

STUDY

Requested by the FEMM committee



Sexual and reproductive health rights and the implication of conscientious objection



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Abstract

This study was commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee. It aims to provide a comparative overview of the situation in the European Union, with particular focus on six selected Member States, in terms of access to sexual and reproductive healthcare goods (such as medicines) and services (such as abortion and family planning), from both legal and practical perspectives. The study looks at the extent to which conscientious objection affects access to sexual and reproductive rights (SRHR). The study will contribute to formulating a clear framework for the improvement of access to sexual and reproductive healthcare goods and services in the EU.

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RESPONSIBLE RESEARCH ADMINISTRATOR

Martina SCHONARD
Policy Department for Citizens' Rights and Constitutional Affairs
European Parliament
B-1047 Brussels
E-mail: poldep-citizens@europarl.europa.eu

AUTHOR(S)

Ludovica ANEDDA, ICF
Lucy ARORA, ICF
Luca FAVERO, ICF
Nathalie MEURENS, ICF
Sophie MOREL, ICF
Martha SCHOFIELD, ICF

SENIOR EXPERTS

The authors are grateful for the feedback of the senior experts:
Prof Anette AGARDH, Lund University
Prof Els LEYE, independent consultant, Ghent University

NATIONAL RESEARCHERS

Czech Republic: Klara KOVAROVA, ICF
Croatia: Jelena MILOVANOVIC, ICF
Italy: Thomas TAYLOR-DI PIETRO and Ludovica ANEDDA, ICF
Poland: Krystyna KACPURA and Kamila FERENC, Federation for Women and Family Planning
Portugal: Dália COSTA, University of Lisbon
Sweden: Jack PALMIERI, Lund University

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LIST OF ABBREVIATIONS

CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CJEU	Court of Justice of the European Union
CoE	Council of Europe
CRC	UN Convention on the Rights of the Child
CRPD	UN Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ECSR	European Committee of Social Rights
EU	European Union
ICCPR	International Covenant on Civil and Political Rights
Istanbul Convention	Council of Europe Convention on preventing and combating violence against women and domestic violence
IPV	Intimate partner violence
LGBTI	Lesbian, gay, bisexual, transgender and intersex
OHCHR	Office of the UN High Commissioner for Human Rights
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually transmitted infections
TEU	Treaty on the European Union
TFEU	Treaty on the Functioning of the European Union
UDHR	Universal Declaration on Human Rights
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

Access to sexual and reproductive healthcare goods and services is a fundamental component of sexual and reproductive rights. Under international human rights law and standards, European Union Member States should ensure **access to safe and quality sexual and reproductive healthcare**. According to the World Health Organization, sexual and reproductive rights is an umbrella term for four separate areas: sexual health, sexual rights, reproductive health and reproductive rights ⁽¹⁾.

On sensitive issues, national legislation often allows for medical practitioners, pharmacists and other health sector professionals to **opt out** of providing goods and services to which they are morally opposed, including performing abortions or prescribing, selling or advising on contraceptive methods. Conscientious objection is 'the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical or ethical beliefs' ⁽²⁾. The right to conscientious objection, however, requires **a balancing of the rights** of health providers to express their beliefs with states' responsibility to ensure people's access to their SRHR, specifically access to related services and goods ⁽³⁾.

The right to health, including sexual and reproductive health, is protected **internationally**. A range of United Nations (UN) treaties ban discrimination in general terms, effectively outlawing discrimination in sexual and reproductive health and rights. These rights include the right to health and the right to family planning, equal access to service, freedom from violence and the right to life. Specific international treaty protections exist to combat discrimination on the grounds of sex, race, disability but not sexual orientation or gender identity. Specialist protection exists for the right to family planning (under the Convention on the Elimination of all forms of Discrimination Against Women) and for those with disabilities (under the Convention on the Rights of Persons with Disabilities). The UN has also included sexual and reproductive health in its Sustainable Development Goals.

At **European level**, the **Council of Europe** protects sexual and reproductive health and rights through the European Convention on Human Rights (and its jurisprudence) and through the Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention). The founding values of the **EU** include human dignity, freedom, equality and respect for human rights ⁽⁴⁾, and the Charter of Fundamental Rights of the European Union (2012/C 326/02) establishes (among others) the right to respect for one's physical and mental integrity (Article 3(1)) and the right to respect for one's private and family life, home and communications (Article 7).

This report examined six Member States (Croatia, Czech Republic, Italy, Poland, Portugal and Sweden) in detail, with respect to their legislation and practices relating to the protection of sexual and reproductive rights and the provision of related goods and services. Of these six, only Portugal and Croatia directly recognise a **general right to sexual and reproductive health**: the right to family planning is enshrined in the Portuguese Constitution, while Croatia's Law on Gender Equality provides for women's right to freely decide on number of children and induced pregnancy terminations (where legally allowable). Although Sweden does not use the term 'sexual and reproductive health' in its legislation, the concept is part of its policy discourse generally. The study examined a number of these

¹ European Parliament, FEMM Committee, Terms of Reference.

² Zampas, C. and Andión-Ibañez, X., Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice. *European Journal of Health Law* 19, 2012, p. 234.

³ Council of Europe's Parliamentary Assembly, Resolution 1763, The right to conscientious objection in lawful medical care, 2010

⁴ Article 2 Consolidated Treaty on the European Union (TEU), 26 October 2012.

key goods (contraceptives, medical treatments for diseases) and services (family planning, abortion and post-abortion care, treatment for victims of female genital mutilation and intimate partner/non-partner violence, obstetric and post-partum care, and breast/cervical cancer screening) in terms of their availability, affordability, quality and equal access. In practice, **access to sexual and reproductive health goods and services varies significantly** across the EU. For example, access to contraception stands at 38 % in Greece compared to 90 % in Belgium and France, and legal abortion rates vary from 0.1 % in Poland to 18.6 % in Estonia. Generally, however, data gaps make it difficult to monitor or evaluate the provision and accessibility of key services at EU level (e.g. data on contraceptive counselling in Portugal has been criticised for being limited to metrics such as numbers of caesareans carried out).

Access to sexual and reproductive health **goods** is regulated either by the requirement for medical prescriptions or inclusion/exclusion from health insurance coverage. National legal provisions vary across the six Member States, being quite nuanced when it comes to the treatment, prevention and disclosure of specific illnesses such as HIV and other sexually-transmitted infections. Portugal, Sweden and Poland all ensure high levels of access to contraception counselling and family planning. In Czech Republic, Croatia and Italy, the law does not guarantee access to these services to the same extent. Even within Member States there may be a gap between legislation and practice. In Poland, for example, legislation recognises the right to make *responsible decisions* about having children, yet hormonal contraceptives are not refunded by public funds.

While all six Member States permit **abortion** in certain cases, the national legislation differs in terms of its restrictiveness. Poland does not allow abortion purely at the woman's behest, while the others permit this up to various points (from 10 weeks in Croatia and Portugal to 18 weeks in Sweden). All Member States allow abortion within a longer timeframe in other circumstances, such as risk to the life/health of the pregnant woman/foetus and/or the non-viability of the foetus. Only Portugal and Sweden make legal provision for post-abortion care, including psychological and social support. In Italy, these services are at the discretion of regional legislation. Key barriers to accessing abortion can be financial (its exclusion from mandatory health insurance, e.g. in Croatia, for voluntary termination, or the requirement to pay for aftercare or medical appointments), cultural (in Poland, hospitals extend the administration needed in order to move beyond the legally allowable timeframe for terminations) and geographical (e.g. location of services in large population centres only).

All Member States criminalise **female genital mutilation**, with specific reference including in the legislation of Croatia, Italy, Portugal and Sweden. A lack of systematic data collection at EU level (with the exception of Belgium and Portugal, which collect hospital data, as does Sweden's specialist staff and centre) reduces the prioritisation of services for victims of this practice.

National laws in Czech Republic, Poland and Portugal include provisions on the care to be delivered to those who have faced **intimate partner violence**. Portugal has the most detailed legislation, which sets out that the National Health Service will provide direct assistance to victims of domestic violence, as well as promoting prevention methods. None of the Member States have specific legislation regulating the provision of care to those who have experienced non-partner sexual violence. A 2012 study by the EU Fundamental Rights Agency found a high rate of women's silence on these types of violence, highlighting the need to reduce stigma and encourage women to report their experiences to trained professionals.

Obstetric, pre-natal and post-partum care is legally regulated in the Czech Republic and Croatia. In Sweden it is simply considered healthcare, meaning that it is available to undocumented persons and asylum-seekers. In practice, there is a lack of data and literature on these aspects of healthcare. In 2017 Poland prepared new regulations on pregnancy confinement and newborn care. These were criticised for removing WHO recommendations and undermining women's empowerment and decision-making, with studies showing that even where women felt their rights had been infringed in this context, only 3 % reported it.

Sex reassignment surgery is legally permitted in all Member States (apart from Poland) under varying conditions. Common challenges include long waiting times, a lack of availability of the service in hospitals and clinics, and a lack of surgeons undertaking sex reassignment operations. The cost and waiting times are recurring issues affecting affordability and equal access. Health programmes such as breast/cervical cancer screening gather data which is published by Eurostat. A rural/urban divide has been noted, with Poland, Portugal and Italy all putting in place mobile screening units to overcome this barrier.

Challenges in national policy include the lack of specific sexual and reproductive health strategies, the exclusion of women's health from policy priorities, an emphasis on traditional models of family, and sex/health education being dealt with at regional rather than national level. A key challenge in practice is the availability of information on sexual and reproductive health. Only Sweden has a national sex education curriculum and demonstrates targeted provision of information to distinct groups. Health organisations are, however, becoming more focused on providing information, including through social media.

Promising practices in national policy include the high accessibility of key services in Portugal, a virtual youth clinic in Sweden (developed in consultation with a youth panel) providing information in multiple languages, and regional initiatives in Italy, including one initiative to improve access to contraception among vulnerable groups (such as young people, unemployed women and those from socioeconomically disadvantaged backgrounds) and another to provide specialist treatment for victims of female genital mutilation.

Despite progress across Europe in terms of legislation and practice, 'women in Europe continue to face widespread denials and infringement of their sexual and reproductive health and rights' ⁽⁵⁾. **Barriers** restricting access to goods and services may be **legal** (e.g. Poland's restrictive anti-abortion law criminalises many medical staff), **procedural** (e.g. Italy's refusal to administer medical abortions after 50 days, when the norm internationally is 63 days), **cultural** (e.g. social stigma relating to abortion, in particular) or **financial** (e.g. the exclusion of legal abortion and contraception from public health insurance). These barriers are exacerbated by a **lack of political support**. Certain groups may experience particular difficulties in accessing appropriate sexual and reproductive health goods and services. In Croatia, for example, there is a lack of sufficient equipment to provide services to women with disabilities. Other at-risk groups include LGBTI people, sex workers unmarried and single women, older women, ethnic minorities and women living in rural areas.

⁵ Council of Europe (2017). Women's sexual and reproductive health and rights in Europe. Issue paper. <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>, p. 5.

A key barrier is driven by religious factors, which underpins the exercise of conscientious objection. Twenty-two Member States ⁽⁶⁾ provide for **the right to conscientious objection**, which is also recognised by UN instruments and the European Convention on Human Rights. It is nevertheless **not an absolute right**, and the ECtHR has held that individuals cannot use their religious beliefs to block others' access to services to which they are legally entitled. UN treaty bodies have affirmed that conscientious objection must not be a barrier to accessing health services and States must appropriately regulate this practice to guarantee that it does not restrict access to sexual and reproductive health care. In addition, States must establish an **effective mechanism of referral** where health service providers exercise their conscientious objection and refuse to perform certain reproductive health services for women. In addition, conscientious objection should not stop services from being performed during emergencies.

In view of its limited competence in this area, the EU has dealt indirectly with conscientious objection solely through the **Employment Equality Directive**. The Directive protects healthcare employees from discrimination due to the exercise of their religion or beliefs. However, a restriction to their freedom of religion or belief can apply when it results from a genuine occupational requirement, the objective is legitimate, and the requirement is proportionate. Arguably, if the objection places a disproportionate burden placed on the employer and on the rights and freedoms of others, as a result of the objection, the right to conscientious objection can be restricted. Some Member States, for example, make specific provision for emergency situations, while others require an obligation to refer the patient to another healthcare provider (Czech Republic and Croatia). Experts note the significant impact of conscientious objection on access to sexual and reproductive health goods and services, but data are lacking. Conscientious objection is driven by religious belief, workplace culture, anti-choice movements and a lack of information.

At EU level, this study **recommends** that the **EU strengthen its legal framework** on equal access to sexual and reproductive health goods and services, including confirming the application of the Directive 2004/113/EC and issuing related guidelines to Member States. The application of the Employment Equality Directive should also be clarified to ensure compatibility of conscientious objection with health rights. In addition, the EU should include sexual and reproductive health in its next **Strategy** on gender equality. Monitoring and measurement should be prioritised (including the collection of EU-wide comparable data), supported by the European Parliament. Finally, **EU funding** programmes should support awareness-raising among citizens and training of healthcare professionals. At **Member State level**, the study recommends that research should be carried out nationally (particularly among vulnerable groups) to assess the provision of goods and services compared to the law. Member States should work to improve access to goods and services, based on the criteria of **availability, affordability, quality and equal treatment**. They should also ensure **effective referral mechanisms** and sufficient numbers of non-objectors to provide a full range of services to all persons in need. Particular attention should be paid to **vulnerable groups**, through the design and implementation of policies that are targeted to the needs of the groups that encounter additional barrier to access sexual and reproductive health goods and services.

⁶ Belgium, Czech Republic, Denmark, Germany, Estonia, Ireland, Greece, Spain, France, Croatia, Italy, Latvia, Luxembourg, Hungary, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, United Kingdom.

1. INTRODUCTION

1.1. Background

Access to sexual and reproductive healthcare goods and services is a fundamental component of sexual and reproductive rights (SRHR). Under international human rights law and standards, European Union (EU) Member States should ensure access to *safe* and *quality* sexual and reproductive healthcare.

As highlighted by the European Parliament, the EU shows 'a disparity in the standard of sexual and reproductive health between and within Member States and inequality of sexual and reproductive health rights (SRHR) enjoyed by women' (7). Available data provide a useful picture of this disparity. For instance, France has the highest level of access to contraception in Europe, at 90 %, while others have contraception access below 50 %, falling as low as 38 % access in Bulgaria and Greece. Limited access can be the result of lack of insurance coverage for contraception (e.g. Slovakia explicitly forbids any kind of reimbursement for contraception). Of the countries ensuring coverage, the percentage of that coverage varies considerably (8).

On sensitive issues, national legislation often allows for medical practitioners, pharmacists and other health sector professionals to opt out of providing goods and services to which they are morally opposed, through 'conscience clauses' – including performing abortions or prescribing, selling or advising on contraceptive methods.

The right to conscientious objection, however, requires a balancing of the rights of health providers to express their beliefs with states' responsibility to ensure people's access to their SRHR, specifically access to related services and goods (9). Regulation should ensure an adequate number of trained providers willing to provide full health services, define the specific cases and circumstances in which conscientious objection can be invoked, including those professionals who can be objectors (10), and should establish mechanisms for referral (11).

In recent years, the use of conscience clauses across the EU has led to denial of specific women's rights, particularly the right to access safe and legal abortions. These clauses may be claimed by direct and indirect providers, such as doctors, pharmacists, nurses, technicians, and even administrators in charge of referral mechanisms (12). Conscientious objection has resulted in limited access to abortion in several European countries and may constitute an outright barrier to accessing SRHR (13).

Legislation varies across countries. Member States have different approaches to conscientious objection, often with significant implications on access to SRHR goods and services, in particular for women.

For example, data from the Italian Ministry of Health (2016) show that an average of 70 % of gynaecologists in Italy decline to perform abortions, and in certain regions the percentages are close

⁷ European Parliament, FEMM Committee, Draft Report on Sexual and Reproductive Health and Rights (2013/2040(INI)) Committee on Women's Rights and Gender Equality, 2013/2040(INI).

⁸ CONTRACEPTION ATLAS, February 2017.

⁹ Council of Europe's Parliamentary Assembly, Resolution 1763, The right to conscientious objection in lawful medical care, 2010.

¹⁰ Bueno de Mesquita, J. & Finer, L. *Conscientious objection: protecting sexual and reproductive health rights*, (n.d.) <http://repository.essex.ac.uk/9715/1/conscientious-objection-protecting-sexual-reproductive-health-rights.pdf>

¹¹ Zampas, C. & Andión-Ibañez, X., 2012.

¹² Bueno de Mesquita, J. & Finer, L. *Conscientious objection: protecting sexual and reproductive health rights* (n.d.) <http://repository.essex.ac.uk/9715/1/conscientious-objection-protecting-sexual-reproductive-health-rights.pdf>

¹³ Heino, A. *et al.*, Conscientious objection and induced abortion in Europe. *The European Journal of Contraception and Reproductive Healthcare*, 18, 2013, pp.231-233.

to 90 %⁽¹⁴⁾. In *IPPF v. Italy*, the European Committee of Social Rights (ECSR) held that states need to ensure that ‘the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are legally entitled under the applicable legislation’⁽¹⁵⁾. Data found that, in 2009, 80 % of gynaecologists refused to carry out induced abortions in Portugal⁽¹⁶⁾. In Austria, a 2011 report from the Ministry of Health found that entire regions lacked abortion providers⁽¹⁷⁾.

The use of conscientious objection can also affect access to contraception. In *Pichon and Sajous v France (2001)*, the applicants were the joint owners of a pharmacy in Salleboeuf, France. Both refused to supply contraceptives to three women who provided regular prescriptions, on the grounds of religious beliefs⁽¹⁸⁾. The European Court of Human Rights (ECtHR) ruled that ‘the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere’⁽¹⁹⁾.

The practice of conscientious objection has become increasingly relevant in several European countries, such as Poland, Slovakia, and the United Kingdom⁽²⁰⁾. Driving factors relate to the rise in anti-abortion movements across Europe, particularly in the past 10 years. Section 4 of this report presents the reasons underlying the extent of conscientious objection at national level.

1.2. Scope and definitions

According to the World Health Organization (WHO), SRHR is an umbrella for various issues affecting men, women, boys and girls alike. It represents four separate areas: sexual health, sexual rights, reproductive health and reproductive rights⁽²¹⁾. These are integral elements of the right to enjoyment of the highest attainable standard of physical and mental health⁽²²⁾. See Section 2 for a detailed summary of SRHR under international and European legal and policy frameworks.

¹⁴ Ministry of Health, as presented by Repubblica (2016), Aborto, legge 194, e medici obiettori.

¹⁵ European Committee of Social Rights, *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, Decisions on the Merits*, 2013. The Committee made reference to a 2012 case of the European Court of Human Rights, *P. and S. v. Poland*.

¹⁶ Heino, A. et al., 2013; Oliveira da Silva, M., Reflections on the legislation of abortion in Portugal. *Eur J Contracept Reprod Health Care*, 14: 2009, pp. 245-8.

¹⁷ Heino, A. et al., 2013; Austrian Ministry of Health. *Österreichischer Frauengesundheitsbericht 2010/2011 [Austrian Women's Health Report 2010/2011]*. Vienna: Ministry of Health.

¹⁸ Nawrot, O., Conscientious objection and European vision of Human Rights. *Prog Health Sci* 2016, Vol 6, No 1, 2016.

¹⁹ European Court of Human Rights, *Pichon and Sajous v. France*.

²⁰ Heino, A. et al., Conscientious objection and induced abortion in Europe. *The European Journal of Contraception and Reproductive Healthcare*, 18, 2013, pp.231-233; Zampas, C. & Andión-Ibañez, X., Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice. *European Journal of Health Law* 19, 2012, p. 234.

²¹ European Parliament, FEMM Committee, Terms of Reference.

²² OHCHR, Commission on Human Rights resolution 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, preamble and para 8, 2003; Bueno de Mesquita, J. & Finer, L. *Conscientious objection: protecting sexual and reproductive health rights*. <http://repository.essex.ac.uk/9715/1/conscientious-objection-protecting-sexual-reproductive-health-rights.pdf>.

Sexual health

Sexual health is physical, mental, and social wellbeing in terms of sexuality. This means safety from sexual illness and violence, including female genital mutilation (FGM), gender-based violence (GBV) and human trafficking.

Sexual rights

Sexual rights are the ability to make decisions with respect to your own sexuality, such as decisions about partners and privacy.

Reproductive health

Reproductive health ensures a healthy reproductive system and healthy pregnancy through access to healthcare, medication and education.

Reproductive rights

Reproductive rights include the right to decide if and when to have children, including freedom from discrimination, coercion, and violence when making family planning choices.

Conscientious objection was initially exercised to refuse military service. It is ‘the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical or ethical beliefs’ (23). In this context, the right to conscientious objection is grounded in the right to freedom of religion, conscience and thought, as recognised under the international and European policy and legal framework (see Section 4.1).

Table 1 below provides an overview of the **sexual and reproductive health goods and services (SRH goods and services)** covered within the scope of this study.

Table 1: Types of SRH goods and services covered by this study

SRH goods	SRH services
<ul style="list-style-type: none"> • Contraception • Medicines for SRH-related illnesses and care 	<ul style="list-style-type: none"> • Family planning • Contraception counselling • Abortion and post-abortion care • Safeguarding and recovery from FGM • Prevention and treatment of victims of intimate partner violence (IPV) and non-partner sexual violence • Obstetric, pre-natal and post-partum care • Sex reassignment surgery • Breast cancer and cervical screenings • Provision of SRH-related information

This Study provides a broad overview of the state of play and challenges in access the above SRH goods and services and is not meant to be exhaustive. Data and information on some of the services are scarce, enabling a more limited analysis.

²³ Zampas, C. and Andión-Ibañez, X., Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice. *European Journal of Health Law* 19, 2012, p. 234.

1.3. Objectives of the study

This study aims to provide a comparative overview of the situation in the EU, with particular focus on six selected Member States ⁽²⁴⁾, in terms of access to sexual and reproductive health goods (such as medicines) and services, and the extent of conscientious objection and its implications for SRHR access. The study will contribute to formulating a clear framework for the improvement of access to sexual and reproductive healthcare goods and services in the EU.

The research paper will investigate existing barriers to the access to SRH goods (e.g. medicines, contraceptives) and services (e.g. safe abortions), by highlighting commonalities and differences across the selected Member States. In addition to providing an overview of these barriers, the research will describe ways in which they might be overcome, as well as identifying potential good practices.

It is particularly important to consider **inequalities** in terms of access to SRH goods and services, especially for vulnerable and disadvantaged groups within the Member States. As defined by the 2016 WHO Europe Action Plan for sexual and reproductive health ⁽²⁵⁾, these groups include adolescents, unmarried people, people at socioeconomic disadvantage, people living with HIV, people with disabilities, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, drug users and those engaged in sex work. In its Commission Staff Working Document on Strategic Engagement for Gender Equality for 2016-2019, the European Commission committed to considering the specific needs of groups facing multiple disadvantage, including single parents and older women, migrants and refugees, Roma and women with disabilities. The current study will (to the extent possible) integrate an intersectional approach, through an understanding that people have multiple identities, and access to SRHR might vary according to the intersection of disadvantages. As stated by General Recommendation no. 28 on the core obligations of State Parties under Article 2 of the CEDAW, 'the discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity'. In the specific case of conscientious objection, the practice puts women in an unequal position, 'depending on their place of residence, socioeconomic status, income, and their ability to travel long distances to access a service to which they are legally entitled' ⁽²⁶⁾.

1.4. Methodology

The study is based on desk research and literature review at international and EU level, as well as national level in six Member States: Croatia, Czech Republic, Italy, Poland, Portugal and Sweden.

National researchers provided detailed information in a country fiche, focusing on access to SRH goods and services and conscientious objection clauses and practice. The study covered relevant legislation, policies and case law in the six targeted Member States.

More precisely, the country fiches were structured to:

- review the national legal and policy framework;

²⁴ Croatia, Czech Republic, Italy, Poland, Portugal and Sweden.

²⁵ WHO, *Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*, 2016, http://www.euro.who.int/_data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf?ua=1

²⁶ WHO, *Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*, 2016, http://www.euro.who.int/_data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf?ua=1 p. 232.

- map the state of play of access to SRH-related goods and services in the country;
- gain an understanding of the barriers and driving factors underlying those barriers;
- gather data on the application of conscientious objection and access to SRH goods and services;
- carry out national level research on relevant literature and new studies or surveys that could map the situation at national level.

Country experts complemented that information through semi-structured interviews with key stakeholders in the area of SRHR and conscientious objection at national level. The consultations aimed to close gaps in information and assess the effective access to SRH goods and services, barriers and the impact of conscientious objection on access. They also facilitated the identification of data not easily accessible through desk research.

Stakeholders included:

- representatives from equality bodies/ decision makers in the context of health policy;
- representatives from the medical community (e.g. doctors and representatives from national medical councils);
- representatives from national civil society organisations specifically involved in SRHR, with a specific focus on disadvantaged and vulnerable groups.

The final report presents a comparative analysis of the findings at national level, together with an understanding of the issue of SRHR and conscientious objection at international and EU level.

1.5. Structure of the report

The report is divided into five sections. **Section 1** introduces the study, its aims and scope. **Section 2** provides an overview of the policy and legal framework for SRHR at international and EU level. It explores SRHR through the United Nations (UN) instruments, the Council of Europe (CoE) and the EU legal and policy framework, including their links with other categories of rights relating to gender equality and health. This section also provides an overview of the national legal frameworks in Croatia, the Czech Republic, Italy, Poland, Portugal and Sweden for access to SRH goods and services.

Section 3 looks at the current state of access to SRH goods and services in the six targeted Member States. Accessibility is assessed in the light of four indicators: (a) availability, (b) affordability, (c) equal access, and (d) quality. Section 3.3 specifically highlights the barriers faced by different groups, particularly women, in accessing such goods and services, as well as the underlying driving factors. These barriers may be legal, cultural, religious, political and financial. Additional barriers and obstacles for vulnerable groups were identified in the course of the research.

Section 4 considers the conscientious objection clauses (or lack thereof) in the legislation of the six Member States, as well as the practice and its impact on access to SRH goods and services, particularly for women.

Section 5 presents the main conclusions of the research and provides recommendations for the European institutions and Member States, identifying the key issues that need to be addressed for the effective implementation of SRHR across Europe.

Throughout this report, **promising practices** are highlighted, both in terms of policy initiatives and actual provision of SRH goods and services.

2. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: LEGAL AND POLICY FRAMEWORK

2.1. International and European framework

KEY FINDINGS

International legal and policy framework

- The internationally protected **right to health** encompasses the **right to SRH**. A range of UN treaties ban discrimination in general terms, effectively outlawing discrimination in many SRHR. These rights are an umbrella for a range of others, including the right to health and the right to family planning, equal access to service, freedom from violence and the right to life.
- **The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)** was the first human rights treaty to affirm the **right to family planning**. It requires State Parties to ensure that men and women have the same right to 'decide freely and responsibly on the number and spacing of their children' (Article 16). Accordingly, women must be able to **access information about contraceptive measures, sex education and family planning services** (CEDAW General Recommendation No. 21). The weakest treaty protections against discrimination are in the areas of sexual orientation and gender identity, because these are not *explicitly* listed as protected grounds in the text of treaties (even though they have been interpreted as such).
- The **European Convention on Human Rights (ECHR)** protects SRHR implicitly under the right to private and family life (Article 8), the right to freedom from torture and ill-treatment (Article 3), the right to life (Article 2) and the prohibition of discrimination (Article 14).
- The **ECtHR** has made a number of rulings that appear to strengthen SRHR but Member States have considerable discretion on certain issues, for example the conditions under which individuals can access a legal sex change, same-sex marriage and abortion.
- Gender-based violence includes acts that violate women's SRHR e.g. forced sterilisation, forced abortion and others. The Istanbul Convention significantly strengthened the legal framework on violence against women.

