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# **European Union's attitude towards reproductive rights: clear policy or double standards approach?**

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## **Abstract**

Reproductive rights have only recently, and not unanimously, been recognized in the international arena, as a legitimate application of the human rights discourse to reproduction and sexuality. The international conferences held in Cairo and Beijing contributed to the formalisation of this concept and supported the shift towards a paradigm that considers reproduction as an autonomous choice.

The scope of this dissertation has been to analyse how reproductive rights have been approached by the European Union in its relations with the Member States and with Third countries, in order to evaluate the extent of coherence between these two approaches.

While on health protection, the EU clearly lacks a competence to act; in terms of human rights, a number of existing provisions could potentially be applied to reproduction, but this process will depend from the interpretative work of the European Courts. The EU's cautious approach within its borders has been counterbalanced by an assertive endorsement of reproductive rights as human rights in its external policies, through the adoption of a number of instruments and through the translation of this commitment into its development policy. An outline of the potential consequences of this double standards approach in terms of human rights protection will be provided, to support the necessity of a more coherent EU's action.

## Table of Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CFREU	Charter of Fundamental Rights of the European Union
CJEU	Court of Justice of the European Union
ECtHR	European Court of Human Rights
ECHR	European Convention on Human Rights
EU	European Union
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IVF	In Vitro Fertilisation
MDG	Millennium Development Goals
RR	Reproductive Rights
SRR	Sexual and Reproductive Rights
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
UDHR	Universal Declaration of Human Rights
UN	United Nations

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## 1. Introduction

During its October 2013 session, the plenary of the European Parliament sent back a report on sexual and reproductive health and rights<sup>1</sup>, whose text called *inter alia* for safe and legal abortion services (para.33); comprehensive sexuality education (para.39); teaching about negative lesbian, gay, bisexual, transgender, intersexual (LGBTI) stereotypes (para.51); and the prevention and treatment of sexually transmitted infections (STIs) (para.55).

Before the vote, the Report had become the focus of an intense lobbying campaign by religious and conservatives groups that suggested, for instance, that the report would force Member States to change abortion rules, or include mandatory teaching about masturbation to 0-4 year-olds.<sup>2</sup>

Nevertheless, in the same plenary session, the Parliament adopted a Resolution on human rights in the Sahel region<sup>3</sup> that called on the Commission, the European External Action Service (EEAS) and the Council “to encourage more countries in the region to make explicit statutory provisions for women’s and girls’ rights and to prioritise programmes that would secure those rights, in particular access to public services, including in the field of education, access to health, sexual and reproductive rights” (para. 86).

This temporal coincidence provides with a hint about the difficulties of the European Union (EU) and its Member States in facing a sensitive topic such as sexual and reproductive rights. Its adhesion to the European Charter of Fundamental Rights and other international human rights instruments, force the Union to stand against violations of human rights also in the field of sexuality and reproduction. On the other side, the

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<sup>1</sup> European Parliament Committee on Women's Rights and Gender Equality, Report on Sexual and Reproductive Rights, 3 December 2013, A7-0426/2013. The text had been authored by Edita Estrela, a Portuguese parliamentarian, and presented on behalf of the Committee on Women’s Rights and Gender Equality.

<sup>2</sup> European Parliament Intergroup on LGBT rights, *Religious and political conservatives block vote on reproductive health and rights report*, 2013. A revised Report has been proposed afterwards to the Parliament in December and it has been rejected, while a new Resolution stating that “the formulation and implementation of policies on sexual and reproductive health and rights and on sexual education in schools is a competence of the Member States” was approved. European Parliament, Resolution on Sexual and reproductive health and rights, Amendment 2, 10 December 2013, P7\_TA (2013)0548, para.1.

<sup>3</sup> European Parliament, Resolution on the situation of human rights in the Sahel region, 22 October 2013, P7\_TA (2013)0431.

fierce opposition of Member States against the involvement of the Union in what is considered an internal matter and the strong lobbying by a part of the civil society tell to Bruxelles that there is a wide gap between what is intended for human rights by the different stakeholders when it comes to sexuality and reproduction, and that formal adhesion to human rights law instruments is not expected to give birth to practical commitments when it comes to these issues. Yet, the involvement of the Union on these topics in its external relations has been continuous and relevant. Not only, as depicted above, through political recommendations to States for a greater effort in this direction, but also through its development policy and aid delivery.

This alleged schizophrenia and the more general attitude of the EU towards reproductive rights are the object of this dissertation. The purpose of the thesis is to analyse the position held by the EU on reproductive rights in its internal and external relations, to evaluate to what extent coherence between the two approaches is guaranteed. The necessity of coherence between what is done within and outside the EU border has been underlined in numerous occasions by the EU institutions<sup>4</sup>, and it has been described as one of the grounds upon which the EU “substantial political and moral weight” rests.<sup>5</sup> This guarantees, in turn, influence and leverage, which can be deployed “on behalf of human rights and democratisation”.<sup>6</sup>

The second chapter will give a brief overview over the concept of *reproductive rights*, its birth, evolution and employment in the international agenda, in order to better define the content of this theoretical construct. To do so, a short parallel analysis of the concept of *sexual rights* will be done, given the strong interrelation between the two concepts that is furthermore tangled by a contradictory use of the terms by different stakeholders.

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<sup>4</sup> See, *inter alia*, Commission of the European Communities, Communication from the Commission to the Council and the European Parliament, on *The European Union's role in promoting human rights and democratisation in Third countries*, 8 May 2001, COM(2001) 252 final, p.3; Council of the European Union, *EU Annual Report on Human Rights 2001*, pp.45-46; and European Parliament Committee on Civil Liberties and Internal Affairs, *Annual Report on Respect for Human Rights in the European Union* (1997), 2 December 2008, A4-0468/98, para. 2.

<sup>5</sup> Commission of the European Communities, Communication from the Commission to the Council and the European Parliament, on *The European Union's role in promoting human rights and democratisation in Third countries*, 8 May 2001, COM(2001) 252 final, pp. 3-4.

<sup>6</sup> *Ibidem*.



A key phase of the outlined process will then be analysed, that is to say the transition in the approach towards reproduction, that led to see reproduction not anymore as merely a health issue but also as the object of human rights concern. The scope is to describe these two different approaches and better define the rights-based approach that will be employed in the final section. The final section of the second chapter will explore concretely to what extent a rights-based approach can be applied to reproduction: a list of fundamental rights will be examined to test their applicability to reproductive issues and, from this analysis, a conclusion will be drawn on the key role played by knowledge, in its various conjugations, for the exercise of these rights.

The third chapter will be devoted to the analysis of the EU's approach towards reproductive rights within its borders. The analysis will take into consideration two approaches: one that handles reproduction as a mere public health issue and the other that considers reproduction as a human rights concern.

The first part of the third chapter will explore the connection between human rights and reproduction grounding on the analysis of two fundamental texts such as the Charter of Fundamental Rights of the European Union (CFREU) and the European Convention on Human Rights (ECHR) and on their interpretation provided by the jurisprudence of the European Court of Justice (ECJ) and the European Court on Human Rights (ECtHR).

The second part of the third chapter will scrutinise to what extent reproduction has been handled by the EU as a public health issue, by analysing the competence of the EU in this field and exploring some actions implemented by the EU concerning reproduction.

These two approaches will help define the EU's internal policy on reproductive rights that will be instrumental to evaluate the coherence with the external approach, outlined in the fourth chapter.

The fourth chapter will therefore aim at assessing the involvement of the EU concerning reproductive rights in its external action, by analysing the most relevant commitments taken by the EU at international level and some examples concerning the translation of this commitment into EU policies affecting the relations with Third countries. Given the broad network of external relations and the number of policies

regulating them, the development policy has been chosen as object of the analysis due to its relevant role in the promotion of human rights in Third countries.<sup>7</sup>

Where information are available, a specific focus will be maintained, throughout the dissertation, on knowledge as a key component for the exercise of reproductive rights.

In the last chapter, a synthesis of the findings will be provided together with some conclusions about the implications of the EU's approach towards reproductive rights in its internal and external relations.

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<sup>7</sup> A more extensive explanation of this choice will be provided in Chapter 4.

## **2. Reproductive rights: when human rights meet sexuality and reproduction**

This second chapter is aimed at defining the central topic around which the dissertation is developed, that is to say reproduction and reproductive rights. To achieve this objective, three steps will be taken. At first, the *reproductive rights* (RR) concept will be investigated: its origin, its employment in the international arena and its evolution will be analysed in order to fill this concept with content. By doing so, part of the text will deal with the concept of *sexual rights* given the strong interrelation between the two concepts, which is nurtured by a natural bond between sexuality and reproduction and by the contradictory employment of these concepts by various stakeholders.

The second part will focus on a key phase of the outlined process that is the transition in the approaches towards reproduction. The scope is to introduce the rights-based approach that will be later employed and to argue that reproductive choices are not merely the outcome of health-based considerations, but they touch upon different spheres of an individual's life and different rights.

The final part will explore how this rights-based approach can be applied to reproduction: a list of fundamental rights will be analysed to evaluate to what extent these provisions can be employed while dealing with reproductive issues. A specific focus will be maintained, when it comes to reproductive choices, on the role played by knowledge in its different conjugations: information, counselling and education.

### **2.1. Origin and evolution of reproductive rights as a concept**

The term *sexual and reproductive rights* (SRR) has generally been used to refer to the application of human rights to the fields of sexuality and reproduction.<sup>8</sup> This basic definition already enshrines a doubt concerning the distinction between sexuality and reproduction, and the contingent need for such a differentiation.

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<sup>8</sup> One example can be the International Planned Parenthood Federation Charter on Sexual and Reproductive Rights (London: IPPF, 1996), p. 18. Concerning only reproductive rights, see also, *inter alia*, UN Population Fund, *Report of the International Conference on Population and Development*, Cairo 5-13 September 1994, A/CONF.171/13/Rev.1, para. 7.3; United Nations, *Report of the Fourth World Conference on Women*, Beijing 4-15 September 1995, A/CONF.177/20/Rev.1, para. 95; and Cook & Fathalla, 1996, pp.115-117.

Indeed, it can be argued that the concept of sexuality is broader and it includes reproduction, the contrary, or even that these concepts are so naturally intertwined that is difficult to discern their content in a functional way. Moreover, when dealing with the literature about SRR, one can frequently find mentioned the ideas of sexual health and reproductive health.<sup>9</sup> Finally, to add hurdles to a precise understanding of these concepts, the four terms (reproductive health and rights, and sexual health and rights) are currently being used interchangeably to favour simplification and a popularisation of the related claims.<sup>10</sup>

Surely, the terms *sexual rights* and *reproductive rights* share a common doctrinal framework since they both envisage the application of the same range of human rights to sexuality and reproduction: namely, *inter alia*, the right to life and right to health, freedom from torture and inhuman and degrading treatment, freedom of expression, right to education; economic rights and privacy rights as well as freedom from discrimination.<sup>11</sup>

Despite this application of common principles, the two categories showed a *distinct advocacy genealogy*<sup>12</sup> since their theorization and development as concepts have followed different ways: *reproductive rights* have been strongly connected with the idea of health and family planning, being therefore conceived as natural rights, while sexual rights, given the more recent appearance in the public discourse, have been referred to as socially constructed.<sup>13</sup>

Given this seemingly more *natural* character, RR enjoyed an earlier formal acknowledgment in the international arena in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The resulting Programme of Action (hereinafter, the Cairo Programme) defined reproductive rights as resting “on the recognition of the basic right of all couples and individuals to decide freely and

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<sup>9</sup> In various texts, reproductive health is described as partially comprising sexual health since under the concept of reproductive health and reproductive freedom is ascribed the right to choose “not to reproduce”. Cook et al, 2003, p.13.; Eriksson, 2000, p. 240. The concept of health in relation to sexuality and reproduction will be extensively analysed in the next subchapter.

<sup>10</sup> Corrêa, S., 1997, p.108.

<sup>11</sup> Cook & Fathalla, 1996, pp.115-121.

<sup>12</sup> Miller & Roseman, 2011, p.104.

<sup>13</sup> Ibidem.

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. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”<sup>14</sup>

The definition was conceived in strict connection with the concept of reproductive health, intended as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”<sup>15</sup>.

This first definition represented a milestone and is often mentioned among the achievements concerning women’s rights that connoted the last decade of the 20<sup>th</sup> century, sometimes called the United Nations (UN) Decade for Women<sup>16</sup>, together with the recognition that women’s rights are human rights and that violence on women is a violation of human rights.<sup>17</sup>

Although the Programme was adopted by 184 United Nations (UN) Member States, revealing a broad consensus on the necessity to address these issues, some aspects remained controversial and a strong effort on language negotiation had to be put on some provisions. Most notably, several reservations were made by States about the employment of the term *individuals* and *family* that could be misinterpreted in order to allow same-sex relationships.<sup>18</sup> Language negotiation concerned particularly the right to access abortion, which was afterwards intended as bipartite: where abortion was legal, it had to be accessible; where illegal, women should not die because of the effects of unsafe abortion.<sup>19</sup>

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<sup>14</sup> UN Population Fund, *Report of the International Conference on Population and Development*, Cairo 5-13 September 1994, A/CONF.171/13/Rev.1, para. 7.2.

<sup>15</sup> Ibidem.

<sup>16</sup> Nowicka, 2011, p.119.

<sup>17</sup> World Conference on Human Rights, Vienna Declaration and Programme of Action, 14-25 June 1993, A/CONF.157/23.

<sup>18</sup> Supranote (14). Part Two, Chapter One.

<sup>19</sup> Berer, 2009, pp.152-163.

If RR are clearly mentioned in this text, the conceptualization of *sexual rights* followed a less linear path. Before the 1990s, sexuality as such was not present in human rights discourses and “sexual life was acknowledged only implicitly and then confined within the bounds of heterosexual marriage and reproduction”<sup>20</sup>. The Vienna Conference in 1993 turned out to be a turning point, although sexuality was approached with a mere focus on its negative aspects, namely on all forms of gender based violence and sexual harassment and exploitation, and the responsibility of the international community in addressing these issues. The same approach was reiterated in the context of the Declaration on the Elimination of Violence against Women, passed the same year that upheld a strong condemnation of sexual violence against women.<sup>21</sup>

Following this trend, sexual rights were not included in the Cairo Programme but sexual health was mentioned, intended as an integral part of reproductive health and requiring “that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so” (para. 7.2). The positive light shed for the first time on sexuality was confirmed by the purpose of sexual health described as “the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases”(para. 7.2). Although sexual activity was therefore recognised for the first time as a positive aspect of our society<sup>22</sup>, Corrêa has described the inherent difficulties of this process by revealing that, during the ICPD preparatory process, feminists lobbied official delegations for the inclusion of “sexual rights” in the text aiming instead at retaining the words “reproductive rights”, which was at stake, in the final draft.<sup>23</sup>

The Beijing Fourth World Conference on Women in 1995 was considered the first step in the integration of the concept of sexual rights in the international arena. The

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<sup>20</sup> Petchesky in Parker et al, 2000, p.83.

<sup>21</sup> United Nations General Assembly, Declaration on the Elimination of Violence against Women, adopted on 20 December 1993, A/RES/48/104, para. 2.

<sup>22</sup> Petchesky acknowledges the merit of the feminist coalition lobbying in Cairo in “transforming the discourse of reproductive rights from a Westernist code for abortion into an international United Nations language denoting women’s human right to self-determination over their fertility, motherhood and, to a limited degree, sexuality”. Petchesky in Parker et al, 2000, p.86.

<sup>23</sup> Corrêa, 1997, p.109.

Declaration and Platform for Action<sup>24</sup> produced during the conference enshrined a first definition of sexual rights, which states: “The human rights 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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences” (Annex II, para. 96).

Despite some shortcomings (e.g. the absence of sexual orientation, women as the only targeted group<sup>25</sup>), the text had the merit of acknowledging the right of every woman to decide autonomously about sexuality without any requirement in terms of age, marital status or other status (Annex II, para. 96). It is relevant to underline that, as previously told, the concepts of sexual health and sexual rights were not acknowledged the same legitimacy from the beginning: sexual health was, indeed, already mentioned in the Cairo Programme and generally better accepted because of the growing concern of the international community towards sexually transmitted infections (STIs).<sup>26</sup>

Political and cultural changes in societies contributed to the evolution and the upgrade of *sexual rights* as a concept: on one side, the link between sexuality, reproduction and inequalities between sexes led to the birth of the concept of sexual self-determination, while on the other side, the mobilization of the LGBTI communities supported the expansion of the applicable grounds of discrimination. In terms of *sexual rights*, the standard of legitimacy has also arguably moved in favour of affirming principles of

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<sup>24</sup> The Fourth World Conference adopted the Beijing Declaration and Platform for Action through Resolution 1: the Declaration enshrines the basic principles agreed to, while the Platform of Action is a programmatic document containing a series of objectives and the actions to be undertaken to reach them. The text of the Resolution is part of a broader Report produced by the Conference. United Nations, Report of the Fourth World Conference on Women, Beijing 4-15 September 1995, A/CONF.177/20/Rev.1.

<sup>25</sup> Women can be considered the primary interest parties in reproductive rights because it's women's bodies which become pregnant. Nonetheless, reproductive health is an important component of both genders' health. It is more critical for women because “a major burden of disease is related to their reproductive function and reproductive potential, and the way in which society treats or mistreats women because of their gender” Cook et al, 2003, p.8.

<sup>26</sup> Petchesky, 2000, p.84 in Parker et al; Corrêa, S., 1997, p.109.

autonomy, consent and non-discrimination benefiting from the progressive application of a rights-based approach to these issues.<sup>27</sup>

The rights-based approach has therefore contributed to expand sexual rights' legitimacy more beyond a concept including mere freedom from sexual violence or sex as instrumental to reproduction within marital relationships, to focus more on individual preferences and decisions. Therefore, the concept expanded to include rights associated with men and women, different sexual conducts and orientations, as well as claims related to the choice to link sex and reproduction or not.<sup>28</sup>

The current stage of this evolution is represented by the contemporary sexual rights movement, that has overtaken the perception of sexuality as a "health issue" and that has laid claim to a concept of sexual rights that avoid hierarchies among rights and the normalisation of certain rights (typically hetero-related rights) but not of others, in an exclusionary way.<sup>29</sup>

This intertwined evolution of reproductive and sexual rights has contributed to a general confusion about the employment of the terms. As Petchesky describes it: each concept is a "kind of code that means different things to different speakers, depending on power position, sexual orientation, gender, nationality and so on".<sup>30</sup> While keeping the Cairo definition of *reproductive rights* as a reference point for the rest of the dissertation, it is useful, therefore, to keep in mind what Miller identifies as a "common thread" for the whole category of *sexual rights*, as containing *reproductive rights*, that is to say the "rejection of the policies, conditions and practices that deny the full and equal enjoyment of the right of all persons to determine their own sexual lives, not only specific conduct but also the meaning of sexuality to them and their communities. In addition, sexual rights address the ability of the persons to link or separate sexual conduct from procreation and the relevance of sexuality to accessing the full measure of citizenship in order to thrive locally and globally."<sup>31</sup>

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<sup>27</sup> Petchesky, 2000, p.89 in Parker et al; Miller & Roseman, 2011, p. 322-325 (b).

<sup>28</sup> Miller & Roseman, 2011, p. 105 (a).

<sup>29</sup> Miller & Roseman, 2011, p. 333-335 (b).

<sup>30</sup> Petchesky in Parker et al, 2000, p.81.

<sup>31</sup> Supranote (29), p. 323.



## **2.2 Are reproductive rights human rights? Health-based approach versus rights-based approach**

In the second half of the 20<sup>th</sup> century, reproduction began to be perceived not merely as an issue related to public morality concern, but as a public health concern<sup>32</sup>, whose social dimension opened the way, later on, to the incorporation of a rights-based approach. Until this latter phase came into place, reproduction was addressed by governments through two paradigms: population control policies and public health policies.

On one side, reproduction was perceived as within the domain of health given its natural connection with biology and embodiment, and it was subject to a process of medicalisation, generally intended as “the process by which some aspects of human life come to be considered as medical problems, whereas before they were not considered pathological”<sup>33</sup>. Contextually, for over thirty years the population policy was dominated by the so-called “population control” paradigm, developed in the 1950s by American demographers and premised on the belief that a rapid population growth could negatively affect development and that therefore serious measures were necessary to curtail fertility levels.<sup>34</sup>

The shift from this double understanding of reproduction towards a new paradigm encompassing health and rights was favoured by the ICPD in Cairo and fostered by the idea, developed in the 1990s, that a right to health had to be established.<sup>35</sup>

This new model contended that demographically driven programs were “inherently coercive and abusive of women's right to choose the number and timing of their children”.<sup>36</sup> On this premise, a new model was proposed in Cairo, centred on health

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<sup>32</sup> Cook et al, 2003, p. 204.

<sup>33</sup> Maturo, 2012, p.122 More recent approaches are pushing for a differentiation between conditions that necessitate of medical care (e.g. pregnancy or transsexuals or intersexual) and conditions that necessitate of medical care and are acknowledged and labelled as diseases.

<sup>34</sup> McIntosh & Finkle, 1995, pp.226-227.

<sup>35</sup> Miller & Roseman, 2011, p. 330 (b). For an historical and sociological overview over this paradigm shift see Caulier, 2010, pp.347-376.

<sup>36</sup> McIntosh & Finkle, 1995, p. 227.

framed in human rights and focused on gender equality and women's empowerment as key determinants.<sup>37</sup>

The health-based approach contributed to put the individual's interest at the centre of the discussion, but it also produced detrimental effects: e.g. the pathologisation of pregnancy or sexual conducts that fell outside heteronormativity and the focus on HIV/AIDS in the 1990s that stimulated awareness raising campaigns about sexually transmitted infections (STIs) but also contributed to label the homosexual community as disease-ridden.<sup>38</sup>

Grounding on the health definition provided by the World Health Organisation (WHO) where "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", it is evident this health is recognised as being determined by factors that are not only biological, but also social and economic.<sup>39</sup> Indeed, it is the denied relevance of the social determinants of health that represents the greatest limitation of this approach.<sup>40</sup>

Female genital mutilations provide an example of this interdependence between health and social determinants. These mutilations include all those procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons, and give no health benefit for the subject undergoing them. Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of new-born deaths.<sup>41</sup> In this case, biologic and health-related processes such as diseases and pregnancy are provoked, worsened and/or rendered pathological by social determinants, intended as "the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries" and that include "the distribution of power, income, goods and services, and the circumstances of people's lives".<sup>42</sup>

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<sup>37</sup> Austweg, 2011, p.26.

<sup>38</sup> Miller & Roseman, 2011, p. 329 (b).

<sup>39</sup> WHO, Preamble to the Constitution of the WHO, 1946. On the controversy about the broad character of this definition and on its impact on "the right to health" see Zuniga et al, 2013, p.5.

<sup>40</sup> Porter, 2013, p.136.

<sup>41</sup> World Health Organisation (WHO), Female Genital Mutilation Factsheet N°241, February 2014.

<sup>42</sup> World Health Organisation (WHO), Commission on Social Determinants of Health. Report by the Secretariat, 16 March 2009, A62/9, para. 2.

Therefore, in this case, reproductive health is affected by social patterns characterised by inequality and external control, where inequality is intended “as an imbalance in access to power and resources” that “makes the control of women’s reproduction by others both more possible and more likely”. Inequality and social control can reiterate through centres where power is kept such as the patriarchal family, which can be characterised by gender inequality evaluating women primarily for their “service as wives and sexual partners to men and as producers and rearers of children”.<sup>43</sup>

As summarised by Coliver<sup>44</sup>: “[...] while individuals can make decisions that influence their own personal health (and must be empowered to do so), those decisions are embedded in, and constrained by social and economic systems that must also change if human rights [...] are truly to be vindicated”.<sup>45</sup>

Acknowledging this broader concept of health opened up to the idea, emerging within feminist organisations in the 1980s, that human rights could be applied to sexuality and reproduction.<sup>46</sup>

In the UN guidelines, the rights-based approach has been theorised as a model in which every human being is recognized both as a person and as a right-holder. This approach should strive to secure the freedom, well-being and dignity of all people everywhere, within the framework of essential standards and principles, duties and obligations.<sup>47</sup> The formula “respect-protect-fulfil”<sup>48</sup> has been adopted to summarise the

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<sup>43</sup> Coliver, 1995, pp.6-7. Social patterns take on a significance that is worthy of consideration if we think to what extent human rights law, as international law more in general, is grounded in State-based systems and how its evolution has been determined by States. In this perspective, “direct state regulation of sexuality arises primarily in family and personal status law, health administration, and criminal law. More indirect regulation also operates through citizenship and immigration, housing and inheritance laws”. International Council on Human Rights Policy, *Sexuality and Human Rights*, 2009, p. 21.

