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on Sexual and Reproductive Health and Rights
(2013/2040(INI))

Committee on Women's Rights and Gender Equality

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on Sexual and Reproductive Health and Rights

(2013/2040(INI))

The European Parliament,

– having regard to the Universal Declaration of Human Rights, adopted in 1948, in particular Articles 2 and 25,

– having regard to Articles 2(2), 3, and 12 of the United Nations International Covenant on Economic, Social and Cultural Rights, adopted in 1966, and as interpreted in General Comment no 14 of the United Nations Committee on Economic, Social and Cultural Rights,

– having regard to Articles 2, 12(1), and 16(1) of the 1979 United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which refer to women's health, marriage and family life, and to General Recommendations 21 (1994) and 24 (1999),

– having regard to Articles 2, 12, and 24 of the Convention on the Rights of the Child, adopted in 1989, which refer to non-discrimination, the right of the child to be heard, and the protection of maternal, infant and child health, in addition to developing family planning education and services,

– having regard to the Declaration and Programme of Action of the United Nations International Conference on Population and Development (Cairo, 13 September 1994), and to the United Nations General Assembly Resolution 65/234 on the follow-up to the International Conference on Population and Development beyond 2014 (December 2010),

– having regard to the Beijing Declaration and Platform for Action, adopted by the Fourth World Conference on Women on 15 September 1995 and to Parliament's resolutions of 18 May 2000 on the follow-up to the Beijing Action Platform, of 10 March 2005 on 'the follow-up to the Fourth World Conference on Women – Platform for Action (Beijing+10) and of 25 February 2010 on the follow-up to the Beijing Action Platform (Beijing +15),

– having regard to the millennium development goals adopted at the Millennium Summit of the United Nations in September 2000,

– having regard to the parliamentary statements of commitment on 'the Implementation of the ICPD Programme of Action' from Ottawa (2002), Strasbourg (2004), Bangkok (2006), Addis Ababa (2009), and Istanbul (2012),

– having regard to the United Nations Report of the Special Rapporteur on 'The right to education', A/65/162 (2010),

– having regard to the World Health Organisation Global Strategy for Women's and Children's Health, launched in 2010,

– having regard to Paragraph 16 of the United Nations Interim Report of the Special Rapporteur on 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', A/66/254 (2011),

– having regard to the United Nations Report of the Special Rapporteur on 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', A/HRC/17/25 (2011),

– having regard to the United Nations Human Rights Council Resolution 21/6 of 21 September 2012 on 'Preventable Maternal Mortality and Morbidity and Human Rights',

– having regard to the United Nations Population Fund Report 'State of the world population 2012: By choice not by chance' of 14 November 2012,

– having regard to Paragraphs 45-50 of the United Nations Report of the Special Rapporteur on 'Torture and other cruel, inhuman or degrading treatment or punishment', A/HRC/22/53 (2013),

– having regard to the European Convention on Human Rights, and the jurisprudence of the European Court of Human Rights, in particular Article 9, relating to the right to belief and conscience,

– having regard to Resolution 1399 of the 2004 Parliamentary Assembly of the Council of on a 'European strategy for the promotion of sexual and reproductive health and rights',

– having regard to Resolution 1607 of the 2008 Parliamentary Assembly of the Council of Europe Resolution on 'Access to safe and legal abortion in Europe',

– having regard to Articles 2, 5, and 152 of the EC Treaty,

– having regard to Articles 8, 9, and 19 of the Treaty on the Functioning of the European Union, which refer to combating discrimination based on sex and the protection of human health,

– having regard to the Charter of Fundamental Rights of the European Union,

– having regard to the European Consensus on Development (2005),

– having regard to Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries[1],

– having regard to the Regulation (EC) No 1922/2006 of the European Parliament and of the Council of 20 December 2006 on establishing a European Institute for Gender Equality[2],

– having regards to Regulation (EC) No 851/2004 of the European Parliament and of the

[1] OJ L 224, 6.9.2003, p.1.
[2] OJ L 403, 30.12.2006, p.9.