EU legal and policy framework

- Non-discrimination and equal treatment are fundamental EU principles. Directive 2004/113/EC guarantees **equal treatment between men and women** in 'access to and supply of goods and services' but there is ambiguity in relation to the provision of SRH goods and services.
- The **Charter of Fundamental Rights** protects key SRHR but allows for considerable discretion on certain issues, such as the national regulation of marriage and the exact forms of preventative healthcare and medical treatment that must be accessible to the population.
- **Directive 2011/24/EU on the application of patients' rights in cross-border healthcare** provides that patients must receive all of the information necessary to make informed choices.

SRHR are **not an area of focus** in either the gender or health strategy of the European Commission. The European Parliament has, however, stated its commitment to encouraging greater access to SRHR via education on sexuality and FGM, among others.

2.1.1. International legal and policy framework

SRHR are an umbrella for other rights, ranging from the right to health to the right to family planning and to life. Although there is no agreed list, international organisations such as the UN Population Fund commonly associate a broad range of rights (see box below) with SRHR.

Common SRHR
<ul style="list-style-type: none"> <p>• Right to life: the right not to die from preventable, pregnancy-related causes or from child birth (Article 3 Universal Declaration of Human Rights (UDHR), Article 6(1) International Covenant on Civil and Political Rights (ICCPR), Article 2 ECHR and Article 6(1)(2) CRC)</p> <p>Right to physical integrity: the right to control one's own body, including sexual and reproductive life, and to be free from any intervention, medical or otherwise, save with one's full, free and informed consent (Articles 3 and 5 UDHR, Articles 7, 9(1) ICCPR, Article 37(a) CRC). This right explicitly includes the right of people with disabilities to retain their fertility on an equal basis with others (Article 23(c) Convention on the Rights of Persons with Disabilities (CRPD)).</p> <p>• Right to highest attainable standard of physical and mental health (Article 12 International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 24 CRC, Article 25 CRPD). The right to health includes the right to sexual and reproductive health (General Comment 22, ICESCR). Given historic patterns of discrimination and disadvantage, women and people with disabilities in particular should not be subject to discrimination when trying to access healthcare services, including family planning (Article 12 CEDAW, Article 25 CRPD); no child should be deprived of his or her right of access to healthcare services (Article 24 CRC). Women generally should be guaranteed appropriate health services at times of pregnancy, confinement and during the postnatal period (Article 12(2) CEDAW). Rural women should be assured adequate healthcare facilities, including information, counselling and family planning services (Article 14 CEDAW). States are expected to ensure that people with disabilities can access the same range, quality and standard of free or affordable healthcare/programmes as those available to other persons, including in the area of sexual and reproductive health (Article 25(a) CRPD).</p> <p>• Right to freedom from torture and other cruel, inhuman or degrading treatment: this right can include the right not to be denied access to safe abortion and other sexual or reproductive goods and services (Article 7 ICCPR, Article 3 ECHR, Articles 2 and 16 Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment).</p> <p>• Right to equality and non-discrimination: this right guarantees that international human rights law protects all people equally, regardless of their sex, sexual orientation, gender identity, disability status, ethnic or racial origin, or other protected grounds (Article 14 ECHR, Article 26 ICCPR, Article 2 ICESCR, the CRPD and CEDAW).</p> <p>• Right to respect for privacy and family life: the right to be free from arbitrary or unlawful interference with one's family and private life (Article 8 ECHR, Article 17 ICCPR). This right has also been explicitly affirmed for children and people with disabilities (Article 22 CRPD, Article 16 CRC).</p> <p>• Right to marry and to found a family (Article 12 ECHR, Article 23(2) ICCPR, Article 23(a) CRPD). Some treaties clarify that this includes the right not to enter into marriage without</p>

one's free consent and the right to choose one's spouse (Article 23(3) ICCPR, Article 10 CESC, Article 23(a) CRPD, Article 16(b) CEDAW). Women also have the right to be free from discrimination in marriage and family relations more generally (Article 16(1) CEDAW).

- **Right to decide the number of, and spacing of, one's children**, including the right to access information and education to exercise these rights (Article 16(e) CEDAW, Article 23(b) CRPD).
- **Right to information and education**: the right to education that strengthens respect for human rights and enables individuals to participate effectively in a free society (Article 13 ICESCR). More generally, this right also relates to the free exchange of ideas and information (Article 19 ICCPR, Article 10 ECHR, Article 17 CRC, Article 4(h) CRPD). There is a right to access educational information about the health and wellbeing of families, including family planning (Article 10(h) CEDAW).
- **Right to be free of sexual and gender violence**: this includes the right not to have one's SRHR interfered with (for example via forced abortion, forced sterilisation, FGM or forced marriage) (Article 2 CEDAW (with General Recommendations 19 and 35), Article 19 CRC, Council of Europe (CoE) Convention on preventing and combating violence against women and domestic violence). States are obliged to take measures to protect individuals from violence carried out by third parties.
- **Right to benefit from scientific progress**: this includes the right to benefit from the various applications of scientific progress (Article 15 ICESCR), including potential advances in fertility treatment, genetic testing and embryonic research.

Sources: Gebhard, J. & Trimiño, D. (2012). [Reproductive Rights, International Regulation](#), Max Planck Encyclopedia of Public International Law; UNFPA and the Centre for Reproductive Rights (2012), [Reproductive Rights: A Tool for Monitoring State Obligations](#); UNFPA (2014), [A handbook for national human rights institutions](#).

Section 2.1 presents the international legal and policy framework on SRHR, followed by that of the EU. It begins by presenting the **international legal framework** on SRHR, differentiating between the international treaties of the UN (2.1.1.1) and the legal initiatives of the CoE (2.1.1.2). It goes on to summarise **international policy initiatives** in the area of SRHR, focusing on UN actions (2.1.1.3). It then explains the **EU legal framework** on access to SRH goods and services (2.1.2.1). Finally, it explores the **EU policy framework** on SRHR (2.1.2.2).

Section 2 analyses and compares the national legal frameworks in the six Member States targeted by this study, followed by their policy initiatives.

2.1.1.1. The legal framework on SRHR within UN treaties

Direct recognition that the right to health covers the right to SRH

The ICESCR guarantees the universal right to the highest attainable standard of physical and mental health (Article 12(1)). While the general right to health has been protected for many years, direct recognition that the right to health encompasses the **right to sexual and reproductive health** is a significant development in recent years. In 2016, the UN Committee on Economic, Social and Cultural Rights explicitly affirmed that the right to sexual and reproductive health should be seen as an 'integral part of the right to health' (General Comment No. 22, 2 May 2016). It detailed the actions that States are obliged to take, including:

- End discrimination with ‘immediate’ effect and ensure that the right to SRH can be enjoyed equally by all individuals and groups. In particular, States must repeal legal provisions or policies that undermine the ability of individuals to enjoy this right, for example laws that make abortion a crime or restrict access to it (General Comment No. 22, para. 34).
- Take steps to tackle attitudes that foster inequality and discrimination, particularly discriminatory stereotypes and harmful/restrictive assumptions around sexuality and reproduction (General Comment No. 22, para. 35).
- Avoid any unnecessary backward measures, such as: removing SRH medication from national drug registries ⁽²⁷⁾; removing public health funding for SRH services; blocking access to SRH information, goods and services; introducing laws that restrict SRH behaviours and choices; and pursuing any reforms to policies/laws that decrease the power of the State to monitor private actors’ obligations to restrict individual access to SRH services (General Comment No. 22, para. 38) ⁽²⁸⁾.

SRHR are **not only part of the right to health but indispensable for the exercise of many other human rights**, such as the right to life, the right to privacy and respect for family life, freedom from torture and other cruel, inhuman and degrading treatment, and non-discrimination (General Comment No. 22, para. 10). The inability to access an abortion or emergency obstetric care, for example, can result in maternal morbidity or death ⁽²⁹⁾.

Example: Lack of access to abortion as a form of cruel, inhuman and degrading treatment

The UN Human Rights Committee previously ruled that Ireland’s criminalisation of abortion constituted cruel, inhuman and degrading treatment (violation of Article 7 ICCPR). The law forced a woman to travel to the UK to terminate a non-viable pregnancy. She was denied access to funding support from the public health system, as well as the support of having friends and family around her. She also experienced social stigma, had to leave the baby’s remains in the UK and was not permitted to receive subsidised post-abortion care.

Source: AM v Ireland, CCPR/C/116/D/2324/2013.

International law protecting against discrimination in SRHR

A wide range of international instruments ban discrimination in general terms. Table 1 below summarises the key protections against discrimination for particular characteristics (‘protected grounds’).

Table 2: Treaty protections against discrimination on particular grounds

Protected ground	Summary of treaty protections against discrimination
Sex	There is a general ban on discrimination on this ground in the enjoyment of civil and political rights (Article 26 ICCPR) and economic, cultural and social rights

²⁷ The way in which medication is classified at the national level can have direct consequences on the ease with which it can be distributed and accessed. For example, in Croatia, contraceptives are included in the list of ‘supplementary’ medicines, meaning that that these goods require a supplementary fee when accessed via health insurance.

²⁸ Specific legal obligations outlined in General Comment 22 are provided in Annex 1.

²⁹ See also: <https://www.coe.int/en/web/commissioner/-/protect-women-s-sexual-and-reproductive-health-and-rights?desktop=true>

Protected ground	Summary of treaty protections against discrimination
	<p>(Article 2(2) ICESCR). The general ban on discrimination covers areas such as the right to life, the right to health, the right to freedom from torture and cruel, inhuman and degrading treatment, the right to physical integrity, the right to respect for one's privacy and family life, and the right to benefit from scientific progress.</p> <p>CEDAW went further, becoming a cornerstone international treaty in defining equality between women and men and requiring State Parties to take concrete action to end such discrimination across multiple areas of life.</p>
Race	<p>There is a general ban on discrimination on this ground in the enjoyment of civil and political rights (Article 26 ICCPR) and economic, cultural and social rights (Article 2(2) ICESCR). There is a general ban on discrimination on this ground in the enjoyment of civil and political rights (Article 26 ICCPR) and economic, cultural and social rights (Article 2(2) ICESCR). The general ban on discrimination covers areas such as the right to life, the right to health, the right to freedom from torture and cruel, inhuman and degrading treatment, the right to physical integrity, the right to respect for one's privacy and family life, and the right to benefit from scientific progress.</p> <p>The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1969) also protects against racial discrimination in all fields of 'public life' (Article 1(1)).</p>
Disability	<p>Discrimination on the grounds of disability is prohibited (CRPD, 2006), covering multiple areas of life, including the right to life, health, respect for privacy, freedom from torture or cruel, inhuman or degrading treatment, freedom from exploitation, violence and abuse.</p>
Sexual orientation	<p>This ground is not explicitly protected by the general bans on discrimination (Article 26 ICCPR, Article 2(2) ICESCR). The decisions of UN treaty bodies have confirmed that the treaties can be interpreted to cover sexual orientation and gender identity⁽³⁰⁾, but these do not have the same binding status as the treaty text itself.</p>
Gender identity	<p>This ground is not explicitly protected by the general ban on discrimination (Article 26 ICCPR, Article 2(2) ICESCR). The decisions of UN treaty bodies have confirmed that the treaties can be interpreted to cover sexual orientation and gender identity⁽³¹⁾, but these do not have the same binding status as the treaty text itself.</p>
Other grounds	<p>The general ban on discrimination in the enjoyment of civil and political rights (Article 26 ICCPR) and economic, cultural and social rights (Article 2(2) ICESCR) also covers these grounds: religion, national or social origin, political or other opinion, property, birth or 'other status'. The 'other status' provision can potentially be interpreted to cover grounds such as sexual orientation and gender identity.</p>

All Member States are party to the treaties outlined in Table 1 above⁽³²⁾ and are obliged to implement their provisions. In practice, this means they must guarantee non-discrimination in the SRHR

³⁰ "This position has been confirmed repeatedly in decisions and general guidance issued by several treaty bodies, such as the United Nations Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee on the Rights of the Child, the Committee against Torture, and the Committee on the Elimination of Discrimination against Women". Free and equal: UN for LGBT Equality (n.d.). [International Human Rights Law and Sexual Orientation and Gender Identity](#).

³¹ Free and equal: UN for LGBT Equality (n.d.). [International Human Rights Law and Sexual Orientation and Gender Identity](#).

³² See <http://indicators.ohchr.org/>

summarised at the beginning of the section, including (as indicated in the table above) the right to health, physical integrity/freedom from violence and abuse, respect for one's privacy and family life, and others. The weakest international legal protections against discrimination are for the grounds of sexual orientation and gender identity. While two key treaties (the ICCPR and ICESCR) can be interpreted to cover these characteristics, they are not explicitly covered by the treaty provisions themselves.

Certain important SRHR – namely, the right to family planning, the right to marry, the right to access appropriate health services and the right to be free from violence – also have specialist forms of protection for key groups in international law. These are summarised in the following sections.

1. Right to family planning

CEDAW plays an important role in protecting a wide range of SRHR, particularly because it outlaws sex-based discrimination in marriage and family relations (Article 16 CEDAW). This was the first human rights treaty to affirm the right to family planning, requiring State Parties to ensure that men and women have the same right to 'decide freely and responsibly on the number and spacing of their children' and that they can access the information and education necessary to exercise those rights (Article 16(e)). Women's decisions with regard to having children should not be restricted by a spouse, partner, parent or government, and women must be able to access information about contraceptive measures, as well as sex education and family planning services (CEDAW General Recommendation No. 21 (1994), para. 22).

The same right to family planning – involving free decisions on the number and spacing of children – has been directly affirmed for persons with disabilities (Article 23(1)(b) CRPD), including their right to access age-appropriate information, and reproductive and family planning education to facilitate the exercise of this right. A particular provision protects the right of persons with disabilities to keep their fertility on an equal basis with others (Article 23(1)(c) CRPD), which is highly relevant given the history of forced sterilisation for this group. States are expected to offer appropriate support to persons with disabilities in bringing up children (Article 23(2) CRPD), as well as early and comprehensive information, assistance and services for children with disabilities and their families (Article 23(3) CRPD).

No international treaty provisions explicitly outlaw discrimination in family planning on grounds other than sex or disability. This is a significant gap, especially given the history of forced sterilisations on some ethnic and cultural minorities (for example, Roma women), as well as the denial of family planning rights to same-sex couples or couples with a trans member. The (non-binding) Yogyakarta Principles (adopted in 2006) call on states to prohibit discrimination on the grounds of sexual orientation or gender identity in the right to found a family, including via access to adoption or assisted procreation (Principle 24(A)). There have arguably been attempts on the part of the Committee on the Elimination of All Forms of Discrimination against Women to interpret the CEDAW using an intersectional approach and thus increase protections for minority groups of women – including ethnic or racial minorities and lesbian, bisexual, trans and intersex women – but these have not been consistent or comprehensive (see General Recommendation 28, 2010, para. 18, and Holtmaat & Post, 2015⁽³³⁾).

³³ Holtmaat, R. & Post, P., Enhancing LGBTI rights by changing the interpretation of the Convention on the Elimination of all forms of Violence Against Women? *Nordic Journal of Human Rights*, 33 (4), 2015, pp.319-336.

2. Right to marry

CEDAW protects SRHR by guaranteeing women and men equal **rights to enter into marriage**, to choose a spouse based on free and full consent, and to bear the same rights and responsibilities during/after marriage (including in relation to dissolution of the marriage) (Article 16(a), 16(b) and 16(c)). Forced marriages contravene a woman's right to select a spouse and to freely decide to marry (General Recommendation 21 (1994), para. 16). National laws and practices should not deny women equal status during marriage or assign men the role of the primary decision-maker (General Recommendation 21, para. 17). In situations where same-sex relationships are recognised, State Parties should guarantee the economic rights of women in these relationships (General Recommendation 29 (2013), para. 24).

Persons with disabilities (of marriageable age) likewise have the right to marry based on free and full consent (Article 23(1)(a) CRPD). The equal right to marriage and choice of spouse without any form of racial discrimination has also been confirmed (Article 5(d)(iv), ICERD).

While general human rights instruments protect the right to marry and establish the principle of non-discrimination, there is no specific treaty provision protecting this right for LGBTI persons. As mentioned above, there have been some attempts by the Committee on the Elimination of All Forms of Discrimination against Women to interpret CEDAW using an intersectional approach, but these have not been comprehensive (see General Recommendation 28, 2010, para. 18, and Holtmaat & Post, 2015). The (non-binding) Yogyakarta Principles (adopted in 2006) call on states to take all necessary measures to ensure that same-sex couples enjoy the same entitlements, obligations and benefits as their different-sex peer couples (Principle 24(E)).

3. Access to appropriate health services

State Parties are expected to end discrimination against women in healthcare (Article 12 CEDAW), including by ensuring that all women and girls have the right to sexual health information, education and services. It makes particular reference to female and male adolescents having access to sexual and reproductive health education delivered by adequately trained personnel (CEDAW General Recommendation No. 24, para. 18). In general, healthcare services are deemed 'acceptable to women' when they ensure a woman's fully informed consent and respect her dignity and needs (CEDAW General Recommendation No. 24, para. 22). The Convention on the Rights of the Child further obliges State Parties to 'develop preventative health care, guidance for parents and family planning education and services' (Article 24(2)(f)).

Persons with disabilities should be able to access the same range, quality and standard of free or affordable healthcare and programmes as those given to other individuals, including for SRH (Article 25 CRPD). They should also be able to access the SRH services they need specifically because of their disabilities, and reasonable accommodation should be in place for them to access SRH services (General Comment 22 of the UN Committee on Economic, Social and Cultural Rights, 2 May 2016, para. 24). Racial discrimination is outlawed in the right to public health, medical care, social security and social services (Article 5(iv), ICERD). In one of its General Recommendations (27, 2000), the Committee on the Elimination of All Forms of Racial Discrimination called for states to ensure the equal access of Roma to health care and social security services.

There is a universal right to the highest attainable standard of sexual and reproductive health (Article 12 ICESCR; General Comment 22 of the UN Committee on Economic, Social and Cultural Rights, 2 May 2016). It is significant that General Comment 22 specifically states that non-discrimination in SRHR includes the rights of lesbian, gay, bisexual, transgender and intersex persons, to have respect for their sexual orientation, gender identity and intersex status and that criminalisation of sex between consenting adults of the same gender or the expression of gender identity is a clear violation of human rights (General Comment 22 of the UN Committee on Economic, Social and Cultural Rights, 2 May 2016, para. 23).

4. Freedom from violence

A critical shift in international law was recognition that **violence against women constitutes a form of discrimination against women and thus states have a responsibility** to take steps to protect women against such acts by private actors (CEDAW General Recommendation No. 12, 1989 and particularly CEDAW General Recommendation No. 19, 1992). Acts that violate women's SRHR – for example, forced sterilisation, forced abortion, delaying/denying women access to safe abortions – themselves constitute forms of gender-based violence that, under certain conditions, may constitute torture or cruel, inhuman or degrading treatment (CEDAW General Recommendation No. 35 (2017), para. 18).

2.1.1.2. Legal initiatives of the Council of Europe

The CoE has taken a leading role in considering the issue of SRHR through two instruments:

1. European Convention on Human Rights (**ECHR**) and its jurisprudence;
2. Council of Europe (CoE) Convention on preventing and combating violence against women and domestic violence (the **Istanbul Convention**).

The **ECHR** protects sexual and reproductive rights implicitly through the evolution of the ECtHR jurisprudence interpreting a number of ECHR provisions, including:

- the universal right to respect one's private and family life (Article 8(1));
- the right to freedom from torture and ill-treatment (Article 3);
- the right to life (Article 2);
- the prohibition of discrimination in the enjoyment of Convention rights on these grounds: 'sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status' (Article 14).

The **ECtHR** interprets '**private life**' broadly, encompassing the right to personal autonomy and personal development and including topics such as gender identity, sexual orientation, sexual life, physical and psychological integrity of individuals and decisions on having children⁽³⁴⁾. Although sexual orientation and gender identity are not explicitly mentioned in Article 14, the ECtHR has confirmed that these are included in the 'other' grounds covered by the provision⁽³⁵⁾. In practice, combining Article 8 protection for 'private life' with Article 14 protection against discrimination means there should be no discrimination on the grounds of sex, sexual orientation, gender identity or other

³⁴ ECtHR R.R. v. Poland, Application no. 27617/04, 26 May 2011, para. 180.

³⁵ FRA, 2018, p.178; see also ECtHR *Frette v. France*, No. 36515/97, 26 Feb 2002, para. 32; ECtHR *Identoba and Others v Georgia*, 12 May 2015.

grounds when it comes to people's physical and psychological integrity or decisions on having children. In other words, the Article 14 right to **protection against discrimination** can be invoked in the context of SRHR in conjunction with other provisions of the ECHR (in particular Article 8) to guarantee the right of women to freely decide on their sexual and reproductive choices.

The **right to freedom from torture and ill-treatment** requires states to protect women from any form of torture or ill-treatment related to their sexuality, reproductive capacity and decisions, in particular in the context of healthcare. States must thus ensure that laws, policies and practices related to SRH do not result in physical or mental ill-treatment. Under Article 3 ECHR, the ECtHR has ruled against the practice of forced sterilisation and failure to ensure women's access to abortion services that are already legal under domestic law, as well as access to prenatal testing services ⁽³⁶⁾.

The **right to life** protected by Article 2 ECHR refers, in the context of SRHR, to adequate access to healthcare, including the prevention of maternal mortality and good quality obstetric care ⁽³⁷⁾. In line with international standards, the ECtHR has clarified that the right to life under Article 2 cannot be interpreted as recognising a prenatal right to life ⁽³⁸⁾.

The Court has made a number of relevant rulings in relation to SRHR, including on access to **legal abortion**, legal **recognition of same-sex relationships**, **gender identity**, **freedom from violence** and **home births**. However, it is worth pointing out that the Court has not explicitly recognised sexual and reproductive rights as human rights, unlike the UN treaty bodies outlined above. Rather, it derives SRHR from other articles within the ECHR (see Table 2 below). Criticisms levelled at the Court are that this approach reduces these rights to their procedural aspects, without considering their gendered implications or treating them as a question of equal dignity and respect ⁽³⁹⁾.

Table 3. State obligations in relation to sexual and reproductive rights – ECtHR rulings

Issue	Legal principles and relevant case law	Caveats and unresolved legal issues
Self-determination of gender identity and access of transgender people to marriage	The Court has traditionally been more conservative on the issue of gender identity, e.g. ruling in 1990 that 'gender reassignment surgery did not result in the acquisition of all the biological characteristics of the other sex' ⁽⁴⁰⁾ . In a landmark case, the Court recognised that gender could not be based solely on 'purely biological criteria' ⁽⁴¹⁾ and that was 'no justification' for stopping transsexual	States can still define the conditions under which transsexual marriages occur.

³⁶ ECtHR Press unit (2018), Factsheet Reproductive rights; CoE Commissioner for Human Rights (2017), [Issue paper Women's sexual and reproductive health and rights in Europe](#).

³⁷ ECtHR, [Guide on Article 2 of the European Convention on Human Rights](#), 2017; CoE Commissioner for Human Rights, [Issue paper Women's sexual and reproductive health and rights in Europe](#), 2017.

³⁸ ECtHR Grand Chamber judgment *Vo v. France*, 8 July 2004.

³⁹ Oja, L. & Yamin, A.E., 'Woman' in the European human rights system: How is the reproductive rights jurisprudence of the European Court of Human Rights constructing narratives of women's citizenship? *Columbia Journal of Gender and Law*, 32 (1), 2016, p.94, <https://cjgl.cdrs.columbia.edu/article/woman-in-the-european-human-rights-system-how-is-the-reproductive-rights-jurisprudence-of-the-european-court-of-human-rights-constructing-narratives-of-womens-citizenship/>

⁴⁰ ECtHR *Cossey v. the United Kingdom*, 27 Sept 1990, para. 40

⁴¹ ECtHR *Christine Goodwin v. the United Kingdom*, 11 July 2002, para. 100, 103.

Issue	Legal principles and relevant case law	Caveats and unresolved legal issues
	individuals from accessing the right to marry in all circumstances.	
Coercive medical treatment	Medical interventions carried out against someone's will can be lawful if they are demonstrably shown to be a 'therapeutic necessity'. Treatment can be inhuman or degrading if it involves suffering or humiliation beyond the inevitable elements ⁽⁴²⁾ .	
Gender recognition and compulsory sterilisation	<p>Being sterilised without one's consent ('forced sterilisation') can amount to inhuman or degrading treatment and result in an Article 3 violation ⁽⁴³⁾. Consent cannot be obtained when individuals are not in a position to give it, for example during labour.</p> <p>Since 2017 the field of gender recognition law in Europe has been dominated by the ECtHR finding that compulsory sterilisation and irreversible medical surgery as prerequisites for access to gender recognition procedures is contrary to the ECHR. The judgment ⁽⁴⁴⁾ rendered the laws of 20 CoE Member States incompatible with their ECHR obligations, sparking a series of legal reforms across the continent ⁽⁴⁵⁾.</p>	It is still acceptable for Member States to require a medical diagnosis before someone can have a legal sex change ⁽⁴⁶⁾ .
Legal abortion	When abortion is legal at national level, Member States must fulfil a range of procedural requirements to make the right practical and effective. For example, women must have access to an effective mechanism that can determine if the conditions are in place for a legal abortion ⁽⁴⁷⁾ . The woman must also be involved in the decision-making process to a degree 'sufficient' to ensure 'requisite protection' of her interests ⁽⁴⁸⁾ . Abortion regulations should avoid creating a 'chilling effect' on doctors whereby they fear making decisions due to potential criminal liability. When abortion is legal, mothers must	<p>Member States have broad legal discretion to decide when life begins and the circumstances under which to offer abortion ⁽⁵⁰⁾. There is no clearcut right to abortion under the ECHR.</p> <p>Generally, the Convention does not establish a right to free or specific medical services, but Article 8 can be used to bring claims</p>

⁴² ECtHR V.C. v. Slovakia, 8 November 2011, paras. 103-104.

⁴³ ECtHR V.C. v. Slovakia, 8 November 2011, paras. 118-120, 112.

⁴⁴ ECtHR AP, Garçon, and Nicot v. France, 6 April 2017, App. no. 79885/12, paras. 130-135

⁴⁵ https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf

⁴⁶ <https://strasbourgoobservers.com/2017/05/05/a-p-garcon-and-nicot-v-france-the-court-draws-a-line-for-trans-rights/>

⁴⁷ ECtHR Tysięc v. Poland, 20 March 2007.

⁴⁸ ECtHR R.R. v. Poland, 26 May 2011, para. 191, 193, 197.

⁵⁰ ECtHR R.R. v. Poland, 26 May 2011, paras. 186-187.