<sup>44</sup> Coliver, 1995, p. 8.

<sup>45</sup> This link is nothing new in the human rights literature and the Committee on Economic, Social and Cultural Rights (CESCR) already acknowledged that “the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment”. Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (2000), para. 4.

<sup>46</sup> Petchesky, 2003, pp.1-27.

<sup>47</sup> Stamford Inter-Agency Workshop statement of “Common Understanding” of a human rights-based approach to development cooperation, (2003).

<sup>48</sup> The expression is commonly used in the United Nations documents and was first coined by Asbjorn Eide, as Special Rapporteur on the Right to Adequate Food as a Human Right of the Sub-Commission on

role of the State obligations concerning human rights. The State has, first of all, a negative obligation to respect a specific right, that is to say to refrain from any violation of it. In addition to this more traditional negative obligation, the State is in charge of actively protecting human rights within its jurisdiction. This positive obligation is one “whereby a State must take action to secure human rights”<sup>49</sup> and it entails the concepts of protection and fulfilment. On one hand, the State has to protect the concerned right, that is to say to prevent and punish violations by third parties. On the other hand, the State has to fulfil this obligation by taking steps to ensure the effective enjoyment of that right.

The adoption of a rights-based approach to reproduction has been grounded on the idea that reproductive choices could benefit from the abovementioned paradigm in virtue of the fact that their violation touched upon universally applicable values, such as human dignity and social justice, at the base of the human rights discourse.

The link between human dignity and social justice was at the base of this re-conceptualisation of reproductive and sexual health adopting a “rights terminology”: as Correa explains, the meeting held among women’s health activists to prepare a common approach to ICPD rotated around two conceptual elements, then presented in Cairo, such as the premise of indivisibility of human rights and the notion of an enabling environment for exercising those rights (economic, social and political conditions).<sup>50</sup>

The respect for human dignity entails the right “not to be alienated from one’s own sexual and reproductive capacity; a right not to have one’s sexual and reproductive capacity used as an instrument serving the interests of other individuals, collectivities or States without consent and without the opportunity to participate in the political processes by which such interests are defined”<sup>51</sup>. Therefore, violations of human dignity include a number of practices still in place such as, *inter alia*, forced sterilisation or

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Prevention of Discrimination and Protection of Minorities and used in the Final Report, "The Right to Adequate Food as a Human Right", 1987, E/CN.4/Sub.2/1987/23.

<sup>49</sup> Harris, O’Boyle & Warbrick, 2009, p.18.

<sup>50</sup> Corrêa, 1997, p.108.

<sup>51</sup> Freedman, 1995, p.325.

forced abortions<sup>52</sup>, prohibition of abortion in cases where the mother's life is threatened<sup>53</sup>, genital alteration for non-medical reasons<sup>54</sup> such as or surgical intervention on intersex children or male circumcision.<sup>55</sup>

As a second step, considering social justice as, according to Nussbaum, entailing that “society owes people [...] a basic level of support for nutrition, health, shelter, education, and physical safety”, as well as “effective guarantees of the major liberties of expression, conscience, and political participation” in order for them to realize their “basic human capacities”, across all gender, racial, ethnic, sexual, religious, and other differences<sup>56</sup>, then other rights stem from this value and are related not only to the capability of individuals to make reproductive choices, but also to the possibility of implementing them in an enabling social and political environment: e.g. the decision of using contraceptives can be affected by, *inter alia*, the missing recognition of this right by the law, but also by the economic status of the individual or by the physical accessibility of the place where contraceptives are sold. As Coliver summarizes: “Defining reproductive and sexual rights to include a right to implement decisions ties their implementation directly to the struggle for social justice, to the fight against inequality”<sup>57</sup> and this strengthens the indivisibility of human rights, as a core element of a rights-based approach.

The rights-based approach took the scene but remained constantly challenged by the non-acceptance of a number of civil society groups that still consider reproduction only a health issue. The Millennium Development Goals (MDGs) can be considered a

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<sup>52</sup> Forced sterilisation or abortion can take place in the context of State's population control policies such as the “one-child policy” in China, but also as isolated case targeting only social groups such as ethnic minorities, disabled women or adolescents. On this late circumstance see Zampas & Lamačková, 2011, pp.163-166 and among others the case of the European Court of Human Rights *V.C. v Slovakia*.

<sup>53</sup> Among the countries in which abortion is illegal under any circumstances there are Malta, Nicaragua, Chile, Senegal and Somalia. For an exhaustive list, see Center for Reproductive Rights, The World's Abortion Laws Map 2013 Update Factsheet, p.2.

<sup>54</sup> Ní Mhuirthile (2013).

<sup>55</sup> Nonetheless Coliver underlines that human dignity is a value in itself and that its respect prescinds from its instrumental value: “[...] if women's control over reproduction is regarded only as instrumental, as a means to other ends, then theoretically it becomes dispensable if other means are found to reach those ends.” Coliver, 1995, pp.5-6.

<sup>56</sup> Nussbaum, 1999, p.20. On the specific connection between the concept of sexuality, rights and social justice see Berer, 2004, pp.8-10.

<sup>57</sup> Coliver, 1995, p.6.

current symptom of this constant tension between the two approaches: although reproductive health, as a goal inherited from the Cairo Programme, was present in 3 out of 8 goals, part of the partial failure in achieving them has to be ascribed to the neglected attention towards the power games that led the debate on SRR.<sup>58</sup> A return to a power discourse that necessarily entails a rights-based approach has been envisaged within the UN but has encountered some practical limits in the idea that improvements have to be measurable and quick impacts initiatives have to be preferred to more long-term processes.<sup>59</sup> Ortiz Ortega speaks about a “replacement” of the agreements made in Cairo and Beijing by the MDGs and argues that although the 12 areas of concern of Beijing Platform were integrated into the MDGs, “it was done in a way that reduced their critical edge” and left out a more holistic approach.<sup>60</sup> The revival of the health approach through the MDGs has been accompanied by an erosion of the human rights perspective in order to let space to narrow and technically conceived targets and by a shift of decisional and lobbying power from the civil society organisations to governments and intergovernmental organisations.<sup>61</sup>

Among the ways in which a rights-based approach can be implemented, two main paradigms can be distinguished: one that affirms the novelty of reproductive rights in the human rights discourse and that states the necessity to consider these rights as a new category to be added to the traditional ones, and the other that considers reproductive rights simply as human rights applied to reproduction. This latter approach has been privileged in the academic literature on these issues and it has been adopted as well in the Cairo Programme. It will, therefore, be explored in the following section.

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<sup>58</sup> Austweg, 2011, p.27.

<sup>59</sup> On the necessity of returning to a power discourse see UN Millennium Project, *Who's Got the Power? Transforming Health Systems for Women and Children*, 2005. On the “quick impact” model see Richard et al, 2011, pp.42-52.

<sup>60</sup> Ortiz Ortega, 2011, pp.35-36 An interesting example of how the shift to health can affect rights and social justice is furnished by the evidence that “[...] most countries are making progress, but few are managing to achieve inclusive and equitable progress. Instead, most of the gains are taking place among the top socioeconomic quintiles, while the lower quintiles are seeing little or no progress.” in Richard, et al, 2011, pp.45-46.

<sup>61</sup> Haslegrave, 2013, pp. 61-73. An additional element that can be interpreted as signal of the late tendency toward health in a restricted sense is the fact that “achieving universal access to reproductive health” has been added only later as a new target under MDG5 (Maternal health) as a result of the pressures by UNFPA and numerous NGOs working in the field.

## **2.3 The rights-based approach applied to reproduction**

This final section will employ the previously outlined rights-based approach to explore a number of human rights, as defined in international law<sup>62</sup>, in order to evaluate to what extent RR can be deduced from the existing provisions and if these existing rights contribute to better define what should be the content of RR. The list of rights addressed here is not exhaustive, but it has the purpose of suggesting some of the approaches that may be developed to advance reproductive interests. The following rights have been chosen in virtue of their relevance concerning the juncture between reproduction and knowledge, whereas knowledge is intended as the outcome of three different processes such as the reception of information as a result an individual's request for it, of counselling and of education.

### **2.3.1 Right to life and right to health**

As anticipated in the previous sections, health and life can be affected in a number of ways by choices concerning reproduction. These choices can take place at different stages of life: physical and psychological health, and in some cases life, can be threatened by the choice of carrying on a pregnancy or to have an abortion, whereas it is a free individual's choice or it is imposed by external conditions. In turn, specific health conditions, such as infertility, can affect the reproductive capability and may push the individual to refer to the healthcare system in order to benefit from assisted reproductive technology.

The right to life has been proclaimed in a large number of international law instruments starting with its formulation in article 3 of the Universal Declaration of Human Rights (UDHR) and restatement in article 6 of the International Covenant on Civil and Political Rights (ICCPR). It has been interpreted as the right not to be deprived arbitrarily of one's life and positive obligations on the State have been recognised by the Human Rights Committee (HRC) by stating that "it would be

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<sup>62</sup> The texts taken into consideration in this chapter are some of the core human rights instruments and other texts that help to interpret them (namely, the General Comments). Given the specific focus on Europe of the dissertation, the presence of the same rights at European level will be investigated in the next chapter.

desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy [...]"<sup>63</sup>.

Strictly interrelated to the right to life is the right to health given that good health can positively determine a longer life expectancy, although these two rights have enjoyed a different degree of recognition in human rights law.

The right to health has been recognised in article 25 of the UDHR that upholds for each individual "the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services [...]". The text acknowledges a higher vulnerability of certain groups and states that "motherhood and childhood are entitled to special care and assistance".

Most notably, the right to health has been set forth in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), where "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" is recognised. Among the steps that have to be taken by the States to ensure the realisation of this right one can find: "(a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; [...] (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

The Committee on Economic, Social and Cultural Rights (hereinafter, the Committee) has defined the right to health "indispensable for the exercise of other human rights" and health itself as "conducive to living a life in dignity". In particular, the Committee has recognised the close relation and dependence of the right to health upon the realization of other human rights such the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and

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<sup>63</sup> Human Rights Committee, *General Comment 6, Article 6* (Sixteenth session, 1982), HRI/GEN/1/Rev.1 at 6, para. 5.



movement.<sup>64</sup> Its implementation has to be achieved “through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments”.<sup>65</sup>

As for the content, the Committee explains that “the right to health is not to be understood as a right to be healthy” and that it “contains both freedoms and entitlements. Freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”<sup>66</sup>

The extent to which life can be put at risk by different sexual behaviours depends, *inter alia*, on the quality and quantity of information that are accessible by the individual.<sup>67</sup> Information should be related to STIs and the ways of transmission to the partner and the foetus, to their prevention and to the risks connected with pregnancy (early or late pregnancy, closely spaced pregnancies but also individual-related risks) both for the mother and the infant. Concerning education and information, the Committee has been clear by upholding the “access to health-related education and information, including on sexual and reproductive health” and “the participation of the population in all health-related decision-making at the community, national and international levels” as integral components of the right to health.<sup>68</sup>

The Committee has listed the essential elements of the right to health, namely availability, accessibility, acceptability and quality that apply to health facilities, goods

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<sup>64</sup> UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, para 3.

<sup>65</sup> *Ibidem*, para. 1.

<sup>66</sup> *Ibidem*, para. 8.

<sup>67</sup> This link is expressly recognised also in the Convention on the Rights of the Child (CRC) (f). “[...] all segments of society, in particular parents and children, [have to be] informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents” and “preventive health care, guidance for parents and family planning education and services” have to be developed Art.24 (2) (e) (f).

<sup>68</sup> *Supranote* (63), para 11.

and services.<sup>69</sup> Information and counselling, intended as services, should be available in sufficient quantity; accessible physically, economically and without discrimination; respectful of medical ethics and culturally appropriate but, at the same time, scientifically and medically appropriate and of good quality. Among the four dimensions of accessibility, the *information accessibility* is specifically mentioned and described as the right “to seek, receive and impart information and ideas concerning health issues”, not impairing “the right to have personal health data treated with confidentiality”.

Obligations for States stemming from article 12 of the ICESCR are numerous. The obligation to respect comprises the duty to refrain from “censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people’s participation in health-related matters”<sup>70</sup>. The obligation to protect entails that the State has to ensure “that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services” and that “third parties do not limit people’s access to health-related information and services”<sup>71</sup>. Lastly, the obligation to fulfil implies “the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence [...]”<sup>72</sup>.

Finally, the Committee recognises the specific vulnerability of certain groups such as women, children and adolescents concerning their health status. Thus, it states that “the realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights”.<sup>73</sup>

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<sup>69</sup> Ibidem, para. 12.

<sup>70</sup> Ibidem, para. 34.

<sup>71</sup> Ibidem, para. 35.

<sup>72</sup> Ibidem, para. 36.

<sup>73</sup> Ibidem, para 21.

Children and adolescents have the right to access “child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices”.<sup>74</sup> And again, “States parties should provide a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make.”<sup>75</sup>

A fundamental link with the next section is provided by the concept of the right to informed consent that connects three dimensions: health, information and privacy. This right has been defined as “not mere the acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health care-providers.”<sup>76</sup> The right to informed consent is related to the notion of “legal capacity” which is required to exercise it and is intended as the “ability to comprehend, retain, believe and weigh information provided in arriving at a decision”.<sup>77</sup>

### **2.3.2 Right to private and family life**

Reproductive choices have a relevant impact on the individual’s family life since the family’s status is defined, *inter alia*, by the choice to have or not to have children; family life is defined by the components of this nucleus, by the relations among them and by the decisional power that some components, in most cases the parents, can exercise on others, namely the children.

Reproductive choices affect nonetheless the individual’s privacy in a number of ways: the decision to have or not to have a child pertains to the private sphere of the individual

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<sup>74</sup> Ibidem, para 22 The Committee adopts this approach as stated in the CRC, but this wording is not present in the ICESCR text.

<sup>75</sup> Ibidem, para 23.

<sup>76</sup> UN General Assembly, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health : note / by the Secretary-General*, 10 August 2009, A/64/272, para. 9. The concept of informed concept was formally theorised for the first time in the Nuremberg code with reference to experiments in medical research and subsequently adopted in many other codes of research ethics. A general description of what is covered under the concept of informed consent, applied generally and not only to medical research, is present in the Amsterdam Declaration on Patients’ Rights (WHO), 1994, p.11.

<sup>77</sup> Ibidem, para. 15.

and is therefore protected by a number of external interferences. Moreover, the concept of privacy enshrines to some extent the concept of autonomy, which plays a key role when a decision has to be taken.

The right to private and family life is enshrined in article 12 of the UDHR and in similar terms is protected by the ICCPR through article 17.1 that reads:” No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation”.

The right entails a protection from interferences that could be inflicted either by the State or by third parties. Interferences can be classified as *unlawful*, meaning that are not foreseen by law, or as *arbitrary*, intending that are provided for by law but do not abide by the provisions, aims and objectives of the Covenant.<sup>78</sup>

Given the non-absolute character of this right, the State can interfere with its enjoyment but it is necessary to clarify under which circumstance this is permitted. Moreover the HRC underlines that information related to an individual's private life should only become available for the State whereas essential in the interests of society.<sup>79</sup>

Concerning specifically the gathering of information, the HRC clarifies that “every individual should have the right to ascertain in an intelligible form, whether, and if so, what personal data is stored in automatic data files, and for what purposes [...]” and “which public authorities or private individuals or bodies control or may control their files. If such files contain incorrect personal data or have been collected or processed contrary to the provisions of the law, every individual should have the right to request rectification or elimination”.<sup>80</sup> A final point is related to the concepts of honour and reputation whereas “provisions must also be made for everyone effectively to be able to protect himself against any unlawful attacks that do occur and to have an effective remedy against those responsible.”<sup>81</sup>

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<sup>78</sup> Ibidem, paras. 3-4.

<sup>79</sup> Ibidem, para 7.

<sup>80</sup> Ibidem, para 10.

<sup>81</sup> Ibidem, para 11.

A relevant aspect concerns the possibility to include a right to autonomy within the right to privacy. The concept of autonomy<sup>82</sup>, intended as capability of self-determination, gives rise to the idea of an existing “right to autonomy”, that is to say a right to make decisions and undertake actions, and to do so unimpeded by other people. This right has a positive and a negative dimension: the individual has to be free of taking a decision without unlawful interference (negative), but also to be assisted in order for the decision to be informed (positive). A woman who has to decide whether or not carry out an invasive medical procedure, e.g. sterilisation, has to understand the language in which information about the procedures and risks are provided to her, these information have to be provided timely and have to be complete and accurate, and so on.

The right to autonomy can alternatively be understood as a principle of law on equal footing with human dignity and personal freedom or as a right in itself, stemming from these values and belonging to the broader concept of the right to private life. For our purpose, it will be considered as part of the right to privacy, since a “right to autonomy” as such has not been recognised in international law instruments.

Implications for reproductive rights stemming from the interaction between the right to privacy and information are therefore related to the right of the individual to make informed decisions about one’s private and family life. Taking a decision implies the authority to do so and the access to information that make this decision informed, because aware of all positive and negative implications. The individual should be able to take informed decisions related to whether, with whom and at what age to have sexual relations. He/she should be free to use contraception and decide which type to use; he/she should autonomously decide the number and spacing of children.

### **2.3.3 Freedom of expression**

Each reproductive choice, taken autonomously by the individual, can be seen as the result of a mental process in which a series of information have been received and

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<sup>82</sup> On the possible definitions of autonomy and, in particular, on the implications stemming from a distinction between self-determination, rational self-determination and moral rational self-determination see Maclean, 2009, pp.9-47

evaluated in order to reach that specific conclusion. Therefore, problems arise, for example, when the imparted information are partial or biased both because of a deliberate choice of the person providing the information or because of involuntary circumstances. In this sense, the right to seek, receive and impart information is vital to reproductive choices. An analysis of this right from an international law point of view has to be preceded by a clarification related to the status of this right in international human rights law since it has been included as part of the broader fundamental right to freedom of expression.<sup>83</sup>

Freedom of expression is one of the core human rights principle, protected by international and regional treaties. Article 19 of the UDHR states that: “Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers”.

As vital part of this broader freedom, the right to information has found articulation in various human rights documents, such as the UDHR, the ICCPR<sup>84</sup>, and other *soft law* instruments<sup>85</sup>.

This right includes ideas of all kinds, communicable and receivable through any media and regardless of frontiers, either orally, in writing or in print. It is not absolute and it is subject to limitations provided by law and necessary a) for respect of the rights and reputation of others and b) for the protection of national security, public order or morals. In its General Comment, the HRC offered authoritative interpretation by stating that article 19 protects the right to information held by public bodies and requires the proactive dissemination of information in the public interest, specifically mentioning access to individuals’ personal information and, more specifically, medical records.<sup>86</sup>

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<sup>83</sup> See the UDHR (art. 19) and the ICCPR (art. 19).

<sup>84</sup> International Covenant on Civil and Political Rights (ICCPR), art.19.

<sup>85</sup> See, inter alia, the OSCE (publisher), Joint Declaration on International Mechanisms for Promoting Freedom of Expression (2004).

<sup>86</sup> UN Human Rights Committee (HRC), *General comment no. 34, Article 19, Freedoms of opinion and expression*, 12 September 2011, CCPR/C/GC/34, paras. 18-19.

### 2.3.4 Right to education

Similarly to what asserted for the right to information, reproductive choices are equally affected by information on the topic received in the educational context. Information about sex, obtained in the context of classes provided by the school curricula, can prepare the child or the teenager to face reproduction with a number of instruments apt to preserve their health, to prevent unwanted pregnancies or to face parenthood adequately. As it will be analysed at the end of this chapter, problems may arise when defining an “educational context” and drawing a dividing line between “informative” and “educative” activities.

The right to education has been recognised in a number of international law instruments such as the UDHR (art.26), the ICESCR (art.13 and 14) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (art.10). All these treaties acknowledge an entitlement to free, compulsory primary education for all; an obligation to develop secondary education, supported by measures to render it accessible to all children, as well as equitable access to higher education; and a responsibility to provide basic education for individuals who have not completed primary education. The aim of education is to promote personal development, strengthen respect for human rights and freedoms, enable individuals to participate effectively in a free society, and promote understanding, friendship and tolerance.

Although often perceived as a children’s right, the term “fundamental education” was specifically included in the UDHR “to recognise the right for illiterate adults and others who had not had the opportunity to receive a full elementary education”.<sup>87</sup> In addition, the Committee clearly states that no discrimination on the base of age or gender is permissible in relation to this right.<sup>88</sup> Education has to be accessible, available, acceptable and adaptable, and has to be intended as a goal to be achieved progressively with the involvement of States and other agencies.<sup>89</sup>

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<sup>87</sup> UNESCO, World education report 2000, p.26.

<sup>88</sup> UN Committee on Economic, Social and Cultural Rights, *General Comment No. 13: The Right to Education (Art. 13 of the Covenant)*, 8 December 1999, E/C.12/1999/10, para. 24.

<sup>89</sup> Ibidem, paras.6-7.

### 2.3.5 Right to equality and non-discrimination

Finally, it is vital to analyse the relevance of the listed rights in the light of the principles of equality and non-discrimination. Reproductive choices, have to be equally guaranteed to all individuals without discrimination, and when differentiation of treatment takes place it does not have to be considered discrimination as long as the criteria for it are reasonable and it is aimed at achieving legitimate purposes.<sup>90</sup>

The prohibition of discrimination is among those core principles whose theoretical universality is confirmed by its presence in a number of international and regional human rights texts, such as, *inter alia*, the UDHR (art. 2 and art. 26), the ICCPR (art. 2) and the ICESCR (art. 2.2)<sup>91</sup> As a general principle, the enjoyment of the rights listed in these texts has to be achieved without discrimination, whereas discrimination can be based on different grounds such as race, age, sex, religion, language, social status, political opinion and others.

Equality and non-discrimination can be considered as the positive and negative sides of the same principle, meaning that equality is the absence of discrimination, and non-discrimination produces equality.<sup>92</sup>

What constitutes discrimination is not specifically addressed in the texts of the Bill of Rights, but the HRC has described discrimination as “any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms”<sup>93</sup>.

Sexuality and gender-related aspects are comprised among the grounds on which discrimination is not permitted. Article 16 of the CEDAW applies the principle of non-discrimination concerning marriage and personal relations by restating equality when it

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<sup>90</sup> UN Human Rights Committee, *CCPR General Comment No. 18: Non-discrimination*, 10 November 1989, paras. 10-13.

<sup>91</sup> See also, *inter alia*, the International Convention on the Elimination of All Forms of Racial Discrimination (especially, art.1 and art.2), the CEDAW (especially, art.1; art. 2; art.3; and art. 4) and the Convention on the Rights of the Child (especially, art.2; art. 5; and art. 30).

<sup>92</sup> Bayefsky, 1990, p. 5.

<sup>93</sup> Supranote (90), para. 7.



comes to “[...] (e) the 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”. Moreover, some specific fields in which discrimination against women is present are addressed, such as education (article 10), and health (article 12). Article 10 (h) confirms that State parties should implement all measures necessary to avoid discrimination in the “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning”. Article 12 pushes for “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”.

These provisions create a framework in which individuals have the right to access information concerning sex and reproduction without discrimination.

Discrimination in relation to sexuality and reproduction can articulate differently and can create direct or indirect barriers to the enjoyment of rights. Focusing on discrimination related to information and education one can find: communication and language barriers, lack of information about availability, content and entitlements to services, and cultural and/or psychological barriers in accessing sensitive information

Moreover, as underlined by the Special Rapporteur on Health: “laws restricting information about sexual and reproductive health and which censor discussions of homosexuality in the classroom fuel stigma and discrimination of vulnerable minorities. For example, laws and policies that promote abstinence-only education reduce sexual education to images and stereotypes of heteronormativity, given their focus on procreation; some of these programmes even contain explicitly discriminatory content on gender and sexual orientation. [...] Such laws and policies perpetuate false and negative stereotypes concerning sexuality, alienate students of different sexual

orientations and prevent students from making fully informed decisions regarding their sexual and reproductive health.”<sup>94</sup>

### **2.3.6 The right to know: knowledge applied to reproduction**

This quick overview of some of the most widely recognised human rights makes it possible to make two distinct considerations. On one side, it appears evident how reproductive rights already exist within the most common human rights provisions: it can be argued that reproductive rights do not exist as a separate category, instead they are the result of the application of human rights to reproduction.<sup>95</sup>

On the other side, it emerges the key role played by information for the exercise of these rights: whether a reproductive decision concerns health or family planning, still this decision is partially the outcome of an elaborative process of all the information owned by the individual on that topic. This is self-evident in cases where a positive obligation by the State is invoked, and less in those cases where the State or third parties infringe on their negative obligation, that is to say in those cases where the individual's rights is violated by an action implemented by the State or third parties. A clarifying example is provided by the Roma sterilisation cases since even in those situations the omission of information may represent a violation of human rights. The relevance of knowledge is evident both in terms of public health and empowerment of the individual. From a public health point of view, evidence has massively showed that accurate and complete information are relevant in spacing births, preventing unwanted pregnancies, STIs and other diseases affecting both maternal and infant health.<sup>96</sup> More importantly however, knowledge contributes to the promotion of a higher degree of autonomy for individuals about decisions concerning sexuality and reproduction, and the capability of

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<sup>94</sup> United Nations General Assembly, *Note by the Secretary General on the right of everyone to the enjoyment of the highest attainable, standard of physical and mental health*, 3 August 2011, A/66/254, para. 59.

