José Manuel Barroso at: <http://europa.eu/rapid/pressReleasesAction.do?reference=SPEECH/10/71>

34. (1) Equality in the labour market and equal economic independence for women and men, namely through the Europe 2020 strategy; (2) equal pay for equal work and work of equal value by working with Member States to reduce significantly the gender pay gap over the next five years; (3) equality in decision-making through EU incentive measures; (4) dignity, integrity and an end to gender-based violence through a comprehensive policy framework; (5) gender equality beyond the EU by pursuing the issue in external relations and with international organisations.

Strategy for equality between women and men 2010-2015 [COM(2010) 491 final – Not published in the Official Journal].

35. The Commission has committed itself to monitor gender issues in the field of health in order to assure realization of the key actions. The Commission is committed to progressing equal treatment between women and men, paying particular attention to: the role of men in gender equality; disseminating good practice on redefining gender roles in youth, education, culture and sport; the correct implementation of European legislation, particularly Directive 2004/113/EC on equal treatment in the access to and supply of goods and services and Directive 2006/54/EC on equal opportunities; the governance and tools of gender equality, particularly through the drafting of an annual report on gender equality in order to contribute to a yearly top-level Gender Equality Dialogue involving the European Parliament, the Commission, Member States and key stakeholders. This Strategy also acts a basis for the cooperation between the Commission and the other European institutions, Member States and other stakeholders, as part of the European Pact for equality between women and men.

36. Report on equality between women and men in the European Union – 2010. Rapporteur Rapporteur: Mariya Nedelcheva at <http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&reference=A7-2011-0029&language=EN>

37. New European Pact for equality between women and men for the period 2011 – 2020 at http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/119630.pdf

childcare services and promote flexible working arrangements; strengthen the prevention of violence against women and the protection of victims, and focus on the role of men and boys in order to eradicate violence;

- New European Pact for equality between women and men for the period 2011 – 2020 (2011)³⁸ urging action by the Member States and the Union, by taking measures to: eliminate gender stereotypes, ensure equal pay for equal work and promote the equal participation of women in decision-making; improve the supply of affordable and high-quality childcare services and promote flexible working arrangements; strengthen the prevention of

violence against women and the protection of victims, and focus on the role of men and boys in order to eradicate violence;

- The EP's Report on Reducing Health Inequalities in the EU (2011) states that *"the EU and the Member States should guarantee women easy access to methods of contraception and the right to safe abortion"*³⁹
- EU Directive on patient's rights in cross-border healthcare⁴⁰. The directive strengthens the EU integration in the field of health protection of its citizens. The directive increases possibilities to seek healthcare in another Member State and strengthens cooperation in different areas, such as networks of centers of reference for specialized care⁴¹.

Gender equality in the EU

Among international organizations the EU stands out in its support for gender equality. The Lisbon Treaty considers *"equality between women and men"* among its core values and objectives and since 1996 the EU has committed to integrate gender considerations into all aspects of its operations and policies. It has been recognized that *"gender equality cannot be achieved without guaranteeing women's sexual and reproductive health information and health services are essential for achieving the Beijing Platform for Action, the Cairo Program of Action and the Millennium Development Goals"*³⁹. The idea of women's rights as human rights was being viewed as highly needed for the empowerment of women and

important for the progress of society in general. In its resolution on the follow-up to the ICPD Conference⁴⁴, the EP calls for the EU to play a leading role in promoting the creation of networks, research and information exchange facilities concerning reproductive health care. The EU's policy documents constitute a significant step forward in ensuring equitable access to healthcare. Even if the above mentioned texts are not legally binding for the EU Member States, they send a clear message from the only directly elected body of the EU to European and national decision-makers to protect the rights to access sexual and reproductive health services and supplies.

Lisbon Treaty's impact

Furthermore, the entry into force of the Lisbon Treaty represents a historic opportunity to address the remaining gaps in the EU's human rights and democracy

policy: the Treaty provides the EU with a single legal personality, which will allow it to accede to the European Convention on Human Rights and enable the European

39. REPORT on reducing health inequalities in the EU (2010/2089(INI)), Committee on the Environment, Public Health and Food Safety, Rapporteur: Edite Estrela; <http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&reference=A7-2011-0032&language=EN>

40. Directive 2011/24/EU of the EP and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare at <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>. The directive clarifies the rules for receiving cross-border healthcare and reimbursement of these costs. The Directive was formally adopted by the EP and the Council in 2011, and all Member States have to implement it by November 2013.