Issue	Legal principles and relevant case law	Caveats and unresolved legal issues
	<p>have effective access to relevant information about their health and that of the foetus, including embryo screenings.</p> <p>Even in countries where abortion is controversial, doctors are not absolved of their duties regarding medical secrecy⁽⁴⁹⁾.</p>	<p>relating to insufficient availability of services⁽⁵¹⁾.</p>
<p>Same-sex couples' access to marriage and adoption</p>	<p>The Court expects some form of legal recognition and protection (such as civil unions) to be available to couples in stable relationships⁽⁵²⁾.</p> <p>In adoption procedures, differences in treatment based solely on the ground of sexual orientation may be discriminatory if they are not shown to be necessary for the protection of the family or for the protection of the interests of the child⁽⁵³⁾.</p>	<p>While the Court does not always consider marriage to be between a man and woman (Article 12 ECHR), Member States have broad legal discretion in allowing/prohibiting same-sex marriages⁽⁵⁴⁾.</p> <p>Protection of the family continues to be a lawful ground on which access to adoption can be denied to same-sex couples (provided other conditions are also met), in some cases suggesting that their right to form a family is being undermined.</p> <p>The Court has been reluctant to rule on the question of same-sex couples' parental rights⁽⁵⁵⁾.</p>
<p>Freedom from violence and the right to life</p>	<p>States have an obligation to protect individuals' right to life. This right may be violated if States know, or ought to know, of a real and immediate risk to someone's life and fail to take measures to remove the risk⁽⁵⁶⁾.</p> <p>General passivity on the part of the authorities when dealing with gender-based violence may constitute a form of discrimination in itself (violation of Article 14 ECHR), as it will disproportionately harm women⁽⁵⁷⁾.</p>	

⁴⁹ ECtHR P. and S. v. Poland, no. 57375/08, 30 October 2012, para. 133.

⁵¹ ECtHR R.R. v. Poland, 26 May 2011, para. 198.

⁵² ECtHR Orlandi and Others v. Italy, 14 December 2017, para. 192.

⁵³ ECtHR X and Others v. Austria, no. 19010/07, 19 February 2013, para. 151.

⁵⁴ ECtHR Orlandi and Others v. Italy, 14 December 2017, para. 145.

⁵⁵ ECtHR X and Others v. Austria, no. 19010/07, 19 February 2013, para. 134.

⁵⁶ ECtHR Osman v. United Kingdom, 28 October 1998, para. 116.

⁵⁷ ECtHR Opuz v. Turkey, 9 June 2009, para. 200.

Issue	Legal principles and relevant case law	Caveats and unresolved legal issues
Choice over birth	Concerns over the safety of home births may constitute lawful grounds for restricting women's free choice and thus may not be a violation of Article 8 ECHR ⁽⁵⁸⁾ .	Member States have a wide margin of discretion in the matter of home births ⁽⁵⁹⁾ .

The entry into force of the **Istanbul Convention** in 2014 marked an important moment in strengthening the legal framework to protect women against violence, prosecute perpetrators and provide support services. Many provisions of the Convention relate directly to SRHR:

- Parties are required to criminalise all acts of **forced abortion and forced sterilisation** (Article 39), which, according to the CoE's explanatory report, is to highlight women's reproductive rights by prioritising their power to freely decide on family planning matters (CoE explanatory report, 2011, para. 206).
- The Convention establishes **FGM** as a crime (Article 38), pointing out that it causes lifelong damage and normally does not occur with the victim's consent (CoE explanatory report, 2011, para. 198).
- **Forced marriage** is deemed an offence (Article 37), under which at least one person has faced physical or psychological force to marry and has not voluntarily consented (CoE explanatory report, 2011, para. 195-196).
- Considering **crimes committed in the name of so-called honour**, the Convention does not allow State Parties to see the victim's transgression of cultural, religious, social, traditional or other norms as valid defences in criminal courts for acts of violence (CoE explanatory report, 2011, para. 215).
- **Non-consensual sexual acts** (including rape) should be criminalised (Article 36, Istanbul Convention), as these are seen as a frequent means of exercising power within abusive relationships (CoE explanatory report, 2011, para. 194).
- State Parties must take legislative and other measures to **provide victims with access to healthcare and specialist services**, which are properly resourced and staffed (Article 20(2) Istanbul Convention).

Nineteen of the 28 Member States have ratified the Istanbul Convention ⁽⁶⁰⁾.

2.1.1.3. Policy initiatives of the United Nations

The Declaration and Action Programme of the United Nations International Conference on Population and Development (**ICPD**) (Cairo, 13 September 1994) represented a landmark moment in bringing a human rights perspective to the treatment of population and development issues, advocating universal access to SRH and calling for the protection of reproductive rights ⁽⁶¹⁾. The Declaration and Action Programme of the Fourth World Conference on Women (Beijing, 15 September 1995) further endorsed the ICPD, with Article 96 of the Beijing Platform for Action affirming that:

⁵⁸ ECtHR *Dubská and Krejzová v. the Czech Republic*, 15 November 2016 (Grand Chamber), paras. 186-191.

⁵⁹ ECtHR *Dubská and Krejzová v. the Czech Republic*, 15 November 2016 (Grand Chamber), para. 184.

⁶⁰ <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/210/signatures>

⁶¹ FEMM Committee of the European Parliament, *Sexual and reproductive health and rights: Study, 2016*. Available at: [http://www.europarl.europa.eu/RegData/etudes/STUD/2016/571392/IPOL_STU\(2016\)571392_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2016/571392/IPOL_STU(2016)571392_EN.pdf)

'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 from 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'.

The principles of the ICPD and the Beijing Platform for Action – including support for universal access to SRHR – have been re-affirmed through other UN initiatives, most recently the Sustainable Development Goals (SDGs) agreed in 2015 as part of the Action Plan for *Transforming Our World: the 2030 Agenda for Sustainable Development*. In particular:

- SDG 3: the international community pledges to 'Ensure healthy lives and promote wellbeing for all at all ages'. SDG3 includes the target, by 2030, to guarantee universal access to SRH services (including family planning, information and education) and the inclusion of reproductive health within national strategies and programmes (3.7). It monitors a range of relevant indicators, such as the proportion of women of reproductive age who have satisfactory access to necessary and modern methods of family planning (3.7.1) and the level of coverage of essential services (3.8.1).
- SDG 5: the global community aims to achieve gender equality and to empower all women and girls, including via universal access to the SRHR outlined in the Programme of Action of the ICPD and the Beijing Platform for Action (target 5.6). The goal will monitor the proportion of women (15-49 years old) who make informed choices on their sexual relationships, contraceptive use and reproductive healthcare (5.6.1) and the existence of national laws enabling women aged 15-49 years old to access SRH care and information (5.6.2).

All 53 European Member States of the WHO European Region adopted Health 2020 framework in 2012, which (among other things) aims to provide greater access to comprehensive sexuality education, family planning services and safe abortion, with a view to reducing the number of unintended pregnancies, as well as the level of abortion-related mortality and morbidity. The WHO European Action Plan for Sexual and Reproductive Health ⁽⁶²⁾ goes further in addressing the issue, with three central goals: i) enabling people to make informed decisions about their SRH and guaranteeing that their human rights are respected, protected and fulfilled; ii) guaranteeing that all people can enjoy the highest attainable standard of SRH and wellbeing; and iii) ensuring universal access to SRH care and tackling inequalities.

There are a range of other relevant WHO strategies in the European Region that are likely to strengthen SRHR, especially for women. These include the 2017-2021 Strategy on women's health and wellbeing in the WHO European Region ⁽⁶³⁾, the Action Plan for prevention and control of noncommunicable

⁶² WHO Regional Office for Europe, *Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*, 2016.

⁶³ This strategy explicitly cross-references the specialised Action Plan for Sexual and Reproductive Health and does not mention this issue in detail. However, its areas of focus are likely to support the SRHR of women, for example: strengthening governance for women's health and wellbeing; eliminating discriminatory values, norms and practices that affect the health and wellbeing of girls and women; tackling the impact of gender and social, economic, cultural and environmental determinants on women's health and wellbeing; and improving health system responses to women's health and wellbeing.

diseases in WHO European Region (2016-2025) ⁽⁶⁴⁾, and the Action Plan for the health sector response to HIV in the WHO European Region (2016-2021) ⁽⁶⁵⁾.

2.1.2. European Union legal and policy framework

2.1.2.1. EU legal framework on access to SRH goods and services

The EU legal framework in relation to SRH can be approached from two main angles:

- gender equality and non-discrimination;
- health.

Freedom of religion and belief, in connection with the right to conscientious objection, is examined in Section 4.

EU legal framework on gender equality and non-discrimination

The EU treaties and legislation establish non-discrimination and equal treatment as fundamental principles. The founding values of the Union include human dignity, freedom, equality and respect for human rights ⁽⁶⁶⁾. When defining and enacting policies and activities, the EU pledges to tackle **discrimination on grounds of sex and religion or belief**, among others, and is permitted to take appropriate action to achieve this ⁽⁶⁷⁾. It is also committed to fighting inequality and encouraging **equality between women and men** ⁽⁶⁸⁾, as well as tackling social exclusion and discrimination ⁽⁶⁹⁾.

The Court of Justice of the EU (CJEU) has established that discrimination arising from **gender reassignment** must be considered discrimination based on the sex of the person concerned ⁽⁷⁰⁾. The principle of equal treatment for women and men and the prohibition of sex discrimination thus applies to transgender people who have undergone or are undergoing gender reassignment. In a recent case ⁽⁷¹⁾, the CJEU further expanded the protection for transgender people by ruling that it is not required for a transgender person to have legally had their gender reassigned in order to be protected from discrimination on the ground of sex.

Council Directive 2004/113/EC guarantees equal treatment between women and men with regard to **'access to and supply of goods and services'**, outlawing both direct and indirect discrimination (Article 4(1)) ⁽⁷²⁾. The Directive explicitly prohibits less favourable treatment of women for reasons of pregnancy and maternity. In fact, it enables more favourable provisions to protect women in the areas of pregnancy and maternity (positive action)(Article 4(2)). The Directive's Preamble specifies that **'differences between men and women in the provision of healthcare services, which result from the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'**.

Under the Directive, Member States must ensure that sex as a factor in the calculation of insurance premiums and benefits must not result in differences in individuals' premiums and benefits, which

⁶⁴This does not directly consider the issue of SRHR but proposes action to maximise opportunities for noncommunicable disease (NCD) prevention/control through communicable disease control programmes. This is relevant to the prevention of cervical cancer, for example, which is strongly connected to long-term infection with certain strains of human papilloma virus (HPV), a sexually transmitted (communicable) infection.

⁶⁵ This advocates a range of policy approaches to support people living with HIV, including universal health coverage, continuum of HIV services, a public health approach and others.

⁶⁶ Article 2 Consolidated Treaty on the European Union (TEU), 26 October 2012.

⁶⁷ Articles 10 and 19 Consolidated Treaty on the Functioning of the European Union (TFEU), 26 October 2012.

⁶⁸ Article 8 TFEU, 26 October 2012.

⁶⁹ Article 3(3) TEU, 26 October 2012.

⁷⁰ CJEU Case C-423/04.

⁷¹ [CJEU Case C-451/16](#).

⁷² See also Article 6 of the Treaty of the European Union.

must apply without derogation since 2012⁽⁷³⁾. In addition, pregnancy and maternity related costs must not result in differences in individuals' premiums and benefits.

A key question is whether SRH goods and services fall within the scope of this Directive. According to the Commission, the Directive applies to all goods and services provided against remuneration, including health services. The CJEU confirmed that health services do not have to be paid services in order for EU law to apply⁽⁷⁴⁾.

It can be argued that, by their nature, SRH services are targeted only at a particular sex. Accordingly, discrimination in accessing such services is not linked to discrimination based on sex, since they address people of the same sex. Such discrimination could thus only be based on other grounds (e.g. religion) or other factors, including age-appropriateness⁽⁷⁵⁾. Taking the approach of individual discrimination based on sex, it is unlikely that the Directive would apply to services. However, this does not recognise the fact that limits and barriers to accessing SRH goods and services may be the result of 'historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women'⁽⁷⁶⁾. A more global understanding of unequal treatment and discrimination thus argues that Directive 2004/113/EC applies to SRH goods and services.

Depending on the interpretation at Member State level, this could potentially have a restrictive impact on the sexual and reproductive goods and services covered by this Directive. This lack of clarity in the application of the Directive would benefit from guidance from the Commission and/or the CJEU.

Directive 79/7/EEC⁽⁷⁷⁾ establishes the **principle of equal treatment** for women and men in matters of social security. The Directive applies to statutory social security schemes and social assistance, in so far as it is intended to supplement or replace the former schemes. Directive 79/7/EEC covers the risks related to sickness and prohibits discrimination on ground of sex, either directly or indirectly by reference in particular to marital or family status, in relation to the scope of the schemes and the conditions of access, obligation to contribute and the calculation of contributions and calculation of benefits.

Similarly, the **Racial Equality Directive** (2000/43/EC) outlaws discrimination based on racial or ethnic origin in many areas, including access to and the supply of goods and services 'available to the public' (Article 3(1)(h)).

The EU signed the **Istanbul Convention** in 2017⁽⁷⁸⁾ and is in the process of concluding the Convention. Following its accession, the EU and its Member States will be legally bound by the Convention, with compliance of EU law with the Convention falling under the scrutiny of the CoE Committee of the Parties⁽⁷⁹⁾. However, the EU has not yet introduced a specific Council Directive on implementing the

⁷³ CJEU, Case C-236/09, *Test Achat v Conseil des ministres*, 1 March 2011, OJ C 130, 30.4.2011.

⁷⁴ CJEU, Case C-157/99, *Smits and Peerbooms*, 12 July 2001, para.57.

⁷⁵ European Parliament, [Gender Equal Access to Goods and Services Directive 2004/113/EC European Implementation Assessment, 2017](#).

⁷⁶ Preamble of [Council of Europe Convention on preventing and combating violence against women and domestic violence](#), 2011.

⁷⁷ [Council Directive 79/7/EEC](#) of 19 December 1978 on the progressive implementation of the principle of equal treatment for men and women in matters of social security, OJ L 6, 10.1.1979.

⁷⁸ Council Decision (EU) 2017/866 of 11 May 2017 on the signing, on behalf of the European Union, of the Council of Europe Convention on preventing and combating violence against women and domestic violence with regard to asylum and non-refoulement, OJ L 131, 20.5.2017; Council Decision (EU) 2017/865 of 11 May 2017 on the signing, on behalf of the European Union, of the Council of Europe Convention on preventing and combating violence against women and domestic violence with regard to matters related to judicial cooperation in criminal matters, OJ L 131, 20.5.2017.

⁷⁹ Christofi, A., Fries-Tersch, E., Meurens, N., Morel, S. & Spanikova, H., [Violence against women and the EU accession to the Istanbul Convention](#), European Parliament, 2017.

principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, despite this being proposed by the European Parliament as early as 2008 ⁽⁸⁰⁾.

The **Charter of Fundamental Rights** of the European Union (2012/C 326/02) establishes legal rights with direct relevance to SRHR. These include the individual right to respect for one's physical and mental integrity (Article 3(1)) and the right to respect for one's private and family life, home and communications (Article 7). The Charter prohibits discrimination on a number of relevant grounds, notably sex, sexual orientation and membership of a national minority (Article 21(1)). While there is a guaranteed legal right to marry and found a family, this must be in accordance with national laws that regulate the exercise of these rights (Article 9), indicating an ambiguity on whether or not there is a legal requirement for Member States to provide access to, for example, same-sex marriage. Likewise, while everyone has the right 'to access to preventative health care' and 'to benefit from medical treatment', this must be 'under the conditions established by national laws and practices' (Article 35), meaning that the exact goods and services provided can be decided at national level.

Restrictions on the exercise of the rights in the Charter are permitted only when these are 'provided for by law' and 'respect the essence' of the rights (Article 52(1)). These limits are subject to 'proportionality', and are acceptable only when they are 'necessary' and 'genuinely meet objectives of general interest recognised by the Union or the need to protect the rights and freedoms of others' (Article 52(1)). Any rights in the Charter that correspond to those in the European Convention on Human Rights have the same 'meaning and scope' as those in the Convention (Article 52(3)).

EU legal framework on access to health

Under Article 168 of the Treaty on the Functioning of the European Union (TFEU), the EU should offer guidance in the sphere of public health and foster cooperation between Member States, in particular in cross-border health issues. While the responsibility for defining health policies rests with Member States (Article 168, para 7), the EU must ensure a high level of human health protection in defining and implementing policy actions and activities. EU action should **complement** national policies in improving public health, preventing physical and mental illness and diseases, and combatting sources of major health issues.

The EU public health acquis has been developed to address cross-border health issues as well as in relation to the freedom movement of goods and services. The acquis covers issues ranging from tobacco control to nutrition, and alcohol-related harm reduction. The EU legislation most relevant to SRH concerns health inequality, cancer screening and communicable disease.

Directive 2011/24/EU on patients' rights in cross-border healthcare ⁽⁸¹⁾ is a key piece of EU health legislation with strong relevance to access to SRH services. The Directive applies to any healthcare service, with the exception of long-term care. The Directive provides a number of standards to ensure quality and accessible healthcare. Accordingly, patients must receive all of the information necessary to make an informed choice, including:

- information on patient rights and entitlements;
- treatment options;
- availability;
- quality and safety of the healthcare they provide;
- prices;

⁸⁰ See for example, <https://publications.europa.eu/en/publication-detail/-/publication/b9d8e8ef-3eac-4cf1-9095-8afedc169913>

⁸¹ [Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.](#)

- authorisation or registration status.

Member States must also safeguard access to treatment by ensuring that the cost of the healthcare provided is reimbursed to insured patients and that they have access to any medical follow-up treatment which might be necessary.

Directive 2001/83/EC on **medicinal products** is designed to guarantee high standards of quality and safety of medicinal products aiming at treating or preventing disease in human beings⁽⁸²⁾. Medicinal products must receive authorisation from competent authorities in order to be placed on the market, a principle at the centre of legislative development, particularly as increased harmonisation eases coordinating this transition to market.

To supplement its hard law, the EU has also adopted some **soft law** instruments addressing some health concerns and aiming to ensure high quality health standards. This includes the 2009 Recommendation on patient safety, which encompasses a range of general measures to improve patient safety (although it is not specific to SRHR)⁽⁸³⁾. Using soft law, the EU has also tackled SRH in relation to breast and cervical cancer in the form of Guidelines and a Recommendation. The **Council Recommendation on cancer screening**⁽⁸⁴⁾ lays down principles of best practice for the early detection of cancer and encourages Member States to implement cancer screening programmes. To complement the recommendation, the EU adopted a number of European quality assurance **guidelines for cancer screening**, including cervical cancer screening⁽⁸⁵⁾ and breast cancer screening⁽⁸⁶⁾.

Given the limited competence to adopt holistic SRH legislation in the absence of a cross-border element, EU legislative action on SRH is thus more likely to be framed within the competence of non-discrimination based on sex in access to services, including health services.

2.1.2.2. EU policy framework on access to SRH goods and services

SRHR are **not an area of focus** in the European Commission's gender equality or health strategies (perhaps due to its limited policy competence in this area, as outlined above).

The **European Pillars of Social Rights**, adopted in 2017, aim to guide EU actions towards efficient employment and social outcomes while responding to current and future challenges, and towards ensuring better enactment and implementation of social rights. In one of 20 principles, the Pillars include 'the right to timely access to affordable, preventative and curative healthcare of good quality'. The EU is thus committed to mainstreaming the right to access to healthcare in all EU policies.

The European Commission **Strategic Engagement for Gender Equality 2016-2019**⁽⁸⁷⁾ acknowledges the need to tackle gender-based violence and FGM, as well as to ensure adequate support for the health and wellbeing of victims. As one of its five thematic priorities, the Strategy

⁸² [Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use](#), OJ L 311, 28.11.2001.

⁸³ [Council Recommendation of 9 June 2009 on patient safety](#), including the prevention and control of healthcare associated infections, OJ C 151, 3.7.2009.

⁸⁴ [Council Recommendation of 2 December 2003 on Cancer Screening](#) (2003/878/EC). OJ L 327: 34-38.

⁸⁵ [European guidelines for quality assurance in cervical cancer screening](#), 2008.

⁸⁶ [European guidelines for quality assurance in breast cancer screening and diagnosis](#), 2006.

⁸⁷ European Commission [Strategic Engagement for Gender Equality 2016-2019](#).

includes 'Combating gender-based violence and protecting and supporting victims', with actions including:

- EU accession to the Istanbul Convention, implementation of its provisions and continued encouragement of Member State progress on ratification;
- continue to enforce the Victim's Rights Directive, in particular to ensure access to support for those exposed to gender-based violence;
- continue focused actions to end all forms of gender-based violence and raise awareness;
- continue implementation of measures to tackle FGM and build on those measures to tackle other harmful practices.

The Strategy specifically mentions maternal health and access to SRH services for women and girls as part of the promotion of gender equality *outside* the EU.

The European Commission's **Communication towards the elimination of female genital mutilation (COM/2013/0833/final)** is an important initiative to strengthen EU action in this area. It outlines a range of European Commission actions in the following areas: promoting sustainable social change to prevent FGM; supporting Member States in prosecuting FGM more effectively; ensuring protection for women at risk in the EU; promotion of the end of FGM globally; and effective implementation, monitoring and evaluation.

The Strategic Plan 2016-2020 of DG Health and Food Safety of the European Commission ⁽⁸⁸⁾ does not explicitly name SRHR among its policy priorities. It does, however, seek to monitor the degree to which the European accreditation scheme for breast cancer services is implemented at Member State level, as part of efforts to ensure common EU quality standards in this area.

The **EU Third Health Programme 2014-2020** has the objective to "Promote health, prevent diseases, and foster supportive environments for healthy lifestyles" in Member States' but it does not cover issues specifically relevant to sexuality and reproductive education in schools ⁽⁸⁹⁾.

As early as 2001, the European Parliament stated its commitment to encouraging greater access to SRHR in Member States, calling on the European Resolution on sexual and reproductive health and rights (2001/2128(INI)) ⁽⁹⁰⁾ for a range of actions with regard to:

- **contraception:** for example, national level policies on SRH that spread information on methods of family planning (para. 2); the provision of free and/or low-cost contraception to underserved groups (para. 4), promotion of emergency contraception (Article 6);
- **prevention of unwanted pregnancies and abortion:** for example, preventative action to reduce the number of unwanted pregnancies in the first place via the offer of clearer information on SRH (para. 9-10); the existence of 'legal, safe and accessible' abortion (para. 12);
- **adolescent SRH and sexuality education:** for example, gender-sensitive sexuality education from early life through to adulthood (para. 16); the provision of specialist support to pregnant adolescent women (para. 20).

⁸⁸ https://ec.europa.eu/info/sites/info/files/strategic-plan-2016-2020-dg-sante_en_0.pdf

⁸⁹ FEMM Committee of the European Parliament, *Sexual and reproductive health and rights: Study, 2016*, p.17. Available at: [http://www.europarl.europa.eu/RegData/etudes/STUD/2016/571392/IPOL_STU\(2016\)571392_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2016/571392/IPOL_STU(2016)571392_EN.pdf)

⁹⁰ <https://publications.europa.eu/en/publication-detail/-/publication/a4fa9ecc-bb44-4e85-bb51-08107da6dddc/language-en>

More recently, the European Parliament has called for comprehensive SRH education in schools and better inclusion of LGBTI issues in educational curricula (Resolution of 9 September 2015 on empowering girls through education in the EU (2014/2250(INI))).

2.2. Member States' frameworks

KEY FINDINGS

The research revealed a broad range of legal differences at national level across the six Member States (Croatia, Czech Republic, Italy, Poland, Portugal and Sweden) when it comes to SRHR. Some important differences relate to:

- Whether or not the right to SRH is recognised. Only Portugal and Croatia explicitly protect this in law;
- Whether the national health system or mandatory public insurance cover the provision of contraception, abortion services and other SRH goods and services;
- Whether a woman's choice is ever a legal basis for an abortion (this applies in all Member States except Poland);
- The role of third party organisations in regulating the right of access to abortion services, sex reassignment surgery and voluntary sterilisation (among others);
- Whether or not countries legislate to guarantee or standardise specific services, such as care and support for individuals who have undergone FGM, IPV or non-partner sexual violence (generally, countries do not legislate to offer such services).

Of the six Member States, only Portugal has a specific action plan or strategy focusing on SRHR. In Sweden, a more comprehensive set of actions on SRHR issues are being pursued, despite the lack of a specific strategy. The other four Member States are taking more limited action in relation to SRHR

2.2.1. National legal frameworks: comparative overview

2.2.1.1. The right to SRH

Other than Portugal and Croatia, most of the Member States studied do not directly recognise a general **right to SRH**. **Portuguese** legislation is relatively unusual in enshrining part of this protection - the Constitution explicitly protects the right to family planning. The right to family planning and sexual education/health has also been bolstered by two other Portuguese laws ⁽⁹¹⁾. While **Croatia** does not have a constitutional right to SRH, the Law on Gender Equality affirms that a woman has the right to decide freely on her SRHR, including the right to make a free decision about the number of children and the right to induced pregnancy terminations (provided these comply with applicable law) ⁽⁹²⁾. The other four Member States do not legislate directly to guarantee this right, although the **Czech Republic** and **Italy** have constitutional protections for **the right to health** more generally ⁽⁹³⁾.

⁹¹ Law no. 3/84 of 24 March on sexual education and family planning and Law no. 120/99, of 11 August, reinforcing the guarantees of the right to reproductive sexual health.

⁹² Under the conditions laid down in the Law on Health Care measures for exercising the right to freely decide on childbirth (Law on Termination of Pregnancy (Law on ToP)*). More generally, the Constitution in Croatia protects the right to health (Article 59), including informed consent (Article 23). It further guarantees the rights to life (Article 21), a suitable life (Article 63) a healthy life (Article 70) and the right to equality and non-discrimination (Articles 1, 3, 14, 15 and 17).

⁹³ In the Czech Republic, the Charter of Fundamental Rights and Freedoms (1993) protects the right to health protection and offers free healthcare and medical equipment/supplies for goods/services covered by public insurance. The Italian Constitution protects the right to health (Article 32).

In **Poland**, the concept of ‘reproductive rights’ does not exist in national legislation, although public authorities have relevant obligations towards patients, notably the obligation to offer pregnant women appropriate medical, social and legal care⁽⁹⁴⁾, and a wider obligation to provide citizens with free access to the ‘methods and means serving conscious procreation’⁽⁹⁵⁾. These ‘methods and means’ have been historically understood to cover registered contraceptives⁽⁹⁶⁾. The notion that the right to family planning constitutes a personal right is contested but has been strengthened by Court rulings, notably a 2003 Supreme Court judgment that found it would violate a woman’s constitutional right to decide about her *personal life* if she were forced to give birth to a child that resulted from a rape, as well as a 2015 Appeal Court ruling finding that the right to family planning (including the right to terminate a pregnancy) is a personal right⁽⁹⁷⁾. Despite these judicial interpretations, the notion of SRH is not used by the Polish Government, which instead uses the term ‘procreation health’. This suggests some political disagreement in Poland over the concept of a right to SRH. By contrast, Sweden has no concept of SRH in national legislation, yet it is an established part of the policy discourse (for example, in documents published by the Public Health Agency).

In compliance with the Equal Treatment Directive (2004/113/EC)⁽⁹⁸⁾, all Member States should guarantee equal treatment between women and men in accessing healthcare services. Under the Directive, differences in the provision of healthcare services stemming from the physical differences between women and men do not constitute discrimination. All six Member States of this study have transposed the requirements of this Directive in their national legislation, covering both goods and services⁽⁹⁹⁾. Under EU law, protection against sex-based discrimination in healthcare also protects transgender people. However, some research suggests the protections against *indirect* discrimination could be stronger⁽¹⁰⁰⁾. Furthermore, Member States vary in the ways in which they interpret sex-based discrimination in access to healthcare, affecting the strength of protections for transgender and LGB people. For example, the **Czech Republic** interprets gender-based discrimination broadly to include discrimination on grounds of pregnancy, maternity or paternity and sexual identity⁽¹⁰¹⁾ and **Sweden** explicitly includes sex, transgender identity or expression among the grounds on which discrimination in healthcare is not permitted⁽¹⁰²⁾. By contrast, in **Croatia**, the legal framework is unclear for LGBT persons.