<sup>95</sup> Supranote (4). For a theorisation of the insufficiency of the human rights paradigm when dealing with sexual rights see Corrêa et al, 2008, pp.151-163.

<sup>96</sup> See e.g., Concluding Observations A/53/38, 1998, para. 349; CEDAW/C/TOG/CO/5, 2006, para. 29; A/54/38, 1999, paras. 226–227; A/54/38, 1999, para. 154; A/56/38, 2001, para.62; CEDAW/C/CPV/CO/6, 2006, para.29.

the individual to participate to the public debate aimed at shaping and influencing decisions on these issues.<sup>97</sup> The relevance of public debate is often underestimated but, as Coliver underlines, when public discussion is “limited by mechanisms of formal or informal censorship, the result is the adoption of policies that are fundamentally undemocratic”.<sup>98</sup> Therefore, knowledge *per se* contributes to the maintenance of a democratic system based on an informed participation of citizens.

As underlined throughout this rights review, there exist a number of rights related to the possibility to access information that can be personal or general but bonded by their being necessary for a full development of the individual. These information are considered necessary as they enable the individual to make an informed choice about his/her present and/or future well-being.

For the purpose of the dissertation, the *right to know* will be used as an expression able to enshrine the right to access personal and general information, the right to counselling and the right to education, applied to reproduction.

The basic value of knowledge on these issues has been recognised in the words of the Special Rapporteur on the Right to Health, who stated that comprehensive information on reproductive and sexual health is “an essential component of the right to health and to the realization of other rights, such as the right to education and access to information” and criminal and other laws restricting access to information is “incompatible with the full realization of the right to health and should be removed”.<sup>99</sup>

A final remark has to be done concerning the difference between the three components of the *right to know*: information, counselling and education. As deducible,

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<sup>97</sup> “Sexuality education provides accurate information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual diversity; sexual abuse; gender-based violence; and harmful practices.” It should, among other aspects, “involve experts in research on human sexuality, behaviour change and related pedagogical theory in the development of curricula, [...] give clear messages about behaviours to reduce risk of STIs or pregnancy, [...] employ participatory teaching methods that actively involve students and help them internalise and integrate information, and [...] provide scientifically accurate information”. *UNESCO, International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators – Volume II Topics and learning objectives 17-20*, 2009.

<sup>98</sup> Coliver, 1995, p.42.

<sup>99</sup> Supranote (94), para 56.

they constitute close concepts whose difference can not always be defined with strict borders. Education is often used as a term to indicate formal education in a school premise and access to information can take place in counselling office situated in a school premise. The difficulty in pigeonholing an activity in one of the two boxes hinges on the basic premise that giving an information is already educating, whereas education is intended as “all activities by which a human group transmits to its descendants a body of knowledge and skills and a moral code which enable the group to subsist”.<sup>100</sup> If it is considered the case of a woman asking for counselling about the possibility of transmitting STIs to her foetus, it will be hard to describe this activity as a simple conveyance of information or as already part of an educative process in which the individual can retain the information, transmit it and make use of it also in the future, widening her own knowledge and autonomy.

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<sup>100</sup> Beiter, 2005, p. 19.

### **3. The EU approach towards reproductive rights: a missing competence or reproductive rights as fundamental rights?**

Reproduction can be seen both as a public health issue and as a subject of human rights law. That is why, in order to analyse the approach adopted towards RR by the EU, it is necessary to take into consideration these two aspects: on one side, the EU definition of RR and their weight within the EU human rights system and on the other side, the role of reproduction within the EU public health policy. By exploring these issues, the chapter aims at assessing how the EU has approached reproduction that is to say only as a public health concern or also as a relevant issue in terms of human rights.

The first section is aimed at exploring the connection between reproduction and human rights in the EU system. To do so the obligations stemming from instruments adopted by the EU will be considered: the content of various provisions linked with reproduction will be presented together with their interpretation, provided through the jurisprudence of the Courts<sup>101</sup>.

The second section will explore to what extent reproduction has been deemed by the EU as a public health issue, by analysing the competence of the EU in this field and exploring some actions implemented by the EU concerning reproduction. As for the first chapter, a general analysis will be presented, but a specific focus will be maintained on the *right to know* in both sections.

This parallel analysis will lead to the final section in which some conclusions about the EU's approach toward RR will be attempted by pivoting on a Report produced within the EU Parliament, its content and significance concerning previous sections.

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<sup>101</sup> European Court of Human Rights (ECtHR) and Court of Justice of the European Union (CJEU).

### 3.1 Reproduction and human rights in the EU system

#### 3.1.1 Reproductive rights in the CFREU and in the ECHR<sup>102</sup>

The European Union was set up initially with the aim of preventing new conflicts among European States by strengthening cooperation in the economic field. Despite economic integration remained its primary focus, a growing space has been created for human rights thanks to the adoption of instruments for their protection, such as the Charter of Fundamental Rights of the European Union (CFREU) and the European Convention on Human Rights (ECHR).<sup>103</sup>

The first text to be considered is the ECHR, whose relevance for the EU law has been strengthened by the ongoing process of accession to the Convention by the EU.<sup>104</sup> Despite the absence yet of a formal adhesion by the EU to the text, the CJEU has so far referred to the Convention and treated it as part of the EU's legal system, emphasizing

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<sup>102</sup> A short explanation is due to the choice of excluding the European Social Charter (ESC) from this analysis. The ESC and the ECHR have been included in the Preamble of the Charter among the sources enshrining rights that the Charter reaffirms. Despite this reference, a relevant difference exists between the ECHR and the other instruments mentioned in the Preamble. As explained by De Schutter, there is a *tendency to relegate the ESC to the category of instruments destined to remain outside the legal order of the Union itself, while the Union would follow its own path in order to ensure the protection of fundamental social rights in its field of activities. The fate of the ESC stands in striking contrast with that of the European Convention on Human Rights, which has in fact—materially, if not yet institutionally—been incorporated into the legal order of the EU. The contrast between these two Council of Europe instruments cannot be ignored. The (Rev) ESC has inspired the formulation of many provisions of the EU Charter of Fundamental Rights. But the EU Charter has failed to include many of its guarantees, where it has replicated the totality of the rights and freedoms of the ECHR and its additional protocols. Moreover, whereas it was agreed that the provisions of the EU Charter of Fundamental Rights corresponding to provisions of the ECHR should be read in accordance with the interpretation given to these provisions by the European Court of Human Rights [Art.52 (3) ECFR] there is no similar article prescribing that the provisions of the EU Charter of Fundamental Rights be read in the light of the development of the jurisprudence of the European Committee of Social Rights.* De Schutter in De Búrca et al, 2005, p.120.

<sup>103</sup> Although these two texts will constitute the primary focus of the chapter, it should be underlined that they constitute a part of a broader EU human rights policy, comprising the activities of the Human Rights Committee, the Annual report on Human Rights in the World and the Sakharov prize. These activities are, however, focused on human rights abroad since due to the division of labour within Parliament, the Subcommittee on Human Rights does not deal with human rights violations within Europe and have a low impact. On the reasons behind this impact see Lochbihler, 2013.

<sup>104</sup> Article 6(2) TEU stipulates that the Union shall accede to the ECHR and that such accession shall not affect the Union's competences as defined in the TEU and in the TFEU.

in various judgments that it would draw inspirations from it.<sup>105</sup> This traceable line in the CJEU case law is now reflected in the terms of article 6(3) of the TEU.<sup>106</sup>

The Convention enshrines a number of rights and freedoms that apply to reproduction: a right to life (art. 2) as well as freedom from torture (art. 3) are guaranteed, right to respect for private and family life is formalised through article 8; and freedom of expression (art. 10), including the right to receive information, is guaranteed although lawful restrictions are foreseen if aimed at, *inter alia*, protecting health and morals and at preventing the disclosure of information received in confidence. A right to education is protected under article 2 of the First Protocol,<sup>107</sup> although balanced by the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions. Finally discrimination is prohibited (art. 14) on a series of grounds such as, *inter alia*, sex, opinion, national or social origin and other status.<sup>108</sup>

The CFREU entered into force through the adoption of the Lisbon Treaty<sup>109</sup> in 2009 and it enshrines political, social and economic rights for EU citizens and residents into EU law. The provisions are addressed to the institutions and bodies of the Union and to the Member States, only when implementing Union law.<sup>110</sup> The Charter reaffirms the rights as they result, in particular, from the constitutional traditions and international obligations common to the Member States, the Treaty on European Union (TEU), the Community Treaties, the ECHR, the Social Charters adopted by the Community and by

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<sup>105</sup> See, e.g., Case 4/73 Nold v Commission (1974) ECR 491; Case 44/79 Hauer v Land Rheinland-Pfalz (1979) ECR 3727; Others v Commission (2002) ECR I-8375, 273-275.

<sup>106</sup> “Fundamental rights, as guaranteed by the ECHR and as they result from the constitutional traditions common to the Member States, shall constitute general principles of the Union’s law”.

<sup>107</sup> With relation to the “type of education” referred to, the Court clarified that: “[...] While the first sentence of Article 2 essentially establishes access to primary and secondary education, there is no watertight division separating higher education from other forms of education.” (§ 136) and that “it would be hard to imagine that institutions of higher education [...] do not come within the scope of the first sentence of article 2 of Protocol No 1” *Leyla Şahin v Turkey* [GC], no. 44774/98, § 137, ECtHR 2005.

<sup>108</sup> Article 14 must be pleaded in relation to some other rights in the Convention and therefore its violation can not be claimed without such a link. “Although the application of article 14 does not necessarily presuppose a breach [of the substantive provisions of the Convention and its Protocols] – and to this extent it is autonomous – there can be no room for its application unless the facts at issue fall within the ambit of one or more of latter.” *Abdulaziz, Cabales, Balkandali v United Kingdom*, no. 9214/80; 9473/81; 9474/81, § 71, ECtHR 1985.

<sup>109</sup> 2007/C 306/01.

<sup>110</sup> Article 51(1), Charter of Fundamental Rights of the European Union (CFREU).

the Council of Europe and the case-law of the Court of Justice of the European Union (CJEU) and of the European Court of Human Rights (ECtHR).<sup>111</sup>

Two premises have to be done before analysing some Charter provisions. The first is enshrined in article 52(3) that reads that Charter rights that correspond to rights under the ECHR should be given the same scope and meaning, although a more extensive protection can be provided by EU law. The second concerns the different weight accorded to *rights* and *principles* within the Charter: although the Charter does not clearly state which provisions have to be regarded as principles and which ones as rights, Vitorino explained that there is “a right where the holder is clearly designated and there is a principle where the Union is referred to as having to respect or recognise a specific value”<sup>112</sup>. The difference is relevant since “principles may be implemented through legislative or executive acts (adopted by the Union in accordance with its powers, and by the Member States only when they implement Union law); accordingly, they become significant for the Courts only when such acts are interpreted or reviewed. They do not however give rise to direct claims for positive action by the Union's institutions or Member States authorities.”<sup>113</sup>

Some of the rights listed in the CFREU directly contribute to define RR: the right to life (article 2), respect for private and family life (article 7), freedom of expression and information (article 11), right to education (article 14), right to non-discrimination (article 21) and right to health care (article 35). Furthermore, other provisions may as well enrich the definition, e.g. article 3 “Right to the integrity of the person”, article 8 “Protection of personal data”, article 34 “Social security and social assistance” and article 41 “Right to good administration”.

Despite most of these rights are basically expressed in the same terms as they are in the Bill of Rights, the right to health and the right to education deserve a deeper analysis.

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<sup>111</sup> Ibidem, Preamble.

<sup>112</sup> Vitorino, 2001, p.26.

<sup>113</sup> Official Journal of the European Union C 303/17, 14/12/2007, Explanations (\*) Relating to the Charter of Fundamental Rights



The first thing to stress a right to health is not present as such, but rather as a right to health care, defined as “the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices” (art.35 CFREU) and it is referred to as a principle and not a right<sup>114</sup> In terms of content, this difference between health and health care has been interpreted as not relevant since the wording “right to health care” as potentially encompassing the broader right to health since the term “preventive health care” may include pre-conditions for health.<sup>115</sup>

The individual entitlement to health care is then complemented by a mainstreaming obligation, expressed as follows: “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities” (art.35 CFREU).

In the *Explanations*<sup>116</sup> it is clarified that the right to health care is based on article 168 TFEU, but also on other ESC provisions<sup>117</sup>. This is relevant because the Charter, although not incorporated in the Lisbon Treaty, has been accorded the same legal value as the Treaties.<sup>118</sup> The interplay between these sources is regulated by Article 52(2) of the Charter that reads: “rights recognised by this Charter for which provision is made in the Treaties shall be exercised under the conditions and within the limits defined by those Treaties”.<sup>119</sup>

A traditional provision on the right to private life has been integrated by an autonomous provision named “Right to the integrity of the person” (Article 3), which states that “everyone has the right to respect for his or her physical and mental integrity” with a second paragraph dealing specifically with medicine and biology and listing four key principles to be respected: free and informed consent of the person concerned;

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<sup>114</sup> Supranote (112), p.27. On this interpretation, see also Craig, 2010, p.217.

<sup>115</sup> Hervey in De Búrca et al, 2005, p.316.

<sup>116</sup> Supranote (112). Ibidem.

<sup>117</sup> ESC, article 11 (Right to protection of health) and 13 (Right to social and medical assistance).

<sup>118</sup> Article 6(1), TEU.

<sup>119</sup> Craig suggests that “It is common for a Treaty provision to be set in general terms and for more specific conditions for its exercise to be laid down in legislation”. That is why the forthcoming jurisprudence of the CJEU will clarify the terms and limits of interpretation of the Charter provisions. Craig, 2010, p.228.

prohibition of eugenic practices, in particular those aiming at the selection of persons; prohibition on making the human body and its parts as such a source of financial gain, and prohibition of the reproductive cloning of human beings. The autonomy of this provision represents a first difference with the Convention, where integrity is conceived as within the right to private life, but more relevantly the four listed principles have the potential to affect reproduction. Some of the issues that the CJEU will probably be tackling are, in particular, the assisted reproductive techniques when comprising e.g. sperm donation or surrogacy, to establish whether they fall within the use of body parts as a source of financial gain and the definition of eugenics.<sup>120</sup>

Finally, the CFREU guarantees to everyone a right to education and the right to have access to vocational and continuing training (art. 14). No specification is done with reference to age limit or typology of education and if the possibility to receive *free compulsory education*<sup>121</sup> is mentioned, it is not evident whether it refers solely to primary education. Article 14 guarantees, moreover, respect for the freedom to found alternative educational establishments and the right of parents “to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions”.

In an explanatory note, it is affirmed that the right to education as provided in the Charter is based on the common constitutional traditions of Member States and on Article 2 of the Protocol to the ECHR. The specific reference to vocational and continuing training and to free compulsory education is considered as an extension of the “education” meant in the Convention.<sup>122</sup>

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<sup>120</sup> In the *Explanations* (Supranote 113), it is referred to “possible situations in which selection programmes are organised and implemented, involving campaigns for sterilisation, forced pregnancy, compulsory ethnic marriage among others”. However, it could be argued that eugenics could comprise also prospective parents’ choices about reproductive procedures See Wilkinson and Garrard, 2013, pp. 2-4.

<sup>121</sup> In the *Explanations* (Supranote 113) it is clarified that free compulsory education is intended to be provided to children, although no age limitations is provided for vocational continuing training.

<sup>122</sup> Note from the Praesidium, Draft Charter of Fundamental Rights of the European Union. Text of the explanations relating to the complete text of the Charter as set out in CHARTE 4487/00 CONVENT 50, 11 October 2000, CHARTE 4473/00 CONVENT 49.

### 3.1.2 Reproductive rights in the jurisprudence of the European Courts

The abovementioned provisions have been applied to sexuality and reproduction in a number of occasions thanks to individual complaints brought before the ECtHR and the CJEU<sup>123</sup>. A general overview of the case law will be provided at first to map which RR have been tackled by the Courts and, within this framework, a specific focus will then be given on the right to information, counselling and education.

Within the spheres of family planning and abortion<sup>124</sup> the ECtHR had to deal mainly with specific situations such as accession of abortion under different circumstances and accession of medical technology supporting reproduction.

The issue of abortion brought the Court to confront itself with the questions of whether or not women have a right to abortion under article 8<sup>125</sup>, whether the foetus has a right to life under Article 2<sup>126</sup> and whether prospective fathers have any rights under article 8<sup>127</sup>.

The Court has explicitly affirmed that abortion is not a right under the Convention and that, therefore, there is no right to have an abortion<sup>128</sup> or to practice it<sup>129</sup>. However, the Court explained that abortion is not prohibited by the Convention and States are free to decide, for the sake of competing rights, under which circumstances it is permitted. Once the State adopts statutory regulations allowing abortion in some situations, it must not structure its legal framework in a way which would limit possibilities to obtain it.<sup>130</sup>

Concerning the rights of the foetus, the Court has affirmed that it does not enjoy an absolute right to life<sup>131</sup>: “the unborn child is not regarded as a person directly protected

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<sup>123</sup> Concerning the CJEU, an only case will be analysed since RR have not be dealt with by the Court in other occasions.

<sup>124</sup> The dissertation adopts the position of Ericsson who holds that “although family planning and abortion are connected, the latter has to be distinguished since it can not be considered as a desirable method of family planning, but rather as a means to reduce the number of abortions”. Ericsson, 2000, pp. 181-182.

<sup>125</sup> See, *inter alia*, *Silva Monteiro Martins Ribeiro v. Portugal* [GC], no. 16471/02, ECtHR 2004; *Jean-Jacques Amy v. Belgium*, no. 11684/85, ECmHR 1988, *P. and S. v. Poland*, no. 57375/08, ECtHR 2013.

<sup>126</sup> See, *inter alia*, *X v United Kingdom*, no.8416/79, ECmHR 1980; *Vo v France* [GC], no. 53924/00, §80, ECtHR 2004; *Rosemarie Brueggemann & Adelheid Scheuten v the Federal republic of Germany*, no. 6959/75, ECmHR 1977.

<sup>127</sup> See, *inter alia*, *Boso v Italy*, no. 50490/99, ECtHR 2002; *R.H. v Norway*, no. 17004/90, ECmHR 1992.

<sup>128</sup> *Silva Monteiro Martins Ribeiro v. Portugal* [GC], no. 16471/02, ECtHR 2004.

<sup>129</sup> *Jean-Jacques Amy v. Belgium*, no. 11684/85, ECmHR 1988.

<sup>130</sup> *P. and S. v. Poland*, no. 57375/08, ECtHR 2013.

<sup>131</sup> *X v United Kingdom*, no.8416/79, ECmHR 1980.

by Article 2 of the Convention” and if the unborn do have a “right” to “life”, it is implicitly limited by the mother’s rights and interests”<sup>132</sup>. The relativity of the foetus’ right, however, is counterbalanced by the Court stance about the possibility that, in certain circumstances, safeguards that may be extended to the unborn are not ruled out and that choices concerning pregnancy can not be considered as solely a matter of the private life of the mother<sup>133</sup>, given that whenever a woman is pregnant her private life becomes closely connected with developing foetus<sup>134</sup>. Despite the fact that the Court has been more decisive when dealing with therapeutic abortion<sup>135</sup> and stated the necessity of balancing all the rights at stake, a right to abortion as a right to make autonomous decision regarding her own body has not been recognised in consideration of the non-completely private character of pregnancy.

Potential fathers’ rights have been considered in two cases: *Boso v Italy*<sup>136</sup> and *R.H. v Norway*<sup>137</sup>. The Court similarly concluded that the man has no right in relation to abortion since “not only does the woman’s right to bodily autonomy outweigh any right of the man, but he also holds no entitlement to the aborted foetal tissue”.<sup>138</sup> This position is based on the acknowledgment that the woman is “the person primarily concerned by the pregnancy and its continuation or termination”<sup>139</sup>.

Another topic the Court had to deal with, more recently, concerns procreative healthcare. The birth in 1978 of the first ever test tube baby in United Kingdom as a result of *in vitro fertilisation*<sup>140</sup> led to various developments in the field of reproductive technologies where possibilities are related not only to assisted conception, but also to the selection of embryos to be implanted.

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<sup>132</sup> *Vo v France* [GC], no. 53924/00, §80, ECtHR 2004.

<sup>133</sup> *Ibidem*.

<sup>134</sup> *Rosemarie Brueggemann & Adelheid Scheuten v the Federal republic of Germany*, no. 6959/75, EcmHR 1977.

<sup>135</sup> Therapeutic abortion is ending a pregnancy to protect the mother’s health or life or to avoid the development of a foetus affected by serious pathologies. E-Medicine, 2004.

<sup>136</sup> *Boso v Italy*, no. 50490/99, ECtHR 2002.

<sup>137</sup> *R.H. v Norway*, no. 17004/90, EcmHR 1992.

<sup>138</sup> Rothmar Herrmann in Toebe et al, 2012, p.160.

<sup>139</sup> Supranote (130), Para.2 of the section “The Law”.

<sup>140</sup> In vitro fertilisation is a type of assisted reproductive technology that involves fertilizing an egg outside the body, in a laboratory dish, and then implanting it in a woman's uterus.

A general stance by the Grand Chamber has been expressed in *S.H. and others v Austria*, where it considered that “concerns based on moral considerations or on social acceptability must be taken seriously in a sensitive domain like artificial procreation. However, they are not in themselves sufficient reasons for a complete ban on a specific artificial procreation technique such as ovum donation. Notwithstanding the wide margin of appreciation afforded to the Contracting States, the legal framework devised for this purpose must be shaped in a coherent manner which allows the different legitimate interests involved to be adequately taken into account”.<sup>141</sup> The Court had previously stated that the risks associated with new techniques in a sensitive field like medically assisted procreation “must be taken seriously and that it is in the first place for the domestic legislator to assess these risks after carefully weighing the different public and private interests involved and the dangers which might be faced. However, a complete ban on the medical technique at issue would not be proportionate unless, after careful reflection, it was deemed to be the only means of effectively preventing serious repercussions”.<sup>142</sup>

In *Evans v UK* a woman complained against the impossibility to have an *in vitro fertilisation* (IVF) treatment due to the withdrawal of her ex-partner’s consent to implant the embryos created jointly by them. The Court had the chance to clarify an overarching principle: to conceive a genetically related child and to use fertility treatment to achieve this goal falls within the scope of Article 8. The right is not absolute and the margin of appreciation of States has generally been highly respected by the Court in light of the absence of consensus with regard to the regulation of these practices and taking into consideration that “the use of IVF treatment gives rise to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments”.<sup>143</sup> The margin of appreciation guaranteed by the Grand Chamber concerned not only specifically the “detailed rules that [the State] lays down in order to achieve a balance between the competing public and private interests, but

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<sup>141</sup> *S.H. and others v Austria* [GC], no. 57813/00, §100, ECtHR 2011.

<sup>142</sup> *Ibidem*, §76.

<sup>143</sup> *Evans v. the United Kingdom* [GC], no. 6339/05, §81, ECtHR 2007.

more generally the State's decision whether or not to enact legislation governing the use of IVF treatment".<sup>144</sup>

Another case concerned artificial insemination for the applicants, a prisoner and his wife, and its denial by the British authorities. The Court confirmed the margin of appreciation held by States in regulating these issues and stated that the right to access treatment is not absolute, but subject to domestic limitations.<sup>145</sup> Concluding, although a wide margin of appreciation on the issue has been acknowledged to the States, a strict scrutiny has been done by the Court to evaluate if the margin was used in discriminatory terms to restrict access to these techniques, given that the right to conceive a child has been considered an important facet of our existence.