Council of 21 April 2004 establishing a European Centre for Disease Prevention and Control[1],

– having regard to its resolutions of 29 September 1994[2] on the outcome of the Cairo International Conference on Population and Development, and 4 July 1996[3] on the follow-up to that Conference,

– having regard to its resolution of 3 July 2002[4] on sexual and reproductive health and rights,

– having regard to its resolution of 10 February 2004[5] on the proposal for a European Parliament and Council regulation establishing a European Centre for Disease Prevention and Control,

– having regard to its resolution of 4 September 2008 on Maternal Mortality ahead of the UN high-level event on the millennium development goals held on 25 September 2008[6],

– having regard to its resolution of 13 March 2012[7] on equality between women and men in the European Union - 2011,

– having regard to Rule 48 of its Rules of Procedure,

– having regard to the report of the Committee on Women's Rights and Gender Equality and the opinion of the Committee on Development (A7-0000/2013),

A. whereas sexual and reproductive rights are human rights, the violations of which constitute breaches of women's and girls' rights to equality, non-discrimination, dignity and health, and freedom from inhuman and degrading treatment;

B. whereas women and men should have the freedom to make their own informed and responsible choices as regards their sexual and reproductive health;

C. whereas the 2010 Report of the UN Special Rapporteur on 'The right to education', states that the right to comprehensive sexual education is a human right;

D. whereas women are disproportionately affected by a lack of sexual and reproductive health and rights (SRHR) due to the nature of human reproduction, and the gender-based social, legal and economic context in which it occurs;

E. whereas there exists a disparity in the standard of sexual and reproductive health between and within Member States and inequality of sexual and reproductive rights enjoyed by women;

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[1] OJ L142, 30.04.2004, p.1.
[2] OJ C 305, 31.10.94, p. 80.
[3] OJ C 211, 22.7.1996, p.31.
[4] OJ C 271, 12.11.2003, p.197.
[5] OJ L 142, 30.4.2004, p.1.
[6] OJ C 295, 4.12.2009.
[7] P7_TA(2012)0069.

F. whereas opposition to sexual and reproductive health and rights (SRHR) has increased in Europe and worldwide, with the aim of denying women and men the essential sexual and reproductive rights that all EU Member States have committed to safeguard in international agreements;

G. whereas access to safe abortion is banned, except in very narrow circumstances, in three EU Member States (Ireland, Malta and Poland) and remains widely unavailable, though legal, through the abuse of conscientious objection or overly restrictive interpretations of existing limits;

H. whereas maternal mortality remains a concern in some Member States;

I. whereas disparities in abortion rates among Member States and widespread reproductive ill-health in parts of the EU indicate the need for non-discriminatory provision of affordable, accessible, acceptable, and quality services, including family planning and youth-friendly services, as well as comprehensive sexuality education;

J. whereas studies have shown that comprehensive sexuality education does increase the likelihood of responsible behaviour upon first and subsequent sexual activity;

K. whereas the practice of forced or coerced sterilisation of Roma or disabled women still occurs in some Member States;

As regards sexual and reproductive health and rights policy in the EU in general

1. Recalls that 'health is a fundamental human right indispensable for the exercise of other human rights' and that the EU cannot reach the highest attainable standard of health unless the SRHR of all are fully acknowledged and promoted;

2. Recalls that SRHR are an essential element of human dignity to be addressed in the broader context of structural discrimination and gender inequalities; and calls on Member States to safeguard SRHR through the Fundamental Rights Agency;

3. Deeply regrets that the proposal for a new Health for Growth Programme 2014-2020 does not mention SRHR[1];

4. Notes that even though it is a competence of Member States to formulate and implement policies on SRHR, the EU can exercise policy-making competence in the area of public health and of non-discrimination, and support better implementation of sexual and reproductive rights;