In **Italy**, while the Constitution protects equal access to health in a general sense (Article 32)⁽¹⁰³⁾, a law was proposed in 2014 to ensure equal treatment between the sexes, which would also regulate access to health (Article 9)⁽¹⁰⁴⁾. The Framework Law was presented to the Italian Parliament again in March 2018 and has been assigned to the Commission on Constitutional Affairs. However, no additional consideration was given to the framework law since then. This would legally provide for offering care that takes into account ‘gender differences and related specificities’. However, the extent to which

⁹⁴ Article 2(1) of the Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy.

⁹⁵ Article 2(2) of the same act.

⁹⁶ The question of access to contraception, including implementation issues in Poland and elsewhere, is covered in Section 2.2.1.2.

⁹⁷ Polish Supreme Court in the judgment of November 21, 2003; Judgment of the Appeal Court of 12 May 2015 ‘The right to family planning and the resulting right to terminate a pregnancy in the conditions specified in Article 4a of the Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy, is a personal right.’

⁹⁸ <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32004L0113>

⁹⁹ European Parliamentary Research Service (2017). *Gender Equal Access to Goods and Services Directive 2004/113/EC. European Implementation Assessment*, pp. 10-11.

¹⁰⁰ European Parliamentary Research Service (2017). *Gender Equal Access to Goods and Services Directive 2004/113/EC. European Implementation Assessment*, pp. 15-25.

¹⁰¹ Antidiscrimination Law.

¹⁰² See Sweden’s Discrimination Act and Healthcare Act, together.

¹⁰³ Costituzione della Repubblica Italiana, <https://www.senato.it/documenti/repository/istituzione/costituzione.pdf>

¹⁰⁴ Framework Law for equality between sexes and against gender-based discrimination.

other grounds would be explicitly protected against discrimination when it comes to individual access to health is not clear.

2.2.1.2. Access to SRH goods

Access to goods is regulated either in terms of requirements for medical prescriptions or health insurance coverage. The insurance coverage aspect is presented in Section 3, as part of the affordability of SRH contraceptives and SRH-related medicines.

Contraceptives

It is common for Member State legislation to require individuals to obtain a **medical prescription** before accessing certain kinds of **contraceptives**. National laws may also specify **particular providers/arenas** from which contraceptives can be obtained.

- In **Poland**, individuals must get a medical prescription to access *most forms of contraception*, going via a mix of healthcare professionals ⁽¹⁰⁵⁾.
- In **Sweden**, a prescription is needed for hormonal contraceptives only, and must be provided by registered midwives, obstetricians or gynaecologists. Whilst emergency contraception does not require a prescription, it can only be sold at government-approved facilities (pharmacies and clinics) ⁽¹⁰⁶⁾. Also in **Croatia**, a prescription is needed for certain hormonal contraceptives ⁽¹⁰⁷⁾.
- In **Italy**, emergency contraceptives can only be accessed at local family planning offices. The country also specifies that hormonal contraceptives must be on sale at pharmacies but does not state the exact type, which can result in shortages of certain kinds.

The **Czech Republic** does not regulate the private sale of contraceptives on the market.

Portugal allows for individuals to access emergency contraceptives free of charge *without* a prescription in certain settings, namely, health centres, specialised hospital units (family planning/gynaecology/obstetrics) and youth care centres. If these emergency contraceptives are bought from a pharmacy, they may require a prescription ⁽¹⁰⁸⁾.

Medicine and treatment for sexually transmitted infections (STIs)

The legislation in the six Member States is more nuanced when it comes to the **SRH goods available for individuals experiencing SRH-related illness**, including people with HIV. Most countries (**Italy, Croatia, Czech Republic, Poland** and **Sweden**) regulate the care and treatment of particular STIs.

- As the most expansive approach, in **Sweden**, the Infectious Disease Act provides access free of charge to curative, management and preventative medication for gonorrhoea, Hepatitis B, HIV,

¹⁰⁵ In Poland, first time access to contraception requires a medical appointment. A nurse/midwife can prescribe the contraceptives subsequently (see the Act of 6 September 2001 - Pharmaceutical Law).

¹⁰⁶ It is sometimes provided for free at youth clinics.

¹⁰⁷ In Croatia, prescription is exclusively based on the diagnosis of the chosen primary healthcare family doctor, who, based on examination, establishes the need for a contraceptive. However, in Croatia, some forms of contraception can be accessed without prescription, namely two emergency contraceptives (Escapelle and ellaOne), condoms and intrauterine devices.

¹⁰⁸ Paragraph 3 of Law no. 12/2001, of May 29.

chlamydia and syphilis. The prevention and treatment of STIs is regulated ⁽¹⁰⁹⁾ and there is a supporting National Strategy for HIV/AIDS and other infectious diseases (updated 2017) ⁽¹¹⁰⁾.

- Similarly, in the **Czech Republic**, HIV-positive people are eligible for full healthcare under public insurance, without any restrictions, and can access medications under national health insurance ⁽¹¹¹⁾.
- In **Croatia**, individual counselling is free of charge for all affected persons on issues related to HIV/AIDS and other STIs, responsible sexual behaviour and sexual health, vaccination counselling and vaccination against Hepatitis B and HPV. There is also anonymous and free testing for HIV, Hepatitis B and C, and syphilis, as well as information and counselling regarding other medical screening, treatment and support, distribution of educational material and condoms. When it comes to treatment of SRH-related illnesses, drugs that are usually prescribed by doctors. For certain medications necessary for hospitalised patients, approval is given by a hospital's committee for drugs. The Croatian Institute for health insurance (Hrvatski zavod za zdravstveno osiguranje, HZZO) regularly publishes the updated list of drugs whose cost are covered by public health insurance.
- In **Italy**, access to medicines is guaranteed under the national public healthcare structure and insurance system. Italian legal provisions establish requirements when it comes to the prevention of HIV/AIDS, and the training provided to healthcare professionals ⁽¹¹²⁾.
- In **Poland**, the costs of sanitary-epidemiological examinations (excluding laboratory tests) are financed from public funds (regardless of insurance). People with syphilis and gonococcal infections (including those without health insurance) are subject to the obligatory treatment ⁽¹¹³⁾, although they have access to free of charge diagnosis, medical treatment and aftercare. Similar regulations apply to persons infected with HIV. However, while Polish law ⁽¹¹⁴⁾ requires a health policy programme to offer antiretroviral (ARV) treatment to those with HIV, ARV drugs are not available via this programme for pre-exposure prevention, and instead require individuals to obtain a prescription and pay for the treatment themselves. Post-exposure prophylaxis after occupational infection is also regulated differently. Treatment for HIV and AIDS is carried out with antibiotics, which also requires a medical prescription.

National legal provisions are relatively complex when it comes to the prevention and disclosure of sexually transmitted infections (STIs). One regulated area is **reporting and disclosure requirements**. In some countries (**Czech Republic, Poland, Portugal**), **medical practitioners** bear obligations to intervene or to report the situation in the case of certain STIs. For example, in the **Czech Republic**, healthcare providers must report venereal diseases or deaths potentially caused by them ⁽¹¹⁵⁾. In **Poland**, doctors and military surgeons are obliged to tell STI-infected persons to inform their sexual partners ⁽¹¹⁶⁾. In **Portugal**, hospitals must intervene when it is an acute/severe illness. Some national legislation also enshrines reporting obligations **for individuals infected** with STIs. For example, in the **Czech Republic**, HIV positive persons must inform their doctors ⁽¹¹⁷⁾ and in **Sweden**, individuals with

¹⁰⁹ Infectious Disease Act and Infectious Disease Law.

¹¹⁰ This national plan aims to improve the evidence base, decrease transmission, improve treatment/management of STIs and minimise stigma/discrimination.

¹¹¹ Act on Protection of Public Health No. 258/2000 Coll. and a regulation based on § 80 issued by the Ministry of Health.

¹¹² Law no. 135 of 5 June 1990, presenting the 'Programme of urgent interventions for prevention and fight against AIDS'.

¹¹³ Article 40 of the Act of 5 December 2008.

¹¹⁴ Act of 27 August 2004.

¹¹⁵ Regulation in Act No. 258/2000 Coll. on the Protection of Public Health.

¹¹⁶ Article 26 of Act of 5 December 2008 on the prevention and control of infections and infectious diseases in humans.

¹¹⁷ Act on Protection of Public Health No. 258/2000 Coll. and a regulation based on § 80 issued by the Ministry of Health.

certain STIs specified in law must disclose their status to potential sex partners and healthcare staff and engage in contact tracing ⁽¹¹⁸⁾. It is worth noting that in Sweden, the requirement to disclose in cases of HIV has recently come under legal challenge for people who are on effective anti-retroviral treatment (ART), where the chance of transmission is greatly reduced. In one such case ⁽¹¹⁹⁾ before Sweden's highest court, an individual was acquitted despite not disclosing his status to his partner.

Regional variation can be an issue when it comes to the care and treatment of certain STIs, as is the case in Italy. Similarly, in Croatia, there are no national programmes for testing STIs among people aged under 25 (as generally recommended) and relevant initiatives appear to be pursued on a regional and/or ad hoc basis ⁽¹²⁰⁾.

2.2.1.3. Access to SRH services

Contraception counselling and family planning

National laws in Portugal, Sweden and Poland ensure high levels of access to contraception counselling and family planning. In **Portugal**, access to family planning services is often delivered by **health centres** that are qualified to address a range of SRH issues. Likewise, registered **midwives in Sweden** offer family planning and contraceptive services ⁽¹²¹⁾. Finally, in **Poland**, legislation recognises the general right of everyone to make *responsible decisions* about having children and the right to access information, education, counselling and resources to enable the exercise of this right ⁽¹²²⁾. Despite these legal provisions, in practice contraceptive methods can be unavailable and effectively exclude many women from realising their legal rights. As explored in more detail in Section 3 of this report, this may be related to affordability. Hormonal contraceptives are not refunded in Poland, making the price of contraceptives, especially modern hormonal agents, prohibitive for some women.

In the Czech Republic, Croatia and Italy, the law does not guarantee access to these services to the same extent, for a variety of reasons.

- **Italy** gives a significant amount of **discretion to regions** to determine the criteria for the programming, operation, management and control of family planning services (Article 2 of Law n. 405). Whilst this may mean that some areas have advanced contraception counselling and family planning services on offer (as is the case in Emile Romagna and Puglia), it may lead to uneven / inadequate geographical coverage of services across the country as a whole.
- The counselling and services on offer may be of a general nature and **not specialised to SRH**, as is the case in the **Czech Republic**, where the law ⁽¹²³⁾ requires counselling to be offered to women and girls in a difficult life situation (such as in the case of unplanned pregnancy or single motherhood).

¹¹⁸ Infectious Disease Act. 'Contact tracing' means that the healthcare provider, together with the patient, must try to track how the patient became infected and to track down anyone else who may have been exposed to this infection. In practice, in the context of STIs, this often means contacting those with whom the patient engaged in sexual activity.

¹¹⁹ Today's Law (*Dagens Juridik*), HIV-infected individual freed by the High Court after unprotected sex, (*HIV-smittad frias i HD efter oskyddat sex*), 7 June 2018, available at <http://www.dagensjuridik.se/2018/06/hiv-smittad-frias-i-hd-efter-oskyddat-sex-bra-att-juridiken-kommer-ikapp-vetenskapen>

¹²⁰ For example, the Centre for diagnosis of STIs of the Ministry of Health carries out the Programme for testing for sexually transmitted bacteria *Mycoplasma genitalium* and *Chlamydia trachomatis* in the student population of the city of Zagreb. The programme covers the years 2017-2019. More information is available at: <http://www.stampar.hr/hr/program-probira-na-spolno-prenosive-bakterije>

¹²¹ Gynaecologists and obstetricians are also permitted to provide family planning advice.

¹²² Preamble, Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy

¹²³ Act No. 108/2006 Coll. on Social Services.

- There may be a general **lack of regulation of such services**, as is the case in **Croatia**, where there is no information on these services' availability.
- The **services available may be highly limited and difficult to access**. For example, the Croatian Law on Termination of Pregnancy guarantees the right of sterilisation to women and men over 35 years old but this is not covered by health insurance. In addition, the terms regulating women's access can be highly restrictive. In some cases, a woman in Croatia is not permitted to access this right unless she has the permission of her partner or has received approval from a medical commission after having had three caesarean sections (¹²⁴).

Abortion

Whilst all six Member States permit **abortion** in certain cases, the national legislation differs in terms of its restrictiveness. **Poland** has an unusually restrictive regime, in that it does not allow abortion purely based on a woman's choice/request, within any timeframe. In the remaining five Member States, this is permitted but only during the earlier stages of pregnancy, i.e. within the first 10 weeks (**Croatia, Portugal**), within the first 12 weeks (**Czech Republic**) (¹²⁵), within the first 90 days (**Italy**) or up to week 18 (**Sweden**). In Croatia and Sweden, abortion is also permitted for girls (younger than 16 in Croatia or younger than 15 in Sweden), provided that they have consent from their parent/guardian.

All Member States allow abortion within a **longer timeframe** in circumstances other than a woman's choice, most commonly in the case of **risk to the life/health** of the pregnant woman/foetus and/or the **non-viability** of the foetus.

- In the **Czech Republic**, abortion is allowed after the first 12 weeks for health reasons, specifically if there is a danger to the woman's life or health or the healthy development of the foetus, or if the development of the foetus will be generally defective. No end time limit is stated.
- In **Italy**, the legislation also specifies that voluntary termination of pregnancy can be carried out beyond the first 90 days if there are serious factors that are dangerous for the life of the woman or her mental and physical health. No end time limit is stated.
- In **Sweden**, abortions are permitted after week 18, and within any timeframe, where the foetus is considered not to be viable or where there is a serious threat to the child bearer's life or health. However, the National Board of Health and Welfare must approve such abortions and they are normally not allowed after week 22. Where there is an acute threat to the child bearer's life, the approval of the Board is not necessary.

Croatia, Poland and Portugal recognise similar medical grounds for permitting abortion **beyond the early stages**, but they also permit abortion in certain cases when it has been **caused by a crime**. In Poland and Portugal, the exact timeframes for abortion differ depending on the reason.

- In **Croatia**, after the tenth week, termination is permitted if the pregnancy is the result of a crime, poses a risk to a woman's health or life, and in cases of severe foetal impairment.

¹²⁴ In most cases, medical commissions refuse sterilisation or dissuade women from the procedure. This was confirmed via an interview for the study; further information available here: Tadić, M., Sterilisation (*Podvezivanje jajovoda*), trudnoca.hr (2012), available at: <https://www.trudnoca.hr/hocu-bebu/kontracepcija/podvezivanje-jajovoda/>

¹²⁵ However, the abortion cannot go ahead if there are medical conditions present that would not allow its performance.

However, an abortion in such circumstances requires the approval of a medical commission. No end time limit is stated.

- In **Portugal**, in addition to a woman's choice (within the first 10 weeks of pregnancy), abortion is allowed beyond this timeframe when:
 - it is the only means of removing the danger of death or serious and irreversible injury to the body or to the physical or mental health of the pregnant woman (timeframe not stated);
 - it is necessary to avoid danger of death or serious and lasting injury to the body or to the physical or mental health of the pregnant woman (within the first 12 weeks of pregnancy);
 - there are reasonable grounds to expect that the unborn child will incurably suffer from a serious illness or congenital malformation (within the first 24 weeks of pregnancy);
 - the foetus is non-viable (at all times);
 - the pregnancy resulted from a crime against freedom and sexual self-determination (within the first 16 weeks of pregnancy).
- In **Poland**, abortion is legal when:
 - the pregnancy constitutes a risk to the life or health of the pregnant woman (at any time);
 - prenatal tests or other medical evidence indicate a high probability of severe and irreversible disability to the foetus or an incurable illness threatening its life (until the moment when the foetus achieves the ability of life outside the mother);
 - there is a justified suspicion that the pregnancy arose as a result of a crime (within the first 12 weeks of pregnancy).

In both Croatia and Sweden, **once the timeframe has passed** in which a woman is permitted to have an abortion purely of her own volition, it is generally necessary to gain the **approval of an external body** (respectively, a medical commission in Croatia and the National Board of Health and Welfare in Sweden). Similarly in Poland, specialist physicians must certify when the medical grounds for abortion have been met. In addition to the need to gain approval, there may be other elements in legal regulations that serve as a barrier to accessing abortion. For example, in Croatia, mandatory health insurance does not cover voluntary termination of pregnancy and in the Czech Republic women must pay an additional fee to undergo the procedure.

It is worth mentioning that in **Poland**, illegal termination of pregnancy **can be punished criminally**. Anyone who influences a pregnant woman to terminate pregnancy through violence, illegal threats, deceit or other means that do not involve her consent can face between 6 months and 8 years in prison (¹²⁶). Those who assist a woman with an illegal termination of pregnancy *with* her consent are also subject to deprivation of liberty, but for a shorter maximum period of time: up to 3 years in prison (¹²⁷). The woman herself cannot be considered the subject of this crime.

¹²⁶ Article 153 of the Criminal Code.

¹²⁷ Article 152 of the Criminal Code.

Table 4. Grounds under which abortion can be legally permitted

	Woman's choice	Risk to the woman's life or health	Risk to the foetus's life, health or healthy development, including possibility of serious disability	Non-viability of the foetus	Pregnancy results from a crime
Croatia					
Czech Republic					
Italy					
Poland					
Portugal					
Sweden					

Notes: Green signifies that this is a permissible ground. The timeframes relating to these grounds differ, as explained above.

Only two Member States (**Portugal** and **Sweden**) have legislation that provides specifically for **post-abortion care**, which consists of psychological and social support (PT), and a counselling session before and after the abortion, among other things (SE). In Italy, such services are not regulated by national law but some regional legislation (in Emilia Romagna and Puglia) includes post-abortion care in the context of family planning.

Care related to FGM

While all Member States criminalise **FGM**, some do not have specific legislation in place, which limits the regulation of post-FGM support services. This applies in the **Czech Republic** and **Poland**. In contrast, **Croatia**, **Italy**, **Portugal** and **Sweden** all have **specific references to FGM** in their national legislation.

The laws in Italy and Sweden are the most advanced in this regard, as they outline the general need for provision of care to victims. These two Member States are also implementing relevant policy initiatives: **Sweden** is currently pursuing a new strategy to improve care for FGM survivors and **Italy** has released guidelines for healthcare professionals on implementing prevention, assistance and rehabilitation of women and girls who have been subjected to FGM ⁽¹²⁸⁾. Although it represents a less systematic initiative, **Portugal** has some specialised postgraduate courses for nurses and other health technicians on improving the quality of diagnosis, treatment and follow-up of FGM. In **Croatia**, women with FGM-related health complications have free access to reconstructive surgery in hospitals with gynaecological wards.

Care and treatment services for survivors of IPV and non-partner sexual violence

None of the Member States have specific legislation regulating the provision of care to those who have experienced **non-partner sexual violence**. Some national laws include provisions on the care to be delivered to those who have faced **IPV** (**Portugal**, **Poland** and the **Czech Republic**). In other cases, this form of care is covered by general regulations enshrining access to healthcare (**Sweden** and **Italy**). In **Croatia**, the situation is slightly different. There is a Protocol for public institutions on how to act in cases of domestic violence, which states that victims must be informed of their right to free medical

¹²⁸ Linee guida per il riconoscimento precoce delle vittime di mutilazioni genitali femminili e altre pratiche dannose. Per operatori dei CPSA, CDA e CARA. A cura di Associazione Parsec Ricerca e Interventi Sociali; Coop.Soc.Parsec; Università di Milano-Bicocca; A.O. San Camillo Forlanini; Nosotras Onlus e Associazione Trama di Terre, http://www.pariopportunita.gov.it/media/3422/linee-guida_-it.pdf

assistance. In 2012 the Government of Croatia adopted a Protocol on the established institutional pathway in cases of sexual violence, the text of which was revised and aligned with EU regulations in 2014 ⁽¹²⁹⁾.

Of the jurisdictions with specific legal provisions on care for IPV survivors, **Portugal** has the most detailed legislation. Here, a 2009 law ⁽¹³⁰⁾ provides that the National Health Service will provide direct assistance from specialised technicians to victims of domestic violence, and promotes clinics and clinical treatment to prevent the phenomenon (Article 49). The law also provides that the victim is exempt from paying the fees charged by the National Health Service (Article 50). In the **Czech Republic**, the law states that intervention centres should help those threatened by domestic violence ⁽¹³¹⁾. In **Poland**, the law ⁽¹³²⁾ also provides obligations and guidelines for public institutions on organising help for victims of domestic violence, although the current research identified serious problems with enforcement of the law.

Italian law does not include specific provisions on the prevention and treatment of IPV and non-partner sexual violence. However, in 2015, a National Action Plan against sexual and gender-based violence was established (which was renewed in 2017). In January 2018 the government adopted guidelines for hospitals and medical institutes on treatment and assistance for women victims of violence. These guidelines, which build on the Istanbul Convention and on principles of non-discrimination, outline the procedures for health professionals when identifying signs of violence. They also call for training of health professionals.

Obstetric, pre-natal and post-partum care

Obstetric, pre-natal and post-partum care is legally regulated in the Czech Republic ⁽¹³³⁾ and Croatia ⁽¹³⁴⁾, where the delivery of obstetric and gynaecological care is regulated via insurance, and in Sweden, where such services qualify as healthcare ⁽¹³⁵⁾. The fact that they qualify as healthcare in Sweden is significant, as it means they cannot be postponed and are also available for asylum-seekers and undocumented persons. The cost of these services is largely covered by Swedish health insurance, with patients required to pay only a small fee. In the Czech Republic, the conditions of so-called 'confidential birth' are included in public health insurance ⁽¹³⁶⁾. While it may also be possible to access other forms of obstetric, pre-natal and post-partum care via insurance, these are not explicitly covered in the supporting regulation ⁽¹³⁷⁾. In Croatia, all insured women have the right to primary gynaecological care (financed from the budget of the Croatian Institute for Public Health, HZJZ). According to the applicable law ⁽¹³⁸⁾, healthcare measures are: comprehensive healthcare of women, in particular in relation to family planning, pregnancy, delivery and motherhood. Pregnant women therefore have access to free prenatal monitoring by their chosen gynaecologist, as well as delivery and post-natal care provided by a midwife. With a more accessible system than the Czech Republic, during health emergencies Croatia

¹²⁹ *Protokol o postupanju u slucaju seksualnog nasilja*, available at: https://narodne-novine.nn.hr/clanci/sluzbeni/2018_08_70_1418.html

¹³⁰ Law 112/2009, of 16 September revised by Law 24/2017 of 24 May.

¹³¹ Act on Social Services No. 108/2006 Coll.

¹³² Act of 29 July 2005 on counteracting domestic violence.

¹³³ Act on Health Services and Conditions of their delivery; Act No. 48/1997 Coll. on Public Health Insurance.

¹³⁴ Article 17, para. 10 of the law on healthcare.

¹³⁵ Healthcare Act.

¹³⁶ A 'confidential birth' allows a woman to give birth without her personal data being disclosed to the child.

¹³⁷ According to the Act on Public Health Care Insurance, these services are covered by the Act: 'Preventative, dispensary, diagnostic, medical, pharmacy, clinical-pharmaceutical, rehabilitation, spa rehabilitation, assessment, nursing, palliative and health care of donors of blood, tissues and cells or organs related to their collection in all forms of its provision under the Act on Health Services'.

¹³⁸ Article 17, para. 10 of the law on healthcare.

extends the right to free services to persons legally residing in Croatia but without health insurance, including pregnant women.

In **Italy**, it is a legal requirement ⁽¹³⁹⁾ to have consultation offices for family planning, regulated at regional and municipal level. These offer a range of services, including: psychological and social support in preparation for the pregnancy and subsequent maternity and paternity, including relationship issues; tools for couples and individuals to proceed with a healthy and responsible pregnancy; and information through which to promote and prevent pregnancy (including methods and medicine appropriate for each individual case). They do not offer clinical care. Obstetric and pre-natal care services are offered and ensured without any additional cost under the national health system ⁽¹⁴⁰⁾.

In **Poland**, the topic of obstetric, pre-natal and post-partum care is the subject of **controversy**. In early 2017, a government-appointed team began to prepare a replacement regulation to set the organisational standards for physiological pregnancy/delivery, confinement and care for a newborn. However, there are concerns that, because the new standards will become organizational standards for health care and the Ministry of Health will no longer set standards of medical treatment, this may result in hospital-to-hospital variation in how the standards are applied. Furthermore, women will have less power to submit complaints if the standards are not implemented systematically ⁽¹⁴¹⁾. To some extent, this may represent a set-back, as the old standards were intended to empower women and ensure patients' rights ⁽¹⁴²⁾.

Sex reassignment surgery

Sex reassignment surgery is legally permitted in all Member States, apart from Poland, under varying conditions. **Poland** is the most restrictive example, with sex reassignment surgery **neither regulated nor provided for** in law, due to failure to agree on such a bill in 2015. This means that there is no legal recognition of gender identity or definition of transgender.

Sweden and **Portugal** have both recognised the **right to self-determination** of one's gender identity, meaning that (at least legally) such surgery is generally accessible. Following a 2013 legal update, Sweden permits the surgery for over 18s who have lived in the country for one year or more. The legal requirements relating to marital status and sterility are no longer in place. Portugal also recently approved legislation recognising the right to one's self-determination of gender identity and protection of sexual characteristics ⁽¹⁴³⁾, thus individuals aged 16 and over can now undergo this surgery without fulfilling other conditions (such as obtaining a medical diagnosis).

In the other three countries where sex reassignment surgery is permitted, the **conditions of access are more restrictive**. In the **Czech Republic**, individuals are required to: i) have been identified as having gender dysphoria ⁽¹⁴⁴⁾ and shown their ability to live permanently as a member of the opposite sex; ii) either not be in a marriage or civil union (or similar bond with a member of the same sex obtained

¹³⁹ Law n.405 of 29 July 1975 Establishment of Planned Parenthood clinics.

¹⁴⁰ Ministero della Salute, *Esenzioni per gravidanza*,

<http://www.salute.gov.it/portale/esenzioni/dettaglioContenutiEsenzioni.jsp?lingua=italiano&id=1016&area=esenzioni&menu=vuoto>; Act on essential levels of assistance (Decreto del presidente del consiglio dei ministri 12 gennaio 2017

Definizione e aggiornamento dei livelli essenziali di assistenza, di cui all'articolo 1, comma 7, del decreto legislativo 30 dicembre 1992, n. 502.),

<http://www.salute.gov.it/portale/esenzioni/dettaglioContenutiEsenzioni.jsp?lingua=italiano&id=4773&area=esenzioni&menu=vuoto>

¹⁴¹ <https://fakty.interia.pl/raporty/raport-opieka-okoloporodowa/opieka-okoloporodowa/news-minister-zdrowia-powolal-zespol-ds-opracowania-standardow-op,nld,2358685>

¹⁴² For example, the old Perinatal Care Standards indicated inter alia that a woman in labour can drink, can be active, can have a vertical position during her labour and can have skin-to-skin contact with her newborn for two hours.

¹⁴³ Law of self-determination of gender identity (38/2018).

¹⁴⁴ Member States do not always refer to this in this way (some use 'sexual identity disorder', etc.).

abroad) or be able to demonstrate that this has ended; iii) be over 18; and iv) make a written request and gain approval from the expert commission⁽¹⁴⁵⁾. In **Italy**, request for the surgery must be presented at the local tribunal and gender dysphoria must be diagnosed prior to hormone therapy (with documents from a psychologist, psychiatrist and endocrinologist needed to present the request to the court). The operation entails the annulment of one's marriage agreement, but only after the surgery has been performed. Similarly, in **Croatia**, individuals must gain approval from the National Health Council to undergo the surgery. They must also provide supporting medical evidence of gender dysphoria from a psychiatrist, a clinical psychologist, the competent centre for social welfare on personal and family opportunities, and a medical specialist in endocrinology and diabetes (this last form of evidence is not always necessary). As there is no law on sex reassignment surgery, the issue is dealt with from the perspective of the right to personal name, but Croatian law does not specify the minimum age to change one's personal name. However, in the case of hormone therapy specifically, this is offered to individuals aged 16 and over who have been diagnosed with gender dysphoria⁽¹⁴⁶⁾.