41. The directive can be used to advance women's access to SRHR services and can improve the access to abortion. Due to the restrictive law access to abortion is limited, moreover even women who are legally entitled to abortion are often denied access to services (e.g. Poland). It is assumed, once the directive is implemented, women will be given the opportunity to seek the services abroad, and the state of a woman's origin will be obliged to reimburse the costs of services.

42. Declaration of the European Union Conference of Ministers of Gender Equality, Luxembourg, 4 February 2005

43. The European Parliament(EP) has also committed itself to the Programme of Action (PoA) of the International Conference on Population and Development (ICPD). In 1994 it passed a resolution supporting the ICPD PoA, and in 1996 another resolution supporting the implementation of the Cairo PoA.

44. Entered into force on the 1, December 2009.

Court of Human Rights (ECHR) in Strasbourg to verify compliance by EU acts with the Convention. Moreover, with the entry into force of the Treaty of Lisbon, the EU's Charter of Fundamental Rights became legally binding, thus strengthening protection of human rights in Europe. The Charter of Fundamental Rights of the European Union can be utilized to advance SRHR as it upholds many human rights that can be adopted for the SRHR field, for example: the right to respect for his or her physical and mental integrity (Art 3), respect for private and family life (Art 7), freedom of expression and information (Art 11) and non-discrimination (Art

21), equality (Art 23) and right to access to health care (Art 35). The Charter reaffirms these rights as they exist in current treaties, including the European Convention for the Protection of Human Rights and Fundamental Freedoms, and in the case-law of the European Court of Justice and the European Court of Human Rights. Human dignity, freedom, democracy, equality, the rule of law and the respect for human rights: these are the core values of the EU, which are set out at the beginning of the Treaty of Lisbon. They are common to all Member States, and any European country wishing to become a member of the Union must respect them⁴⁵.

SRHR agenda in the European Parliament

The EP has played an important role in promoting human rights and SRHR in particular. This role, however, has been primarily limited to advancing SRHR within the EU's development policy and has not been effectively applied to policies and practices within EU member states themselves.

The Committee on Women's Rights and Equal Opportunities of the EP has certain powers and responsibilities in the EU. They include the evaluation and implementation of women's rights in the EU, and follow-up and implementation of international agreements and conventions involving the rights of women. It is extremely important to stress the human rights perspective while advocating for SRHR.

However, commitments to progressive policies in the field of SRHR are not universal within the EU Member States' programmes and policies. New Member States, but also some of the 'old' ones, bring different experiences and perspectives and, in some cases, different approaches to SRHR issues. In many new Member States, there is tension between the way SRHR is treated on the conservative domestic agenda and the way it is treated on the international agenda – despite the fact that most new Member States' governments ratified international agreements related to SRHR, including CEDAW and the ICPD Programme of Action. And it is increasingly clear that support for SRHR issues within the EU is not as strong as it used to be.

ASTRA mission: SRHR monitoring in the EU

ASTRA has monitored the SRHR-related developments on the EU arena for 12 years and has advocated for advancement of SRHR in Central and Eastern Europe. ASTRA acknowledges that the EU has always played an important role in promoting sexual and reproductive health and rights. Although reproductive health policies remain merely within the competence of the Member States, the EU could add value by launching a process of mutual learning, based on comparisons of reproductive

health data and on sharing positive experiences and best practices in Member States' sexual and reproductive health programmes and policies. It is important to stress, however, that an inter-sectoral approach is most effective as SRHR issues are complex and will only be effectively addressed if all the relevant EU institutions acknowledge their responsibility to tackle SRHR and coordinate efforts to advance and promote SRHR in the European Union.

45. The UK and Poland are not bound by the Charter.

ASTRA RECOMMENDATIONS

While we welcome occasional mentions of SRHR in documents issued by the EU institutions, we are growingly worried observing the shift as it regards the EU's investment in sexual and reproductive health. SRHR mostly appears in the development aid context and while being aware of the importance of promoting synergies between development and SRHR policies, we call on the EP to address the disparities in sexual and reproductive health and rights within the EU and within the Member States. It is essential to address the huge inequalities experienced by European women in terms of access to reproductive health services, contraception and abortion. The European Parliament has dealt only summarily with the differences in the situation regarding access to SRHR in the various Member States, and, in particular, has not examined the problem of backstreet abortion, especially where practiced without even minimal standards of hygiene, and of its consequences, which currently affect hundreds of thousands of women throughout the Community.