5. Calls on Member States to work with the European Institute for Gender Equality (EIGE) and civil society to design a European strategy for the promotion of SRHR, and support the elaboration and implementation of comprehensive national strategies for sexual and reproductive health; suggests that the EIGE be empowered to collect and analyse data and best practices;

6. Stresses that the current austerity measures have a detrimental impact, particularly for

[1] COM(2011)709

women, on public health services related to sexual and reproductive health, both in terms of quality and accessibility, on family planning organisations, on NGO service providers, and on women's economic independence;

As regards unwanted pregnancy: access to contraception and safe abortion services

7. Stresses that it is essential for individual, social and economic development that women have the right to decide freely and responsibly the number, timing and spacing of their children, as established by international human rights law;

8. Urges the Member States to promote scientific research on male- and female-controlled methods of contraception, so as to facilitate the burden-sharing of contraceptive responsibility;

9. Underlines that in no case must abortion be promoted as a family planning method;

10. Recommends that, as a human rights concern, abortion should be made legal, safe, and accessible to all;

11. Underlines that even when legal, abortion is often prevented or delayed by obstacles to the access of appropriate services, such as the widespread use of conscientious objection, medically unnecessary waiting periods or biased counselling; stresses that Member States should regulate and monitor the use of conscientious objection so as to ensure that reproductive health care is guaranteed as an individual's right, while access to lawful services is ensured and appropriate and affordable referrals systems are in place;

12. Recommends that the Member States continue providing the information and services necessary to maintain a low level of maternal mortality and to guarantee quality ante- and post-natal care;

As regards comprehensive sexuality education and youth-friendly services

13. Calls on the Member States to ensure universal access to comprehensive SRHR information, education and services; urges 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;

14. Underlines that the sexual and reproductive health needs of adolescents differ from those of adults; calls on the Member States to ensure that adolescents and vulnerable adults (disabled, illiterate, refugees, etc.) have access to user-friendly services where their concerns and rights to confidentiality and privacy are duly taken into account;

15. Calls on Member States to ensure compulsory, age-appropriate and gender-sensitive sexuality and relationship education for all children and adolescents (both in and out of school);

16. Stresses that sexuality education must include the fight against stereotypes and prejudices, shed light on gender and sexual orientation discrimination, and structural barriers to

substantive equality, as well as emphasise mutual respect and shared responsibility;

As regards STI prevention and treatment

17. Urges the Member States to ensure immediate and universal access to STI treatments, provided in a safe and non-judgmental manner;

18. Calls on the Commission and the Member States to address the specific SRHR of people living with HIV/AIDS, with a focus on the needs of women, notably by integrating access to testing and treatment and reversing the underlying socioeconomic factors contributing to the risk to women of HIV/AIDS, such as gender inequality and discrimination;

As regards violence related to sexual and reproductive rights

19. Condemns any violation of the bodily integrity of women, as well as harmful practices intended to control women's sexuality and reproductive self-determination; underlines that these are serious human rights violations that the Member States have a responsibility to urgently address;

20. Calls on the Member States to address the need to protect women, young people, children and men from any abuse, including sexual abuse, exploitation, smuggling, trafficking and violence, including female genital mutilation, supported by educational programmes at both national and community levels, and focus on measures to do so with severe penalties for perpetrators of abuse;

As regards SRHR and official development assistance (ODA)

21. Reminds the Member States that investments in reproductive health and family planning are among the most cost-effective, in terms of development, and the most effective ways to promote the sustainable development of a country;

22. Supports Recommendation 1903 (2010) of the Council of Europe Parliamentary Assembly to allocate 0.7 % of gross national income to ODA; calls on the EU to maintain this commitment through the financing and implementation of the 2014-2020 European external actions instruments and European Development Fund;

23. Urges the Commission to ensure that European development cooperation adopts a human rights-based approach and that it has a strong and explicit focus, and concrete targets on SRHR;

24. Instructs its President to forward this resolution to the Council and the Commission.

EXPLANATORY STATEMENT

Annually the UNDP ranks countries according to their level of gender inequality. The Gender Inequality Index is measured by gender-based disadvantage in three aspects of life reproductive health, empowerment and the labour market.[1] This report focuses on the first element and its corresponding rights, not only as a human rights issue but also as a means to achieve gender equality.