Table 5. Conditions for accessing sex reassignment surgery

Member State:	Minimum age	Residence requirements	Diagnosed gender dysphoria	Marital criteria	Sterility criteria	Approval from another body	Other
Croatia	X (age 16 for hormonal therapies)		X			X	
Czech Republic	X (age 18)		X	X		X	Written request; Proven ability to live as member of opposite sex
Italy	X (age 18) ¹⁴⁷		X	X		X	
Poland							
Portugal	X (age 16)						
Sweden	X (age 18)	X					

Notes: X signifies that this condition must be fulfilled. Red signifies that sex reassignment surgery is not permitted under any circumstances.

¹⁴⁵ Act No. 373/2011 Coll. on Specific Health Services.

¹⁴⁶ Under the Professional Guidelines for medical professionals and psychologists on drafting opinion on sex reassignment procedure or life with another gender identity, approved by the Ministry of Health in 2016 (*Stručne smjernice za izradu mišljenja zdravstvenih radnika i psihologa o promjeni spola ili života u drugom rodnom identitetu, Ministarstvo zdravstva 2016, Official Gazette, Narodne Novine 7/2016*) there is no age limit to legally accessing sex reassignment surgery; both parents are included in the child and adolescent's psychodiagnostic process; the psychotherapy is focused on minimisation of a child's or adolescent's stress related to gender dysphoria. Hormone therapy with adolescents with a diagnosed gender dysphoria begins with suppressed puberty; persons above 16 years of age are given hormone therapies. Surgical interventions for persons going through the transition from one gender to another are done partially – mastectomy is performed, it is possible to remove the uterus but final sex change surgeries are not performed in Croatia. The Professional Guidelines are available at: https://narodne-novine.nn.hr/clanci/sluzbeni/full/2016_01_7_93.html

¹⁴⁷ There have been some cases involving 16-year-olds.

Breast cancer and cervical screening

Four countries (**Czech Republic, Italy, Poland** and **Sweden**) make legal provision for breast cancer and cervical screening. Entitlement to such screening differs, depending on the age range of women who can access them and the regularity with which they attend. In **Italy**, in addition to the legislation (¹⁴⁸), guidelines for health professionals were developed by the *Osservatorio Nazionale Screening*, together with the Ministry of Health. These support the work of health professionals and local health boards and regions for the systematic implementation of cervical and breast cancer screening, as well as screening for colorectal cancer (¹⁴⁹). In **Croatia**, whilst there is no legal provision on these services, the government is currently pursuing a National Plan for early detection of cervical cancer (adopted 15 July 2010) and a National programme for early detection of breast cancer (started November 2011), both of which involve the provision of this screening. Breast cancer screening in **Portugal** is not systematic or legally required, but some places are covered by the Breast Cancer Screening Programme (¹⁵⁰).

The conditions of access to cervical screening vary.

- In the **Czech Republic**, women aged 15 and older are entitled to undergo cervical screening once a year.
- In **Poland**, the cervical cancer prevention programme targets women aged 25-59 who have not had a cytological examination (¹⁵¹) for the last 3 years. Women with additional risk factors – HIV-positive, those taking immunosuppressive drugs, HPV-infected (high-risk types) – can have the test every 12 months. Women younger than 25 years and older than 59 years can have a cytological examination on the advice of a medical specialist.
- In **Sweden**, screening is available to all women aged 23-64. Women aged 23-29 are offered cell tests with analysis for cytology every third year. Women 30-49 are offered cell tests with analysis for HPV every three years and a final cytology test at 41 years of age. Women aged 50-64 receive a cell test with analysis for HPV every seventh year. In theory this means a total of 12 tests (23, 26, 29, 32, 35, 38, 41, 44, 47, 50, 57 and 64). The invitation generally includes a time and a location for the screening, along with details of how to change the appointment. Individuals can access the screening in another region if they prefer.
- In **Croatia**, cervical screenings are targeted at all women (with or without medical insurance) between the age of 25 and 64. The traditional PAPA test is used for the screening, according to the relevant EU directives. Women who have not had a control PAPA test in the previous three years, according to the data of the Croatian Institute for Public Health, are invited for medical screenings.

¹⁴⁸ [Law of 26 May 2004, no. 138, 'Conversione in legge, con modificazioni, del decreto-legge 29 marzo 2004, no. 81, recante interventi urgenti per fronteggiare situazioni di pericolo per la salute pubblica'.](#)

¹⁴⁹ [Osservatorio Nazionale Screening, Gli screening oncologici, Vademecum.](#)

¹⁵⁰ The territory of Portugal (mainland) has 278 counties or municipalities (local public administration unit): 308 in total. The Breast Cancer Screening Programme (developed by the Portuguese League Against Cancer in collaboration with Primary Health Care) has complete coverage of the Central Region of the country (78 counties), some districts in the Alentejo, the North and the Algarve (in this geographical area with the Algarve Oncological Association). In the districts of Porto, Lisbon and Setúbal the coverage is partial (covering only some counties of each district), according to information on the website of the Portuguese League consulted on 14 September 2018. In 2014 the total population coverage rate was 73.1 % for mainland Portugal: see Miranda, N. & Portugal, C. (2015). Programa Nacional para as Doenças Oncológicas. Relatório 2014: Avaliação e Monitorização dos Rastreamentos Oncológicos Organizados de Base Populacional de Portugal Continental. Direção-geral da Saúde. Available at: <https://www.dgs.pt>.

¹⁵¹ Cytological examination as part of the cervical cancer prevention programme can be performed in any gynaecological and obstetric practice which has a contract with the National Health Fund and in the midwife's office within the Basic Health Care system authorised by the National Health Fund. A referral is not required for an appointment with a gynaecologist or a midwife.

In **Italy**, all women between the age of 25 and 26 receive invitations for cervical screening, to be repeated every three years.

The conditions of access to breast cancer screening are as follows:

- In the **Czech Republic**, women aged 45 and older are entitled to undergo a mammography screening once every two years.
- All women registered in **Sweden** (aged 40-74) receive an invitation to attend free voluntary breast cancer screening every 18-24 months. The exact time depends on the county council in question and the age of the women. In most counties, younger women in this range (40-74) are offered access every 18 months. The invitation generally includes a time and a location for the screening, along with details of how to change the appointment. Individuals can access the screening in another region if they prefer.
- In **Poland**, the breast cancer prevention programme includes mammography screening. The test is performed every 24 months for women aged 50-69 years and every 12 months for women aged 50-69, those whose family members have had breast cancer (mother, sisters or daughters) or who have diagnosed mutations within their BRCA 1 or BRCA genes.
- In **Croatia**, mammography screening is offered in line with European guidelines, and is available for women aged between 50 and 69, every two years.
- In **Portugal**, women participating in the Breast Cancer Screening Programme have access to a mammography screening every two years. For women living in areas not covering by the programme, the screening is usually done at the initiative of each person following the identification of concerning symptoms, a doctor's advice or another reason, including general information.
- In **Italy**, all women between the ages of 50 and 69 receive invitations for breast cancer screening, which need to be repeated every two years.

2.2.2. National policies: challenges and promising practices

It is unusual to have a specific action plan or strategy focusing on SRHR, with Portugal the sole exception. Sweden is pursuing a more comprehensive set of actions on SRHR issues, despite the lack of a specific strategy. The other four Member States are taking more limited action in relation to SRHR.

Portugal has a specific strategy on SRHR, having adopted the WHO Action Plan dedicated to this issue in 2016 ⁽¹⁵²⁾. This represents a comprehensive framework to support countries to ensure that people reach their potential for SRH and wellbeing, and includes a number of relevant goals and objectives ⁽¹⁵³⁾. Portugal also has three relevant Action Plans attached to its equality strategy ⁽¹⁵⁴⁾, focusing on: i) equality between women and men; ii) tackling violence against women and domestic violence (including harmful traditional practices such as FGM and early, forced and child marriage); and iii)

¹⁵² Action Plan for Sexual and Reproductive Health. Available in English at: <http://www.saudereprodutiva.dgs.pt/gestao-de-noticias/action-plan-sexual-reproductive-health.aspx>

¹⁵³ For example, Goal 2.1 is to address the needs or concerns of all people in relation to their sexuality, SRH and rights, Objective 2.6 is to establish and strengthen programs for the prevention, diagnosis and treatment of reproductive system cancers, Objective 3 is to ensure universal access to SRH and eliminate inequality, including Goal 3.1: Extend the scope of SRH services for adolescents and Goal 3.2: Establish and strengthen access to SRH services for population groups with specific needs.

¹⁵⁴ National Strategy for Equality and Non-Discrimination 2018-2030.

fighting discrimination based on sexual orientation, gender identity and expression, and sexual characteristics.

Promising practice for access: high accessibility of key services in Portugal

Portugal provides free access to publicly-run family planning consultations, contraceptive methods and voluntary termination of pregnancy services. During the first consultation with pregnant women considering voluntary termination of pregnancy, providers must give clear, verbal and written information on existing social supports.

Foreigners who are legally resident in Portugal can also access health services and, under certain conditions, foreigners without authorisation to stay can also access services.

Although it lacks specific SRHR strategies, **Sweden** pursues a significant range of relevant policies within wider health/equality strategies. Its public health policy (adopted in 2018) ⁽¹⁵⁵⁾ includes a range of relevant points, including a focus on promoting gender equality among youth, increasing uptake of contraception via improved subsidies, and undertaking the first population study specifically targeting SRHR. The document also refers to a need to improve equal rights and opportunities for the LGBTI community, in connection and collaboration with the country's equality strategy ⁽¹⁵⁶⁾. The country's 2018 budget also included relevant actions on HIV infection and other STIs, SRH (especially in women with migrant backgrounds), strengthened childbirth care (especially in socioeconomically disadvantaged areas), greater use of web-based technology for youth SRHR, and an overall move towards better conditions for increased SRHR. Finally, as part of a 10-year plan laying out the government's feminist strategy, Sweden promotes equal access to health for women and men and aims to end the threat of men's violence against women ⁽¹⁵⁷⁾.

Promising practice for reaching young people: Virtual youth clinic in Sweden

Sweden has developed an online youth clinic to provide SRHR information to young people. The website provides text, films, animations, test and illustrations based on a rights-based and norm critical inclusive approach. It also has a searchable catalogue of all youth clinics with contact details. It provides a safe space to access advice from peers and professionals.

The online clinic was developed in consultation with a panel of young people (aged 13-25) and is coordinated by the National Board of Social Welfare in collaboration with experts, clinics, student health, local authorities, and NGOs working in the field of SRHR.

In 2016, the Swedish government tasked the Agency for Youth and Civil Affairs to work with the youth clinic to produce and disseminate a version of the virtual clinic in multiple languages aimed primarily at newly arrived and asylum-seeking youth aged 13-20. SEK 5 million (EUR 474,405) was provided for the project. The result, Youmo, provides information and services in Swedish, English, Tigrinya, Somalian, Dari and Arabic.

The **Czech Republic** and **Italy** take a more ad hoc approach to SRHR in health policies. For example, the Czech Republic's long-term programme, Health for Everybody in the 21st century, includes a relevant goal about preventing infectious diseases. In addition, the country's gender equality strategy

¹⁵⁵ 'Good and equal health - a developed public health policy'.

¹⁵⁶ National Strategy for Equal Rights and Opportunities.

¹⁵⁷ 10-year action plan centred on power, goals and agencies.

(¹⁵⁸) includes a goal to decrease levels of gender-based violence, including increasing awareness of reproductive rights, creating mechanisms for compensation and offering free legal assistance to victims of rights violations (¹⁵⁹). In Italy, there have been generic strategies on women's health, such as awareness-raising (including the establishment of 22 April as the 'National day for women's health') and some positive moves with regards to HIV prevention/care and the promotion of gender-sensitive public health (¹⁶⁰). However, neither country has a comprehensive approach to SRHR.

Promising practice for widening contraceptive access: Regional initiatives to improve access to contraception in Italy

The Region of Piedmont (Italy) passed a law through which contraceptives (both condoms and hormonal methods) could be given for free to young people (under 24), unemployed women up to the age of 45 years, and women from difficult socioeconomic backgrounds.

This approach was also previously adopted for condoms in family planning centres in the Region of [Puglia](#) in 2008, the Region of [Emilia Romagna](#), in 2017, and in the Region of Lombardia from 1 August 2018. However, this practice remains dependent on the will of political parties at local level.

Neither Croatia nor Poland has an SRHR-specific policy, and both appear to be implementing a more limited or generic set of actions than the other four Member States examined. The most relevant programme in **Poland** promotes 'procreation health protection' (¹⁶¹), offering infertility diagnosis and treatment to those who need it, focusing especially on people in marital relationships/partnerships. It also establishes a network of at least 16 reference infertility treatment centres, offers training in this area to medical personnel, aims to improve infertility diagnostics, provides psychological care and improves patient referrals. However, it has been criticised on the grounds that it does not sufficiently *treat* infertility (focusing more on diagnosis). **Croatia** only covers the issue of SRHR in a general way, via its wider health strategies (¹⁶²).

The research identified a range of challenges in the pursuit of SRHR policies:

- **most countries do not have an SRHR-specific strategy or action plan;**
- in some cases (Czech Republic, Croatia, Poland, Italy), SRHR was **not considered to be a political priority**. For example:
 - in Croatia, in the proposal of the National Policy for the Promotion of Gender Equality, the area of Women and Health was excluded from the priorities for the period 2011-2015, despite the fact that set targets for the previous period (reducing the incidence of STIs, raising the level of protection and health at work, especially women's mental health, improving measures to preserve reproductive health of women etc.) were not attained;
 - in Poland, critics point to an active public policy bias towards promoting more traditional models of the family;

¹⁵⁸ Government Strategy for Equality of Women and Men in the Czech Republic 2014-2020.

¹⁵⁹ An indicator identified in relation to this specific goal: 'Women and men are systematically informed of their reproductive rights. A compensatory mechanism is set and free of charge legal assistance for victims of violation of their rights is provided'.

¹⁶⁰ The focus on gender-sensitive health has been not only at national level but also within some regions, for example in Emilia Romagna, which has its own Framework Law for equality between sexes and against gender-based discrimination. This legislation has a chapter (Titolo IV) entirely dedicated to the health and wellbeing of women. This is not specific to SRHR but concerns the integration of a gender-based approach to medicine and healthcare.

¹⁶¹ The 'Programme for comprehensive procreation health protection in Poland', implemented from September 1, 2016 to December 31, 2020.

¹⁶² Specifically, National Strategy for Health Care Development 2012-2020, OG 116/12; Health Care Plan of Republic of Croatia, OG 86/12.

- in some cases, comprehensive **sexuality and reproductive education is not part of the school curriculum** (cited as an issue in Poland, Italy and Portugal). For instance, in Italy, there is no structure for sexual and reproductive education within the school system. It is conducted in different forms and determined at local level, without any national overview. Portugal has insufficient nationally implemented SRH programmes for young people.

These challenges are explored in greater detail in Section **3** of the report.

3. ACCESS IN PRACTICE TO SEXUAL AND REPRODUCTIVE HEALTH GOODS AND SERVICES ACROSS THE EUROPEAN UNION

KEY FINDINGS

- **Practical access to SRH goods and services varies significantly across the EU.** For example, the level of population access to modern forms of contraception from 90 % in Belgium and France to just 38 % in Greece. Likewise, there is marked variance between Member States' (legal) abortion rates, with Estonia having the highest rate at 18.6 %, compared with Poland's far lower rate of just 0.1 %.
- A wide range of barriers can operate to restrict individual access to SRH goods and services. These include: 1) **Legal obstacles**, such as the restrictive conditions limiting access to abortion and sex reassignment surgery in Poland; 2) **Financial obstacles**, for example where national insurance systems do not subsidise or cap the cost of key goods and services. In the Czech Republic and Poland, contraceptives are not covered by public health insurance, which may mean women face financial difficulty in accessing these goods; 3) **Cultural obstacles**, for example deep social stigma with regard to accessing abortion services and contraceptives. This was particularly noted by researchers in Italy, Portugal and Poland; 4) **Information obstacles**, such as a lack of available and comprehensive SRHR information in Croatia, Czech Republic, Italy and Poland. This was not noted as an issue in Sweden, where SRH education is mandatory in schools at both primary and secondary level.
- The **quality of key SRH services is not always effectively assured.** Too often, training on relevant issues is implemented on a case-by-case basis, rather than at a national scale.
- Despite the legal protections for different groups at international and EU level, **particular groups may be disadvantaged in their access to quality, appropriate SRH goods and services.** For instance, in Croatia, the research identified a lack of sufficient equipment to provide services to women with disabilities. In Portugal, girls under 16 may face specific problems to accessing abortion services, due to the need for parental authorisation. Other groups seen to be disadvantaged in the provision of SRH goods and services include LGBTI people, sex workers, unmarried and single women, older women, ethnic minorities and women living in rural areas.
- There are **insufficient data available** to monitor and evaluate the provision and accessibility of key SRH services at the EU level, such as safeguarding and treatment services for FGM, family planning and contraception counselling, etc.

While the previous section looked at the legal framework regulating access to SRH goods and services, this section presents a comparative overview of access in practice to SRH goods and services in the EU. For the purpose of this research, accessibility in practice is assessed in light of four indicators:

- 1) **Availability:** whether or not there is sufficient geographical coverage in both urban and non-urban areas;
- 2) **Affordability:** the extent to which SRH goods and services are covered by insurance/social security coverage;

- 3) **Equal access and treatment:** equal treatment of all individuals and absence of stigmatisation in accessing certain SRH services;
- 4) **Quality:** quality standards, sufficient skilled/trained staff performing SRH services and sufficient equipment.

The focus remains on the six Member States for which qualitative national research was undertaken: **Croatia, the Czech Republic, Italy, Poland, Portugal and Sweden**. Where available, EU-wide data on access to goods and services are also presented.

Data on the quality of services was particularly scarce across the six Member States, due to the lack of monitoring and evaluation mechanisms to assess them at national level. Moreover, information related to some services is here not comprehensive, due to the complexity and broad nature of the issue, which would go beyond the scope of this study. This is the case, for example, of the provision of services for survivors of intimate partner violence and non-partner sexual violence, as well as obstetric, pre-natal and post-partum broadly. In these cases, information was not provided according to the four indicators highlighted above, but the issues were highlighted because of their strong relevance in the context of SRHR.

3.1. Access in practice to sexual and reproductive health goods

In this section, access to SRH goods focuses on contraceptives and medicines for SRH related diseases, such as STIs.

3.1.1. Contraceptives

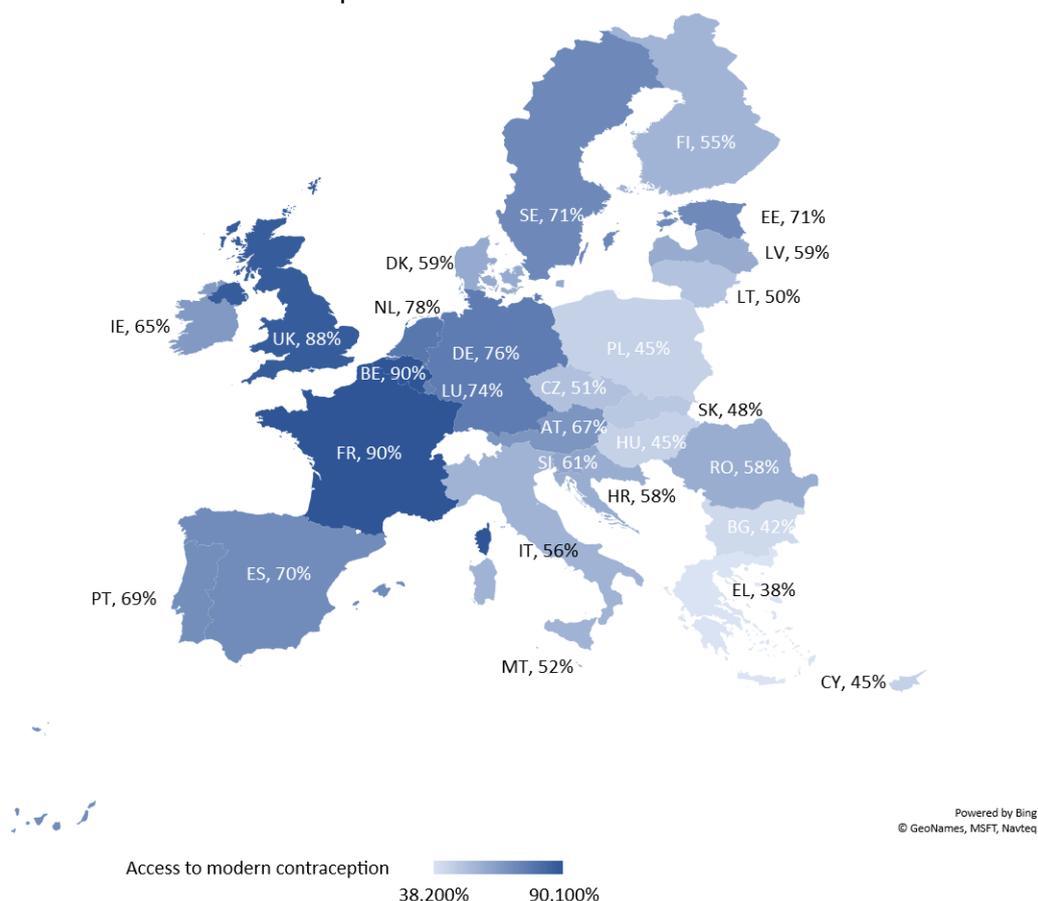
Availability

EU-wide data on access to modern contraception are available, which is particularly important given the various international policies committed to achieving universal access to safe, reliable family planning methods, including the 1994 UN Programme of Action of the International Conference on Population and Development (ICPD) and the SDGs (specifically Target 3.7).

As Figure 1 indicates, the level of access to contraception varies between Member States (¹⁶³). The 2018 benchmarking figures here are based on the findings of an initiative between the European Parliamentary Forum on Population & Development (EPF), Third-I and a group of SRHR experts. The countries with the lowest rates of access, and thereby the populations with the greatest unmet need in contraception terms, are Greece (38 %) and Bulgaria (42 %). By contrast, the populations with the most effective provision of access to contraception are Belgium (90 %) and France (90 %).

¹⁶³ European Parliamentary Forum on Population & Development (EPF) initiative, 2018, [European Contraception Atlas](#).

Figure 1. Access to modern contraception



Practical access to contraceptives is central to SRHR. Across the six Member States examined for this study, access to contraceptives varies depending on the type of contraceptive method. In **Italy** and **Sweden**, access to SRH goods varies across regions as well, due to the decentralised healthcare system, even if access may be guaranteed via national policies and guidelines.

Contraceptives such as condoms are widely available in supermarkets and pharmacies in all six Member States. The ranking of the European Parliamentary Forum and Development on the availability of contraceptives and family planning counselling shows **Poland** as having one of the lowest rates in Europe⁽¹⁶⁴⁾.

In **Sweden**, contraceptives requiring medical prescription are available in most pharmacies across the country. Universities and schools also provide access free of charge to contraceptives that do not require a prescription, as do most youth clinics⁽¹⁶⁵⁾. In general, contraceptives are free of charge for young people under 21 years old. It is also possible to obtain and renew prescriptions via online services, and pharmacy stocks themselves can be checked online as well⁽¹⁶⁶⁾. Certain contraceptives

¹⁶⁴ European Parliamentary Forum on Population & Development (EPF) initiative, 2018, [European Contraception Atlas](#).

¹⁶⁵ Projekt6, About P6, 2018, available at: <http://projekt6.se/en/om/>; UMO, Condoms (Kondomer), 2018, available at: <https://www.umo.se/sex/skydd-mot-konssjukdomar/kondom/>

¹⁶⁶ 117 Care Guide (117 Vårdguiden), 2018, Find a clinic (Sök mottagning), available at: <https://www.1177.se/Hitta-vard/?q>; Kry (2018), Can I get a prescription via KRY? (Kan jag få recept via KRY?), available at: <https://support.kry.se/hc/sv/articles/115002430125-Kan-jag-få-recept-via-KRY->

which do not require a prescription but require assistance for usage, such as the copper coil, can be obtained from gynaecological and midwifery clinics (¹⁶⁷).

In **Croatia**, the stakeholders interviewed noted that the use, availability and accessibility of modern contraception and reproductive services remain at a low level. Until 2010, emergency contraceptives were not available at all, but have been issued without prescription since 2016.

In **Italy**, since 2017, emergency contraceptives are no longer among the list of medicines that a pharmacy must have available at all times. Stakeholders noted that this is particularly problematic for women living in rural areas and small towns, where there is not an option to visit multiple pharmacies to access emergency contraception.

Hormonal contraceptives such as the pill, patches and vaginal rings are available with a medical prescription across pharmacies in **Croatia, Czech Republic, Italy, Portugal and Sweden**.

Affordability

In terms of affordability, the six Member States show important differences in the **degree to which contraceptives are covered by public health insurance**.

The **Czech Republic** represents the most restrictive regime, as no forms of contraception are covered by public health insurance. In Croatia, Italy, Poland and Sweden, however public health insurance typically covers a restricted range of contraceptives (e.g. at least emergency contraceptives), with a financial contribution required from the user.

- In **Croatia**, contraceptives are considered a 'supplementary' form of medicine in public health insurance, meaning users must pay an additional fee. The Croatian Institute for Health Insurance (Hrvatski Zavod za zdravstveno osiguranje, HZZO) does not cover the costs for intrauterine devices or for the majority of hormonal contraceptives. Some are partially covered, while others are covered only if prescribed with another indication, such as hyperandrogenism. The price of the contraceptive pill was HRK 100 (EUR 15) (¹⁶⁸). The average price for contraceptives more broadly is HRK 200 (around EUR 30) (¹⁶⁹). Young women, and those most vulnerable (e.g. with low income and unemployed, in schooling or in abusive relationships) may struggle to afford these prices. Some women are forced to choose lesser quality pills at a more affordable price or to practice unsafe family planning methods (¹⁷⁰).
- In **Italy**, emergency contraceptives are covered by the national health services, but non-emergency contraceptives are no longer provided for free (since 2017). Some regions (i.e. Puglia, Emilia Romagna, and Piedmont) provide access to contraceptives for free via family planning and counselling centres to specific groups, such as young people (under 24), unemployed women up to the age of 45 years and women from difficult socioeconomic backgrounds. However, this is not a widespread practice and depends greatly on political will at regional and local level.

¹⁶⁷ 117 Care Guide (*117 Vårdguiden*), 2018, Find a clinic (*Sök mottagning*), available at: <https://www.1177.se/Hitta-vard/?q>

¹⁶⁸ Cesar, S., For the freedom of choice, (*Za slobodu izbora*), Libela, 2011, available at: <https://www.libela.org/sa-stavom/2082-za-slobodu-izbora/>: interviews with stakeholders.