As it has been showed by this overview, Article 8 played a relevant role in proceedings involving reproductive choices since the notion of private life has been defined as a broad concept including, *inter alia*, the right to decide to have and not to have a child or to become genetic parents,<sup>146</sup> the right to conceive a child and the right to conceive a genetically related child that implies the right to make use of medically assisted procreation for that purpose<sup>147</sup>, and the right to personal autonomy and personal development, with its effects on reproductive choices<sup>148</sup>. As Rothmar Herrmann underlines, "the case law [about reproductive health] taken as a whole demonstrates a considerable reluctance in taking a stance on many issues, although some of the issues involved, which require that rights must be prioritised in the balancing between the various involved actors, have been clearly established"<sup>149</sup>

### **3.1.3 Information and education concerning reproduction in the Court's jurisprudence**

The Court dealt with the *right to know* concerning various aspects of reproduction, namely the right to informed consent to procedures affecting sexual and reproductive

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<sup>144</sup> Ibidem, §82.

<sup>145</sup> *Dickson v the United Kingdom* [GC], no. 44362/04, § 76, ECtHR 2007.

<sup>146</sup> *Evans v. the United Kingdom* [GC], no. 6339/05, § 71, ECtHR 2007.

<sup>147</sup> Ibidem, § 82.

<sup>148</sup> *A, B and C v. Ireland* [GC], no. 25579/05, §212, ECtHR 2010.

<sup>149</sup> Rothmar Herrmann in Toebe, 2012, p.152.

health and the right to receive information and education about sexuality in formal and informal contexts.

As argued in the second chapter, informed consent is a key concept when dealing with RR since it connects three dimensions such as health, privacy and information. The autonomy and empowerment of the individual stem, indeed, from the capability of making a voluntary health-related decision on the base of the information provided.

The right to informed consent has been brought before the Court in relation to specific medical procedures such as sterilisation operations and gynaecological examinations.<sup>150</sup>

Gynaecological examinations were at the core of cases brought against Turkey whereas the procedures were implemented without the women's consent, while they were in police custody, or without their consent being free and informed.<sup>151</sup>

In the attempt of clarifying the concept of free and informed consent, the Court mentions<sup>152</sup> article 5 of the Council of Europe Convention on Human Rights and Biomedicine that reads: "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time."<sup>153</sup> The Court stated that "any medical intervention against the subject's will, or without the free, informed and express consent of the subject, constitutes an interference with his or her private life"<sup>154</sup>, unless justified as being in accordance with the law and necessary in a democratic society.

The Court has taken in consideration also other factors affecting the integrity of the consent e.g. the conditions in which it is requested: a person who is detained is considered to be in a state of vulnerability, given her being at the hands of the authorities, who exercise complete control over her throughout her detention, and in view of this state it can not be expected that the individual resist submitting to such an

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<sup>150</sup> See, inter alia, *Salmanoğlu and Polattaş v. Turkey*, no. 15828/03, ECtHR 2009; *Juhnke v. Turkey*, no. 52515/99, ECtHR 2008; and *V.C. v. Slovakia*, no. 18968/07, ECtHR 2012.

<sup>151</sup> *Salmanoğlu and Polattaş v. Turkey*, no. 15828/03, ECtHR 2009, and *Juhnke v. Turkey*, no. 52515/99, ECtHR 2008.

<sup>152</sup> *Juhnke v. Turkey*, no. 52515/99, § 76, ECtHR 2008.

<sup>153</sup> Council of Europe, Convention on Human Rights and Biomedicine, art.5.

<sup>154</sup> Supranote (146). Ibidem.

examination.<sup>155</sup> Moreover an informed consent can be expressed only where exhaustive information are provided on the nature and reasons for the examination. The Court has noted that whereas the claimant “might have been misled into believing that the examination was compulsory”<sup>156</sup>, the consent loses its free and informed nature.

Informed consent was invoked also concerning sterilisation operations carried out in Slovakia on Roma women.<sup>157</sup> The Court relied on both the abovementioned Convention and its Explanatory Comment to provide further details on the concept of free and informed consent that is given “on the basis of objective information from the responsible health care professional as to the nature and the potential consequences of the planned intervention or of its alternatives, in the absence of any pressure from anyone”<sup>158</sup>. Information provided must comprise “the purpose, nature and consequences of the intervention and the risks involved. Information on the risks involved [...] must cover not only the risks inherent in the type of intervention contemplated, but also any risks related to the individual characteristics of each patient, such as age or the existence of other pathologies. Requests for additional information made by patients must be adequately answered. Moreover, this information must be sufficiently clear and suitably worded for the person who is to undergo the intervention. The patient must be put in a position, through the use of terms he or she can understand, to weigh up the necessity or usefulness of the aim and methods of the intervention against its risks and the discomfort or pain it will cause.”<sup>159</sup> The Court underlined the link between consent and autonomy when it held in *V.C. v Slovakia* that: “the way in which the hospital staff acted was paternalistic, since, in practice, the applicant was not offered any option but to agree to the procedure [...] However, in similar situations informed consent was required, promoting autonomy of moral choice for patients.”<sup>160</sup> The Court recalls the principle of women’s right to autonomy and choice in the context of health care by

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<sup>155</sup> *Y.F. v. Turkey*, no. 24209/94, ECtHR 2003.

<sup>156</sup> Supranote (146). Ibidem.

<sup>157</sup> See, *inter alia*, *V.C. v. Slovakia*, no. 18968/07, ECtHR 2012 and *N.B. v Slovakia*, no. 29518/10, ECtHR 2012; and *K.H. and Others v. Slovakia*, no. 32881/04, ECtHR 2009.

<sup>158</sup> Supranote (113), para. 35.

<sup>159</sup> Ibidem, 35-36.

<sup>160</sup> *V.C. v. Slovakia*, no. 18968/07, § 114, ECtHR 2012.



referring to the CEDAW and to the Universal Declaration on Bioethics and Human Rights.<sup>161</sup>

A second issue is related to the right to receive personal or general information about reproductive issues.<sup>162</sup> The conclusions of the Court in the sterilisation cases were equally restated in cases in which personal information were requested or provided, not with the objective of implementing a procedure, but to discourage a specific intervention, namely abortion.<sup>163</sup> In both cases, the applicants (a woman and an adolescent) sought abortion and were denied relevant information or examination that could provide with important information about their health. In *RR v Poland* the woman had an ultrasound scan during her pregnancy and was told that the foetus could have a genetic malformation. The woman communicated to the doctor her intention to interrupt the pregnancy, if so. However, when she tried to undergo further tests to prove the existence of such a circumstance, she was denied the examinations, to which she was entitled under Polish law. The Court underlined that the denial of health information, regardless of what a woman chooses to do with them, has repercussion on her most fundamental rights: “In the context of pregnancy, the effective access to relevant information on the mother’s and foetus’ health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy.”<sup>164</sup>

In *P. and S. v Poland* the Court stressed that “the applicants were given misleading and contradictory information. They did not receive appropriate and objective medical counselling which would have due regard to their own views and wishes”<sup>165</sup> as one of the circumstances that led to the violation of their right to private life and to freedom from torture and other degrading treatments.

Two milestone cases have contributed to shade a light about the approach of the two Courts in cases of non-directive counselling, where general information about medical services was provided: the *Grogan* case and the *Open Door Counselling Ltd. and*

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<sup>161</sup> Ibidem, § 115.

<sup>162</sup> Differently from the “informed consent” cases, what is discussed here is the possibility to receive information that, although capable of influencing the individual’s choice, do not involve any form of “consent”.

<sup>163</sup> *R.R. v Poland*, no. 27617/04, ECtHR 2011; and *P and S. v Poland*, no. 57375/08, ECtHR 2013

<sup>164</sup> *RR v Poland*, no. 18968/07, § 197, ECtHR 2012.

<sup>165</sup> *P and S. v Poland*, no. 57375/08, § 108, ECtHR 2013

*Dublin Well woman Centre v. Ireland* case. These two cases, brought respectively before the CJEU and the ECtHR, shared the same protagonist, the Society for the Protection of Unborn Children (SPUC).

The SPUC had, in the eighties, sought to stop women from travelling abroad for an abortion and initiated a series of proceedings against the Irish agencies *Open Door Counselling* and *Dublin Well Woman Centre* who provided non-directive counselling about legal abortion services abroad. In 1988, the Irish Supreme Court granted an injunction restraining the two counselling agencies from assisting pregnant women “to travel abroad to obtain abortions by referral to a clinic, by the making for them of travel arrangements, or by informing them of the identity and location and method of communication with a specified clinic or clinics or otherwise”.<sup>166</sup> The Agencies decided, therefore, to bring the case before the ECtHR that held that the restriction was prescribed by law and ‘pursued the legitimate aim of the protection of morals of which the protection in Ireland of the right to life of the unborn is one aspect’. The acknowledgment of a missing consensus on the conception of morals provided Contracting States with a wide margin of appreciation. Nonetheless, the Court found the restriction imposed by the Government as disproportionate to the aims pursued, given “the absolute nature of the injunction that imposed a “perpetual” restraint on the provision of information to pregnant women concerning abortion facilities abroad, regardless of age or state of health or their reasons for seeking counselling on the termination of pregnancy”.<sup>167</sup> Violation of the right to receive information has been confirmed also in consideration of other factors: the assessment that the link between the provision of information and the destruction of unborn life was not as definite as contended<sup>168</sup>; that information could be obtained from other sources in Ireland<sup>169</sup>; the ineffectiveness of the restriction in protecting the right to life of the unborn since it did not prevent large numbers of Irish women from obtaining abortions in Great Britain<sup>170</sup>;

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<sup>166</sup> The Attorney General (*Society for the Protection of the Unborn Children (Ireland Ltd) v. Open Door Counselling Ltd* [1988] IR 593, at 625.

<sup>167</sup> *Open Door and Dublin Well Woman v. Ireland*, nos.14234/88 and 14235/88, § 73, ECtHR 1992.

<sup>168</sup> *Ibidem*, §75.

<sup>169</sup> *Ibidem*, §76.

<sup>170</sup> *Ibidem*.

the fact that the injunction created a risk to the health of women seeking abortions at a later stage in their pregnancy due to the lack of proper counselling and the adverse effects of the injunction on women who were not sufficiently resourceful or did not have the necessary level of education to access alternative sources of information<sup>171</sup>.

Right before this judgment, the SPUC had decided to bring a similar complaint<sup>172</sup> against three students' unions that distributed free handbooks containing information about abortion services available in England. The unions contended that Irish citizens had a right to receive and impart information about services lawfully available in other Member States according to article 59 and 60 of the EEC Treaty (now 56 and 57 TFEU) and the High Court asked the CJEU for a preliminary ruling on three questions: (a) whether abortion was a 'service' within the meaning of the EEC Treaty; (b) if so, whether the distribution of information regarding those services constituted a restriction within the meaning of article 59 of the Treaty; and (c) if so, whether such a restriction could be justified under Community law.

In its preliminary ruling, the ECJ rejected SPUC's claim that abortion was 'grossly immoral' and could not come within the definition of a service<sup>173</sup>. It held that termination of pregnancy, as lawfully practised in several Member States, is a medical activity which is normally provided for remuneration and may be carried out as part of a professional activity. Therefore the Court concluded that medical termination of pregnancy, 'performed in accordance with the law of the State in which it is carried out', constitutes a service within the meaning of Article 60 of the Treaty (now Article 57 TFEU). However, the Court held that the links between the activities of the students' unions and the providers of abortion services in the United Kingdom or elsewhere, were 'too tenuous', for the prohibition on the distribution of information to be regarded as a restriction within the meaning of the EEC Treaty<sup>174</sup>.

Finally, as expounded in the previous chapter, reproductive choices can be affected also by information received in educational contexts. The Court had the chance to take a

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<sup>171</sup> Ibidem, § 77.

<sup>172</sup> Case 159/90, *Society for the Protection of Unborn Children Ireland Ltd. (SPUC) v. Gogan*, 1991-8 E.C.R. I-4685, [1991] 3 CMLR 849 (1991).

<sup>173</sup> Ibidem, § 17-21.

<sup>174</sup> Ibidem, §24.

stance on the right to education in two cases where sexuality has been the subject of teaching.<sup>175</sup> The Court considers education as “the whole process whereby, in any society, adults endeavour to transmit their beliefs, culture and other values to the young, whereas teaching or instruction refers in particular to the transmission of knowledge and to intellectual development”<sup>176</sup>.

The first case<sup>177</sup> brought before the Commission concerned a group of parents who claimed that sex education lessons organised in Danish state schools offended their religious sentiments. The Commission clarified that “the setting and planning of the curriculum fall in principle within the competence of the Contracting States. This mainly involves questions of expediency on which it is not for the Court to rule and whose solution may legitimately vary according to the country and the era.”<sup>178</sup>

The autonomy recognised to parents in Article 2 of the Protocol does not affect the possibility for States to impart through teaching or education information or knowledge of a directly or indirectly religious or philosophical kind. Moreover, the Commission affirmed that Article 2 “does not even permit parents to object to the integration of such teaching or education in the school curriculum, for otherwise all institutionalised teaching would run the risk of proving impracticable. In fact, it seems very difficult for many subjects taught at school not to have, to a greater or lesser extent, some philosophical complexion or implications.”<sup>179</sup>

By doing this, the Commission recalled the overarching principle stated in the *Belgian Linguistic Case* whereas: “the right to education [...] by its very nature calls for regulation by the State, regulation which may vary in time and place according to the needs and resources of the community and of individuals.”<sup>180</sup> In the specific case, the Commission acknowledged that “the Danish legislator [...] clearly took as his starting point the known fact that in Denmark children nowadays discover without difficulty and

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<sup>175</sup> *Dojan and others v Germany*, no. 319/08, § 2, ECtHR 2011; and *Kjeldsen, Busk Madsen and Pedersen v. Denmark*, nos. 5095/71; 5920/72; 5926/72, ECtHR, 1976.

<sup>176</sup> *Campbell and Cosans v the United Kingdom*, nos. 7511/76; 7743/76, § 33, ECtHR, 1982.

<sup>177</sup> *Kjeldsen, Busk Madsen and Pedersen v. Denmark*, nos. 5095/71; 5920/72; 5926/72, ECtHR, 1976.

<sup>178</sup> *Ibidem*, § 53.

<sup>179</sup> *Ibidem*.

<sup>180</sup> *Case “Relating to certain aspects of the laws on the use of languages in education in Belgium” v Belgium (Merits)*, nos. 1474/62; 1677/62; 1691/62; 1769/63; 1994/63; 2126/64, §3, ECtHR 1968.

from several quarters the information that interests them on sexual life. The instruction on the subject given in State schools is aimed less at instilling knowledge they do not have or cannot acquire by other means than at giving them such knowledge more correctly, precisely, objectively and scientifically.”<sup>181</sup>

Furthermore, the Commission assessed that the legislation “in no way amounts to an attempt at indoctrination aimed at advocating a specific kind of sexual behaviour. It does not make a point of exalting sex or inciting pupils to indulge precociously in practices that are dangerous for their stability, health or future or that many parents consider reprehensible. Further, it does not affect the right of parents to enlighten and advise their children, to exercise with regard to their children natural parental functions as educators, or to guide their children on a path in line with the parents’ own religious or philosophical convictions.”<sup>182</sup>

On this point, the test adopted by the Court in this and in other cases<sup>183</sup> where the right to education was challenged by parents’ philosophical or religious convictions has been the following: “the State, in fulfilling the functions assumed by it in regard to education and teaching, must ensure that information or knowledge included in the curriculum is conveyed in an objective, critical and pluralistic manner. If this is not the case, the State authorities are under an obligation to grant children full exemption from the lessons in accordance with the parents’ religious or philosophical convictions”<sup>184</sup> So in the Danish case, the Commission evaluated that parents’ rights were not violated but it did not tell much about the role that sex education plays within the boundaries of the right to education.

A second case, *Dojan v Germany*, having as central issue the teaching of sexual education in public schools, has been submitted to the Court more recently but declared inadmissible. In its unanimous decision the Court observed that “sex education classes at issue aimed at [...] the neutral transmission of knowledge regarding procreation,

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<sup>181</sup> Ibidem, § 54.

<sup>182</sup> Ibidem.

<sup>183</sup> See, *inter alia*, *Folgerø and others v Norway* [GC], no. 15472/02, ECtHR 2007 and *Appel-Irrgang and Others v. Germany* (dec.), no. 45216/07, ECHR 2009.

<sup>184</sup> Council of Europe Research Division, Cultural rights in the case-law of the European Court of Human Rights, pp.18-19.

contraception, pregnancy and child birth [...]. The goal of the theatre workshop “My body is mine” was to raise awareness of sexual violence and abuse of children with a view to its prevention.”<sup>185</sup>

Moreover, the Court took into consideration the declared aim of the domestic law and, specifically, the objectives pursued by the State while providing sex education, that is to say: “to provide pupils with knowledge of biological, ethical, social and cultural aspects of sexuality according to their age and maturity in order to enable them to develop their own moral views and an independent approach towards their own sexuality. Sexual education should encourage tolerance between human beings irrespective of their sexual orientation and identity” and found these aims consonant with the principle of pluralism and objectivity embodied in Article 2, Protocol 1.

Some conclusions about the Court’s approach towards the *right to know*, in its various forms, can be drawn from this general overview. Firstly, the Court has extensively clarified the notion of “informed consent” relying both on the ECHR and on the Convention on Human Rights and Biomedicine. The Court has underlined the key role that informed consent and the right to receive personal health-related information (even when consent is not involved) play in supporting the principle of women’s right to autonomy and choice in the context of health care, demonstrating a “rights embracing approach”<sup>186</sup>. Secondly, concerning the provision of information to a general public, the Court has been more cautious in its judgment: although in the *Open Door* case it has assessed that the right to receive information was violated, it has nonetheless recognised that on the conception of “morals” still lacked consensus and therefore a wide margin of appreciation had to be recognised. The contingent CJEU decision recognised abortion as a service that can indeed be object of advertising campaigns, but the link between the service and the related information must be direct and strong. Finally, the Court recognised the autonomy of States to include education about sex in school curricula, and, contextually, the primacy of the children’s right to receive education, when it is conveyed in an objective, critical and pluralistic manner.

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<sup>185</sup> *Dojan and others v Germany*, no. 319/08, § 2, ECtHR 2011.

<sup>186</sup> Westeson, 2013, p.175

### 3.2 Reproduction as a public health issue in the EU

A first necessary terminological and substantial premise to this section concerns the distinction between medicine and public health, whereas medicine is concerned more with the health and rights of the individuals, public health is more aimed at the protection of collective health interests. Gruskin and Tarantola have claimed that the most recently adopted human rights approach has determined a softening of the boundary between the two concepts and their field of application: although applying different methods of work, the two fields “seek to ensure every person's right to achieve the highest attainable standard of health”, and State’s responsibility to respect, protect and fulfil health-related rights concerns both fields.<sup>187</sup> This caveat is relevant to the argument presented in the section since public health can no longer be treated as something excluding a human rights approach and an integration of the disciplines is inevitable.

The main responsibility for health protection in the EU lies primarily with national authorities<sup>188</sup>: despite a shared competence on common safety concerns in public health matters<sup>189</sup>, Member States retain the competence to protect and improve human health with the EU having a supporting competence on this matter, that is to say having the legal capacity to carry out actions to support, coordinate or supplement the actions of the Member States.<sup>190</sup>

Article 168 TFEU holds that “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities” and explains that “Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring early warning of and combating serious cross-border threats to health”. And Member States

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<sup>187</sup> Gruskin & Tarantola in Detels et al, 2002, p.327.

<sup>188</sup> Article 168, Treaty on the Functioning of the European Union (TFEU).

<sup>189</sup> Ibidem, art.4 (2) (k).

<sup>190</sup> Ibidem, art.6. The same principle of supporting competence applies to education [Art.6 (e)].

shall, in liaison with the Commission, coordinate among themselves their policies and programmes in these areas. Moreover, Article 9 TFEU reads that in defining and implementing its policies and actions, the Union shall take into account requirements linked to, inter alia, a high level of education, training and protection of human health.

This clear division of competences has been challenged by the increasing integration of the European Union that has contributed to a growing unclearness on this issue. As described by McKee, health began to be included in European treaties by stating that, despite the relevance of coordinating issues entailing trans frontier implications, health care organisation at the national level remained something on which States had a clear sovereignty.<sup>191</sup> The greatest challenge to this principle has come from the European economic integration and from the increasing privatisation affecting the health sector: the growing mobility of patients, goods and services has jeopardised the sovereignty of States on health. Furthermore, the expanding scope of the EU law in areas that affect healthcare together with a raising awareness of individuals toward the rights stemming from this process, has contributed to a growing tension.

In this evolving framework reproduction and sexuality have been addressed only to the extent that they are linked to common safety concern, namely the prevention of STIs, but this concern has played an important role in the process described by McKee since one of the first public health programme implemented by the Commission was *Europe against AIDS*, that was applied in 1991 even before the Maastricht Treaty introduced any Community competencies in the field or before these were extended by the Amsterdam Treaty.<sup>192</sup> The growing visibility of the link among health and socio-economic factors made intersectoriality in public health inevitable and the EU role on this issue changed rapidly. According to Guigner, the Commission strengthened its role on the matter by using *emancipation strategies such as bench-marking or soft law, in order to get around the constraint imposed by member States and the challenge of political legitimacy*.<sup>193</sup>

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<sup>191</sup> McKee et al, 2002, p.13.

<sup>192</sup> Guigner in Smith, 2004, p.96.

<sup>193</sup> Ibidem, p.97.



In this conquered space, some programmes partially related with informal education<sup>194</sup> have been funded by the EU and policies against HIV/AIDS transmission have been established by the Commission, trying to assert an indirect influence on member States. The policies to support the prevention of Sexually Transmitted Diseases (STDs)<sup>195</sup> have been grounded on the idea of raising awareness concerning risks: the aim of these policies has been to improve data collection on STDs, as well as to share examples of good practice concerning the monitoring and the prevention of STIs and STDs. The concrete implementation of these policies has been funded through the EU Health Programme 2008-2013<sup>196</sup>, that listed sexual health among the key factors to take action on in order to “promote and improve mental and physical health, creating supportive environment for health lifestyle and preventing diseases”<sup>197</sup>. Most importantly, the Programme pointed at some key settings in which actions should be implemented such as education and workplace, and across the life cycle.

Besides these policies, a number of projects related with sexual education have been promoted. The EU has co-funded these projects under the EU’s Health Programme 2008-2013 and delegated the implementation to external organisations. Some projects shared the overall goal of developing and promoting knowledge and information about sexuality among youngsters through different communication methods such as web series<sup>198</sup>, modern tutorial techniques and mobile technology.<sup>199</sup> Key common action have been the collection of data and information about sexual and reproductive health and policies across Member States.<sup>200</sup>

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<sup>194</sup> School-based sexuality education is managed by the national Ministries of Education and of Health and the contents of the teaching are mostly decided by the school itself. European Parliament, Policies for sexuality education in the European Union, 2013, p.45.

<sup>195</sup> Although, the two terms are often used interchangeably, it is relevant to note that not all STIs turn into a disease.

<sup>196</sup> Official Journal of the European Union L 301/4, 20/11/2007, Decision No 1350/2007/EC of the EU Parliament and of the Council of 23 October 2007.

<sup>197</sup> Ibidem, para. 2.2.1.

<sup>198</sup> Project No. 20091203 “BoysandGirls” targeting teenagers and young adults, especially the 15-25 year-olds who are neither at school nor at work.

<sup>199</sup> Project No. 20091217 “SafeSex” targeting young people aged from 13 to 18 years old in six EU countries.

<sup>200</sup> Projects No 20091217 “SAFE” and No 2007305 “Sunflower”.