Being among the most developed countries in the world, Member States (MS) take the lead in the global ranking of countries according to the state of their populations' reproductive health.[2] However, the data available from MS reveal a stark disparity of women's sexual and reproductive health across Europe.

On various occasions, the European Parliament (EP) has expressed its support for investing in sexual and reproductive health and rights (SRHR). A strong EU position on SRHR will only be possible with a strong push from this institution.

This report comes at a very important timing. The current political and economic context threatens the respect of the SRHR. 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[3]. Additionally, very conservative positions regarding SRHR have arisen all around Europe. As clearly manifested in countries such as Spain and Hungary, and in regional forums such as the Parliamentary Assembly of the Council of Europe, the European Committee on Social Rights, and even at the EP, the anti-choice opposition is becoming stronger and more vocal. Given these attacks, it is more critical than ever that the EP stands up for sexual and reproductive rights as human rights and provides a useful summary of the current state of play of SRHR at the European level.

Sexual and Reproductive Health

The WHO states that "reproductive health addresses the reproductive processes, functions and system at all stages of life. [*It*] therefore, implies that people are able to have a responsible, 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. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[4]

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[1] UN Development Fund (2011). Human Development Report 2011: Sustainability and Equity: A Better Future for All, Technical Note 3.
[2] As demonstrated by the indicator data used to calculate the Gender Inequality Index. UNDF(2011). Human Development Report 2011: Sustainability and Equity: A Better Future for All. Statistical Annex, Table 4.
[3] EP resolution of 12 March 2013 on the impact of the economic crisis on gender equality and women's rights.
[4] Global Policy Committee of the WHO(1994). Position Paper on Health, Population and development for the International Conference on Population and Development, Cairo 5-13 September 1994, p. 24, para. 89.

Sexual health is defined as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[1]

Sexual and Reproductive Rights

Sexual and reproductive health is safeguarded by sexual and reproductive rights. As recognised by article 96 of Beijing Platform for Action (1995), those rights are based on human rights of equality and dignity.

Sexual and reproductive rights, including the right to maternal health care and family planning, include both freedoms and entitlements linked to many of the already established civil, political, economic, social, and cultural rights. Although not interchangeable, reproductive rights are one aspect of sexual rights, just as sexual rights are one part of reproductive rights.[2]

Maternal Mortality

Although the majority of MS continues to maintain very low ratios of maternal mortality (MMR) (between 2 and 10 maternal deaths per 100,000 live births)[3], in some MS these ratios are significantly higher (34 in Latvia, 27 in Romania, 21 in Hungary, and 20 in Luxembourg). A number of MS show encouraging trends for instance, from 1990 to 2010, Romania's MMR decreased from 170 to 27, Latvia's from 54 to 34, Bulgaria's from 24 to 11, Lithuania's from 34 to 8. However, at the same time, other MS are showing worrying trends and fluctuations; Luxembourg's estimated MMR has steadily increased from 6 in 1990 to 20 in 2010, while Hungary succeeded in lowering its 1990s MMR of 23 to 10 during the 2000s, only to have it spike up again in 2010 at 21.[4] In its resolution of 13 December 2012, on the annual report on Human Rights and Democracy in the World 2011 and the EU's policy on the matter, the European Parliament recalled that the prevention of maternal mortality and morbidity requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, education, information and health. The EP stressed that the EU must therefore play an important role in contributing to the decline of preventable complications occurring before, during and after pregnancy and childbirth.

Data collection

Many MS do not collect the necessary data to fully measure reproductive and sexual health.