Taking into consideration that the most recent complex EU document addressing SRHR was issued almost a decade ago, ASTRA is of the opinion that the European Parliament should put forward concrete proposals, within its competences, to deal with the following issues:

- Drafting a second report on sexual and reproductive rights based on monitoring of the status of SRHR in Europe in the context of EP decisions and commitments;
- Calling on Member States to (1) guarantee women's sexual rights; (2) bolster sex education programmes,

especially those aimed at younger people; (3) guarantee the free provision of contraceptives and the dissemination of information on the different types of contraception at schools and higher education institutions; (4) make greater efforts in respect of specific preventive action to reduce HIV infection among women; (5) legalize induced abortion on the principle that it must be the woman herself who takes the final decision;

- Putting more pressure on the Member States to implement the existing Directives and Programmes dealing with elimination of inequality in these areas, through the legal system and by taking the necessary measures to ensure their effectiveness in the socio-economic domain;
- Taking measures to ensure the compliance of Member States' national laws and policies with international human rights standards and World Health Organization recommendations calling on states to ensure access to a wide range of family planning services by making them accessible and affordable to all;
- Urging Member States to abide to their human rights obligations;
- Increasing political will within in the EU structures and in EU Member States to recognize that the EU has the mandate and responsibility to address SRHR issues within its entire territory.
- Implement fully the EU commitments made in Cairo and Beijing before the Cairo+20 Summit in 2014.

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ASTRA - Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights is a regional network created in December 1999 by women's rights organizations and activists from Central and Eastern Europe. Currently ASTRA consists of 28 organizations from 17 countries.

ASTRA mission

ASTRA advocates for full implementation of sexual and reproductive health and rights (SRHR) with special focus on specific reality of SRHR of women in Central and Eastern Europe. ASTRA aims at the prioritization of SR HR on international, regional and national agendas, in particular in the EU and UN institutions. ASTRA works towards transforming gender power relations in society so that women, girls, men and boys can enjoy their sexual and reproductive rights, and are equal, free and live in dignity.

ASTRA activities:

1. Organizing international seminars, conferences and public events: i.e. Women and HIV in CEE. Bringing different communities together (2005), two hearings in the European Parliament on SRHR in Central and Eastern Europe (2006, 2009), Conference on Youth Sexuality (2008).
2. Organizing capacity-building trainings and workshops e.g. on Human Rights Instruments (2003), on Advocacy at the Council of Europe (2009), on Integration of HIV/AIDS and Gender Equality issues (2010).
3. Publishing the monthly e-bulletin "CEE Bulletin on Sexual and Reproductive Health and Rights" as well as reports, guides and fact-sheets, e.g. Guide on How to use the European Convention for the Protection of Human Rights and Fundamental Freedoms in matters of reproductive law (2004), Report on Sexual and Reproductive Health and Rights and Gender Equality: Fundamentals of Demography Policies in Europe (2007).
4. Preparing numerous letters and position statements addressing the UN and EU institutions related to current developments in the area of SRHR, i.e. regarding the EU's anti-discrimination horizontal directive and cross-border health care directive.
5. Advocacy for SRHR agreements in the context of relevant international events - participation in the international conferences addressing women's rights, reproductive health and rights, sexuality, gender issues and population policies.
6. Supporting ASTRA Youth network, affiliated with ASTRA which gathers young activists from the Central and Eastern Europe and Balkan region.

ASTRA partners include: Center for Reproductive Rights (CRR), International Women's Health Coalition (IWHC), Association of Women's Rights in Development (AWID), EuroNGOs.

ASTRA Members:

Albanian Center for Population and Development, Albania
Women's Rights Center of Armenia, Armenia
Center "Women and Modern World", Azerbaijan
Women's Independent Democratic Movement of Belarus, Belarus
Bulgarian Family Planning and Sexual Health Association (BFPA), Bulgaria
Demetra Association, Bulgaria
Gender Education, Research and Technologies, Bulgaria
Bulgarian Gender Research Foundation, Bulgaria
B.a.b.e.- Be active be emancipated, Croatia
CESI – Center for Education and Counseling and Research, Croatia
Women's Room – Center for Sexual Rights, Croatia
Women's Center, Georgia
The Legal Center for Women's Initiatives "Sana Sezim", Kazakhstan
Family Planning and Sexual Health Association of Latvia, Latvia
Family Planning and Sexual Health Association of Lithuania, Lithuania
Shelter Centar – Macedonian Women's Rights Centre, Macedonia
Reproductive Health Training Center, Moldova
Federation for Women and Family Planning, Poland
The East European Institute for Reproductive Health, Romania
Asociatia pentru Libertate si Egalitate de Gen - A.L.E.G., Romania
ECPI - Euroregional Center for Public Initiatives, Romania
AnA: Romanian Society for Feminist Analysis, Romania
Institute of State and Law, Russian Academy of Sciences, Russia
Novgorod Gender Center, Russia
ANO "Women's Health", Russia
Pro Choice, Slovakia
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