These limited actions and this focus on STIs as a main issue suggest that the approach toward reproductive health, especially concerning information and education, has been cautious and highly respectful of the division of competences on the matter. A clear sign of the limited space of action of the EU in this field, and its future orientation, has to be found in the current *Health for Growth Programme 2014-2020*, approved by the EU in March<sup>201</sup>. Any direct or indirect referral to sexual and reproductive health is completely absent in the text and HIV/AIDS is solely mentioned as a risk factor and the only communicable disease related to sex that should be the object of an effective response by the institutions.<sup>202</sup>

### **3.3 The Estrela report: a failed conjunction of health and human rights**

The Report on Sexual and Reproductive Health and Rights<sup>203</sup> (hereinafter, the Report) produced by the Committee on Women's Rights and Gender Equality (FEMM) and presented by the Rapporteur Estrela in December 2013 can be interpreted as an attempt to bring the issue of sexual and reproductive rights inside the European Parliament and to tackle sexuality and reproduction as issues that deserve to be approached both as a public health issue and as involving human rights questions.<sup>204</sup>

The FEMM is responsible, *inter alia*, for the definition, promotion and protection of women's rights in the Union and related Union measures<sup>205</sup> and in pursuing these objectives, it can rely on a number of initiatives: it can draw up, amend and adopt legislative proposals and own-initiative reports; it can consider Commission and

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<sup>201</sup> Official Journal of the European Union L 86/1, 21/03/2014, Regulation (EU) No 282/2014 of the EU Parliament and of the Council of 11 March 2014.

<sup>202</sup> Ibidem, para.1.3.

<sup>203</sup> Supranote (1). Ibidem.

<sup>204</sup> The Report made reference to a previous EU Resolution clearly mentioning SRHR, that held that policies concerning reproductive health fell within States' competence and that the role played by the EU should be *to 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 and Accession Countries sexual and reproductive health programmes and policies.*(Part 1) Official Journal of the European Union C 271 E/003, 12/11/2003, European Parliament resolution on sexual and reproductive health and rights

<sup>205</sup> European Parliament, Rules of procedure of the European Parliament, 7th parliamentary term March 2014, Annex VII Powers and responsibilities of standing committees, XIX. Committee on Women's Rights and Gender Equality, adopted by decision of Parliament of 6 May 2009.

Council proposals and, where necessary, draw up reports to be presented to the plenary assembly.<sup>206</sup>

The Report called on an EU Parliament Resolution on Sexual and Reproductive Health and Rights (SRHR) affirming a comprehensive approach toward sexuality and reproduction. Among the central aspects there was the affirmation of health as a fundamental human right and the idea that the highest attainable standard of health is not achievable without a full integration of SRHR within the concept and their promotion.<sup>207</sup> According to the Report, SRHRs are an essential element of human dignity and their violation has a direct impact on women's and girls' lives from different perspectives, including their access to decision-making, participation in public life and education.

The Report concerns various aspects composing SRHR: sexual and reproductive health and rights policy in the EU in general; unintended and unwanted pregnancy (access to contraception and safe abortion services); comprehensive sexuality education and youth-friendly services; STIs prevention and treatment; violence related to sexual and reproductive rights; and SRHRs and official development assistance (ODA).

The idea of a fundamental access to information, counselling and education is present throughout the Report and Member States are required to provide quality sexual and reproductive health services ensuring a geographically adequate distribution.<sup>208</sup> Furthermore, Member States and candidate countries should develop national policies comprising the provision of comprehensive information concerning effective and responsible methods of family planning.

The Report called on States to make information available to the general public and to strengthen their awareness-raising policies on STIs, and to provide prevention activities besides voluntary counselling and testing. Fully informed consent should be requested prior to all medical services and procedures, such as contraceptive services, sterilisation and abortion.

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<sup>206</sup> Ibidem, Title II, Chapter 2.

<sup>207</sup> Supranote (1). Para. 1.

<sup>208</sup> Ibidem, 5. Services like counselling have to be included in the category of health services.

Under the *Education* headline, the Report called on Member States to ensure universal access to comprehensive SRHR information, education and services urging them *to ensure that this information covers a variety of modern methods of family planning and counselling, skilled birth attendance, and the right to access gynaecological and obstetric emergency care, and that it is non-judgmental and scientifically accurate about abortion services*. A specific focus is devoted to the participation of youngsters in the development, implementation and evaluation of programmes in order to render sexuality education more effective. Methods for reaching out young people such as peer education publicity campaigns, social marketing for condom use and other methods of contraception, and initiatives such as confidential telephone helplines are encouraged. Sexuality education classes should be compulsory for primary and secondary school with constantly reviewed and updated teaching and with special emphasis on gender equality.<sup>209</sup> Education should be provided through a holistic approach that tackle both bio-medical and psycho-social aspects; rights-based and positive approach. Moreover, it should include sensitive topics such as STIs transmission and non-discriminatory information about LGBTI.

As described in the explanatory note, Member States are among the leading countries in the United Nations Development Programme ranking on Gender Inequality Index, however the available data show a high degree of differentiation among them. The current political and economic context is identified as a threat to SRHR since “due to the current financial crisis and economic downturn and the related cuts in the public budgets there is a tendency among MS to accelerate the privatisation of health services and decrease access to and quality level of health services”. Moreover, conservative positions towards SRHR have arisen across Europe and become more vocal. Therefore, the Committee holds that it is more critical than ever that the Parliament stand up for SRHR as human rights.

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<sup>209</sup> The Report confirms that sexuality education programmes are slowly improving, but holds that the sharing of common goals and best practices among EU states would serve to facilitate the harmonisation of sexuality education standards and to contribute to more equal sexual and reproductive health for all.

As anticipated, the Report was rejected and another Resolution<sup>210</sup> was passed, that clarified that the EU definition of SRHR mirrors the one of the Cairo programme. The text was reduced at one page and contained solely a remainder about the fact that the formulation and implementation of policies on SRHR and on sexual education in schools is a competence of Member States and the EU can only contribute to the promotion of best practices among Member States.

The Report and its failed adoption represent more than a mere missed opportunity but they shed a light on a broader process of inevitably difficult interaction between the EU competences, as established in the Treaties, and the potential space of action guaranteed by the respect of human rights as defined in the CFREU and in the ECHR. As underlined by Craig, *at the beginning the framers did not realise that the Treaty, with its economic focus, could encroach on traditionally protected fundamental human rights*, because the Community action, now Union, could affect social, political and economic issues, despite the initial absence of human rights in the EEC Treaties.<sup>211</sup>

Therefore, the future of reproductive rights in the EU system will depend on the interpretation of the Charter by the CJEU and on the ECHR by the ECtHR, but also on the interaction between the Charter and the EU Treaties on health. This interaction is partially governed by Article 51(2) CFREU: “The Charter does not extend the field of application of Union law beyond the powers of the Union or establish any new power or task for the Union, or modify powers and tasks as defined in the Treaties.” Craig suggests that: “the fit between Art 51(2) and the substantive provisions of the Charter may be questioned. Much turns on the precise meaning of the words “power or task”, that could be interpreted to mean a new head of legislative competence. If viewed in this way Art 51(2) prohibits construction of the Charter such as to afford new or modified legislature competence to the Union. The application of this precept may, however, be problematic given the uncertainties concerning competences under the Lisbon treaty. It is important to note, however, that the denial of new heads of legislative competence would not preclude, for example, claims to new social entitlements from the EU on the

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<sup>210</sup> European Parliament, Resolution on Sexual and reproductive health and rights, Amendment 2, 10 December 2013, P7\_TA(2013)0548

<sup>211</sup> Craig, 2010, p.194.

basis of fundamental social rights so long as those claims can be satisfied through the exercise of an existing competence.”<sup>212</sup>

The refusal of the Report is, indeed, a worrisome signal from the Parliament’s side, trying to take the distance from issues deemed to be sensitive and that do not encounter the same level of endorsement in all the Member States. As showed, out of an extensive Report with nearly 90 recommendations covering reproductive rights in a number of ways, the Parliament voted an alternative proposal containing an only paragraph, in which it refused competence over education and did not address the other provisions. It is yet to be seen to what extent the pressure exercised by cases brought before the Courts and by the FEMM activity within the Parliament will drive the EU to address these issues in the future.

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<sup>212</sup> Ibidem, pp.214-215.

#### **4. The European Union's approach towards reproductive rights in its relations with Third countries.**

As expounded in the previous chapter, the EU's internal approach has been twofold, interpreting reproduction as a human rights issue and as a public health concern. Nonetheless, the EU's caution has led to the absence of legislative instruments concerning reproductive rights as such and, therefore, to a real difficulty in investigating the EU's stand on this concern.

The scope of this chapter is to outline the position taken by the EU in its external relations concerning reproduction and related rights in order to evaluate to what extent it mirrors the position held internally.

As a first step, the EU's stance will be investigated through the examination of international instruments on reproductive issues endorsed by the Union. The focus will, then, shift towards the EU's development policy<sup>213</sup>, as one of the fields of EU's external action, to evaluate if and to what extent this international commitment on reproductive rights has been translated into this policy. To achieve this objective, an analysis will be done of some EU Regulations concerning development and reproductive rights; and of development projects implemented in Third countries, on the basis of these Regulations. Where possible, as done in the previous chapters, a specific focus will be maintained on the right to know applied to reproductive issues.

##### **4.1 The EU's commitment concerning reproductive rights on the international stage**

The EU's approach towards sexual and reproductive health and rights on the international stage has been defined through the adhesion to two *soft law* instruments:

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<sup>213</sup> Given the diversification of the EU's external policies, the reason behind the choice of development policy for this dissertation will be explored in chapter 4.2.

the UNFPA Programme of Action (hereinafter, Cairo Programme) of 1994<sup>214</sup> the +5 Key Actions<sup>215</sup> and the Beijing Declaration and Platform of Action.<sup>216</sup>

#### **4.1.1 The Cairo Programme and the +5 Key Actions**

The Cairo Programme comprised different sections dealing with a variety of population issues, including population growth, migration, urbanisation, health and education, but the most relevant chapter for this dissertation is the one entitled *Reproductive rights and reproductive health* (Chapter VII).

The definition of reproductive rights, already mentioned in the first chapter, was the basis on which the commitments of the various stakeholders were made and the EU's adhesion<sup>217</sup> to the text makes it relevant to describe what kind of commitments stem from these provisions concerning information, counselling and education.

A general commitment foresees that the exercise of these rights should be the fundamental basis for government and community-supported policies and programmes in the area of reproductive health, this including a “full attention to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality” (para. 7.3).

The objectives of the Programme concerning health can be summarised as follows: a) to ensure that comprehensive and factual information and a full range of reproductive health care services should be affordable, accessible, acceptable and convenient to all users; b) to enable and support responsible voluntary decisions concerning family planning, together with the relevant information and education; c) to meet changing reproductive health needs over the life cycle with attention to the diverse contexts (para.

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<sup>214</sup> Supranote (14). Ibidem.

<sup>215</sup> UN General Assembly, Resolution on Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, adopted on 8 November 1999, A/RES/S-21/2.

<sup>216</sup> Supranote (24). Ibidem.

<sup>217</sup> I use the word “adhesion” in the text in order to underline that, although the EU has not incorporated the text in its law, representatives of the EU were present at the Conference and showed endorsement of the principles enshrined in the text. This endorsement has been reiterated in numerous EU texts, and most notably in European Commission Regulations 1567/2003, 1905/2006, 233/2014.



7.5). The achievement is subject to a series of listed actions that comprise substantially the provision of goods and services related to reproductive health, a greater involvement of civil society on these issues and the cooperation among countries (paras. 7.6-7.11).

It is relevant to note the great focus posed on information, education and counselling concerning human sexuality, reproductive health and responsible parenthood as essential components of reproductive health care to be provided. Responsible for the provision of healthcare goods and services are not only the governments, but also the international community and this is a major point on which the EU aid can rely (para. 7.25). These soft obligations are repeated more in detail in the different sections devoted to STDs and prevention of HIV, family planning, sexuality and gender relations, and adolescents. Furthermore in the specific chapter dedicated to *Population information, education and communication* (Chapter XI B), it is acknowledged that a greater degree of knowledge at all levels is vital to the achievement of the Programme goals: at the national level, information enables planners and policy makers to make appropriate plans in relation to population and sustainable development, while at the individual level more adequate and appropriate information is conducive to informed, responsible decision-making concerning health, sexual and reproductive behaviour, family life, and patterns of production and consumption (para. 11.1).

It is important to underline that, although most commitments are addressed to governments and countries, a specific section contains what is expected from regional and sub-regional organisation. Considering that all the EU states have adopted the Programme and the EU has done it as well, there is a series of cumulative obligations for the EU to be active on the basis of this document and, *inter alia*, the obligation to play an active role on their side in the implementation and follow-up of the Programme (para. 16.6).

The position undertaken at this meeting was confirmed at the special session of the United Nations General Assembly (ICPD +5) in June 1999, where a Resolution<sup>218</sup> was adopted comprising key actions for the further implementation of the content of the Cairo Programme, including new benchmark indicators of progress in four key areas:

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<sup>218</sup> Supranote (215). Ibidem.

education and literacy (paras. 34-35), reproductive health care and unmet need for contraception (paras. 53; 58), maternal mortality reduction (para. 64), and HIV/AIDS (para. 70).

The text assigns a major responsibility to governments in implementing key actions and adopting general policies about the topic, nonetheless a role is given to donors that are supposed to cooperate in order to achieve these results (para. 17).

Concerning specifically reproductive rights, the text calls on the governments to strengthen “the reproductive and sexual health as well as the reproductive rights focus on population and development policies and programmes” (para. 40). Interestingly enough, it is made explicit that reproductive rights enjoy their own autonomy as a concept and they are to be comprised within the broader human rights category (para. 41), while a specific relevant role is confirmed to both information and education (paras. 35 and 52).

The right to information linked with reproductive matters is discussed in detail and all the various aspects of it are taken care of. It is specifically emphasised that United Nations and other donors should support governments in “[...] (a) Mobilizing and providing sufficient resources to meet the growing demand for access to information, counselling, services and follow-up on the widest possible range of safe, effective, affordable and acceptable family planning and contraceptive methods, including new options and underutilized methods; (b) Providing quality counselling services and ensuring ethical, professional and technical standards of care, as well as voluntary, free and informed choices in an atmosphere of privacy, confidentiality and respect” (para. 57). Dealing specifically with abortion, it is held that “post-abortion counselling, education and family planning services should be offered promptly” (para. 63). Whereas, concerning STIs “advocacy and information, education and communication campaigns developed with communities and supported from the highest levels of Government should promote informed, responsible and safer sexual behaviour and practices, mutual respect and gender equity in sexual relationships” (para. 68).

Education is recognised as a broad concept involving educators, parents and leaders at all levels in promoting and respect reproductive rights (para. 50), and deemed to include

at all levels of formal and non-formal schooling, education about population and health issues, including sexual and reproductive health issues (para. 35).

Last but not least, the section *Mobilising resources* (Chapter VI) describes the foreseen commitments of each stakeholder: developed countries are required to mobilise financial resources while donor countries and international funding agencies “are urged to support the inclusion of South-South components in development cooperation programmes and projects so as to promote cost-effectiveness and sustainability” (paras. 92-94). Finally, “with full regard to their respective jurisdiction and mandates, legislators and other decision makers are encouraged to undertake measures to increase support for achieving the goals and objectives of the Programme of Action through legislation, advocacy and expanded awareness-raising and resource mobilization. Advocacy efforts should be increased at all levels, both national and international, to ensure that the resource goals are met. (para. 96)”

The EU’s commitment to these objectives has been reaffirmed in a text produced by the Council of the European Union (hereinafter, the Council) in 2004, following the review of the programme ten years after its declaration. Three aspects in this document are relevant to describe the EU approach: its financial commitment<sup>219</sup>, its recognition of reproductive rights and of a rights-based approach to reproduction, and the approach to reproductive rights mainly as an issues concerning developing countries.

Concerning the mobilisation of resources, the Council establishes three points. It reaffirms a previous financial commitment agreed in 2002<sup>220</sup>, that foresaw the raise of the level Official Development Aid to 0,7 % of the Gross National Income for each EU member state and a mechanism of balance within the EU so that collectively a European Union average of 0.39% had to be reached by 2006<sup>221</sup>; it restates “its commitment to provide the EU’s share of the resources estimated to be required to implement the ICPD

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<sup>219</sup> Besides the financial commitment, the EU action in this context is foreseen as a close collaboration with inter-parliamentarian groups, multilateral institutions (UNFPA and other UN agencies) and organizations, as well as NGOs and civil society at large. Ibidem, para.4.

<sup>220</sup> Council of the European Union, *Report: Cairo/ICPD +10 - Council Conclusions*, 24 November 2004, 15157/04, Annex, p.3. This document reaffirms the previous Council Conclusions of 20 May 2003 on Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries and Aid for Poverty Related Diseases.

<sup>221</sup> Presidency Conclusions, Barcelona 15 and 16 March 2002, SN 100/1/02 REV 1, para.13.

Programme of Action”(para. 5); it acknowledges the necessity of additional resources to permit the implementation of the ICPD agenda by focusing in particular on sexual and reproductive health and rights, also encouraging the European Commission and the Member States to provide financing through different instruments within the EU and through additional resources from the UN and other international development agencies and the UNFPA to fill the gap in terms of commodities (paras. 6-7). Summarising, the EU committed itself to a general increase of resources for development aid, a specific financing for the ICPD agenda on reproductive rights and additional resources to be mobilised for the ICPD agenda by the EC and member states both in terms of funds and commodities.

The second aspect concerns reproductive rights as such since in the text the EU welcomes the shift towards a rights-based approach *which puts the wellbeing and free choice of the individual at the centre of its concern* and holds the need for a strong EU leadership in this context. This is relevant when confronted with the health approach adopted internally and with the absence of reproductive rights, as such, in the EU internal framework. Most notably, in this context the strong emphasis on the key role of information and education is particularly relevant (paras. 9-10).

Finally, the third aspect is related to the approach towards reproductive rights as an issue to be addresses mainly in developing countries. Reproductive rights are described as relevant to the achievement of the Millennium Development Goals (paras. 2-3), whose primary focus is on developing countries. This link with the MDGs is further recognised in the Council Conclusions of 2005, where it is held that “MDGs cannot be attained without progress in achieving the Cairo goal of universal sexual and reproductive health and rights”.<sup>222</sup>

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<sup>222</sup> Council of the European Union, Conclusions of the Council and the Representatives of the Governments of the Member States Meeting within the Council. Millennium Development Goals: EU Contribution to the Review of the MDGs at the UN 2005 High Level Event, 24 May 2005, 9266/05, para.3.

#### **4.1.2 The Beijing Platform of Action: women's rights as human rights**

The Beijing Conference in 1995 contributed to enhance the global discussion on reproductive rights, by introducing the new concept of sexual rights.<sup>223</sup> Besides this aspect, the outcome of the Beijing conference has been a text<sup>224</sup> based on the promotion of equality, development and peace for all women, with a clear focus on the empowerment of women as a transversal mean to reach those objectives.<sup>225</sup>

Reproductive rights are reaffirmed in this text by referring to the Cairo programme (para. 223), and consequently a series of actions are envisaged in order to promote their implementation.

When dealing with health, it is recognised that a limited power over sexual and reproductive lives is among the leading factors that adversely affect health (para. 82), and that inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services represent the first cause of not enjoyment sexual health by a high number of individuals (para. 95).

The Conference found that a lack and inadequacy of sexual and reproductive health information and services, combined with a trend towards early sexual experience, leads to unwanted pregnancies, unsafe abortions and STDs; and that these outcomes, in turn, affect educational and employment opportunities (para.93).

Therefore, among the envisaged actions there is the improvement of services concerning sexual and reproductive health: priority has to be given to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, achieve mutual respect in matters concerning sexuality and fertility and educate men regarding the importance of women's health and well-being (para. 107). In the field of education, it is acknowledged that the lack of sexual and reproductive health education has a profound impact on women and men, and therefore the action should be to "remove legal, regulatory and social barriers, where appropriate, to sexual and

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<sup>223</sup> The birth of this concept has been explained in the second chapter of this dissertation, page 8.

<sup>224</sup> Supranote (24). Ibidem.

<sup>225</sup> These objectives are stated in numerous occasions throughout the text. See, *inter alia*, Annex I, para. 3 and para. 7.

reproductive health education within formal education programmes regarding women's health issues" (para.83).

As for the Cairo programme, part of the text has been devoted to the role and commitments by the various stakeholders: a role is recognised to national governments, but also to regional or other type of organisations, that should feel involved in the implementation of the actions and in the mobilisation of resources (para. 351).

Contextually, it is relevant to note that the presence of EU representatives at the Conference has been accompanied by two statements on behalf of the EU and of the European Commission. From these statements, the support and recognition of the value of the Platform and the principles concerning reproductive issues is evident: "The European Union wishes to express its firm belief in the importance of promoting sexual and reproductive health for women and men [...]. The European Union reaffirms its commitment to ensure the full enjoyment by women and the girl child of all human rights and fundamental freedoms, including their sexual and reproductive rights, and to take effective action against violations of these rights and freedoms."<sup>226</sup>

As for the Cairo programme, the emphasis is on these measures as vital to developing countries more than European countries themselves: the reference to the EU's internal dynamics concerns solely the issue of gender equality and the position of women in the economy, but not the status of reproductive and/or sexual rights. This attitude shows through the constant reference to the EU's involvement in development aid: "as the largest donor of ODA in the world, the European Union feels that gender-sensitive development co-operation is a key strategy [...] we are committed to solidarity with and support to women throughout the world [...]"<sup>227</sup> The approach is reiterated in the European Commission's statement when underlining that: "in its bilateral relations, the European Community, which has signed more than sixty cooperation and trade agreements, is guided by the principle that the human rights of women and the girl-child are an inalienable, integral and indivisible part of universal human rights. By

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<sup>226</sup> Statement by European Union, HE Ms Cristina Alberdi (EN), Minister of Social Affairs for Spain, on behalf of the European Union, 5 September 1995, available at [www.un.org/esa/gopher-data/conf/fwcw/conf/una/950905120855.txt](http://www.un.org/esa/gopher-data/conf/fwcw/conf/una/950905120855.txt) [accessed 20 April 2014].

<sup>227</sup> Ibidem.

incorporating a specific clause on human rights in all new agreements with third countries, the Community is helping make the principle of human rights a reality. This is extremely important, given that the Community, with its Member States, is the first bilateral aid donor in the world with 41 per cent of total Overseas Development Aid”.<sup>228</sup>

#### **4.2 EU’s approach towards reproductive rights in its development policy**

Supporting development is one of the core aspect of EU’s external action together with its foreign, security and trade policies. The chief objective of EU’s development policy has been defined as the eradication of poverty in the context of sustainable development; and the achievement of this aim is associated to complementary objectives such as the promotion of good governance and respect for human rights.<sup>229</sup>

The development policy is modelled by a series of documents that define the EU’s approach and that regulate the delivery of aid through programmes and projects across the world. As stated by Williams, “determining the scope of the obligations with regard to developing states whilst identifying those rights that should be respected and promoted in the process, have brought collective notions into play”<sup>230</sup>. Development policy is, therefore, one of the “fundamental point of confrontation” for the EU when it comes to define human rights in a context of global evolution, also keeping into consideration their relationship with other concepts such as democracy or the rule of law.<sup>231</sup>

The next sections will explore how reproductive rights, promoted by the EU on the international stage, have been defined and incorporated into its development policy. The starting point will be the legislative framework on which this policy is grounded in

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<sup>228</sup>Statement by Commissioner Flynn on behalf of the European Commission, 6 September 1995, available at [www.un.org/esa/gopher-data/conf/fwcw/conf/una/950914182732.txt](http://www.un.org/esa/gopher-data/conf/fwcw/conf/una/950914182732.txt) [accessed 20 April 2014].

<sup>229</sup> Official Journal of the European Union C 46/1, 24/02/2006, Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy: ‘The European Consensus’, 2006/C 46/01, p.2.

<sup>230</sup> Williams, 2004, p.4.

<sup>231</sup> Ibidem.

order, then, to move on to actions implemented on the basis of these legislative instruments.

#### **4.2.1 Legal basis for the EU's external aid on reproductive issues**

The key document to understand the EU's development policy is the European Consensus on Development<sup>232</sup>, which comprises the EU's vision of development with its objectives, common values and principles. In this document, sexual and reproductive health and rights (SRHR) are mentioned under the *Human Development* heading, listed, *inter alia*, as one area of EU's action. It is stated that "the Community [now, Union]<sup>233</sup> will support the full implementation of strategies to promote sexual and reproductive health and rights and will link the fight against HIV/AIDS with support for reproductive and sexual health and rights."<sup>234</sup>

Besides this overarching declarative document, the legal basis for the EU's action on reproductive issues in Third countries has to be found in three subsequent Regulations: the EC regulation 1567/2003<sup>235</sup> on aid for policies and actions on reproductive and sexual health and rights in developing countries, the EC regulation 1905/2006<sup>236</sup> establishing a financing instrument for development cooperation, and the EC regulation 233/2014<sup>237</sup>, which has been recently approved and replaces Regulation 1905/2006.