[1] WHO (2006). Defining sexual health: Report of a technical consultation on sexual health; 28–31 January 2002, Geneva.
[2] Yamin, A. E. (Ed.), 2005, Learning to dance: Advancing women's reproductive health and well-being from the perspectives of public health and human rights, Cambridge, Harvard University Press.
[3] It is assumed that "countries with 1–10 deaths per 100,000 births are performing at essentially the same level and that differences are random", see footnote 1.
[4] UN Maternal Mortality Estimation Inter-agency Group (2012). Trends in maternal mortality 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank estimates.

For example over two-thirds of MS have no information on the percentage of pregnant women who have received at least one antenatal visit and over one-quarter of MS have no data on the percentage of births attended by a skilled health care professional.[1] While compiling such data may be considered redundant by some highly developed countries, they are nevertheless important indicators that allow the consistent monitoring of reproductive health standards. It is necessary that the MS compile and monitor more comprehensive data and statistics regarding sexual and reproductive health indicators (STIs, abortion and contraception rates, unmet need for contraception, adolescent pregnancy...), disaggregated at least by gender and age. In order to get a better overview of the situation in the whole Union, the European Institute for Gender Equality should therefore be empowered to ensure the collection and analysis of data and best-practices.

Sexuality Education

In most MS, sexuality education is compulsory by national law, although content and quality vary. According to a recent study, the best practices of sexuality education are to be found in the Benelux and Nordic countries, France, and Germany. MS of Eastern and Southern Europe tend to have deficient or inexistent sexuality education programmes.[2]

Higher rates of teenage births, abortion, and sexually transmitted infections (STIs) have a tendency to be linked to flawed or insufficient sexuality education. Current EU data is congruent with this premise, as seen by the highest rates of adolescent births and abortion among MS of Eastern Europe[3].

Although the general trend is that sexuality education programmes are slowly improving, 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 European youth.

Adolescent Birth Rates and Unwanted Pregnancy

Teenage childbirth rates[4] vary significantly between MS. The lowest adolescent birth rates (between 5 and 9 births per year) are currently found in the Netherlands, Slovenia, Denmark, Sweden, Cyprus, Italy, Luxembourg, and Finland. Somewhat higher adolescent birth rates (between 10 to 20 births) are found in the majority of MS: Germany, Austria, France, Belgium, Greece, Spain, Czech Republic, Latvia, Poland, Portugal, Ireland, Lithuania, Hungary, and Malta. Highest rates of teenage childbirth are found in Slovakia (22), Estonia (24), UK (26), Romania (40), and Bulgaria (44).

Despite encouraging trends in some MS, the stark disparity between the Netherlands'

[1] UNDF(2011). Human Development Report 2011: Sustainability and Equity: A Better Future for All. Statistical Annex, Table 4.
[2] Beaumont, K; Maguire, M; Schulze, E; European Parliament (2013). Policies for Sexuality Education in the European Union, available at: http://www.europarl.europa.eu/committees/en/femm
[3] European Centre for Disease Prevention and Control (June 2012). Sexually Transmitted Infections in Europe 1990-2010.
[4] Annual number of births to girls aged 15-19 years per 1,000 girls in that age group.

adolescent birth rate of 5, UK's 26, and Bulgaria's 44, indicates that much of the EU's youth still lacks the necessary skills and knowledge to make responsible sexual and reproductive choices.

Aside from the unplanned nature of most teenage pregnancies and young girls' general unpreparedness for motherhood, adolescent childbirth frequently results in long-lasting consequences. Pregnancy-related health issues are more commonly present during teen pregnancies than adult pregnancies (e.g. miscarriage, neonatal death). Studies also suggest that adolescent mothers are less likely to graduate from high school and more likely to live in poverty. Furthermore, children of adolescents are often born underweight and experience health and developmental problems.[1]

Adult women also face the problem of unwanted pregnancy, which may occur for many reasons: failed contraception, improper or inconsistent use of contraception, sexual partners who oppose using contraception, coerced sex or rape, or health reasons. As the WHO notes, "even a planned pregnancy can become unwanted if circumstances change."[2]