¹⁶⁹ Knežević, S. & Grgić, H., How much abortion is in fact 'legal' in Croatia?, (*Koliko je abortus zapravo 'legalan' u Hrvatskoj?*), Libela, 2012, available at: <https://www.libela.org/sa-stavom/3006-koliko-je-abortus-zapravo-legalan-u-hrvatskoj/>

¹⁷⁰ Cesar, S., For the freedom of choice, (*Za slobodu izbora*), Libela, 2011, available at: <https://www.libela.org/sa-stavom/2082-za-slobodu-izbora/>

- **Polish** law requires that all citizens must be provided with free access to contraception, including intrauterine devices and emergency methods ⁽¹⁷¹⁾. However, hormonal contraceptives are not refunded, which can serve as a barrier to access. For some women, the price of contraceptives, especially modern hormonal agents, is prohibitive.
- In **Sweden**, the Healthcare Act regulates hormonal contraceptives and treats these as a prescribed medicine, meaning individuals must pay, up to a set cap (SEK 2250 (or EUR 210.63) per annum). Emergency contraceptives are provided free of charge. Those under 21 have free access to prescription medicine ⁽¹⁷²⁾. Non-hormonal, non-emergency contraceptives are freely available to buy and are not covered by this act.
- In **Portugal**, contraceptive methods, emergency contraception and voluntary termination of pregnancy are all covered by the National Health Service. This system takes into account the economic and social conditions of citizens, meaning it offers many treatments free of charge. The 'Free distribution of preventative and informative materials' programme was established to provide condoms and material in health services, schools, municipalities, NGOs and youth organisations.

Quality

The quality of the medicines sold in pharmacies across the six Member States, including contraceptives, is guaranteed by national systems, such as the National Pharmaceutical Agency (Agenzia Italiana del Farmaco, AIFA) in **Italy**. The Medicine Board (Läkemedelsverket) in **Sweden** approves medicines, as well as the use of generics, a large number of which have been approved for contraceptives ⁽¹⁷³⁾. In **Croatia**, the Croatian Society of Gynaecologists and Obstetricians published guidelines in relation to intrauterine contraception (S2E guidelines) and emergency oral contraception. Contraceptives are approved by the Croatian Agency for medication and medical products, HALMED (Hrvatska agencija za lijekove i medicinske proizvode).

In **Poland**, each medicine undergoes a verification procedure that checks whether it meets scientifically specified requirements of quality, effectiveness or safety of use. The procedure is carried out by the President of the Office for Registration of Medicinal Products, Medical Devices and Biocidal Products, who individually assesses a medical product (including contraceptives and medicines for SRH-related illnesses) on the basis of a summary of product characteristics and other documentation provided by the producer, and decides whether or not to grant a marketing authorisation. All medicines admitted to trading in Poland are entered into a special register available on the website of the Office for Registration of Medicinal Products, Medical Devices and Biocidal Products.

It is important to bear in mind that the quality of medicines also depends on adequate and quality health counselling, taking into account the medical conditions of the individuals. Indeed, some contraceptive methods may increase health risks for certain populations (i.e. higher risk of cardiac arrest for individuals taking the hormonal pill who present some risk factors such as smoking, hypertension, diabetes mellitus, hypercholesterolaemia, and obesity). See Section 3.2.1 for more on quality of contraception counselling.

¹⁷¹ Article 2(2) of the Polish Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy.

¹⁷² In some counties in Sweden, this applies to individuals younger than 25.

¹⁷³ FASS, Startside, 2018, available at: <https://www.fass.se/LIF/startpage>

Equal treatment

Overall, national legislation does not sufficiently ensure or address equal access to contraceptives. Barriers to the availability and affordability of contraceptives are known to affect particularly vulnerable groups. Some local practices engage specific groups, such as women victims of sexual violence, or young people.

- In **Croatia**, the use, availability and accessibility of modern contraception and reproductive services remains low level, with SRH goods and services mostly excluded from coverage by the Croatian Institute for Health Insurance. This particularly affects vulnerable groups. Age, education, living area, marital status and working status were associated with some aspects of contraceptive use⁽¹⁷⁴⁾: women living in urban areas used more coitus interruptus, while those living in rural areas used more pills. The most frequently stated reasons for the use of certain methods were as follows: the method is simpler to use (32.9 %), it is safe (24.6 %), and it is efficient and safe (22.8 %). As noted above, hormonal contraceptives are not affordable for vulnerable groups.
- In the **Czech Republic**, contraceptives that require a prescription are linked to health insurance. Women with migrant backgrounds might face difficulties in accessing these contraceptives if they do not have public insurance. According to a representative of the medical community, the basic insurance covers only acute medical care.
- The legislation in **Italy** provides access to contraceptives for everyone under the national health system. In practice, this is not the reality, as 'economic and social barriers are not taken into account by the framework on immigration and foreigners, and policies to prevent discrimination'⁽¹⁷⁵⁾.
- In **Poland**, as highlighted above, one of the main barriers relates to the high cost of contraceptives. This has a direct impact on unequal access.
- In **Portugal**, the national list of contraceptives to be delivered free of charge to the health services of the National Health Service has been expanded to ensure diversity of methods, allow a choice adapted to the largest number of users, and ensure women's freedom of choice.
- In **Sweden**, there are few known disparities in equal access. The majority of individuals over 21 can reportedly afford contraception. Those who rely on financial support from social services have the costs of their prescription drugs covered under the 'reasonable standard of living'⁽¹⁷⁶⁾.

3.1.2. Medicine for SRH-related illnesses and care

Availability

In terms of medicines for SRH-related illnesses and care, available data and information is limited mostly to STIs, in particular HIV/AIDS treatments.

In 2012 the European Centre for Disease Prevention and Control produced a report on STIs in Europe between 1990-2010⁽¹⁷⁷⁾. The report looked at data on various specific STIs, such as chlamydia, gonorrhoea, syphilis, lymphogranuloma venereum and congenital syphilis. In addition to reporting the

¹⁷⁴ Benčić, M. & Vrcić-Keglević, M., Use of contraception in women from the ZAPREŠIĆ area and factors influencing the choice of method: a cross-sectional study. *Acta medica Croatica*, 68 (4-5), 2015, pp.337-342.

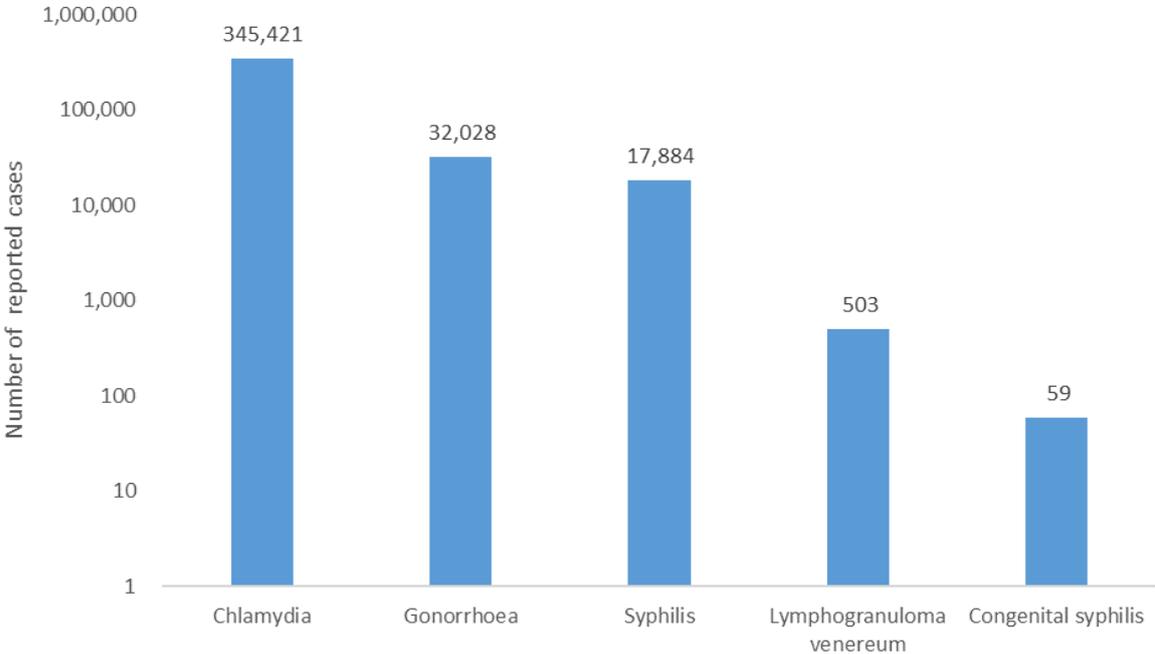
¹⁷⁵ IPPF European Network, *Barometer of Women's Access to Modern Contraceptive Choice in 16 EU Countries*, 2015.

¹⁷⁶ Law 2001:453 Social Services Law (*Socialtjänstlag*), 7 June 2001, Updated 2018:872.

¹⁷⁷ <https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/201206-Sexually-Transmitted-Infections-Europe-2010.pdf>

number of cases each year, it also explores breakdowns by gender, age, sexual orientation (particularly for homosexual men), by 100,000 of the population, and also the stage of infection for cases. Figure 8 below (¹⁷⁸) shows the numbers of STI cases reported by EU/ EEA Member States (¹⁷⁹) during the period in question.

Figure 2: Numbers of STI cases reported by EU/ EES in 2010, (ECDC, 2012)



Chlamydia appears as the most common STI across EU and EEA Member States, with 345,421 reported cases in 2010. The second most common STI is gonorrhoea (32,028), followed by syphilis (17,884), lymphogranuloma venereum (503) and congenital syphilis (53). Not all data was available across Member States, such as when observing trends in reported congenital syphilis, which have remained fairly stable throughout the decade from 1990 to 2010. The report highlights concerns that there is considerable under-reporting, with nine Member States not reporting on congenital syphilis and a further seven reporting no cases in 2010.

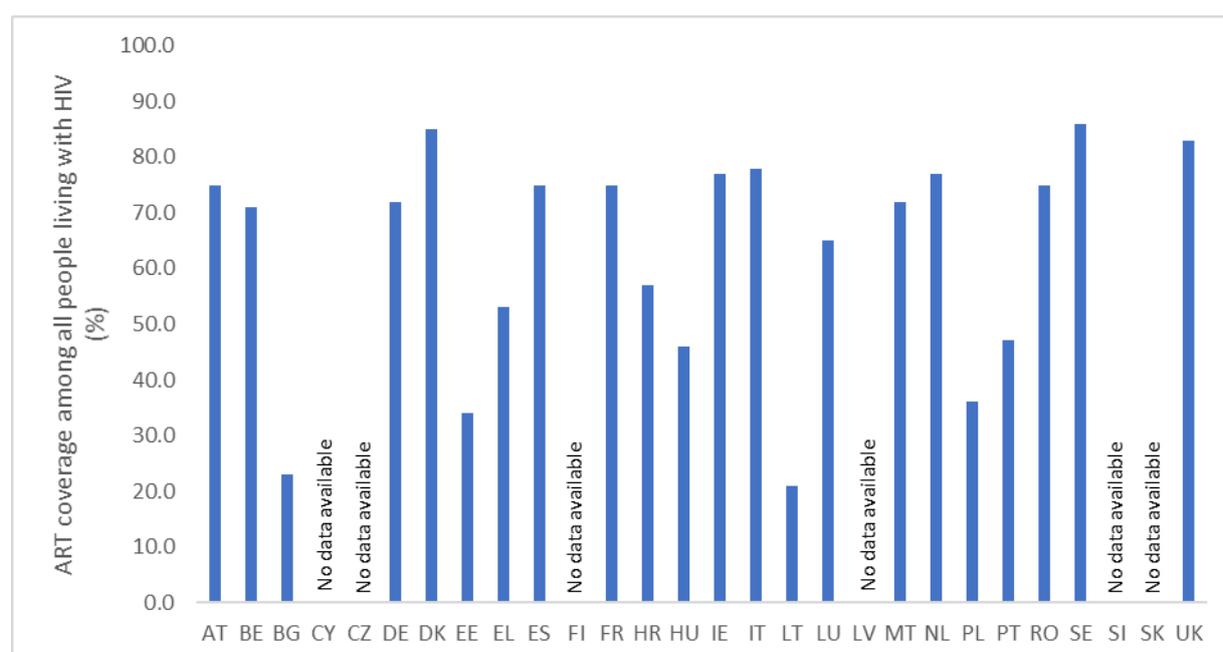
Significantly, in the past decade rates of AIDS in the EU/EEA have decreased substantially (¹⁸⁰). This reflects improved access to treatment, as well better case management. The numbers of people on antiretroviral therapy (ART treatment) increased by almost 20% in 18 EU/EEA countries (¹⁸¹) between 2014 and 2016, from 344,000 to 406,000 (¹⁸²). In relation to treatment scaling up, data are available for 15 EU/EEA countries (¹⁸³) and indicate that the numbers of people on treatment more than doubled

¹⁷⁸ Axis of the figure is in logarithmic scale to ease comparability of shape differences in reported cases
¹⁷⁹ Not all EU/EEA Member States reported all STIs, for more information see European Centre for Disease Prevention and Control. Sexually transmitted infections in Europe 1990–2010. Stockholm: ECDC; 2012.
¹⁸⁰ https://ecdc.europa.eu/sites/portal/files/documents/AER_for_2016-HIV-AIDS.pdf
¹⁸¹ Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Germany, Estonia, Finland, Hungary, Lithuania, Poland, Romania, Spain, Sweden, United Kingdom.
¹⁸² <https://ecdc.europa.eu/sites/portal/files/documents/HIV%20treatment%20and%20care.pdf>
¹⁸³ Belgium, Bulgaria, Czech Republic, Germany, Estonia, Spain, Croatia, Cyprus, Lithuania, Hungary, Poland, Romania, Finland, Sweden, United Kingdom.

between 2009 and 2015 ⁽¹⁸⁴⁾. Data reported to ECDC for 2015 by 28 EU/EEA countries shows that there are 590,000 people in these countries who are receiving treatment for HIV ⁽¹⁸⁵⁾.

Issues with access to, and uptake of, HIV testing and counselling can be seen in the data on stage of infection and diagnosis. Although early introduction of ART has been proven to be beneficial, many people are diagnosed with HIV at an advanced stage, and about 15 % of the estimated 810,000 people with HIV in the EU/EEA are undiagnosed ⁽¹⁸⁶⁾. In a 2016 report, the ECDC calculated that 71 % of people living with HIV in 21 EU/EEA countries ⁽¹⁸⁷⁾ (813,000 people in total) are on ART. This includes people living with undiagnosed HIV. The report suggests that there is still a need to improve access to treatment ⁽¹⁸⁸⁾. The treatment rate varies considerably between Member States, from as low as 21 % in Lithuania to 86 % in Sweden, as shown in Figure 3 below.

Figure 3: Antiretroviral therapy coverage among all people living with HIV (ECDC, 2017) ⁽¹⁸⁹⁾



In **Sweden**, medicines for SRH-related illnesses and care are available via prescription from a licensed clinic or healthcare centre and then collected at a pharmacy, which are widespread throughout the country. Sweden was the first European country to achieve the United Nations 90-90-90 goal. In 2016 it was estimated that 10 % of all HIV-infected subjects in Sweden remain undiagnosed. Among all diagnosed patients, 99.8 % were linked to care and 97.1 % of those remained in care ¹⁹⁰.

In **Italy**, the website of the Ministry of Health provides information on legislation, as well as on the clinics and hospitals providing the services for SRH related illnesses and care. Moreover, a free public

¹⁸⁴ <https://ecdc.europa.eu/sites/portal/files/documents/HIV%20treatment%20and%20care.pdf>

¹⁸⁵ <https://ecdc.europa.eu/sites/portal/files/documents/HIV%20treatment%20and%20care.pdf>

¹⁸⁶ https://ecdc.europa.eu/sites/portal/files/documents/AER_for_2016-HIV-AIDS.pdf

¹⁸⁷ Belgium, Bulgaria, Germany, Denmark, Estonia, Greece, Spain, France, Croatia, Italy, Luxembourg, Hungary, Austria, Netherlands, Poland, Portugal, Romania, Spain, Sweden, United Kingdom.

¹⁸⁸ <https://ecdc.europa.eu/sites/portal/files/documents/HIV%20treatment%20and%20care.pdf>

¹⁸⁹ The date for the data ranges between Member States, from 2012 through to 2016.

¹⁹⁰ Gisslén, M., Svedhem, V., Lindborg, L., Flamholc, L., Norrgren, H., Wendahl, S., Axelsson, M. and Sönnnerborg, A. (2017), Sweden, the first country to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Health Organization (WHO) 90-90-90 continuum of HIV care targets. *HIV Med*, 18, pp. 305-307

phone number can be reached to ask additional information about the tests ⁽¹⁹¹⁾. In 2017, new guidelines targeted to health professionals, specifically providing indications for retroviral therapy and to support the diagnosis and care of people with HIV were developed by the Italian Society of Tropical and Infectious Diseases, together with the Ministry of Health ⁽¹⁹²⁾.

Poland has adopted a health policy programme, 'Antiretroviral treatment of people living with HIV in Poland'. The programme aims to reduce mortality due to AIDS among people infected with HIV, reduce the HIV/AIDS risk of infection, increase access to antiretroviral drugs for HIV-infected patients, provide antiretroviral drugs necessary for the prevention of vertical infections (a child by the mother), individual immunisation for infants born to HIV-infected mothers, and provide antiretroviral drugs to those who may have become infected as a consequence of risky situations (e.g. sexual violence). The programme primarily targets people infected with HIV and AIDS, particularly pregnant women infected with HIV, newborns of HIV-infected mothers, people who require antiretroviral drugs after exposure to HIV infection as a result of sexual violence, needlestick injuries of unknown origin, fight or assault.

Important work to improve access to SRH-related medicines is also taking place outside of the EU. For example, the European and Developing Countries Clinical Trials Partnership (EDCTP) is a public-private partnership working in sub-Saharan Africa, which funds and supports clinical trials and capacity-building for poverty-related or neglected diseases. The EDCTP's current programme EDCTP2 has invested EUR 100 million specifically for HIV and tuberculosis ⁽¹⁹³⁾.

Affordability

Global guidelines for HIV treatment recommend that all individuals with HIV should be offered antiretroviral treatment. This has significant cost implications, with a (2016) estimated cost of first-line antiretroviral treatment per patient per year ranging from EUR 1000 to 20,000 across the WHO European Region ⁽¹⁹⁴⁾. The cost of second- and third-line antiretroviral therapy¹⁹⁵ resulting from HIV-resistant strains is several times higher. Overall, these costs mean that many countries find it difficult to afford to treat all diagnosed individuals, particularly in eastern Europe.

There have been issues surrounding the affordability of certain recently authorised medicinal products, such as treatment of Hepatitis C ⁽¹⁹⁶⁾. Recent direct-acting antiviral drugs for Hepatitis C are highly effective but also more expensive than previous therapies. The high cost of such medicines per patient has a negative impact on national health budgets, and thereby impacts patients' access to these treatments ⁽¹⁹⁷⁾. This has led to calls from the European Commission to improve cooperation between Member States and strive to ensure all European patients have access to these products. The Commission is also working to bring together a range of stakeholders, including Member States, healthcare professionals, regulators, health technology assessment bodies, industry, and the patients themselves to encourage dialogue and shared expectations in improving access.

The affordability of medicines for SRH-related illness in the six Member States varies. **Sweden** guarantees access free of charge to curative, management and preventative medication for

¹⁹¹ Ministero della Salute, Gratuita del test HIV,

<http://www.salute.gov.it/portale/esenzioni/dettaglioContenutiEsenzioni.jsp?lingua=italiano&id=1018&area=esenzioni&menu=vuoto>

¹⁹² Linee Guida Italiane sull'utilizzo della Terapia Antiretrovirale e la gestione diagnostico-clinica delle persone con infezione da HIV-1, http://www.salute.gov.it/imgs/C_17_pubblicazioni_2696_allegato.pdf

¹⁹³ https://ec.europa.eu/health/sites/health/files/communicable_diseases/docs/swd_2018_387_en.pdf.

¹⁹⁴ https://ec.europa.eu/health/sites/health/files/communicable_diseases/docs/swd_2018_387_en.pdf.

¹⁹⁵ Details on second-line ART can be found at: <http://www.who.int/hiv/pub/guidelines/arv2013/art/secondlineadults/en/>; Details on third-line ART can be found at: <http://www.who.int/hiv/pub/guidelines/arv2013/art/thirdlineart/en/index1.html>

¹⁹⁶ https://ec.europa.eu/health/sites/health/files/communicable_diseases/docs/swd_2018_387_en.pdf.

¹⁹⁷ https://ec.europa.eu/health/sites/health/files/communicable_diseases/docs/swd_2018_387_en.pdf.

gonorrhoea, Hepatitis B, HIV, chlamydia and syphilis. The prescription costs for these medicines are covered by the state for those under 18. For those aged over 18, these medicines are included in the high cost coverage, capped at SEK 2,250 SEK (around EUR 220) per year. For infectious diseases considered a danger to the public, medicine is provided free of charge. Similarly, in the **Czech Republic**, HIV-positive people are eligible for full healthcare on public insurance, without any restrictions ⁽¹⁹⁸⁾, while in Italy, access to medicine is guaranteed under the national public healthcare structure and insurance system. In **Poland** medicines for venereal diseases and HIV/AIDS are provided for free (financed from the state budget) due to the regulation that medical treatment in these cases is obligatory, even if a patient has no health insurance. However, despite the adoption of the Antiretroviral treatment programme mentioned above, individuals must pay for the ART drugs treatment related to the pre-exposure prevention themselves. ⁽¹⁹⁹⁾

Those unable to afford the medicines can receive support from the welfare system. In **Croatia**, the **Czech Republic** and **Italy**, these medicines are covered under the national health systems. In the **Czech Republic**, tests for HIV can be done free of charge in all regions. There is also an anonymous and free telephone line that provides counselling services. A website promoting HIV prevention provides a list of clinics and centres in each region where individuals may undergo HIV testing.

Quality

Research for this study showed a lack of information on the quality of medicines for SRH-related illnesses and care. In general, all the countries have established authorities and regulations to approve the medications that can be sold on the national market. Details on these structures can be found above in Section 3.1.1, in relation to the quality of contraceptives.

Equal treatment

SRH infections, in particular STIs such as HIV/AIDS and viral Hepatitis B, particularly affect some vulnerable groups (e.g. sex workers, gay men.). Those infections themselves further contribute to marginalisation of those affected, as a result of stigma and discrimination. This marginalisation may lead to diminished access to healthcare services as well as medicines, which may result in further transmission of STIs.

Affordability of treatment will impact access to medicines and treatments for vulnerable groups. Targeted health programmes may also improve equal access. This study did not find sufficient data to draw conclusions on equal treatment in access to SRH-related medicines and care across the six Member States analysed. However, the ECDC analysed data for the regions of Europe and Central Asia and highlighted that over half of the countries do not provide treatment for HIV to undocumented migrants. Individuals in certain vulnerable groups therefore encounter more barriers to access and longer-term treatment, in this case due to a lack of residence status or health insurance.

3.2. Access to sexual and reproductive health services in practice

This section presents an overview of the access to SRH services in practice. The analysis in this section relies on the national research on the six Member States, together with available EU-wide data. Eurostat, EU Statistics on Income and Living Conditions (SILC) and a number of reports produced by recognised international and national authorities in this field (such as the WHO) were analysed in order

¹⁹⁸ The Act on Protection of Public Health No. 258/2000 Coll. and a regulation based on § 80 issued by the Ministry of Health.

¹⁹⁹ Act of 27 August 2004.

to gain an overview of the availability of data in the EU, develop understanding with regard to access, and ascertain the current state of play. This section is divided into eight focus areas, to allow for greater detail in each case.

3.2.1. Family planning and contraception counselling

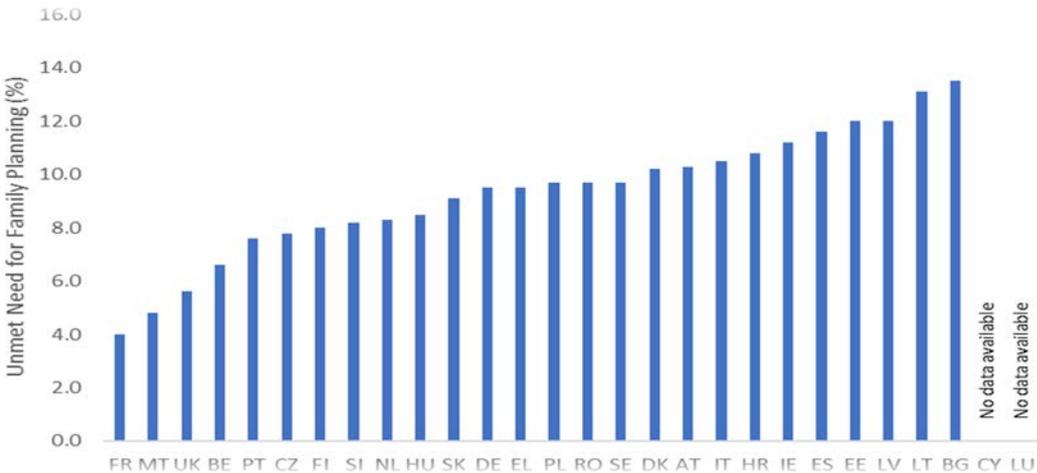
Availability

The unmet need for **family planning** was an indicator of the Millennium Development Goal to ‘achieve universal access to reproductive health by 2015’. It is now part of SDG goal 3, to be achieved by 2030, which includes as a target ‘to ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes’.

In a 2017 WHO report, the unmet need for family planning was assessed across the world’s regions and in individual countries ⁽²⁰⁰⁾. Figure 4 indicates the prevalence of the ‘unmet need for family planning’ for almost all European Member States (excluding Cyprus and Luxembourg). The unmet need for family planning is defined as: ‘the percentage of married or in-union women of reproductive age who want to stop or postpone childbearing but who report that they are not using any method of contraception to prevent pregnancy’ (p.23).

This measure of unmet need broadens the policy focus in this field from contraception alone to the ability of individuals to realise their fertility preferences. The report asserts that unmet need is often highest where contraceptive prevalence is low. Generally, as contraceptive prevalence increases, the level of unmet need decreases (p.9).

Figure 4: Unmet need for family planning across European Member States (WHO, 2017) ⁽²⁰¹⁾



The research for this study shows that for most of the six Member States covered by this study, family planning and contraception counselling are **publicly** available in **Croatia, Italy, Portugal, Sweden** as well as in the **Czech Republic** to a lesser extent. **Poland** does not provide such services. In the latter

²⁰⁰ http://www.un.org/en/development/desa/population/publications/pdf/family/WFP2017_Highlights.pdf.

²⁰¹ Data refers to medians for model-based estimates for unmet need for family planning.

case, counselling is sometimes made available through private or religious organisations, with all of the related implications and complications this might entail.

Among the countries providing family planning, the availability and approaches vary. **Italy** has approximately one family planning and counselling office for every 25,000 inhabitants, according to data provided by the Ministry of Health ⁽²⁰²⁾. However, stakeholders interviewed reported this to be inaccurate, noting that these offices are unequally distributed across the Italian territory, and that not all of them are fully operational, due to being increasingly under-staffed and under-funded. Family planning is available in **Sweden** at any youth clinic, primary care centre or gynaecological clinic in the country, as well as through a number of private healthcare centres. In addition, registered midwives also offer family planning and contraceptive services. In **Portugal**, family planning services are often delivered by health centres that are qualified to address a range of SRH issues. **Croatia**, which has the highest unmet needs of the six countries examined for this study, also has a low number of women seeking contraceptive or family planning counselling from their gynaecologist, with only 10 % of women of reproductive age visiting a gynaecologist for such counselling. Women thus rely more heavily on the rest of the healthcare system (e.g. family doctors) and in the field of school and youth clinics for family planning and reproductive health counselling ⁽²⁰³⁾. The **Czech Republic** has no well-established system of family planning at national level, most likely as a result of a lack of political priority. Some NGOs provide family planning and contraceptives counselling. Women typically turn to mainstream healthcare services to access family planning and counselling, in the absence of other alternatives ⁽²⁰⁴⁾.