These Regulations have been conceived in the light of Article 208 TFEU (ex art. 179, Treaty establishing the European Community) that states that the "European Parliament and the Council, acting in accordance with the ordinary legislative procedure, shall adopt the measures necessary for the implementation of development cooperation policy which may relate to multiannual cooperation programmes with developing countries or

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<sup>232</sup> Supranote (229) Ibidem. The document as such is of an informative type and does not constitute part of the EU law. Nonetheless, it constitutes a fundamental guideline to the EU's development policy.

<sup>233</sup> Documents produced before the entry into force of the Lisbon Treaty employ the term Community, which has to be understood today as referring to the Union.

<sup>234</sup> Ibidem, para. 94.

<sup>235</sup> Official Journal L 224/01, 06/09/2003, Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003. The regulation shall apply until 31 December 2006.

<sup>236</sup> Official Journal L 378/41, 27/12/2006, Regulation (EC) No 1905/2006 of the European Parliament and of the Council of 18 December 2006.

<sup>237</sup> Official Journal L 77/44, 15/03/2014, Regulation (EC) No 233/2014 of the European Parliament and of the Council of 11 March 2014.



programmes with a thematic approach”. Article 208 TFEU contains a reference to the principles and objectives that guide the EU’s external action as listed in article 21 TEU and therefore comprising universality and indivisibility of human rights as a principle and consolidation and support of human rights as an objective.

Regulation 1567/2003<sup>238</sup> states in article 1 (1) that the Community (now, Union) shall support “actions to improve reproductive and sexual health in developing countries and to secure respect for the rights relating thereto” through the provision of financial assistance and appropriate expertise with a view to promoting a holistic approach to, and the recognition of, reproductive and sexual health and rights as defined in the Cairo Programme.<sup>239</sup> The purpose of the activities carried out under this Regulation should be, *inter alia*, to enable women, men and adolescents to have access to a comprehensive range of high-quality, safe, accessible, affordable and reliable reproductive and sexual health care services, supplies, education and information, including information on all kinds of family planning methods (art.2 b).

Despite the expiration of the text in terms of applicability, it is relevant to notice that the EU’s approach toward reproduction has consisted of two intertwined elements: the improvement of reproductive health and the recognition and protection of related rights, with an emphasis on adequate information and education as key conditions.

Regulation 1905/2006, repealing the previous Regulation, aimed at setting up a financing instrument for development cooperation, the *Development Cooperation Instrument* (DCI), which replaced the range of geographic and thematic instruments created over time with the general objective of improving development cooperation. The text underlines that the Community’s development cooperation policy is guided by the MDGs and that the abovementioned *European Consensus* provides a general framework for action.<sup>240</sup>

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<sup>238</sup> In 1997, the European Union adopted a Regulation on aid for population policies and programmes in the developing countries with a view to implementing the major elements of the Cairo Action Plan (Regulation (EC) No 1484/97). This Regulation therefore replaces the 1997 Regulation.

<sup>239</sup> Supranote (235), Art. 1 (2).

<sup>240</sup> Title I, Article 2.

The Regulation provides that the Union's aid is provided mainly through geographic and thematic programmes.<sup>241</sup>

Geographic programmes are planned to support the development of, and reinforce the cooperation with, countries and regions in Latin America, Asia, Central Asia, the Middle East and South Africa. Among the thematic areas interested by cooperation activities, one is defined as *Human development*, whose *Health* component makes specific reference to the goal of improving SRHR as set out in the Cairo agenda.<sup>242</sup>

Thematic programmes instead should provide distinctive added value and complement programmes of a geographic nature. They should be implemented by, or through, intermediary organisations, such as non-governmental organisations, other non-State actors, international organisations or multilateral mechanisms.<sup>243</sup> Amongst the five thematic programmes foreseen in the text, the *Investing in people* one is relevant for the dissertation since a series of projects dealing with RR have been implemented under the health section of this programme.

In December 2013, the expiration of this text has rendered necessary the replacement by a similar Regulation which has established a financial instrument for development cooperation for the period 2014-2020.<sup>244</sup>

In this new Regulation, the bipartite division between geographic and thematic programme persists with an additional Pan-African programme to support the strategic partnership between Africa and the Union,<sup>245</sup> and RR still play a key role in since they are mentioned both in the Thematic programmes<sup>246</sup> and in the Geographic programmes<sup>247</sup>.

Under the *Health* category for both Programmes, one of the objective is to promote “the full and effective implementation of the Beijing Platform for Action and the

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<sup>241</sup> Programmes of a geographic nature constitute the main framework for Community cooperation with third countries. Development cooperation implemented through thematic programmes should be subsidiary to the geographic programmes set out in this Regulation and in Regulation EC No. 1638/2006 and to cooperation under the European Development Fund, para.13.

<sup>242</sup> Title II, art. 2 (b) (ii).

<sup>243</sup> Title II, art. 11.2 (a).

<sup>244</sup> Supranote (237). Ibidem.

<sup>245</sup> EC Regulation No 233/2014, Title I, art.1.

<sup>246</sup> Ibidem, Annex II, Section A, III (a) (iv).

<sup>247</sup> Ibidem, Annex I, Section A, II (a) (iv).

Programme of Action of the International Conference on Population and Development and the outcomes of their review conferences and in this context sexual and reproductive health and rights”<sup>248</sup>. Another related objective, in the Thematic programmes, is the improvement of “health and well-being of people in developing countries through supporting inclusive and universal access to, and equal provision of, good quality essential public health facilities, goods and services with a continuum of care from prevention to post-treatment and with special emphasis on the needs of persons belonging to disadvantaged and vulnerable groups”<sup>249</sup>.

#### **4.2.2 The *Investing in People* programme**

As described, reproductive issues have been taken into account in the definition of the EU’s development policy and they have played a prominent role in the *Investing in People* programme. Hence, this final part will explore the programme and some of the projects that have been implemented contextually during the period 2006-2013.<sup>250</sup>

General aim of the programme was to support actions in areas which directly affect people’s living standards and wellbeing, focusing on the poorest and least developed countries and the most disadvantaged sections of the population (title II, art. 11.1). Among the areas of activity, *Good health for all* represented the category under which activities touching upon RR are included. Under this heading, four macro objectives were mentioned in order to cover the concept of health: fight against poverty diseases targeting the major communicable diseases; improvement of sexual and reproductive health and rights; improvement of equitable access to health providers, commodities and health services; and a balanced approach between prevention, treatment and care, with prevention as a key priority (title II, art.12).

Within the second goal, reproductive health and reproductive rights are linked and promoted together. Moreover, it is interesting to note that sexual rights and health are again mentioned as separate and complementary aspects of an idea of health that

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<sup>248</sup> Ibidem supranote (246) and (247).

<sup>249</sup> Ibidem, Annex II, Section A, III (a) (i).

<sup>250</sup> The description of the Programme is present in the text of the EC Regulation 1905/2006. All the references in the text are, therefore, to this Regulation.

mirrors the one promoted by the WHO.<sup>251</sup> Recognition of both sexual and reproductive rights, as defined in the Cairo programme, is one of the goal for whose achievement, “universal access to a comprehensive range of safe and reliable reproductive and sexual health care and services, supplies, education and information, including information on all kinds of family planning methods” (title II, art.12.2 (a) (ii)) have to be guaranteed.<sup>252</sup> Target of the activities related to the achievement of this goal are all individuals, namely men, women and adolescents; resources to be mobilised are funds and appropriate expertise.

As evident in the Strategy Paper for the Thematic Programme<sup>253</sup>, the Union considers itself as a “driving force in the field of sexual and reproductive health and rights”<sup>254</sup>.

This area is directly linked with the other health-related objectives and the EU’s action is deemed necessary to address countries that present “the worst indicators for sexual and reproductive health and worst status of sexual and reproductive rights of women, men and adolescents in every part of the world, in particular where governments have been unable or unwilling to take effective action on their own”<sup>255</sup>. The idea is that the different countries’ positive experiences in this field can be replicated and /or scaled up, and that outcomes on these issues should be measured and sound data produced on a regular basis.<sup>256</sup>

The EU considers health as a key precondition for achieving progress in other areas of human and social development and, at the same time, one of the areas where the European Commission has gained experience, strong credibility and leadership, especially concerning the coordination between research and development regarding STIs and the promotion of SRHR. A final aspect concerns the acknowledgment by the

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<sup>251</sup> Supranote (39). Ibidem.

<sup>252</sup> This idea had been introduced in the initial part of the Regulation, art.18, and it is repeated in the same wording.

<sup>253</sup> European Commission, *Investing in People. Strategy Paper for the Thematic Programme 2007–2013*, available at [ec.europa.eu/development/icenter/repository/how\\_we\\_do\\_strategy\\_paper\\_en.pdf](http://ec.europa.eu/development/icenter/repository/how_we_do_strategy_paper_en.pdf) [consulted on 25 April 2014].

<sup>254</sup> Ibidem, p.12.

<sup>255</sup> Ibidem.

<sup>256</sup> Ibidem.

EU of a crisis in human resources for health care and sexual and reproductive health and rights that should be approached by investing in policy, advocacy and capacity-building.

For the period 2007-2013, the EU funds for the *Investing in People* programme have been 1.043 million euros with an allocation of 580 million to activities that go under the heading *Good Health for All*, that represents the 55,6% of the budget.<sup>257</sup> Considering that *Good Health for All* is only one of the four macro categories funded<sup>258</sup>, it appears that the EU has showed a strong willingness to be incisive on these issues and in the Strategy Paper it is confirmed that this relevant financial investment has been implemented in virtue of the above described leading role. Among the funds allocated for *Good Health for All*, the money granted for the “Implementation of the Cairo Agenda, including provision of Commodities and supporting civil society in the countries with the worst indicators” have represented the 7,6% of the *Good Health for All* budget in the first three years 2007-2010.<sup>259</sup>

#### **4.2.3 From theory to practice: reproductive rights in the *Investing in People* projects**

In the light of EC regulation 1905/2006 and of the Strategy Paper, a series of projects have been funded in different countries all over the world in the period 2006-2013.<sup>260</sup> Some of these projects<sup>261</sup> be investigated will to point out which are the practical

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<sup>257</sup> Information available at [ec.europa.eu/europeaid/how/finance/dci/investing\\_en.htm](http://ec.europa.eu/europeaid/how/finance/dci/investing_en.htm) [consulted on 12 May 2014].

<sup>258</sup> The other three macro categories are education and skills, gender equality and other aspects of human and social development, such as: employment and social cohesion (to improve working conditions at international level), children and youth (against the exploitation of children and in favour of improving job prospects for the young) and culture. Supranote (253), p.2.

<sup>259</sup> European Commission, *Investing in People. Strategy Paper for the Thematic Programme 2007–2013. Annexes*, Annex 7.2 available at [http://ec.europa.eu/development/icenter/repository/how\\_we\\_do\\_strategy\\_annexes\\_en.pdf](http://ec.europa.eu/development/icenter/repository/how_we_do_strategy_annexes_en.pdf) [consulted on 25 April 2014].

<sup>260</sup> For the period 2014-2020, the EU Regulation 233/2014 foresees the indicative allocation of 7008 EUR millions for the Thematic Programmes, of which 5101 EUR millions to the heading “Global Public Goods and Challenges”. Of this latter amount, a minimum of 40% will have to be allocated to the Health projects. Supranote (237), Annex IV.

<sup>261</sup> The Final Reports of the projects financed by the EU under the Investing in People Programme are not published and they are not present online. They have been therefore personally requested via the EU Commission website through the Document Request Form. Only the Reports of the projects analysed here have been attached to the dissertation, in the Annex section. Where possible, the format and font of

implications of the policy described above, stressing particularly the role played by informational or educational activities concerning reproduction.

In the project *Increasing Sexual and reproductive health of displaced and their host communities in the North and Eastern region of Sri Lanka* (annex 1), a number of activities have been aimed at the dissemination of information about sexual and reproductive health (SRH) and at the education of professional health staff to be deployed in the target areas.

The opening of clinic centres in these areas has been followed by the training of 300 Community Mobilizers in order to establish a close link between the project and the community and to facilitate the implementation of other activities. The trainings, held by specialists and health authorities, concerned different topics such as SRH, Family Planning (FP), HIV/AIDS, Gender Based Violence and Adolescents Health. A specific training has been provided also on media advocacy related to SRH and psychosocial counselling.

Among the educational activities, education sessions were held by the clinic centres for community members in order to raise their awareness on subjects related to, *inter alia*, SRH and Family Planning (Activity 7). The sessions had as target groups, *inter alia*, the community members, including school children over fifteen years of age, youth, adults, community leaders, teachers, and members of various organisations, etcetera. A relevant space has been devoted to peer education (Activity 8) with the creation of youth friendly centres as a base for the peers educators to create awareness about SRH among similar age groups and school children.

Informational activities were carried out to the overall target population through the design and production of materials, which was distributed and used as information and education tools concerning SRH and Gender Based Violence in the implementation of other activities (Activity 6).

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the original document has been maintained. Due to the length of the texts, only the extracts that are relevant for the dissertation have been attached. A list of all the projects funded under the various instruments is available at

<https://webgate.ec.europa.eu/europeaid/online-services/index.cfm?do=publi.welcome> [consulted on 12 May 2014].

The project *Access to Sexual and Reproductive Health Care for Uprooted People and Romani Women and Youth in southern Serbia* (annex 2) had the objective of granting specific training both to healthcare providers and to target groups, namely Romani women and youth.

Goal of the activities was to engage these women to become self-supportive on SRH and related social issues by addressing the individual level of knowledge, by promoting an improvement of SRH related behaviour, and by raising awareness about how to deal with norms that negatively affect SRH. As in the previous project, part of the budget was devoted to the training of individuals able to act as mediators between the activities and the target group, in this case Community Health Mediators and Youth Health Mediators, while another component has been the provision of information, counselling and education to the target group by means of the mediators.<sup>262</sup> Subjects of the mediators' training have been: SRH, communication and community mobilization. The young mediators have capitalised on this earning experience in order to organise, in turn, SRH educational sessions, a lecture on the protection and improvement of SRH in the local secondary school on the topics of pubescence and transformations with a short educative animated and other material being distributed.

A different example comes from the project *From donorship to Ownership: securing the future of Public, Political and Financial Commitments to Sexual and Reproductive Rights in West Africa* (annex 3), implemented by the International Planned Parenthood Federation in Burkina Faso, Gambia, Ghana and Nigeria.

Family planning associations in these countries have been direct beneficiaries of capacity building activities, while national stakeholders such as parliamentarians, non-governmental organisations, senior government officials and representatives of the Economic Community of West African States and its specialised health agency have been indirect beneficiaries.

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<sup>262</sup> It is interesting to note that the project addresses a specific problem linked with information and counselling: e.g the belief that a lack of availability of family-planning and other related SRH counselling and information in their own language represented one of the barriers for Roma IDP women to access those services.

The various activities have comprised: the organisation of a regional conference and of a one-day parliamentary hearing on SRHR at the Economic Community of West African States, the development of national conferences about SRHR and three national level advocacy strategies, communication and capacity building meetings for the various SRHR stakeholders.

These kind of activities had the effect to promote awareness and knowledge about SRHR at an institutional level and among the civil society organisations in order to strengthen the lobbying capacity on the national governments and to include these issues on their agendas. This double purpose constituted the overall objective of the project: the improvement of awareness on reproductive health policies in these countries towards increased access to comprehensive SRH policies and care.

This description of some examples of EU funded projects provides with some elements concerning the practical implications of the EU's development policy, when implemented. Common feature of these projects has been their focus on the promotion of reproductive health both through the delivery of specialised services and through information, counselling and education. Direct and indirect beneficiaries have been not only the persons who have received treatments, but also civil society organisations and institutions, that is to say also all those stakeholders who are able to affect in the long term the inclusion of reproductive rights in their national agendas. It is necessary to underline that reproductive rights are often mentioned in these projects and they are, when not directly, indirectly promoted by training sessions for community operators and target groups since knowledge about reproductive health inevitably contributes to increase awareness of related rights and it promotes self-empowerment and autonomy in decisions attaining this sphere.

In this sense, the commitments made by the EU at international level through the adhesion to, *inter alia*, the Cairo programme and the Beijing Platform, have been followed, and still are, by the financial mobilisation of internal resources to be deployed in development projects in Third countries.

Signs of the European Union's willingness to keep its development actions coherent with its international commitments in term of reproductive rights are, therefore, the projects financed through the Investing in People programme between 2006 and 2013,



but also the renewed financial commitments made for the next seven years, through the adoption of Resolution No 233/2014.

## 5. Conclusion

Reproductive rights have only recently and not unanimously been recognised on the international agenda as a legitimate application of the human rights discourse to reproduction and sexuality.<sup>263</sup>

This process has benefited from the Cairo and Beijing Conferences that introduced and formalised these concepts, while strongly affirming the priority of free and informed reproductive choices in the framework of human rights protection. The programmes of action produced in those occasions clearly shifted the focus from planning population policies to a new paradigm that incorporated a vision of reproduction as a health concern that deserved nonetheless a rights-based approach in order to handle all the social determinants when it comes to reproductive choices.

The definition agreed in Cairo in 1994 upheld reproductive rights as resting “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. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”<sup>264</sup> The Cairo conference expressed the view that reproductive rights embrace certain rights that are already acknowledged in international human rights documents.<sup>265</sup> By adopting this view, the dissertation analysed how the right to life and health, freedom of expression, the right to private and family life, the right to education and freedom from discrimination, can be applied to reproduction, providing the label reproductive rights with content. This overview also contributed to recognise the key role played by knowledge in the exercise of these rights. Knowledge has been understood as any information concerning reproduction that can be provided in different contexts, such as counselling, education or when information is requested as such.

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<sup>263</sup> Examples of stakeholders who thwarted the recognition of reproductive rights, are the Holy See, the Organisation of the Islamic Conference and their NGO allies. See, Miller & Roseman, 2011, p. 103 and the reservations made to the Cairo Programme, supranote (14), Chapter V, pp. 132-148.

<sup>264</sup> Supranote (14). Ibidem.

<sup>265</sup> Ibidem, para. 7.3.

Despite the Cairo definition has become a milestone in the international debate, the understanding and recognition of reproductive rights continues to be heavily thwarted by conservative forces in Europe and all around the world. The reform of abortion law in Spain<sup>266</sup>, the European Committee of Social Rights sentence against Italy on conscientious objection<sup>267</sup> and the issues raised by reproductive tourism across the EU Member States<sup>268</sup> are only some of the current puzzling issues that show to what extent reproductive rights are not considered legitimate claims by part of the civil society.

It has been therefore the scope of the dissertation to analyse the position held by the European Union towards reproduction and reproductive rights with its Member States and with Third countries.

The second chapter contributed to outline a twofold EU's approach in its internal policy: on one side, reproduction has been handled as a mere health issue, while on the other side, its implications in terms of human rights have been acknowledged at judicial level. Analysing the two EU pillars in terms of human rights, the Charter on Fundamental Rights and the European Convention on Human Rights, it is evident that a number of provisions are applicable to reproduction in virtue of the way in which they are worded and that only the interpretation by the Courts will better define the extent of this applicability. The work of the Courts so far, in particular of the European Court on Human Rights, has contributed to confirm the applicability of certain provisions to the field of reproduction, in the case, for example, of violation of the right to privacy (article 8) when abortion is prohibited also when the mother's life is at risk. Despite some clarifications, the ECtHR has generally been considered reluctant in providing precise guidelines, and it has tended to decline responsibility in favour of a broad margin of appreciation guaranteed to the States.

From the analysis, it emerged that reproduction has been handled also as a public health issue, although with strong limitations that derive from the absence of

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<sup>266</sup> Kassam, 2014.

<sup>267</sup> International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, Complaint No. 87/2012, European Committee of Social Rights 2014. For an overview of conscientious objections in Europe and the related difficulties in regulating this practice, see Zampas & Andión-Ibañez, 2012, pp.231-256.

<sup>268</sup> See, *inter alia*, Pennings, 2004 and Deech, 2003.

competence for the EU on health protection. However, on the base of a shared competence on common safety concerns in public health matters, the EU has addressed reproduction by pivoting on the fight against STIs through public health programmes that revealed a cautious approach, highly respectful of the division of competences on the matter, especially concerning information and education.

In confirmation of the EU's prudence towards reproductive issues has been read the rejection of the Estrela report that presented an approach incorporating health and human rights in dealing with sexuality and reproduction.

The absence of competence, invoked by the Parliament as a justification for the refusal of the Report, is surprising if compared to the approach adopted by the EU in its external relations. The adoption of a series of international documents, such as the Cairo Programme and the Beijing Platform of Action, revealed a strong endorsement of reproductive and sexual rights by the EU. This endorsement has produced practical effects in the development policy adopted by the EU, which became visible through the various Resolutions on development aid adopted in the last ten years and through the projects implemented in Third countries in virtue of those Resolutions.

The analysis of the Resolution provides an image of the EU as greatly committed to the implementation of sexual and reproductive health and rights in Third countries, and indeed its remarkable financial commitment mirrors the belief in SRR as a crucial concern for the development of Third countries.

The analysis of some of these development projects has confirmed this engagement and it has revealed an approach that integrates health and human rights concerns: the provision of reproductive health services is constantly integrated with activities of awareness raising about reproductive rights; in particular, the "knowledge" component is often present in a number of forms from counselling services to educational classes on reproduction and sex.

This comparison shows an evident gap between the stand taken in the relations with member States within the EU perimeter and outside, with Third countries. The analysis done in this thesis has highlighted that this gap is constituted by a twofold discontinuity between the two approaches: on the definition of reproductive rights and on the activities carried on to promote these rights.

If in the internal approach, reproductive rights are not defined as such, but merely defined case by case through the work of the Courts, on the external approach the EU has clearly endorsed the comprehensive definition, agreed in Cairo and Beijing.

On the side of the promotion of these rights, the EU has revealed a partial inaction by contributing to the implementation of projects that endorsed a health perspective; while in its external action the EU has contributed, through the funding of development projects, to the promotion of reproductive rights, by endorsing a perspective that took into account not only the health dimension of reproductive choices, but also the rights connected to it.

Although it was beyond the scope of this dissertation to analyse the reasons behind this incoherence<sup>269</sup>, the dissertation contributed to show that the “lack of competence” argument, outlined in the third chapter, plays a role. As recalled by the Parliament when refusing the Estrela Report, the EU lacks the legal competence to deal with issues such as education (in this specific case, the referral was to sexual education), while the legal basis on which its development policy is grounded guarantees to the EU a role of promoter of human rights, and of reproductive rights as part of this category, that is not equally mirrored in its internal affairs. Moreover, the Courts, that have the task to address violations of human rights, can only support the interpretation of human rights’ provisions and, therefore, only indirectly contribute to the promotion of human rights.

Furthermore, the rejection of the Report could have been replaced by an alternative proposal, which reaffirmed the relevance of SRR, although declining competence on specific matters, such as education or health. The complete refusal could be, therefore, interpreted as a voluntary step back from the Parliament on these issues in favour of a broad “margin of appreciation” of Member States.

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<sup>269</sup> In order to understand the reasons beyond this double standards approach it would have been necessary, not only to analyse all its current facets, but also to trace out the origin and the evolution of the EU internal human rights policy and of its development policy. Besides the “lack of competence” argument, a number of reasons could lie behind this “bifurcation” in the promotion of human rights internally and externally. For an extensive analysis, also picking the enlargement policy as a further term of comparison, see Williams (2004).

A number of studies<sup>270</sup> have been done to scrutinise the partial incoherence between the EU's internal and external action when it comes to human rights: these studies have contended that the human rights standards that the EU pose to candidate countries or Third countries are higher than the one foreseen for States that already member of the Union. The analysed framework of theory and actions demonstrated that this incoherence does exist also in terms of reproductive rights, and a final word must be spent on the potential problems that can arise due to this discrepancy. Weiler and Alston have exposed three potential effects of this incoherence.<sup>271</sup> Firstly, an external policy that adopts a paradigm of universal and indivisible human rights is suspect when not mirrored by internal approaches; it can not be "taken seriously" if in practice the Union acts as though this set of universal rights does not apply to its institutions and Member States. Secondly, incoherence leads to "unilateralism and double standards" that undermine the credibility of the Union's actions and suggest that human rights can become contingent principles to be invoked when it is convenient. Thirdly, a Community failing to endorse "a strong human rights policy for itself is highly unlikely to develop a fully-fledged external policy and apply it with energy and consistency".<sup>272</sup>

Although through the development of the case law before the ECJ and the ECtHR these problems will be rendered more visible and hopefully tackled, one important aspect deserves to be underlined through the words of Hillion who speaks about "an externally projected image of fundamental rights as an element of the Union's constitutional identity"<sup>273</sup> that results distorted by this twofold approach. This distorted image is problematic *per se*<sup>274</sup>, but it is even more problematic if it entails, thanks to the EU's action, a higher protection for fundamental rights outside the EU borders than inside. This is already happening if we think about the paradoxical situation in which an Irish woman can not access abortion, whereas a woman in Cambodia has this possibility

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<sup>270</sup> See, *inter alia*, Williams (2004), Hillion (2013), and Kuhnert (2006).