Abortion

Twenty MS legally permit abortion on demand. Of the seven remaining, three MS (Great Britain, Finland, Cyprus) allow for a broad interpretation of the limiting grounds, while in three other MS (Ireland, Poland, Luxembourg) a restrictive interpretation of limiting grounds and general unwillingness or fear to perform abortions has resulted in (reported) legal abortions rarely taking place, if ever. Malta is the only MS to legally prohibit abortion without any exceptions.[3] Limiting grounds for allowing abortion may include if the woman's life or physical and/or mental health is at risk, in case of foetal impairment, in case of rape, or for medical or socio-economic reasons. In the majority of MS the gestational limit for abortion is 12 weeks. Abortion fees vary tremendously according to MS; in countries where national insurance covers abortions, it is usually only those on medical grounds. Some MS require a compulsory waiting period and minors seeking an abortion may require parental consent.[4]

It must be noted that increasingly barriers to abortion services are being imposed in countries even with permissive abortion laws. Mainly, women have to face the unregulated use of conscientious objection of reproductive health care providers, mandatory waiting periods or biased counselling[5]. Conscientious objection's practice has denied many women access to reproductive health services, such as information about, access to, and purchase of contraception, prenatal testing, and lawful interruption of pregnancy. There are cases reported from Slovakia, Hungary, Romania, Poland, Ireland and Italy where nearly 70% of all gynaecologists and 40% of all anaesthesiologists conscientiously object to providing abortion

[1] European Centre for Disease Prevention and Control (June 2012). Sexually Transmitted Infections in Europe 1990-2010.
[2] WHO (2012). Sexual and reproductive health: facts and figures about abortion in the European region..
[3] See in UN ICPD Beyond 2014 Review (July 2012), Country Implementation Profiles; International Planned Parenthood Federation (May 2012), Abortion Legislation in Europe.
[4] IPPF (May 2012). Abortion Legislation in Europe.
[5] Christine McCafferty Report of the Council of Europe, Women's access to lawful medical care: the problem of unregulated use of conscientious objection, 20.07.2010 and Resolution 1763 (2010) of the Parliamentary Assembly of the Council of Europe.

services. These barriers clearly contradict human rights standards and international medical standards.[1]

It is not rare for women living in countries with restrictive abortion policies to travel to other MS to have an abortion. However, this practice presents a high economic burden for certain groups in addition to the possibility of criminal prosecution in their country of residence. Furthermore, it makes difficult the collection of reliable data on abortion. Travelling for a legal abortion is also frequently necessary within some MS for women living in rural areas.[2] Practically, the ban affects more particularly already marginalised women—those who cannot travel easily to other EU states for abortion services, such as those in financially difficult circumstances, asylum seekers, women in care or custody of the state, etc—which contributes to growing health inequities in the Union.

MS with the lowest number of reported abortions[3] are Germany, Greece, Denmark, and Portugal (ranging from 7 to 9 legally induced abortions per 1,000 women aged 15-44 years), while MS with the highest number of reported abortions are Estonia, Romania, Bulgaria, Latvia, Hungary, and Sweden (ranging from 35 to 21 abortions), followed by UK (17) and France (18).[4]

Because of the potential public health consequences of prohibiting abortion, it seems evident that prohibiting abortion will not encourage decreasing its rate; rather it would be more efficient to focus on preventing unwanted pregnancies.[5] Finally, there is very little relationship between abortion legality and abortion incidence, there is a strong correlation between abortion legality and abortion safety. Furthermore, according to the WHO, "the cost of conducting a safe abortion is [. . .] one tenth of the cost of treating the consequences of an unsafe abortion."[6]

It must also be noted that the current focus on family policies due to the demographic crisis has also direct and indirect impacts on political choices made with regards to SRHR. There seems to be the idea that banning abortion will increase births and authorising it would be a factor of population decrease. This idea is not supported by concrete data and we believe that the birth rate in Europe would certainly be more efficiently supported by the improvement of the possibilities for mothers and fathers to better balance their private and professional lives.