Affordability

Family planning counselling in the **Czech Republic** and **Croatia** are mostly provided within the mainstream healthcare system, thus the services provided are covered by the national health insurance system. No further indication of affordability has been identified in those two countries.

Where specific family planning services have been established, these are provided free of charge. In **Portugal**, there is free access to family planning services, often provided by health centres. Similarly, in **Italy**, services within family planning centres are provided free of charge. In **Sweden**, patient fees can be attached to family planning only if performed in conjunction with additional services. Regardless of the employment category of the provider, midwife, gynaecologist or obstetrician, patient fees cannot be attached to counselling pertaining only to contraception and abortion ⁽²⁰⁵⁾. These are always offered for free. Young people receive both advice and services free of charge ⁽²⁰⁶⁾. Many independent organisations offer family planning advice for free. In addition, there are special provisions in Swedish law to ensure access to family planning services for those who depend on financial support from social services (via the Social Services Law) and those who are living in the country without documentation ⁽²⁰⁷⁾.

²⁰² Ministero della Salute, http://www.salute.gov.it/portale/temi/p2_6.jsp?id=1933&area=saluteBambino&menu=assistenza

²⁰³ National strategy for development of healthcare 2012-2020 (*Nacionalna Strategija razvoja zdravstva 2012-2020, NN 116/12*), available at: <https://extranet.who.int/nutrition/gina/sites/default/files/HRV%202012%20National%20Health%20Development%20Strategy.pdf>

²⁰⁴ <http://rodina.prorodiny.cz/rodina/programy-a-aktivity/planovani-rodicovstvi-prirozenou-metodou/>

²⁰⁵ Hälso- och sjukvårdsförvaltningen (2018), Patient fees framework (*Regelverk för patientavgifter*), available at: <http://www.vardgivarguiden.se/globalassets/patientadministration/01-patientavgifter/01-avgiftshandboken/regelverk-for-patavgifter.pdf?IsPdf=true>

²⁰⁶ 117 Care Guide (117 Vårdguiden) (2018), Patient fees (*Patientavgifter*), available at <https://www.1177.se/Skane/Regler-och-rattigheter/Patientavgifter/>

²⁰⁷ Law 2001:453 Social Services Law (*Socialtjänstlag*), 7 June 2001, Updated 2018:872

In **Poland**, legislation recognises the general right of everyone to make *responsible decisions* about having children, together with the right to access information, education, counselling and resources to enable the exercise of this right ⁽²⁰⁸⁾. Public bodies must offer free access to 'methods and means serving conscious procreation' (i.e. contraception), as well as relevant information and prenatal tests (particularly when the life of the foetus is at risk). Despite these expansive legal provisions, it should be stressed that hormonal contraceptives are not even partially refunded by public funds, meaning in practice these methods can be unavailable, and many women are excluded from the possibility of exercising their legal rights.

Quality

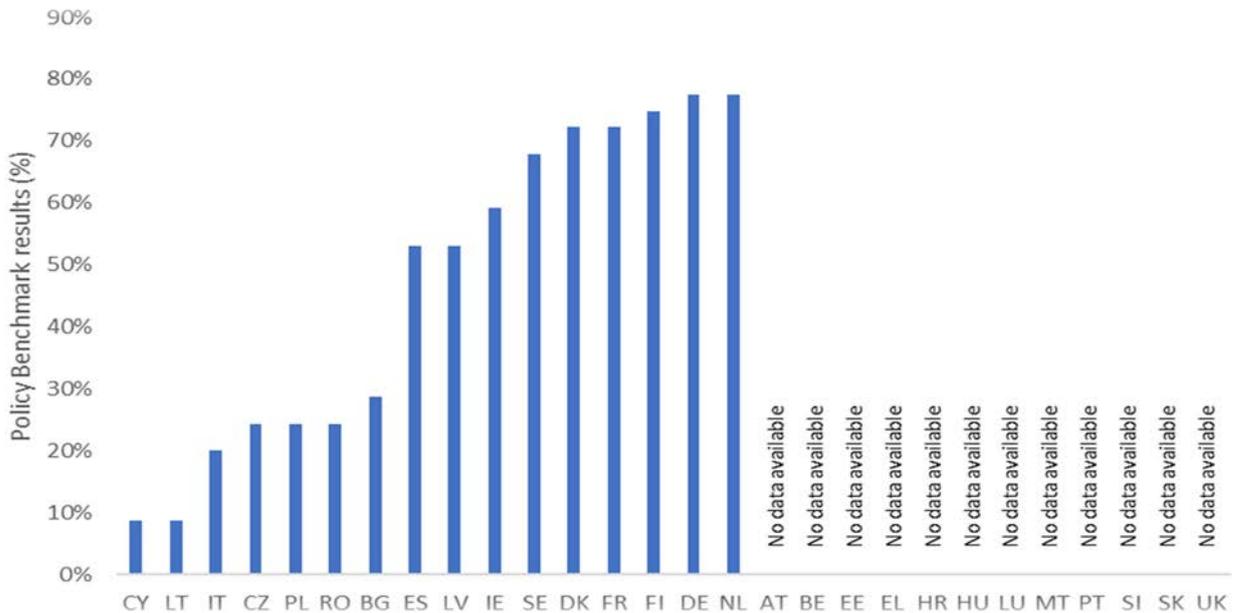
No comprehensive data on **contraception counselling** are available for Europe as a whole, despite targeted counselling being an important factor in quality healthcare service provision. However, the International Planned Parenthood Federation European Network (IPPF EN) compiled a Barometer report in 2016 which analyses access to contraception in 16 Member States ⁽²⁰⁹⁾. The report looks at various policy areas, including education and training of healthcare professionals and service providers, general awareness of SRHR and modern contraceptive choices, and - of particular relevance here - the report also assesses the provision of individualised counselling and quality services on SRHR. Within this policy area, IPPF EN considers whether Member States implement minimum quality standards and improve accessibility to ensure individualised counselling is a key part of quality SRHR services, the development of regularly updated guidance for healthcare professionals on individualised counselling, and the extent to which individualised counselling is part of the country's medical curriculum.

The report by IPPF EN found that over half of the 16 Member States that were part of their survey were aware of the importance of individualised counselling but reflected this in their respective policy and legislation to varying degrees. For instance, six Member States explicitly include individualised counselling as an objective in their relevant policy frameworks (Finland, France, Germany, Latvia, Sweden and the Netherlands). The implementation of guidelines on individualised counselling also varies across different regions within Member States due to differing clinical policies and/or awareness. On the other hand, individualised counselling is not required or recommended by the governments in six Member States (Bulgaria, Cyprus, the Czech Republic, Italy, Lithuania and Poland). The extent to which confidentiality is respected also varies, with healthcare professionals failing to adhere to this in Lithuania, Cyprus, Latvia and Romania, despite confidentiality of counselling services being protected by law. Based on this (relatively) broad assessment of various factors contributing to the quality of provision of individualised counselling, a policy benchmarking score was generated for each of the 16 Member States. Figure 5 displays the results for each country. The data shows that policy benchmarking scores are around 20 % and 25 % for the **Czech Republic, Italy and Poland**.

²⁰⁸ Preamble, Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy.

²⁰⁹ : Bulgaria, Czech Republic, Germany, Denmark, Ireland, Spain, France, Italy, Latvia, Lithuania, Cyprus, the Netherlands, Poland, Romania, Finland and Sweden. International Planned Parenthood Federation European Network (IPPF EN), [Barometer report 2016](#).

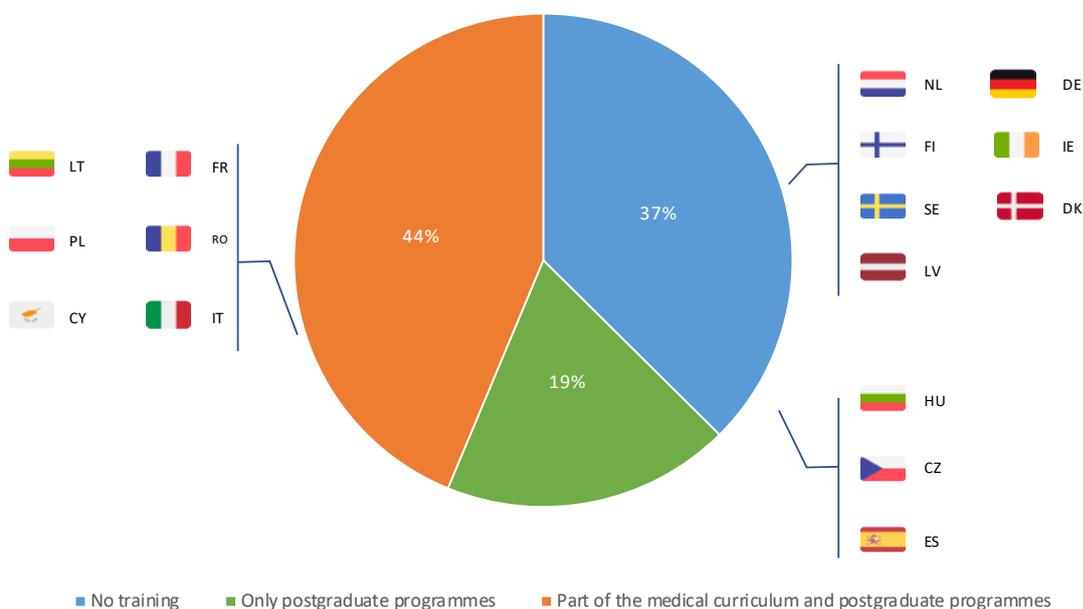
Figure 5: Provision of individualised counselling: policy benchmarking results by country (IPPF EN, 2016)



Turning to training on individualised counselling offered to healthcare professionals, Figure 6 below shows that only Latvia, Finland, Denmark, Ireland, Germany, the Netherlands and Sweden provide healthcare professionals with this training as part of their medical curricula and in postgraduate programmes. In the Czech Republic, Bulgaria and Spain, training is only provided in postgraduate programmes.

In Lithuania, France, Italy, Poland, Cyprus and Romania, no formal training is embedded in either medical curricula or postgraduate programmes.

Figure 6: Training on individualised counselling for healthcare professionals (IPPF EN, 2016)



While counselling on SRH can be provided by gynaecologists and family doctors (Croatia, Portugal, Italy, Sweden), family planning centres may be specifically established by national healthcare systems for that purpose (Italy, Sweden). In **Sweden**, no quality issues were identified. In **Portugal**, however, it is difficult to obtain data on the availability of such centres. According to one of the interviewed stakeholders, 'The statistics on sexual and reproductive health are reduced to the number of deliveries and caesareans. Similarly, if we are to obtain data on the delivery of primary healthcare services, we will obtain the overall number of consultations, but without specific reference to sexual and reproductive health'.

Equal treatment

No Member State pays particular attention at national level to access to family planning services and contraception counselling for **vulnerable groups**. This does not imply that additional barriers are not present, but, rather, that these issues are overlooked by policy and practice. This was reported by the stakeholders interviewed in Italy, who noted a lack of awareness among health professionals within family planning and counselling services on SRH issues among LGBTI people.

In **Sweden**, family planning is predominantly offered in Swedish. However, the Healthcare Act and patient laws include provisions for patients to receive information which they can understand regardless of their age, maturity, experience and linguistic background, for example through the help of an interpreter ⁽²¹⁰⁾.

The linguistic barrier is likely to be an issue across the other five Member States as well. No specific information on this was retrieved in the course of the research, although it was raised as an issue by some of the stakeholders interviewed.

Interviewed experts in **Italy** noted that family planning offices and centres are often visited by women from migrant backgrounds, given that they are free of charge. Such access is, however, limited depending on location. In fact, these centres are unequally distributed geographically across the country, with many not fully operational due to understaffing and lack of funding. This constitutes an additional barrier for people living in rural areas, as well as people with limited financial resources, including young people.

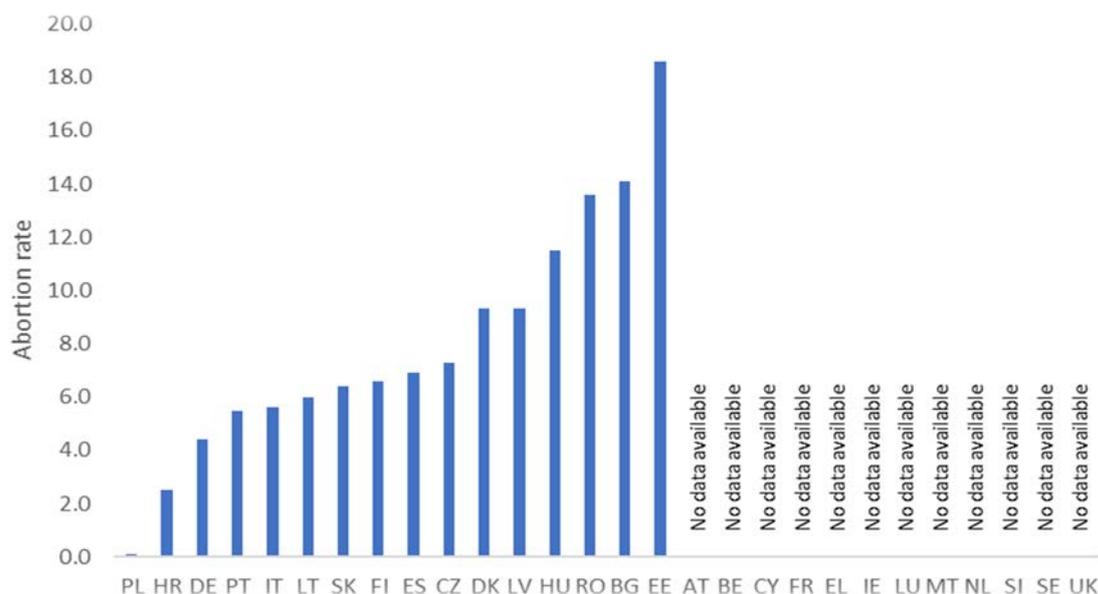
3.2.2. Abortion and post-abortion care

Availability

A number of EU datasets indicate the scale of registered abortions in the EU. Eurostat collected data on the abortion rate across the EU, showing the number of abortions per 1000 women of reproductive age in a given year, with data available for 2013, 2014 and 2015. Data on abortion rates are not available for many European countries and Figure 6 thus shows data from 2014, as this incorporates more Member States than the 2015 data. There is a marked variance between Member States' abortion rates, with Estonia having the highest rate at 18.6 %, compared with Poland's far lower rate of just 0.1 %.

Figure 7: Available data on abortion rates (number of abortions per 1000 women of reproductive age) (Eurostat, 2014)

²¹⁰ National Board of Health and Welfare (*Socialstyrelsen*), Interpreters for healthcare and dental care (*Tolkare för hälso- och sjukvården och tandvården*), 2016, available at: <https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/20184/2016-5-7.pdf>



Data are also available which provide an abortion ratio for Member States, looking at the number of abortions per 1000 live births in a given year, also across 2014, 2014 and 2015. Data on post-abortion care are not available at European level.

Practical access to abortion and post-abortion care varies between the six Member States, primarily because of the legal frameworks in place (see Section 2.2.1).

In **Poland**, legal access to abortion is very limited. Many facilities contracted by the National Health Fund refuse to perform these services. In 2016, legal abortions were carried out in 47 units, which is about 10 % of all facilities covered by contracts with the Fund. The data is particularly alarming, showing that only two abortions (Podkarpackie), five abortions (Lubelskie) and nine abortions (Lubuskie) were carried out in 2016. Data shows that accessibility varies geographically and that there are entire regions without access to legal abortion ⁽²¹¹⁾.

The published statistical material confirms the conclusions reported by the Federation for Women and Family Planning in 2016 'Good morning, I want to stop my pregnancy' ⁽²¹²⁾. This report clearly indicates the unlawful behaviour of Polish hospitals, who use arbitrary internal procedures (both written and unofficial) to avoid carrying out abortions, despite the fact that abortion belongs to the services listed in the Regulation of the Minister of Health of 22 November 2013 on guaranteed services in the field of hospital treatment (Rozporządzenie Ministra Zdrowia z dnia 22 listopada 2013 r. w sprawie świadczeń gwarantowanych z zakresu leczenia szpitalnego) ⁽²¹³⁾. Healthcare entities use a broad range of measures to circumvent the law by extending diagnostic and bureaucratic procedures in order to cross the statutory deadline for terminating a pregnancy. These include: ordering tests irrelevant to the diagnosis made; artificial extension of waiting time for the results of conclusive research (such as amniocentesis); requirement to provide additional documents that are difficult to obtain (e.g.

²¹¹ Report of the Council of Ministers on the implementation of the law on family planning, 2016, available at: <https://bip.kprm.gov.pl/kpr/bip-rady-ministrow/informacje-i-sprawozda/5208,informacje.html>.

²¹² Federation for Women and Family Planning, Report 'Good morning, I want to stop my pregnancy', 2016, available at: <http://federa.org.pl/wp-content/uploads/2017/06/RAPORT-SZPITALNE-FEDERACJA.pdf>.

²¹³ Regulation of the Minister of Health of 22 November 2013 on guaranteed services in the field of hospital treatment (Rozporządzenie Ministra Zdrowia z dnia 22 listopada 2013 r. w sprawie świadczeń gwarantowanych z zakresu leczenia szpitalnego), Journal of Laws 2013 pos. 1520.

certificates from the National Consultant for Gynaecology and Obstetrics); calling meetings; and obligatory psychological consultations. It should be emphasised that all of the abovementioned activities are not required by law or for medical reasons.

In addition, accessibility varies geographically and there are entire regions without access to legal abortion. For instance, in the Podkarpackie Voivodeship region, there is no medical entity that could perform termination of pregnancy due to application of the conscience clauses (see Section 4). Access to abortion is significantly impeded and the Podkarpackie Division of the Provincial National Health Fund does not currently provide patients with relevant information about other locations where these services may be accessed. For example, the provincial consultant in the field of obstetrics and gynaecology for the Podkarpackie region himself has no knowledge of 'which therapeutic entity in the province is able to perform pregnancy termination'. In some cases, it is also noted that healthcare entities circumvent the law by extending diagnostic and bureaucratic procedures in order to cross the statutory deadline for terminating pregnancy.

Geographical disparities also exist in **Italy** and **Croatia**. In Italy, for example, some regions have a higher number of conscientious objectors which inevitably translates into a limited availability of services (see Section 4). Nevertheless, in some cases (in both Italy and Croatia), women seek assistance from private institutions, either for better treatment or cheaper treatment (crossing the border to Serbia and Bosnia and Herzegovina, for example).

It is important to note the distinction between medical abortion, through the administration of mifepristone (also known as RU486) and surgical abortion performed through a surgical operation.

In **Italy**, like many other Member States, RU486 was introduced to the market under the mutual recognition procedure⁽²¹⁴⁾. However, while in most countries this can be administered to the patient up to 63 days into the pregnancy, in Italy it can be administered only up to 49 days (seven weeks). This can be particularly problematic, as a pregnancy might be discovered too late to be eligible for this method. Women at that point therefore need to access services for surgical abortions, with all of the barriers and challenges this entails. When women are eligible for medical abortion, most Italian regions require that they are hospitalised for three days, creating an additional procedural barrier (see Section 3.3).

National researchers and stakeholders from **Croatia**, **Italy**, and **Poland** noted the widespread practice of illegal abortion, practiced outside the health system and authorised medical infrastructures, for a price. In **Croatia**, some estimates suggest that 40 % of abortions performed in the country are illegal⁽²¹⁵⁾. In **Italy**, 2012 data from the Ministry of Health estimated 12,000-14,000 illegal abortions for Italian women, and 3,000-5000 illegal abortions for foreign women in the country⁽²¹⁶⁾. Stakeholders noted that, given the irregularity of the practice, no detailed data can provide a comprehensive picture of illegal abortions and any estimate might actually be an underestimate.

²¹⁴ 'Mutual recognition ensures market access for products that are not subject to EU harmonisation. It guarantees that any product lawfully sold in one EU country can be sold in another. This is possible even if the product does not fully comply with the technical rules of the other country'. European Commission, http://ec.europa.eu/growth/single-market/goods/free-movement-sectors/mutual-recognition_en

²¹⁵ Grujić, J., Younger poor women are most affected by the reduction of right to abortion, (*Redukcijom prava na pobač aj najviše c e biti pogođene mlade siromašne žene*), Lupiga, 2015, available at: <https://lupiga.com/intervju/intervju-pravo-na-pobacaj>. Estimates come from stakeholder interviews and are based on consultations with women, their experiences shared on internet forums, poor official recording of data, availability of abortion in neighbouring countries and general population data analysis.

²¹⁶ *Relazione del Ministro della Salute sulla attuazione della legge contenente norme per la tutela sociale della maternità e per l'interruzione volontaria di gravidanza (Legge 194/78)*, 2017.

In **Sweden**, abortions take place at general hospitals or at other approved health facilities around the country. Sweden allows for a choice of clinic for all general care and some specialist care ⁽²¹⁷⁾. Individuals can therefore access this service at any place in the country.

Affordability

Affordability of abortion services varies across the six Member States.

- The cost of a termination of pregnancy increased in **Croatia** in 2018. The average price reaches HRK 2,300 (approximately EUR 330), excluding supporting services.
- In the **Czech Republic**, abortions requested by women are not covered by health insurance. There are some exceptions, such as if a woman is older than 35 years, or where the pregnancy is the result of a violent criminal act. Abortions for specific health reasons are covered by health insurance.
- In **Italy**, abortions are completely free and covered by the national health system, whether undertaken within public hospitals or private clinics.
- In **Sweden**, all individuals under 18 are exempt from medical fees. In the specific case of abortion, the service is free for patients but adults will be asked to pay the cost of the medical appointment. This cost varies across regions but is approximately SEK 350-700 (EUR 34-67). In cases where individuals are not able to afford these fees, help can be sought from the National Board of Health and Welfare.

Quality

Stakeholders noted a lack of training for health professionals in the provision of abortion services. In **Italy**, for example, gynaecologists graduating from their medical specialty typically have not acquired the necessary competence to undertake abortions, either practically or in terms of knowledge about the legal framework. This issue was not particularly highlighted by stakeholders in the other five Member States, but it would be interesting to specifically investigate the training and education systems for gynaecologists across Europe, beyond the scope of the present study.

Overall, no specific monitoring or evaluation mechanisms for service quality were reported across the six Member States.

Equal treatment

Equal access to abortion services is ensured in **Sweden** where, since January 2018, foreign women (including asylum-seekers, non-residents and those not registered as living in Sweden) have access to abortions under the same conditions as Swedish citizens. This issue is not specifically tackled across the other five Member States at the core of this study.

Overall, it can be stated that women from disadvantaged socioeconomic backgrounds particularly struggle to access abortion services, for reasons of cost.

Geographical disparities translate to additional barriers for women living in rural areas, far from medical infrastructures or, in the case of **Italy**, not close to hospitals where non-objecting medical professionals are likely to provide the service. More information about these challenges in relation to the exercise of

²¹⁷ 117 Care Guide (117 Vårdguiden) (2018), Choosing a clinic (Välja vårdmottagning), available at <https://www.1177.se/Skane/Tema/Patientlagen/Valja-varld/Valja-varldmottagning/>

conscientious objection is provided in Section 4. In **Croatia**, as a consequence of high and unequal prices, women from rural areas and women living on islands are less likely to afford the intervention and the cost of travel to the nearest facility which provides the procedure ⁽²¹⁸⁾.

In **Italy**, equal access is affected by the procedures relating to the abortion service itself. In fact, even for a medical abortion (through the administration of RU486) most regions require women to be hospitalised for three days, as specified by the guidelines published by the Ministry of Health in 2010²¹⁹. This can be particularly problematic for women from disadvantaged socioeconomic backgrounds, as well as single mothers, who simply may not be able to stay in hospital, without working, for three full days. Civil society organisations led by practicing gynaecologists are committed to requesting a change to this procedure, with the stakeholders interviewed reporting that it is unnecessarily cautious. Some Regions and Provinces (e.g. Emilia Romagna, Piedmont and the Autonomous Province of Trento, among others) have given the option for mifepristone to be administered in the so-called "day hospital", which entails hospitalisation simply during the day, without an overnight stay in the hospital ⁽²²⁰⁾.

3.2.3. Safeguarding and recovery from FGM

Availability

No comprehensive Europe-wide data set exists to indicate levels of access to safeguarding and recovery services for victims of FGM. Focus at national level, however, reveals that access to these services is determined by relevant Member State policy. These services may include defibulation, treatment of physical complications due to FGM, psycho-sexual counselling, reconstructive (clitoral) surgeries. Systematic national measures contrast with the more anecdotal or regional measures of collecting data seen in other Member States. For example, in Italy, a cross-sectional survey conducted by the Regional Institute of Statistics and the University of Milan-Bicocca was undertaken in the region of Lombardy in 2010 to assess the prevalence of FGM in migrant communities in the area ⁽²²¹⁾.

Whilst efforts are being undertaken across Member States to assess the scale of women and girls who have undergone FGM in the EU and their access to support services, there is a distinct lack of systematic data collection at European level ⁽²²²⁾.

Reflecting the lack of legislation on FGM (see Section 2 of this report), **Croatia** and **Czech Republic** have no specific services for safeguarding and recovery from FGM. In **Croatia**, there are no reported cases of FGM and no specific information on related support services at national level. Similarly in **Poland**, no information is available on the issue of FGM, as this is not a diagnosed systematic problem across the country.

Italy has no specific service provided at national level but some good practices have been implemented at local level, for example in the regions of Lazio and Tuscany in 2007, with funding from

²¹⁸ Gender Equality Ombudsperson, Practice of Health Institutions in Croatia to Ensure the Availability of Legally Induced Abortion (*Istraživanje: praksa zdravstvenih ustanova u Hrvatskoj po pitanju osiguranja dostupnosti legalno induciranog pobačaja*), 2014, available at: https://www.prs.hr/attachments/article/1555/05_ISTRA%C5%BDIVANJE%20-%20Praksa%20zdravstvenih%20ustanova%20u%20RH.pdf

²¹⁹ http://www.salute.gov.it/imgs/C_17_pubblicazioni_1302_allegato.pdf

²²⁰ Ministry of Health, 'Day hospital' definition,

http://www.salute.gov.it/portale/temi/p2_6.jsp?id=3669&area=ricoveriOspedaliere&menu=vuoto

²²¹ http://ods.ars.marche.it/Portals/0/Materiale%20MGF/Valutazione%20Quantitativa%20e%20Qualitativa%20MGF%20Italia_2009.pdf.

²²² EIGE's studies on FGM in the European Union mapped the situation (2012), as well as provided estimations of girls at risk in Ireland, Portugal and Sweden (2015), and in Belgium, Greece, France, Italy, Cyprus and Malta (2017-2018). Reports are available at: <https://eige.europa.eu/rdc/eige-publications/estimation-girls-risk-female-genital-mutilation-european-union-report>

the Department of Equal Opportunities (223). In 2007, guidelines were published at national level to provide guidance for health professionals working with women from countries in which FGM is practiced, with the aim of prevention, assistance and rehabilitation of women and girls who have already been victims of the practice (224). More detailed guidelines have been developed at regional level, in the regions of Abruzzo, Sicily, Emilia Romagna and Tuscany.

Promising practices at local level: SRHR and treatment of victims of FGM in Italy

- In the Region of Lazio, Italy, the Department for women's and children's health of the San Camillo- Forlanini hospital in Rome provides assistance to women that suffer from disorders and illnesses related to SRH, including problems during pregnancy, as well as with sexual relations, due to being victims of FGM. Surgery for 'defibulation' (225) is also performed on request.
- In Tuscany, the University Hospital Careggi di Firenze, with the Regional Reference Centre for the prevention and treatment of FGM- related complications, has a specific protocol for 'defibulation' surgery, and has a holistic approach to assist victims of FGM, taking into account cultural and legal dimensions. The hospital works in a network with family planning offices, as well as cultural associations with different migrant communities.
- The Region of Piedmont led a 2016 campaign to encourage FGM victims to access family planning and counselling offices, in parallel with a training initiative specifically targeting health professionals. This campaign addressed the issue of FGM and the approach to be undertaken when assisting and providing SRH services to victims of FGM (226).