<sup>271</sup> Alston and Weiler, 1999, pp.8-9.

<sup>272</sup> Ibidem.

<sup>273</sup> Hillion, 2013, p.1.

<sup>274</sup> Williams identifies the same problem about incoherence and states that what will be compromise is any long-term ambition of the Union to acquire an identity in the world. Williams, 2004, p.8.

thanks to the EU funds.<sup>275</sup> This is also the case of the above analysed *right to know*: sexual education is nowadays prohibited in a number of European countries and this creates again a paradoxical situation by which an Italian girl has no access to reproductive health education because of her State's decision and because of the EU's inaction, while a Serbian Roma girl is provided with educational classes about these issues through the EU's action. It is, therefore, not just a matter of image, although relevant, but a matter of a lower degree of human rights protection that the EU guarantee to its citizens when compared to the one provided to individuals living in Third countries.

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<sup>275</sup> European Dignity Watch, 2012, p.28.

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## Annexes

### Annex 1

#### FINAL NARRATIVE REPORT

##### 1. DESCRIPTION

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**1.1 Name of Beneficiary of grant contract:** Population Services Lanka, 155, Kirula Road, Colombo 5, Sri Lanka

**1.2 Name and Title of Contact person:** Suren Raymond, Country Director

**1.3 Name of Partners in Action:** N.A.

**1.4 Title of Action:** Increasing Sexual and Reproductive Health Equity of Displaced and their Host Communities in the North and Eastern Region (Puttalam, Vavuniya, Horowpathana, Mannar, Trincomalee and Akkaraipattu) of Sri Lanka

**1.5 Contract No.:** SANTE 2007/127–274

**1.6 Start date and end date of the reporting period:** 01 January 2008 to 30 June 2012

**1.7 Target Country:** SRI LANKA (North and East)

**1.8 Target Beneficiaries &/or Target Groups** (if different) (including numbers of women & men)

IDP Women Age group 25 – 49 yrs - 32,167  
IDP Men Age group 25 – 49 yrs - 31,468  
IDP Poor female youth 15 – 25 yrs - 18,587  
IDP Poor male youth 15 – 25 yrs - 17,482  
Under Five Children - 13,986  
Community Health Promoters - 270  
(Community Mobilizers)  
Peer Educators - 270  
PSL Staff Trained in GBV - 83  
DHA Staff receiving logistic support – 25

**Final Beneficiaries**

430,000 women men and children from Puttalam, Vavuniya, Mannar, Horowpathana, Trincomalee and Akkaraipattu  
6 District Health Authorities  
30 Religious Leaders  
60 Village Heads  
1000 Member RDS WDS and CBOs and NGOs  
30,000 Partners and family members of clients of the project  
20 GO, CBOs and GOs involved in related network

### 1.9 Country (ies) in which the activities take place (if different from 1.7):

N. A.

## 2.1 Activities and Results

### Activity 1. Training and deployment of PSL team members:

The numbers and designations of project staff as of 30<sup>th</sup> June 2012 are given in Table 1.0.

A Field Project Manager was put in charge of the six clinic centres and given the responsibility for activities of the project. The staff were trained by the Project Manager, Finance Director, HR Manager and the Country Director of PSL. There were three Field Managers in charge of two centres each, one for Trincomalee and Akkaraipattu, one for Horowpathana and Puttalam and the other for Vavuniya and Mannar.

**Table 1.0 Project Staff as at 30<sup>th</sup> June 2012**

Clinic Level	Puttalam	H'pathana	Vavuniya	Mannar	Trincomalee	A'pattur
Medical Officer	1	1	2	1	1	1
Counsellor	0	1	2	1	1	1
Nurse	1	1	2	1	1	1
Asst. Nurse	1	1	0	1	1	1
Dispenser	1	2	1	2	2	1
Mobile Service Provider	1	1	1	2	1	1
Clinic Aide	1	1	1	1	1	1
Driver	1	1	1	1	1	1
Coordinator	1	1	1	*1	1	1
Nurse	1	1	1	1	1	1
Field Manager	1		*1		1	
Field Project Manager	1					

\*Mannar Coordinator promoted as Field Manager continued to serve as the Coordinator

In Puttalam counselling is provided by other staff, especially by the doctor and the nurse. In Puttalam and Horowpathana, PSL did not have permanent doctors for the centres but the doctors from the area took turns to serve at these centres.

PSL trained and appointed 300 Community Mobilizers (CMs) initially for establishing a close link between the project and the community, and for easy facilitation and implementation of activities in collaboration with the DHAs. CMs were trained by subject specialists and health authorities in Sexual Reproductive Health (SRH), Family Planning (FP), HIV/AIDS, Gender Based Violence (GBV) and Adolescent Health (AH), during the total project period as detailed in Table 2.0 which included training in "Legal support for GBV" as well. Those who left the project areas due to resettlement were replaced with new recruits and trained. PSL put in much effort to build the capacity of CMs for ensuring the sustainability of the project once it is completed. As at end of project there were 231 CMs, some of them working with the DHA authorities. Each CM was provided with two sets of

uniforms per year and a push bicycle to make it easy for them to access clients and carry the message on services available through the project and the DHA.

**Table 2.0 Capacity building provided to Community Mobilizers and Other staff during the project**

Activity / Location / Centre	No. of participants	No. of programs	No. of days / program
<b><i>Initial training in 'STI/RTI, GBV, HIV/AIDS, BCC, Adolescent Health'</i></b>			
6 centres	all CMs	18	1
<b><i>Initial training on 'Reproductive Health in Eastern Province'</i></b>			
Trincomalee	50 CMs, 8 PSL staff, 15 PHMs, 17 PHIs by PDHS	1	1
<b><i>In-service program on 'FP &amp; prevention on unwanted pregnancies'</i></b>			
6 centres	250 CMs, 58 PSL staff	6	1
<b><i>In-service Training in 'Reproductive Health'</i></b>			
6 centres	238 CMs, 44 PSL staff	6	1
<b><i>In-service Training in 'HIV/AIDS, BCC'</i></b>			
6 centres	225 CMs, 54 PSL staff, 10 MOHs	6	1
<b><i>Training in 'Reproductive Health &amp; FP'</i></b>			
6 centres	242 CMs, 44 PSL staff	2 – 3 / yr/centre	1
<b><i>Training in 'STI/RTI'</i></b>			
6 centres	238 CMs, 44 PSL staff	2 – 3 / yr/centre	1
<b><i>Training in 'Community Mobilization &amp; Communication'</i></b>			
6 centres	140 CMs, 18 PSL staff	6	2
<b><i>Training in 'GBV &amp; IEC materials / Adolescent Health'</i></b>			
6 centres	236 CMs, 48 PSL staff	36	Over 4 days
<b><i>Training in 'Legal support for GBV' &amp; 'Counselling'</i></b>			
6 centres	240 CMs, 24 staff, dispenser, counsellor, nurses	12	1
<b><i>Training in 'Data Collection'</i></b>			
6 centres	220 CMs & 2 staff from each centre	2 – 3	2 - 3
<b><i>Training in 'Monitoring &amp; Reporting'</i></b>			
Mannar	41 CMs, 3 staff	1	2
Puttalam	10 CMs, 2 staff	1	1
Vavuniya	83 CMs, 8 staff	1	2
Horowpathana	14 CMs, 6 staff	1	1
Akkaraipattu	26 CMs, 8 staff	1	1
Trincomalee	22 CMs, 3 staff	1	3

<b><i>Training in 'Infection prevention &amp; quality maintenance'</i></b>			
6 centres	4 Centre staff/centre	1	1 day
Colombo	4 staff		
<b><i>'Psychosocial Counselling' &amp; In-service program</i></b>			
6 centres	6 PSL counsellors, 58 staff & 90 community members	6	2
Puttalam	Practical counselling session for 18 counsellors & PSL staff & 50 community members	2	1
<b><i>ToTs on 'Training Peer Educators'</i></b>			
6 centres	245 CMs	24	3
<b><i>Training for Peer Educators</i></b>			
6 centres	2,900 peer educators	4 – 6 /centre	1
<b><i>Refresher training for CMs</i></b>			
6 centres	245 CMs	4 – 5 /centre	Over a mth
<b><i>Refresher Training for peer educators on 'STI'</i></b>			
6 centres	2,750 Peer Educators, 25 CMs, 6 MSPs, 6 Coordinators	4 – 5 /centre	3
Training in conducting a Media Advocacy program on SRH services			
Trincomalee	54 CMs & DHA & PSL staff	1	1
<b><i>Training on 'PSL Services'</i></b>			
6 centres	248 CMs, 48 centre staff	2 /yr/centre	1

The training in regards to Media Advocacy on SRH services was conducted by an external resource person and focussed on organizing advocacy programs in future. The training included information collection, data analysis, preparing a publicity message and using the media to impart this message to the community and respective authorities.

PSL staff participating in training and capacity building efforts included the coordinator, mobile service provider (MSP), nurses, dispensers and counsellors attached to the six centres.

Training in 'Infection Prevention & Quality Maintenance' was provided by a foreign consultant from Bangladesh for 4 staff members from each centre and 4 PSL staff members from the head office in Colombo. Training in 'Psychosocial Counselling' for CMs was done by the NGO Women In Need (WIN).

Activity 6. Design and production of Behaviour Change Communication (BCC) materials and activities:

PSL made great efforts at disseminating much needed information on SRH and GBV in project areas. During the project period, the following materials were produced and distributed and used as information and education materials at various activities relating to SRH and GBV.



## 2010

- i. Life Skill Manual including information on GBV and HIV/AIDS printed in Tamil (3000 copies) and Sinhala (1000 copies).
- ii. Training Manual for TOT programs on Gender & GBV, STI, HIV/AIDS, Adolescent Health & Effective Communication.
- iii. Flash cards on FP printed in Tamil (800 copies) and Sinhala (200 copies) re-printed due to demand.
- iv. Tamil Guideline on School Health Program for use by public health Staff (750 copies) re-printed due to demand.
- v. POG Indicators & BMI Indicators (1,000 each) re-printed due to demand.
- vi. Voice dubbing of “Udavu Wasanthaya”, 7 episodes from Sinhala to Tamil done by the Sri Lanka Rupavahini Corporation through the Health Education Bureau, for the project.

In 2010 the project distributed 800 books on Reproductive Health for auxiliary health workers, printed by UNFPA for PSL's previous project and 720 books on 'Udavoo Yawwanaya' (Re-awakened Youth) printed by Family Health Bureau.

## 2011

- I. 5,000 units of two types of four-colour stickers on GBV printed in Tamil.
- II. 8-page Flip Chart on HIV/AIDS were printed in two colours.
- III. Leaflets were printed in Sinhala & Tamil for the 'Triple Benefit' programs and advertised in the Sunday newspapers of Lake House in all three languages. The program was conducted in all 6 centres on the following:
  - Diabetic Awareness, 14 to 26 November 2011 (50% discount on Glucose Check).
  - De-worming adults & children, 28 November to 10 December 2011 (50% discount on Worm Treatment).

Family Planning 12 to 23 December 2011 with free FP counselling (50% discount on FP products)

Leaflets were printed in Tamil and Sinhala languages on this program & it was advertised in the national newspapers Sunday Observer, Silumina (Sinhala) & Weerakesari (Tamil).

## 2012

- I. Nawadivisuwa Piriksumpatha (Check List for newly married couples) printed in Tamil and Sinhala
- II. The 'Triple Benefit' program was repeated in 2012 and leaflets were re-printed in Sinhala & Tamil for this program.
- III. Printing 2,000 books on 'Women and Health' in Sinhala and Tamil at 1,000 each.

### Activity 7. Community awareness raising education sessions

Throughout the project period, the centres took up the responsibility of conducting awareness raising education sessions for community members that included school children over 15 years of age, youth, adults, community leaders, teachers, members of various societies such as Rural Development Societies (RDS), Women's Rural Development Societies (WRDS), funeral societies, etc., through a variety of activities. These included innovative activities such as Street Drama competitions, art and essay competitions, quiz competitions, and the use of publications, leaflets, etc. Awareness was created on subjects

such as SRH, STD/STI, HIV/AIDS, GBV and child abuse, Family Planning, breast feeding, nutrition, child care and adolescent health, and dengue.

Awareness programs were held for small community groups on GBV, HIV/AIDS, STI & SRH with training on communication to strengthen their capacity to educate the communities. All programs on SRH and GBV were refreshed by community mobilizers and centre staff with the support of local resources from the Health Department, other NGOs dealing with GBV and representatives from the Ministry of Child Protection and Women Empowerment. All HIV/AIDS awareness programs were conducted by a consultant specialist while GBV programs were conducted by the GBV consultant.

Awareness creation on PSL activities included a total of 102,968 of the target group members through 6,914 programs. Specific activities relating to awareness and capacity building organized by PSL through the centres are listed below.

- A seminar on SRH for 66 students of the Faculty of Applied Science and awareness creation on HIV/AIDS for 400 university students in Vavuniya.
- Awareness on FP, RH, HIV/AIDS, Child Care for 335 ANC mothers, 209 women of 18 – 45 years of age, 958 community members
- Awareness on GBV for 12,534 community members, 98 ANC mothers, 1,257 students, 51 students from the School of Agriculture in Vavuniya, 747 funeral society members, 100 school youth parents & 51 out of school youth parents.
- Held 120 multiple programs over 5 months for creating awareness on GBV, FP, Nutrition, Dengue & breast feeding for 7,386 ANC mothers, female youth & students and 57 male students.
- Awareness on HIV/AIDS, STI, SRH, GBV & communication for 169 youth.
- Awareness on Nutrition for 192 women (18 – 45 years) and 102 ANC mothers.
- 13 Adolescent Health awareness programs were held over 5 months involving 1,223 students, 146 students Faculty of Applied Science in Vavuniya, 45 teachers, 46 labourers & 112 villagers.
- Horowpathana held an awareness program on 'Preventing the use of Alcohol' in collaboration with the Dangerous Drugs Control Board for 56 community members and 19 CMs.
- Akkaraipattu held a special pre-conceptual awareness program for 47 pre-conceptual participants with the SPHM.
- Various training programs for CMs, health staff
- Program to celebrate the World Mental Health Day was held in Akkaraipattu for 233 community members with the participation of CMs, RDHS Staff and Health Staff.

In addition to the above, Focus Group Discussions were held with community members on STI/HIV/AIDS, FP, GBV, Nutrition & Cancer. CMs of the respective areas and PSL staff together with the health staff participated and/or assisted in all of the above programs. Special awareness on GBV was done by the GBV consultant for 50 military servicemen, 100 religious leaders and 53 Grama Niladharis. Three programs were conducted for 140 military servicemen on STI obtaining the services of the MO/STI of the STI clinic in Anuradhapura hospital.

#### Activity 8. Peer education

Youth friendly centres established in each centre acted as the base for the peer educators to create awareness among similar age groups and school children. These centres were well accepted by youth in these areas as these keep them occupied. They visited these centres and learnt about SRH, referred reading materials on SRH and played games and watched films on SRH services and GBV. They worked jointly with community groups and participated in meetings, training programs and assisted small groups to pass information to the community. Refresher training on GBV, STI & adolescent health was conducted in each centre for the peer educators.

There were 2,800 peer educators between the ages 18 to 25 selected from the project areas and trained initially. Master Trainers were trained in the first instance. These Master Trainers in-turn trained the Peer Educators over a two-day program. There was a delay in training the 500 peer educators from Mannar due to a delay in obtaining PTF approval. However, they were all trained after PTF approval was obtained. All the peer educators were provided training in SRH, GBV and HIV/STI by respective consultants with the coordination of the DHA. Peer Educators worked with CMs in forming small groups consisting 10 members and providing awareness to youth in their villages.

They worked in close collaboration with small groups and supported them for conducting programs on GBV, HIV/STI and SRH. They met one another monthly and discussed about GBV in their areas and helped CMs to refer these cases for legal aid, to the Legal Aid Commission, Police Women Desk, Women In Need (WIN), GBV Forum and for counselling by PSL counsellor. Peer educators supported CMs to implement community based events such as street marches, street dramas and stage programs for providing awareness on GBV & Child Abuse, FP, HIV/STI and SRH.

Refresher training programs on GBV and Adolescent Health were done for the peer educators to refresh their knowledge and to motivate them to pass the message to the community. These programs were conducted by consultants, resource persons from WIN, Health Authority, other organizations and project staff.

As a result of these education efforts, a total of 95,526 female youths and 77,474 male youths were reached with information by peer educators on SRH, HIV/AIDS and GBV during the project period.

## **Annex 2**

Grant Contract Health/2007/127-366

Access to SRH Care for Uprooted People and Roma Women and Youth in South Serbia

CARE Deutschland/Luxemburg e.V

Final Narrative Report – Period 01 Dec 2007 – 30 June 2011

### **1 Description**

*Name of beneficiary of grant contract*

CARE Deutschland/Luxemburg e.V., Dreizehnmorgenweg 6, 53175 Bonn, Germany

*Name and title of the Contact person:*

Felix Wolff, Programme Director, Development Cooperation

*Name of partners in the Action:*

NGO Nexus - Vranje, NGO Centre E8 - Belgrade, NGO Generator - Vranje, NGO People's

Parliament - Leskovac, Serbian Ministry of Health

*Title of the Action:*

Access to Sexual and Reproductive Health Care for Uprooted People and Romani Women and

Youth in southern Serbia

*Contract number:*

Health/2007/127-366

*Start date and end date of the reporting period:*

01 Dec 2007 – 30 June 2011

*Target country (ies) or region(s):*

Republic of Serbia, south Serbia

*Final beneficiaries &/or target groups1 (if different) (including numbers of women and men):*

According to the project proposal:

“600 Roma and uprooted youth attending sexual and reproductive health (SRH) education sessions,

480 Roma and uprooted women attending SRH education session, 1,250 persons attending theatre performances, 44 health mediators trained (24 trained as peer educators), 24 trained Primary Health Care Centre (PHCC) providers.

The project will also indirectly benefit ca. 3.000 uprooted and Roma women and youth who will receive information materials on SRH practices. In addition, improved SRH services through better trained (PHCC) staff will be available and accessible and benefit all those seeking SRH advice in the target cities.”

*Country (ies) in which the activities take place (if different from 1.7): N/A*

[..]

#### **2.1.4.3 SRH counselling in Roma and Albanian language**

This activity was based in the project proposal on a largely presented belief that a lack of availability of family-planning and other related SRH counselling and information in their own language represented one of the barriers for Roma IDP women to access those services. This assumption was used even by the Serbian MoH for some their future planning (providing counselling in the languages of the minorities). However, at the beginning of the project implementation, during the project positioning in the local community and towards the target population and later in the process of the Social Analysis, project beneficiaries, Roma in particular, claimed that they have no language barriers in accessing the SRH services and that therefore this problem in reality does not exist in the three target municipalities. For example, in Bujanovac the PHCC has patients of Serbian, Albanian and Roma ethnicity, but the medical staff there is also mixed and there is therefore the possibility for patients to choose the language of medical, including SRH, counselling. In the PHCCs Vranje and Leskovac, according to the interviews and consultations with beneficiaries and medical workers, language barriers do not exist. Since this sensitive minority rights issue corresponds to CARE’s project implementation principle of a rights based approach, in spite of the stated tendency, this circumstance was rechecked throughout the project implementation, through internal and external analysis of the situation (by the project partners and external project evaluators – initial Social Analysis, mid-term project review and final evaluation). On all occasions, beneficiaries claimed no language barriers in accessing

the SRH services. This activity was, therefore, omitted within the project implementation, with constant confirmation of the mentioned circumstances.

[..]

### **2.1.5 Activities to achieve expected result 2: “Uprooted and Roma women are selfsupportive on SRH and related social issues“**

Initial information from the field and especially the Social Analysis showed that uprooted and Roma women lack the basic knowledge on SRH necessary to seek out necessary preventative services and make decisions that protect their health. The SA findings undoubtedly demonstrated that the gender and social norms, especially among Roma, prevent families from making decisions regarding preventing STI/HIV and family planning that would improve their SRH. The activities proposed to achieve Expected Result 2 address the individual level of knowledge, the improvement of SRH related behaviour, and deal with norms that negatively affect SRH.

At the time of the project design, CARE and partners decided that the majority of project activities should be implemented through a group of health mediators (HM, youth and senior) in order to implement community outreach/education activities, peer education events, facilitate linkages between

target population and health care services, and community SRH education through interactive community theatre. The HMs’ function as project field workers/emissaries, is to interact directly with the target communities. The project team has decided to work through health mediators due to the existing gap between health care providers and the community they serve. The intention was not that they become a permanent part of the health care system, but rather that, within the duration of the project, they would facilitate the formation of linkages between communities and the health care system.

The project engaged the total of 44 Health Mediators, throughout its duration. These HMs were subdivided into two groups: group one, composed of 20 persons (Community Health Mediators - CHM), in average 7 per city, were responsible for working with health care providers, and adults (mostly women) in target communities, contributing to the achievement of the Expected Result 2. The second group of 24 Youth Health Mediators (YHM), in average 8 per city, was responsible for youth outreach activities and peer education thus contributing to the achievement of the

Expected Result 3: See sections 2.1.6.3 and 2.1.6.4 for additional information on the details of the YHM engagement.

Possible drop out: In the effort to realize the designed project goals, CARE and partner organizations were dedicated towards the continuous work with individual activists engaged in the project (HMs and theatre group) throughout the project duration, in order to secure their constant and unreduced engagement. Both HMs and theatre activists received prestigious trainings and moderate fees for their work on education sessions/actions/theatre performances, which certainly added to their interest and motivation. However, from the first partners meetings and later, in the process of the Social Analysis and the integration of its results, partners discussed the possible and probable drop out of certain number of HMs and theatre performers and the ways of compensations. It was therefore decided that the refresher trainings, planned for the second half of the project, would be used not only as an opportunity to renew the knowledge of the existing activists, but also as an opportunity to select and train new members of the project team. It was presumed then that the drop out level would be particularly high among the YHMs, because of low expectancy of commitment at their age, but also because of changes of their life situations and statuses during the project's duration (continuing education out of their places of origin, possible employment, marriage – especially for female Roma YHMs, etc.). For that reason, the project team had planned that refresher training for YHMs would actually be a repeated initial YHM training, with new candidates. Nexus and CARE were planned to monitor the drop out numbers during the first half of the project and to decide on the next steps accordingly. Nevertheless, throughout the project implementation, the team faced a rather low drop out level of all HMs (especially in the CHMs group, where there was no drop out), mainly as a result of intense and dedicated work of partner organization Nexus, who kept the project activists active and interested. The small monthly compensation of their work (around 65 EUR, depending on the engagement) represented an additional motivation, together with continuous education and practice. These factors were clearly shown in the MTA findings, as well as in the project final evaluation, where CHMs expressed great satisfaction with their work and presented it as a meaningful and engaging endeavour.

For the reason of low drop out, the funds planned for refresher trainings could be invested in further training of project activists. Engagement of project activists throughout the project duration: the project engaged the initially planned number of mediators (CHMs/YHMs) in the first two project years. At the beginning of 2010, CARE and Nexus agreed on the schedule of engagement of project activists – Youth and Community Health Mediators (YHMs and CHMs) for the final implementation period. It was then decided that the full number of activists – 20 CHMs and 24 YHMs would be kept active until end of May 2010 when they would reach the planned total number of beneficiaries who passed educational sessions. From June 2010 to May 2011, a smaller - core group of 14 YHMs who showed the best results in the previous period, continued their engagement on organizing larger scale community actions and initiatives, mostly aimed at sustainability of project activities and influence.

[..]

#### 2.1.5.2 Capacity building of Community Health Mediators

This activity, initially planned for months 6-7 of the project, was intentionally postponed to months 9 – 11, partially due to the reasons explained above (see Ch. 2.1.5.1) and partially because the team wanted to prevent the logistic challenge of organizing trainings for the entire group of 44 HMs simultaneously or in close intervals. The Curriculum for the capacity building program for CHMs was based on the experience, knowledge, contacts and pre-existing materials of CARE and Nexus, utilizing the SA findings as a starting point. Also, in each of the training programs, special attention was paid on highlighting gender/social/cultural norms which greatly influence access to health care services, information and health seeking behaviour and reproductive health choices. The recruitment of external (domestic) trainers for capacity building of all HMs throughout the project was done by the CARE PM, in consultations with Nexus. The trainers were selected on the basis of positive work experience within previous CARE/Nexus projects, and were engaged according to the detailed Terms of References prepared by the CARE PM and by signing Service/Author's Contracts with CARE.