Sexually Transmitted Infections

The EU systematically surveys some STIs: HIV, syphilis, congenital syphilis, gonorrhoea, chlamydia, and lymphogranuloma venereum (LGV). According to Decision 2119/98/EC, MS are expected to submit data related to all required variables; however, this does not always happen in practice, in addition to the non-comprehensiveness of certain national STIs surveillance systems. Consequently, comparing and identifying trends may rely on

[1] WHO (2nd ed, 2012), Safe abortion: technical and policy guidance for health systems
[2] IPPF (May 2012), Abortion Legislation in Europe.
[3] Excluding Member States with the most restrictive policies (Ireland, Poland, Luxembourg, Malta).
[4] Data for Austria, Cyprus, Luxembourg, and Malta are not available. UN Department of Economic and Social Affairs: Population Division (March 2011), World Abortion Policies 2011.
[5] IPPF (May 2012), Abortion Legislation in Europe.
[6] WHO (2012). Sexual and reproductive health: facts and figures about abortion in the European region.

insufficient or nonexistent data.

The average rate of new HIV cases per year in MS is 5.7 per 100,000 inhabitants with the lowest rates in 2010 being reported by Slovakia (0.5) and Romania (0.7) and the highest rates reported by Estonia (27.8), Latvia (12.2), Belgium (11) and UK (10.7). From the data aggregated by age, 11% of new HIV cases were among young people aged 15 to 24.[1]

It is important that the European Commission (EC) and the MS address the specific SRHR and needs of women living with HIV, as part of a holistic approach to curbing the epidemic. This can be achieved by expanding access to sexual and reproductive healthcare programmes, integrating access to HIV/AIDS testing and treatment, peer-support, counselling and prevention services and by reversing the underlying socioeconomic factors contributing to women's HIV/AIDS risk, such as gender inequality, discrimination and lack of human rights protection.

Violence related to sexual and reproductive rights

It is estimated that seven in ten women experience physical and/or sexual violence in their lifetime. Gender-based violence is a form of discrimination that seriously inhibits their ability to enjoy rights and freedoms on a basis of equality with men. Sexual violence has a devastating lifelong impact on the psychological and physical health and well-being of the victims and survivors of such violence. Respecting, promoting sexual and reproductive health, and protecting and fulfilling reproductive rights is a necessary condition to achieve gender equality and the empowerment of women to enable them to enjoy all their human rights and fundamental freedoms, and to prevent and mitigate violence against women.

Particular attention should also be given to harmful traditional practices, such as female genital mutilations/cutting, early and forced marriage, because those practises can have a damaging effect on the well being, sexual relations, pregnancies, and childbirth but also on the communities.

SRHR in Official development assistance

SRHR are essential elements of human dignity and human development, and a core basis for social and economic progress. Recent collected data show persisting grave challenges in sexual and reproductive health matters all around the world and more particularly in developing countries.

Besides producing strong policy commitments, the EU should also take up its role as a development and a political actor in the fight for SRHR. The EU has an important role on the promotion, enforcing and defence of SRHR at the international level, including in the post-2015 development framework, to ensure that population and SRHR are prioritised in shaping the post-2015 global development framework and the follow-up to the Rio+20 conference.

MS should contribute to accelerate the progress in order to achieve Millennium Development

[1] European Centre for Disease Prevention and Control (ECDC)/WHO Regional Office for Europe, HIV/AIDS surveillance in Europe 2011.

Goal 5 and its two targets by addressing reproductive, maternal, newborn and child health in a comprehensive manner. This might include the provision of family planning, prenatal care, skilled attendance at birth, emergency obstetric and newborn care, postnatal care and methods of prevention and treatment of sexually transmitted diseases and infections, such as HIV. MS should also promote systems that provide equal access to affordable, equitable and high-quality integrated health-care services and include community-based preventive and clinical care.

The EC can play an important role, by ensuring that the European development cooperation adopts a human-rights-based approach with an explicit focus and concrete targets on SRHR.