#### ***CHMs Training Program:***



Within the Project proposal, it was planned to organize the trainings in a way to cover the needs of the initially planned HM tasks – educational sessions in months 8-20 of the project duration and community SRH actions in months 23-34. Therefore, it was initially planned to organize Training 1, prior to the start of the sessions (on community mobilization, facilitation, program planning, communication and basic information on SRH) and Refresher Training, planned for month 23, prior to the actions (on gender/masculinity norms that negatively impact SRH and methods of designing and implementing local community actions). However, upon undertaking Social Analysis, the project team decided to alter the schedule of HM's activities to distribute educational sessions and community actions from November 2008 until the end of the project duration. The training program was tailored to match the new arrangement.

Throughout the project, the capacity of CHMs was raised through various trainings and enabled them to fulfil their duties in mobilizing the target communities and spreading the SRH information. The project team decided to expand on the planned training program and equip the project activists with knowledge that would serve not only the implementation of activities designed within this project, but also their eventual activism upon the project end. Thus, during the project implementation, CHMs received the total of 17 training days instead of 11 planned in the project proposal. This was made possible through savings in accommodation – most of the trainings were organized in Vranjska Banja, near the place of living of majority of CHMs, so the project covered only the local transportation and refreshments costs.

The first set of trainings for CHMs included two modules. According to the Project Proposal, it was planned that the Module 1 would be a workshop providing CHMs with skills required for community mobilization, facilitation, program planning and communication and that Module 2 would focus on basic SRH information (importance of prenatal care, danger signs during pregnancy, prevention and treatment of STI/HIV, and the social and cultural norms which impact SRH outcomes). However, at the time of training planning, Nexus and CARE decided to reverse this order and organize Module 1 as a three-day training focused on SRH topics, in order to start the CHMs training program by bringing the main project substance to the activists. It was decided that the Module 2 would after that be used not merely to provide the basic skills for

community mobilization and facilitation, but also as a four-days training which would produce as outputs concrete plans for the first local actions in all 3 cities and the first round of educational sessions.

[..]

#### 2.1.5.3 SRH Educational Sessions organized by CHMs

CHMs work on educational sessions started in December 2008. Working in teams (one per target city) and coached and monitored by Nexus, they have initiated the process of forming eight groups of 20 women each, in each target city. Groups were selected from the local community – IDPs collective centres and Roma settlements (where IDPs and local Roma people live together) and were comprised of women in similar life situations, for example, of young married women, pregnant women, etc. specified according to their socio-cultural background, in accordance with findings of the Social Analysis and later also recommendations of the MT evaluation.

Upon the completion of the CHM training program, the draft plans for education sessions, obtained as outputs of the trainings, were further developed in numerous meetings of CHM teams in all three cities, with and/or without Nexus presence. These preparatory meetings were held in the premises of Nexus for the CHMs from Vranje and Bujanovac and in People's Parliament office for the group in Leskovac. The outputs were detailed and concrete plans for the educational sessions, the exact division of tasks and responsibilities and concrete estimations of costs. CHMs also would specify which promotional/educational materials would be needed for the sessions and in what quantity.

Educational sessions were specifically designed to meet the needs of women, for each group of participants. Themes were finally determined by Nexus and CHMs and varied, from general SRH topics, such as: contraception, family planning, abortion, menopause, breast and cervical cancer prevention, child care and mother-child relation etc. to the topics more related to gender issues: gender and sex, labelling of persons, gender based violence, sex violence. In addition to interactive presentations of the SRH information, at the sessions, women also received brochures on the specific session topics, created by CARE and Nexus, in cooperation with professional external associates.. CHMs and Nexus engaged as much as possible local medical staff as external associates for various

SRH topics at the sessions, thus improving visibility of local health care stakeholders in the target communities.

### **2.1.6 Activities to achieve expected result 3 : “Uprooted and Roma youth have increased awareness of sexual and health issues and reproductive health”**

[..]

#### **2.1.6.2 Capacity Building for Youth HMs**

Training in SRH Peer Education: Youth HMs were trained over a period of seven days as peer educators. The training was organized in the mountain resort Kukavica, near Leskovac on 14-20 August 2008. The first training was also the first opportunity for the team to face the problem of drop out, where, in spite of the efforts of Nexus, 21 YHMs participated, instead of initially 24 selected (for the reasons for drop out, see Ch. 2.1.5. *Possible dropout*). The training was based on the methodology of the Y-Peer Network, a regional and now global program of peer educators, managed by UNFPA, Family Health International/YouthNet, and United Nations Partners (UNICEF, WHO and UNESCO). In Serbia, in order to secure training quality, the Y-Peer network established national standards in peer education, with the support of the Serbian Ministries of Health and Education.

The Training program was adapted to integrate the findings of the social analysis and was facilitated by a team of trainers from Centre E8. It was initially planned that the training will be facilitated by three full time trainers and supported by seven professional health lecturers, visiting the training for single lectures. However, from the time of the project proposal development to the implementation of this activity, Centre E8 abandoned this practice in order to improve the training quality by harmonizing the lectures and introduced an additional, fourth full time trainer. The training topics included: presentation of Y-Peer and peer education methodology, team work, SRH, STIs, HIV/AIDS, proper use of condoms, public appearance, team roles, field work with vulnerable and non accessible groups, communication, discrimination, sex and gender. The participants received a set of handouts, with extensive information on the covered issues, especially on SRH. Apart from doing the pre and post tests, participants also had the final “exam” answering to the questions from the training materials.

#### **2.1.6.3 Youth led SRH education sessions**

In each of the three target cities, YHMs – divided into three groups, one per each target city - in cooperation with Nexus, have the task of forming the total of eight groups of 24 young uprooted and Roma per city, to participate in educational sessions. According to the project proposal, it had been planned that the sessions design and monitoring would be conducted by Center E8. However, due to a clearer division of responsibilities between the project partners and the fact that Nexus is responsible for the entire engagement of Health Mediators, it was decided that Nexus will be in charge of supervision of the preparation process for all educational sessions, engaging, when necessary, Centre E8 as a resource organization. Through a number of preparation meetings, organized in the premises of Nexus in Vranje and People's Parliament in Leskovac, YHMs selected the topics, lecturers (among themselves), acquired the premises for the sessions (usually Youth clubs, Roma cultural centres etc.) and gathered necessary materials/handouts to be used at the sessions. Particular compositions of the groups and the topics for the sessions were determined in accordance with the findings of the Social Analysis and information YHMs received in particular local communities. Each group of beneficiaries received three educational sessions within the project. In general, topics of the sessions focused on issues of utmost importance for young beneficiaries and questions to which teenagers have difficulties to find correct answers. They included basic SRH information: female and male, reproductive system, pregnancy, contraception, sexually transmitted diseases, abortion, breast and cervical cancer prevention, sexual maturation, HIV. The sessions also introduced the topics of traditional norms concerning SRH, virginity cult and the cult of the first wedding night and dealt with issues of gender roles in relationships, violence and sexual violence, labelling of persons of different sexual and other orientation etc. Given the fact that through the project implementation YHMs became rather visible members of the local communities and represented particular role models for young beneficiaries, they used every opportunity, within and out of the project activities, to promote healthy lifestyles among their peers. In the process of design and realization of educational sessions, YHMs extensively exercised peer educational methods, for which they had been trained within the project - they used techniques of interactive learning and other workshop skills and utilized informative brochures (those developed within the project and the one

made by the Serbian Y-Peer network on contraception and STIs and donated to the project, see Ch. 3.3) other printed and educational materials. During the educational sessions, YHMs were also delivering condoms to the participants and providing advice on their proper use.

#### 2.1.6.4 Youth led SRH Community Actions

[..]

Youth led community actions were aimed at increasing SRH awareness and knowledge, and at addressing gender norms that negatively impact SRH. The actions were planned to target not only the members of the project target group, but also local youth, with the aim to spread the project ideas on wider population.

**YHM Community Action 1** was organized in Leskovac, on April 7, 2009 - The World Health Day, with SRH awareness of the youth as the main topic. The action was organized through three separate activities – the first was a quiz on SRH for 50 young Roma girls and boys from two local settlements in Leskovac, organized in the local primary school, which offered its premises for free. Apart from this, YHM also organized a street walk – “Walking towards the Good Health”, with the distribution of SRH educational brochures developed within the project to the passers-by. The third activity was a performance of forum theatre play developed within the project - “I Have to Know That” in Leskovac Cultural Centre. Since the play had the similar topic to the action – STIs and healthy lifestyles, it provided a significant contribution to the entire action. The action targeted in total around 200 beneficiaries. [..]

## Annex 3

### FINAL NARRATIVE REPORT

- This report must be completed and signed by the Contact person
- The information provided below must correspond to the financial information that appears in the financial report.
- Please complete the report using a typewriter or computer (you can find this form at the following address <Specify>).
- Please expand the paragraphs as necessary.
- Please refer to the Special Conditions of your grant contract and send one copy of the report to each address mentioned
- The Contracting Authority will reject any incomplete or badly completed reports.
- Unless otherwise specified, the answer to all questions must cover the reporting period as specified in point 1.6
- Please do not forget to attach to this report the proof of the transfers of ownership referred to in Article 7.3 of the General conditions.

#### **1. Description**

- 1.1. Name of beneficiary of grant contract: International Planned Parenthood Federation (IPPF)
- 1.2. Name and title of the Contact person: Matthew Lindley, Head of Resource Mobilization
- 1.3. Name of partners in the Action: Association Burkinabe pour le Bien-Etre Familial (ABBEF), Gambia Family Planning Association (GFPA), Planned Parenthood Federation of Ghana (PPAG), Planned Parenthood Federation of Nigeria (PPFN), IPPF Africa Regional Office and Economic Community of West African States (ECOWAS)/ West Africa Health Organization (WAHO).
- 1.4. Title of the Action: From Donorship to Ownership: Securing the Future of Public, Political and Financial Commitments to Sexual and Reproductive Rights in West Africa
- 1.5. Contract number: SANTE/2006/129-582
- 1.6. Start date and end date of the reporting period<sup>1</sup>: 1 January 2007 to 30 June 2009
- 1.7. Target country(ies) or region(s): Burkina Faso, The Gambia, Ghana and Nigeria

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<sup>1</sup> The entire implementation period of the Action

1.8. Final beneficiaries &/or target groups<sup>2</sup> (if different) (including numbers of women and men): IPPF Member Associations in Burkina Faso, the Gambia, Ghana and Nigeria and their partners in the coalitions are the target groups as they are the direct beneficiaries of the capacity building activities. Other include national stakeholders such as parliamentarians, NGOs, senior government officials, and representative of the Economic Community of West African States (ECOWAS) and its specialized health agency, West Africa Health Organization (WAHO), who will benefit from increased awareness and knowledge on reproductive health policies and their linkages to overall national development. The indirect beneficiaries of the project are marginalized and underserved groups such as people living in resource-poor settings, women, and young people, who will in the long term gain increased access to comprehensive sexual reproductive health care and information.

1.9. Country (ies) in which the activities take place (if different from 1.7):

## Executive Summary

The International Planned Parenthood Federation (IPPF) Africa Region and its Member Associations played a key role in the processes that led to the formulation and adoption of two key SRH continental policy frameworks: The Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) (2006), and the Maputo Plan of Action (2007). Following the adoption of these agreements IPPFAR has been leading the response to mobilize and unify key stakeholders, at both national and sub-regional level, to turn existing political support into the commitments required to adequately finance the unmet need of SRHR services and supplies in Africa. The response has been piloted through this European Commission (EC) funded project: From Donorship to Ownership: securing the future of public and financial commitments to sexual and reproductive health.

The overall objective of the project was to improve awareness on reproductive health policies among in-country key stakeholders in Nigeria, Burkina Faso, Gambia, and Ghana, in particular key decision-makers, in order for governments to allocate adequate resources, both human and financial, for sexual and reproductive health. The project's purpose was twofold:

- Foster ownership and leadership for sexual and reproductive health and rights (SRHR) in ECOWAS governments with a view to securing increased funding for SRHR policies
- Strengthen the advocacy capacity of IPPF at the Member Association level to support and monitor political and resource commitment to SRH in target countries.

This advocacy initiative was implemented at two levels: regional and national. At regional level, IPPF Africa Region worked with the Economic Community of West African States (ECOWAS) and its specialized health agency, the West Africa Health Organization (WAHO), towards ensuring that regional agreements on reproductive health, in particular the Maputo Plan of Action, were translated into programmatic work plans with sufficient financing to address the unmet need for SRHR services and commodities. While at the country level, IPPF Member Associations in Nigeria, Burkina Faso, Gambia, and Ghana, rallied key stakeholders in reproductive health in advocating for increased public funding allocations and expenditures at state level for sexual and reproductive health.

At country level, the Member Associations formed national sexual and reproductive health coalitions comprising a wide cross section of national stakeholders. The coalitions, hosted by IPPF Member Associations, developed country-specific advocacy strategies and action plans, and launched the project to national stakeholders including policy makers, parliamentarians and high-level ministry of health officials. While in Ghana and The Gambia the coalitions mapped out the government budgetary processes and studied reproductive health policies and programmes in their respective countries, the Burkina Faso coalition engaged the media constructively to put sexual and reproductive health issues in the public arena. Overall, the project strengthened the advocacy skills of the Member Associations. At the regional level the project has received high-level support from the ECOWAS Commission following the sub-regional consultative meeting organized by IPPF Africa Region and the Planned Parenthood Federation of Nigeria (PPFN) in collaboration with ECOWAS/WAHO and UNFPA.



Table 1 – Description of Action (January 2007 to June 2009)

	Activity	Dates & venue	Reasons for modification	Results
1a.	1. Regional conference in association with UNFPA, ECOWAS and WAHO - to launch regional advocacy initiative to ECOWAS parliamentarians, WAHO and relevant stakeholders and key country representatives and decision makers.	Meeting on 'Ownership and Leadership of SRH in West Africa' was held in Abuja, Nigeria on 14 to 15 April 2008 which launched the project at regional level. It was attended by over 45 participants who comprised representatives of civil society organizations from: Nigeria, Burkina Faso, The Gambia and Ghana; parliamentarians from Nigeria and the Gambia; government officials from Nigeria; ECOWAS and WAHO; the European Commission (EC); and UNFPA.	The regional launch programme was modified to cover 1 (b) below. It proved difficult to convene The ECOWAS Parliamentary Health Committee whose members are drawn from seven Member States in the Region in April. This is because the Committee normally meets in September.	<p>The meeting communiqué was presented to Senator Dr. Olorunnimbe Momora of Nigeria who is also the Vice-chair of the ECOWAS Parliamentary Health Committee. In September 2008 Dr. Momora tabled the communiqué before the Parliamentary Committee at its sitting.</p> <p>This action contributed towards raising awareness of critical SRH issues at ECOWAS level also aimed to ensure that SRHR issues are given priority and increased budgetary allocation at both the ECOWAS Secretariat and national levels.</p> <p>Decision makers participating in the meeting renewed their commitment to promoting sexual and reproductive health in their countries. For instance, the Deputy Speaker of the National Assembly of The Gambia, Hon. Abdoullie Bojang, committed to working closely with the IPPF Member Association to promote SRH in his country.</p> <p>The meeting received support from the President of the ECOWAS Commission, Dr. Mohammed Ibn Chambers who sent a goodwill message through a senior ECOWAS official. Senator Iyabo Obasanjo-Bello, Chairperson of Nigeria's Senate Committee on Health, and the Permanent secretary in the FMOH, Dr. Shehu Sule (representing the Health Minister), also committed to pushing the SRHR agenda in Nigeria'.</p>
1b.	Organize a one-day Parliamentary hearing on SRHR at ECOWAS level, with support from UNFPA and regional institutions such as WAHO	This was held as part of the above regional meeting. The meeting outcomes were presented to the Senator Dr. Olorunnimbe Momora of Nigeria who is also the Vice-chair of the ECOWAS Parliamentary Health Committee	As the budget for the regional meeting was limited and was not sufficient to accommodate seven high-level MPs, it was agreed it would be more cost effective to invite the Vice Chair of the ECOWAS Parliamentary Committee to participate in	<p>The meeting communiqué was presented and deliberated upon by the ECOWAS Parliamentary Committee at its sitting in September 2008.</p> <p>Through the meeting IPPFAR and its Member Associations have gained the support of some key decision makers in the ECOWAS Secretariat and Nigeria's Federal Ministry of Health, as well as the Senate.</p>
			the meeting and then request him to convey the meeting outcomes to the ECOWAS Parliamentary Health Committee.	
2.	Develop key partners and contacts - map the key partners and contacts within ECOWAS and target governments that, as a group, can ensure better SRHR outcomes in the future.	<p>This was an ongoing process with the Member Associations identifying and developing a directory of key stakeholders and partners at country level. (See attached Annex II List of partners). The coalitions continued to grow as they became more established.</p> <p>Prior to the regional launch of the meeting a local organizing committee comprising IPPFAR, PPFN, ECOWAS, WAHO, Federal Ministry of Health (FMOH) and UNFPA was formed to coordinate the advocacy initiative. The committee held several meetings in Abuja, between February and April 2008. This led to the strengthening of relations between PPFN/IPPFAR, UNFPA, ECOWAS and WAHO.</p>		<p>Each Member Association developed a directory of key national stakeholders. Many of the partners identified have become active members of the advocacy coalitions at national level. They come from diverse sectors and backgrounds, and bring different skills and contacts to the groups, which has contributed towards strengthening the coalitions at the national level.</p> <p>At the regional level, IPPFAR formalized its collaboration with WAHO by signing a Memorandum of Understanding in 2009 as a direct outcome of this project. IPPFAR is currently supporting the recruitment of an SRH expert who will work within the organization to ensure that SRHR issues are prioritized within WAHO, the ECOWAS Secretariat, and subsequently in ECOWAS Member States.</p>
3.	National conference in each country to launch the project to key national stakeholders, partners, and interest groups.	The national launches were held as follows: In Ghana the project was launched on 11 November 2008 in Accra under the theme: 'Improving maternal health through sustainable funding of SRH'. The meeting attended by over 50 key	All the coalitions were launched towards the end of 2008 because it took time to build relations among the partners and for them to agree on the advocacy issues the coalition would focus on.	<p>SRH coalitions have been formed in the four countries. The project has been launched in three countries - Ghana, The Gambia and Nigeria. During the national launches, key decision makers delivered positive statements in support of SRH in their respective countries.</p> <p>The national launches received extensive media coverage, which put SRH issues in the public arena. In Burkina Faso, the coalition engaged the media constructively to stimulate</p>

		<p>stakeholders was presided over by the Deputy Minister of Manpower, Youth and Employment, Hon. Frema Opare, who represented the then First lady, Her Excellency Theresa Kufuor.</p> <p>In Nigeria the project was launched on 5 August 2008 in Abuja. The meeting was attended by over 60 key stakeholders and was presided over by Dr. Wapada Balami, the Head of the Reproductive Health Unit, federal Ministry of Health who represented the Health Minister, and Senator Olurunnimbe Momora, the Deputy Chair of the ECOWAS parliamentary Committee on Health.</p> <p>In The Gambia the project was launched on 9 October 2008 and was attended by over 40 key stakeholders. It was attended by high-level officials including Dr. Malick Njie, Secretary of State for Health; Alhadji Omar Taal, Deputy Permanent Secretary for Health/ West African Organization (WAHO) Liaison Officer and Mr. Yankuba Colley - Lord Mayor of Kanifing Municipality.</p> <p>The project launch has not been done in Burkina Faso.</p>		<p>public discussions around SRH issues. Using national newspapers, radio and television, the coalition sponsored a media campaign throughout the country that helped focus the attention of opinion leaders and the public on the importance of reproductive health in national development and the need to invest more funds and human resources to improve the country's health services. The media campaign not only increased the coverage of sexual and reproductive health issues in the print and electronic media, but also raised awareness of journalists on the linkages between SRHR and the country's overall development.</p>
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	<p>b). <u>Three national level advocacy strategy</u>, communications and capacity building meetings per country for the various SRHR stakeholders.</p>	<p>During the period between February and August 2008, each coalition held three meetings where country specific advocacy strategies and action plans were developed.</p>	<p>Due to the short period of the project, the coalitions were not able to develop communications strategies or hold capacity building meetings.</p> <p>However, this work is continuing outside the remit of the project.</p>	<p>Country-specific advocacy issues were agreed upon by the coalition members and advocacy strategies developed in the four countries.</p> <p>In Nigeria, the coalition agreed to focus on advocating for increased budgetary allocation to health by ensuring provision for SRH in local, state and national government budgets.</p> <p>In Ghana, the coalition agreed to advocate for the inclusion of family planning (FP) commodities in the National health Insurance Scheme as well as in the government's essential drug list.</p> <p>In the Gambia, the coalition agreed to focus on advocating for increased human resources for SRH.</p> <p>The coalition in Burkina Faso agreed to focus on repositioning Family Planning in key government processes such as the National Development Plan and the Poverty Reduction Strategy Paper.</p>
4.	<p><u>Developing national advocacy networks of existing NGOs.</u> In project countries, IPPF will facilitate and support the formation of nationally-driven advocacy networks that will be supported by the national Member Association.</p>	<p>This was an ongoing activity with Member Associations inviting key partners to join the coalition during the project period.</p>		<p>All IPPF Member Associations successfully rallied a wide range of stakeholders (including non-governmental organizations (NGOs), faith-based organizations, women's and youth groups, parliamentarians, and health service providers) in their respective countries to form national sexual and reproductive health coalitions with functional secretariats hosted by IPPF Member Associations. These coalitions are recognized as strong and well-organized national advocacy groups committed to increasing awareness of reproductive health among decision-makers and stakeholders.</p> <p>In Nigeria, the coalition held several meetings with parliamentary committees for Health; Appropriation, Women Affairs and Social Development and MDGs and urged the members to work towards increasing national budgetary allocations to reproductive health. In recognition of its advocacy efforts, the IPPF Member Association in</p>

				Nigeria, as the Secretariat of the coalition, was invited by the Federal Ministry of Health to join two key national technical committees: The Integrated Maternal, Neo-natal, and Child Health (IMNCH) and the Population Technical Working group (PTWG). This provided an opportunity through which the coalition could consistently advocate for increased resources for reproductive health by sensitizing members of the committees on the importance of increasing financial investments to reproductive health.
5.	Advocacy Strategy - develop an advocacy strategy and action plan to ensure that governments are implementing the Maputo Plan of Action and to increase the relevance of, and funding available for, SRHR programming and monitoring, including reproductive health supplies.	Each national coalition developed its own advocacy strategy focusing on a specific issue as mentioned above.	IPPFAR decided to focus its efforts to support country-level advocacy where tangible results could be demonstrated. Besides working with the ECOWAS Secretariat required an enormous amount of time, financial resources and effort mainly due to bureaucracy inherent in intergovernmental organizations. This activity will eventually be implemented following the signing of the MoU with WAHO.	<p>This activity was not implemented as initially envisaged.</p> <p>It was decided that the scope of the project should be kept to achievements at the national level. It was felt that this would ensure more support and success for the Member Associations.</p>
6.	Providing support to specific national advocacy initiatives. The project will provide support to the nationally-driven advocacy networks to monitor policy developments, and to develop a series of events and initiatives to inform the national debate about SRHR	IPPFAR held 2 meetings with the national advocacy officers responsible for coordinating the coalitions on 16 April in Abuja, Nigeria and 18 to 19 December in Accra, Ghana. The meeting discussed progress, potential advocacy opportunities at regional and		The IPPF Member Associations hosting the coalition secretariats developed action plans for sustaining the coalitions after the funding period ends. IPPFAR has continued to support the MAs and the coalitions to implement key advocacy interventions since the project period ended in June 2009.
	and ensure that the Maputo commitments are met.	national levels, and plans for sustaining the project after the funding has ended.		
7.	Identify, facilitate and coordinate regional advocacy opportunities for national level action.	This activity was implemented.	IPPFAR's effort and support was instead directed towards identifying national level advocacy opportunities and strengthening the coalition building.	<p>This activity was not implemented as initially envisaged.</p> <p>It was decided that the scope of the project should be kept to achievements at the national level. It was felt that this would ensure more support and success for the Member Associations.</p>