In **Portugal**, FGM is recorded in data collected through the 'Health Data Platform', which allows for the registration and sharing of information among the various institutions of the National Health Service. This platform has an individualised filter for clinical data on FGM, recording the following information for each woman victim: current age, date of registration in healthcare unit, institution where registration is introduced, type of mutilation, age and country where mutilation was done, where the woman was observed (consultation, hospitalisation, pregnancy, puerperium), whether the patient was informed of the legal framework, and associated complications (such as uro-gynaecological, sexual, obstetrical, psychological). In terms of services for safeguarding and recovery from FGM, there are some specialised postgraduate courses for nurses and other health technicians on how to improve the quality of diagnosis, treatment and follow-up of FGM. However, no additional information on specific services was collected.

In **Sweden**, care can be accessed at any healthcare centre in the country. The larger hospitals have staff trained in FGM care (227). Referrals to these specialists are done through gynaecologists or midwives.

²²³ AIDOS, FGM: the situation in Italy, 2017, http://www.aidos.it/wp-content/uploads/2017/02/COUNTRY-INFO-PAGES_ITALY_ITALIAN-FINAL.pdf

²²⁴ Ministero della Salute, Linee guida destinate alle figure professionali sanitarie nonché ad altre figure professionali che operano con le comunità di immigrati provenienti da paesi dove sono effettuate le pratiche di mutilazione genitale femminile per realizzare una attività di prevenzione, assistenza e riabilitazione delle donne e delle bambine già sottoposte a tali pratiche. Roma: Ministero della Salute, 2007, http://www.salute.gov.it/imgs/C_17_pubblicazioni_769_allegato.pdf

²²⁵ 'Defibulation (i.e. surgical opening of the labia) is reconstructive surgery of the scar tissue caused when the labia are joined together by infibulation'. WHO, Female Genital Mutilation and other harmful practices, Treatment of persons with female genital mutilation, http://www.who.int/reproductivehealth/topics/fgm/defibulation_type_iii/en/

²²⁶ <http://www.regione.piemonte.it/sanita/cms2/notizie-87209/notizie-dallassessore/4178-no-mgf-prevenzione-e-contrasto-delle-mutilazioni-genitali-femminili-in-piemonte>

²²⁷ 117 Care Guide (117 Vårdguiden) (2018), FGM (Könsstympning), available at <https://www.1177.se/Skane/Fakta-och-rad/Sjukdomar/Konsstympning--omskuren-kvinna/>

There is one specialist clinic in Stockholm, which provides care specifically for victims of FGM ⁽²²⁸⁾. This clinic is accessible to anyone in the country.

Affordability

Services for the safeguarding and recovery from FGM (which are often supported by civil society organisations) are provided for free across the different countries. However, the research found a lack of such initiatives across the six countries at the core of this study.

The examples described above are all services that are provided for free in both Italy and Sweden.

Moreover, women victims of FGM, presenting complications due to the practice, access general health services as well. The affordability of these services would then rely on the national health systems.

Quality

An overall lack of data on FGM and related services in the six Member States, and the consequent lack of literature in this context, does not allow for an effective assessment of the quality of the existing services. In **Sweden**, a 2006 study found that the majority of healthcare staff working in gynaecology, midwifery or maternal services had been exposed to and experienced visits from women victims of FGM. The study recommended additional training in intercultural communication to help with this ⁽²²⁹⁾.

Training on FGM and its consequences, as well as training in intercultural communication, may well be relevant to all six of the Member States discussed here.

Equal treatment

The lack of services generally affects the most vulnerable groups. The promising practices highlighted in **Italy**, for example, are implemented by hospitals in main cities. This implies that women from rural areas and those from disadvantaged socioeconomic backgrounds cannot easily access this service. In order for everyone to equally access such services, they would need to be implemented more widely at national level. This is true for all six Member States at the core of this study. However, the lack of data on FGM cases may mean that there is insufficient information for policy makers to undertake initiatives in this context. In **Sweden**, the National Board of Health and Welfare has been commissioned to examine equity in access to FGM services in the country and to prepare draft recommendations for improvements to the law ⁽²³⁰⁾.

Undocumented migrant women are a particularly vulnerable group in this context. Being a migrant woman, with a residential status that is insecure might increase the likelihood not to receive appropriate treatment for her FGM-related issues. Moreover, young migrant girls encounter the risk of not being adequately protected.

²²⁸ Södersjukhuset, Amel clinic (*Amelmottagningen*), 2018, available at

<http://www.sodersjukhuset.se/Avdelningar--mottagningar/Mottagningar/Mottagning-for-konsstymade/>

²²⁹ Tamaddon, L., Johndotter, S., Liljestrang, J. & Essén, B., Swedish Health Care Providers' Experience and Knowledge of Female Genital Cutting, *Health Care for Women International*, 27(8), 2006, pp. 709-722.

²³⁰ Government Offices of Sweden (*Regeringskansliet*) (2018), Action plan against FGM of women and girls (*Handlingsplan mot könsstympning av flickor och kvinnor*), available at <https://www.regeringen.se/informationsmaterial/2018/06/handlingsplan-mot-konsstymning-av-flickor-och-kvinnor/>

3.2.4. Care and treatment services for survivors of IPV and non-partner sexual violence

The 2017 signing of the EU's accession of the Istanbul Convention (the first legally binding international instrument on preventing violence against women) represents significant progress in international policy measures to tackle violence against women. However, despite the extent of violence against women across the EU - just over one in five women have experienced physical and/or sexual violence from a current or previous partner ⁽²³¹⁾ - there is a distinct lack of comprehensive and comparable data, particularly when considered against other areas, such as employment. This is largely because the majority of violence against women is hidden, with women not being effectively encouraged to speak out to police or victim support organisations. For many years, there have been calls for improved data collection in the area of violence against women from inter-governmental organisations, civil society, research institutions, and other stakeholders. The lack of data dissuades policy makers and politicians attempting to tackle the issue of violence against women through the development of effective policy and legislation, as well as compromising the ability of support services to tailor their service to the needs of affected women (including healthcare professionals, employers and internet service providers). As a result, the needs of affected women are not being adequately met.

In response to these calls for improved data, the European Union Agency for Fundamental Rights (FRA) carried out an EU-wide survey in 2012. The survey was completed by 42,000 women across the EU and covered different forms of violence against women, including psychological violence, stalking, physical violence, sexual violence and sexual harassment, with distinctions between violence from partners and non-partners.

EIGE's Gender Equality Index ⁽²³²⁾ is another important source of data in this context, thanks to the satellite domain of violence. It is important to bear in mind that high levels of violence may indicate greater willingness on the part of women to report their experiences. Further contextual analysis for the available data is necessary in order to obtain a full picture of the issue, for example by looking at the perceptions of gender-based violence in the country, as well as trust in the police and justice systems ⁽²³³⁾.

The scope of this study does not permit an in-depth exploration of the issue of IPV and non-partner sexual violence. This section will focus on providing information on services within the health sector that offer a specific perspective on the care and treatment of survivors of IPV and non-partner sexual violence.

Availability

Other than the sources outlined above, there is an apparent lack of data looking specifically at the care and treatment of survivors of IPV and non-partner sexual violence. Figure 7 below shows data collected by FRA (2012), which offers an insight into the services that women feel comfortable approaching to report abuse and which could usefully be used to shape support services. Figure 7 also shows that many women, across all types of abuses and perpetrators, did not speak to anyone, highlighting that greater efforts must be made to encourage women to report violence. Women who suffered from sexual violence by any partner were the most likely to have contacted the police or other services (39

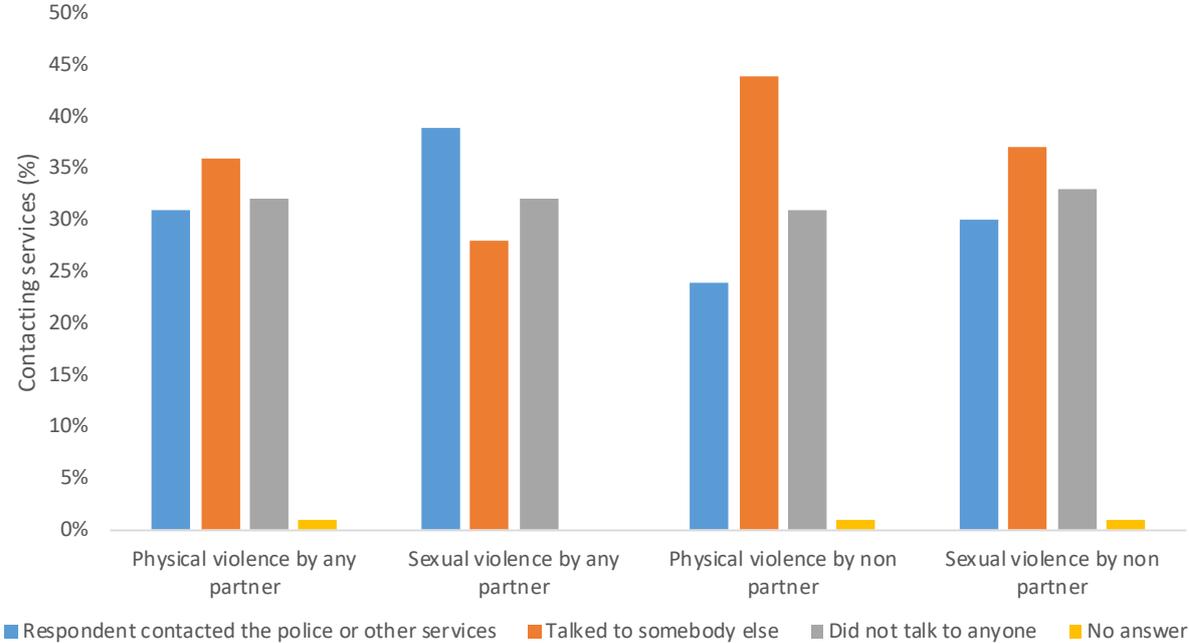
²³¹ http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-at-a-glance-oct14_en.pdf.

²³² EIGE, Gender Equality Index, 2017, <https://eige.europa.eu/gender-equality-index/about>

²³³ EIGE, Gender Equality Index 2015, <https://publications.europa.eu/en/publication-detail/-/publication/9035e5ba-343d-4423-8a99-2464d3e81919/language-en>

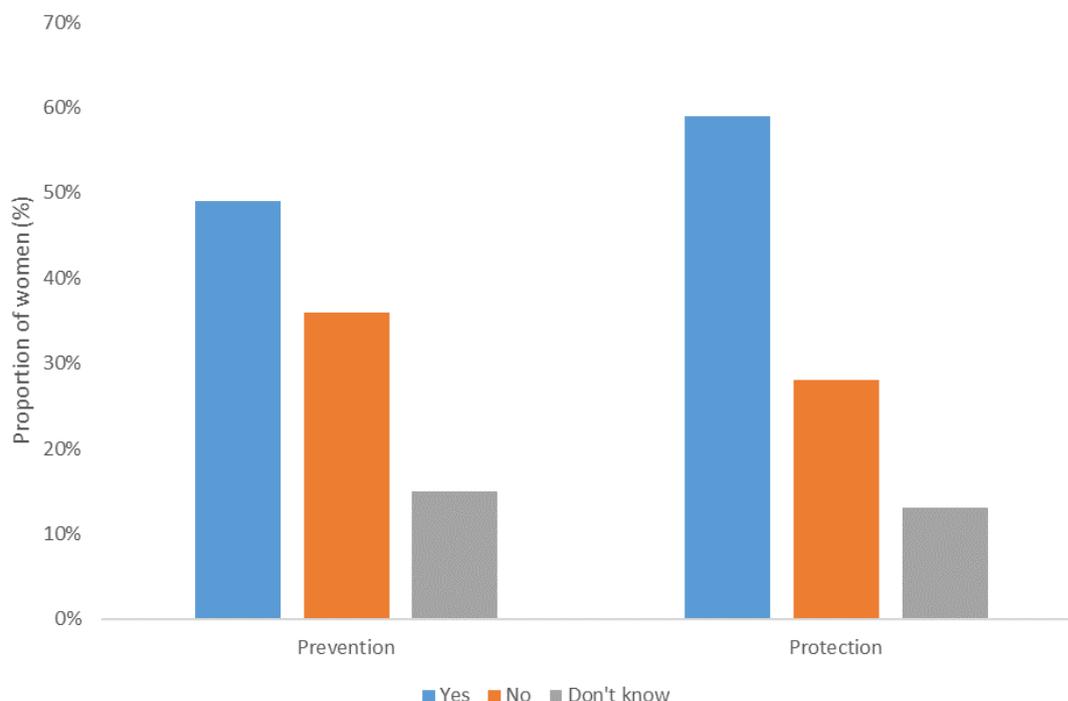
%) while those suffering from physical violence by non-partners most frequently reported talking to somebody else about the experience (44 %).

Figure 8: Contacting services and talking to other people about the most serious incident since the age of 15, by type of violence and perpetrator (%) (FRA, 2012)



A number of other findings relate specifically to prevention. For instance, the survey results showed a relationship between a partner’s heavy alcohol use and increased violence. Thus, national violence prevention measures and campaigns from the alcoholic drinks industry should address heavy alcohol use, given the evidence of the link to IPV. Further data could be systematically collected by the police on alcohol abuse following reported incidents of domestic violence. Figure 8 below shows that half of the women surveyed stated either that there was no domestic violence legislation in their country or that they were not aware of it. The data also show women tend to be slightly more frequently aware about laws or initiatives to protect them in case of domestic violence (59 %) compared to women aware of laws or initiatives for preventing violence (49 %). Thus while many women victims may know about protection measures, there is clearly more work to be done to increase knowledge on relevant laws and initiatives, which in turn should improve the level of reporting of such crimes.

Figure 9: Level of awareness of specific laws or political initiatives in the EU-28 (%) (N = 42,000) (FRA, 2012)



As noted in Section 2, none of the six Member States provides for clear legislation on services for the care and treatment of survivors of IPV and non-partner sexual violence. In **Sweden**, IPV care is predominantly provided at primary health centres. In **Italy**, the implementation of guidelines for hospitals in the specific context of helping and assisting women victims of violence ⁽²³⁴⁾ may be implemented differently depending on the institution. Support is often provided by NGOs and shelters, including in the context of awareness-raising and prevention.

Despite a certain lack of information on specific services for the care and treatment of survivors of IPV and non-partner sexual violence across the six Member States, this section intends to highlight the importance of its inclusion when addressing issues in access to SRH.

Affordability

At a practical level, survivors of IPV and non-partner sexual violence are assisted by hospitals under the national health systems. Where specific services are provided, for example by NGOs and shelters, they are offered free of charge and aim to reach the broadest range of victims.

Quality

Across the **six Member States**, there is no monitoring or evaluation mechanism in place that can guarantee implementation of services for the protection and treatment of survivors of IPV. In **Italy**, for example, some of the stakeholders interviewed noted that in some hospitals the approach of health professionals is excellent, while in other cases additional training would be required to effectively implement the national guidelines. This lack of monitoring and evaluation, as well as a certain lack of specific training for health professionals, was noted across the other countries as well.

²³⁴ Linee guida nazionali per le Aziende sanitarie e le Aziende ospedaliere in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza, <http://www.gazzettaufficiale.it/eli/id/2018/01/30/18A00520/SG>

Equal treatment

The issue of equal treatment in the context of gender-based violence is particularly complex, as vulnerable groups might be particularly exposed to specific types of violence. The stakeholders stated that access to health services for survivors of IPV and non-partner sexual violence might be particularly problematic for women and men from vulnerable groups. The stigma associated with this type of violence contributes to these barriers.

3.2.5. Obstetric, pre-natal and post-partum care

Obstetric, pre-natal and post-partum care is covered at least partially under the national health systems and consequently under the national health insurance systems in the **six Member States**. In **Sweden**, the costs are covered by the social insurance system, apart from a small patient fee.

The research for this study shows the need to address the issue of standards of medical treatment when providing health services in obstetric, pre-natal, and post-partum care. There is a significant lack of data and literature on this issue, thus the study will focus on the particular case of **Poland**, for which additional research was conducted at national level.

The case of Poland: standards of medical treatment in obstetric, pre-natal, and post-partum care

Although the Regulation of the Minister of Health on standards of medical treatment in health services in perinatal care for women in the period of physiological pregnancy, physiological delivery, puerperium and care for a newborn (Perinatal Care Standards) ⁽²³⁵⁾ has been in force since 2012, stakeholders noted that the rights of women giving birth in hospitals and maternity wards are not respected. Implementation of the Regulation is slow. A noticeable improvement in the implementation of Perinatal Care Standards is the possibility for the labouring woman's partner to participate during delivery.

Of particular note is the fact that women in Poland still experience physical violence during their stay in hospital, with situations reported where women are tied to the delivery bed or have their legs broken, as well as the carrying out of painful internal examinations without consent, cervical massage and Kristeller's grip. Although the majority of women positively assessed the behaviour of the staff, attitude and communication, information transfer, showing respect, and taking care of privacy and intimacy, data show that 54.3 % of women experienced abuse or violence related to staff behaviour or a failure to follow the procedures. 15.5 % of respondents believed their rights were infringed during their stay in hospital, and 23.6 % of women could not tell if a law had been broken. Even in those cases where women claimed a law had been broken, only 3 % complained ⁽²³⁶⁾.

Since 1 July 2015, epidural anaesthesia in Poland has been refunded by the National Health Fund. The research carried out by the Rodzić po Ludzku Foundation shows considerable variance between hospitals in the availability of epidural anaesthesia during labour. In 83 % of hospitals with third degree of reference of maternity ward, and in only 36 % of hospitals with first degree of reference, a woman may opt for an epidural. In 32 % of hospitals, this type of anaesthesia is not

²³⁵ Regulation of the Minister of Health on standards of medical treatment when providing health services in perinatal care for women in the period of physiological pregnancy, physiological delivery, puerperium and care for a newborn (*Rozporządzenie Ministra Zdrowia z dnia 20 września 2012 r. w sprawie standardów postępowania medycznego przy udzielaniu świadczeń zdrowotnych z zakresu opieki okołoporodowej sprawowanej nad kobietą w okresie fizjologicznej ciąży, fizjologicznego porodu, położu oraz opieki nad noworodkiem*), Journal of Laws 2012 pos. 1100.

²³⁶ Rodzić Po Ludzku Foundation (2018), 'Report from the monitoring of maternity wards – perinatal care in Poland in the light of women's experiences', available at: http://www.rodzicpoludzku.pl/images/rzeczniactwo/RAPORT_FRpL_2018.pdf.

available at all, chiefly due to staff difficulties, with as many as 79 % of the facilities not providing epidural anaesthesia declaring that the problem is the lack of an anaesthesiologist, while another 16 % indicate shortages in appropriate medical staff ⁽²³⁷⁾.

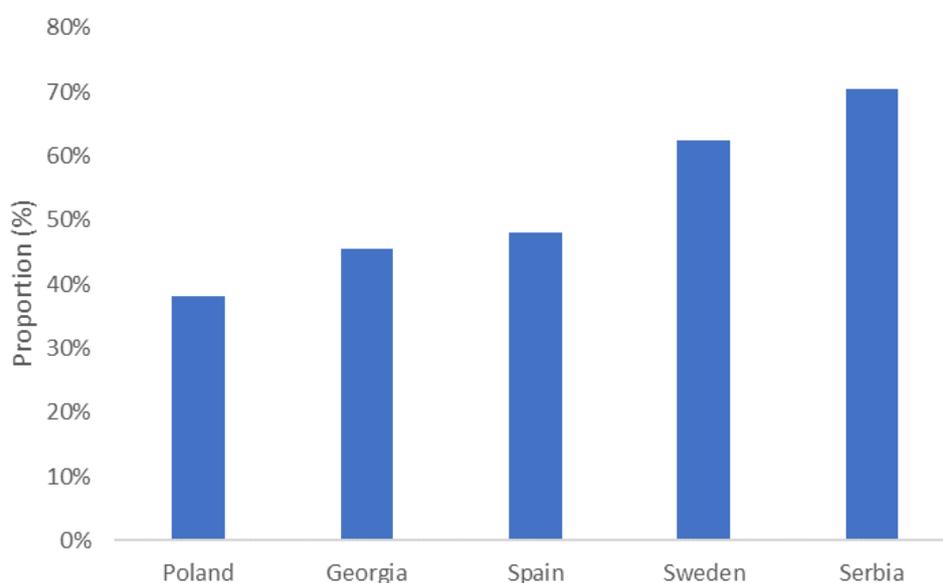
3.2.6. Sex reassignment surgery

Availability

A 2017 study ⁽²³⁸⁾ by Transgender Europe (TGEU) shows that transgender people score lower in terms of health and wellbeing compared to non-transgender individuals. The study is based on data collected from healthcare providers and trans people in Georgia, Poland, Spain, Serbia and Sweden, which were chosen for study due to their geographical and cultural disparity.

Survey participants were asked about their experience of accessing healthcare from different providers, ranging from general practitioners to medical specialists, mental health professionals and non-medical staff. One of the most striking findings of the study was how more than half of respondents (55.8 %) reported having delayed healthcare consultations because of their gender identity. Figure 9 below shows the proportion of individuals for whom healthcare needs were delayed, per country, including in two of the countries at the core of the present study, **Poland** and **Sweden**.

Figure 10: Delaying healthcare needs, by country (TGEU, 2017)



The study also explored reasons for delaying medical consultations, with the main reason being the prospect of being treated badly by practitioners (62.6 %), followed by fear (48.7 %) and unwillingness to disclose trans identity (42.5 %).

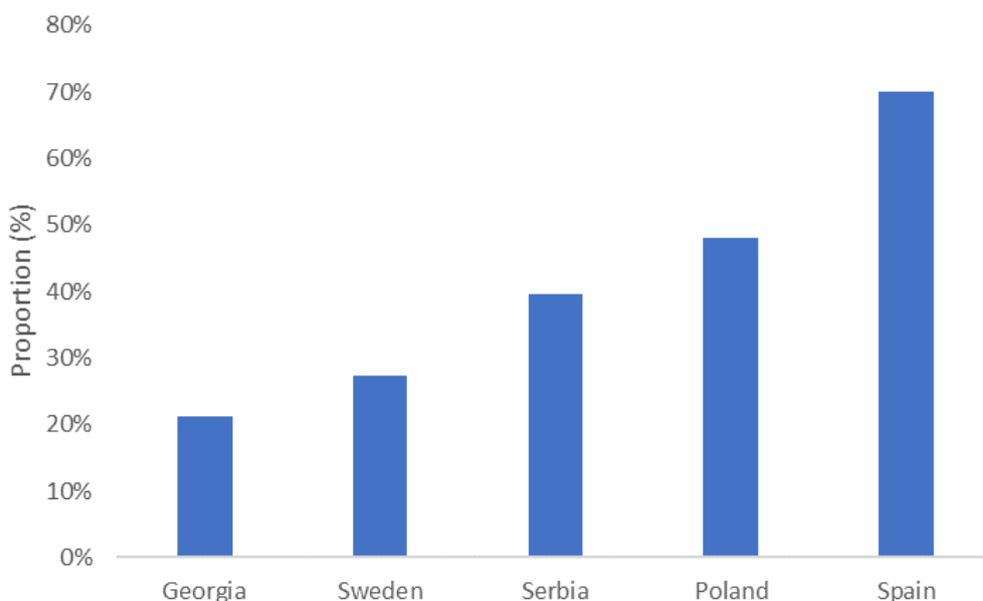
Turning to trans-friendly healthcare providers, the study shows that these facilities tend to be not widely known, with more than half of respondents (58.3 %) reporting that they did not know any. This finding holds across countries, as shown in Figure 10, which explores the proportion of respondents aware of trans-friendly healthcare. The different results could thus reflect the different settings of

²³⁷ Rodzić Po Ludzku Foundation (2018), 'Report from the monitoring of maternity wards – perinatal care in Poland in the light of women's experiences', available at: http://www.rodzicpoludzku.pl/images/rzeczniactwo/RAPORT_FRpL_2018.pdf.

²³⁸ Transgender Europe, *Overdiagnosed but Underserved*, 2017.

healthcare systems across the countries under scrutiny. Further research in this context, with a scope at national level, would be necessary.

Figure 11: Knowledge of trans-friendly healthcare providers, by country



The national research conducted for the present study showed differences and similarities across Croatia, Czech Republic, Italy, Poland, Portugal and Sweden. Common challenges include long waiting times, a lack of availability of the service in hospitals and clinics, and a lack of surgeons undertaking sex reassignment operations.

In **Croatia**, the availability of sex reassignment surgeries is generally limited to Zagreb, with services outside of the capital being fragmented ⁽²³⁹⁾.

The **Czech Republic** was one of the pioneering countries that allowed transgender patients to undergo the entire process of sex reassignment. The procedure lasts for one or two years. A patient undergoes three stages: diagnostic phase, hormone therapy and surgical phase (age limit is 18 years old). Problematic aspects include the need for institutional approval of hormone therapy by a specialist committee, and the age limit. The Ministry of Health also appoints a specialist committee that approves the reassignment surgery.

In **Italy**, few centres within the framework of the National Health System conduct sex reassignment surgery. Waiting lists can be particularly long and people might need to wait for years before the service is provided.

In **Poland**, according to the report 'Transgender and healthcare in Poland', prepared by the Trans-Fuzja Foundation in 2015 ⁽²⁴⁰⁾, access to medical services can be problematic. The respondents of the investigation shared their experience, by noting a number of challenges and barriers encountered, related for example by the refusal of medical professionals to provide services, as well as availability of surgeons for the operation itself, as well as check-ups.

²³⁹ ILGA Europe, Barriers to accessing healthcare for transgender persons in Croatia, https://www.ilga-europe.org/sites/default/files/Attachments/croatia_-_final_product.pdf

²⁴⁰ Trans-Fuzja Foundation, 'Transgender and healthcare in Poland', 2015, available at: http://transfuzja.org/download/publikacje/transplciowosc_a_opieka_zdrowtona_w_polsce.pdf.

In **Portugal** and **Sweden**, sex reassignment surgery is widely available. However, in **Sweden**, the process takes a minimum of two years due to investigation time. In order to access the surgery, the person must be registered as living in Sweden, but not necessarily a Swedish citizen. In 2015, guidelines were adopted on trans healthcare for adults and children. They are not mandatory, however, and implementation may vary depending on the clinic ⁽²⁴¹⁾.

Affordability

In the **Czech Republic** and **Portugal**, sex reassignment surgery is covered by health insurance. Similarly, in **Italy**, the patient can access the sex reassignment surgery for free under the National Health System, however the patient must first obtain a diagnosis of 'gender dysphoria' by a psychiatrist, as well as an authorisation from the courts.

In **Sweden**, each step of the process incurs small patient fees, but the protections offered by the social insurance ensure that the sum total is less than the cap, both for medicines (SEK 2,250 per annum, or around EUR 200) and services (SEK 1,100 per annum, or around EUR 100).

In **Croatia**, mastectomies were covered by the national medical insurance until 2016. Since then, the Croatian Institute for Health Insurance has begun to refuse requests. Until 2016, around 40 persons have benefitted from the service, as covered by the medical insurance. Several persons are still awaiting a decision. From now on, transgender persons will need to cover the fees themselves. Mastectomies can cost up to around HRK 7,400 (around EUR 1000). Gynaecomastia is covered for persons who have previously obtained a change on their ID documents. Hormone therapy is not covered by health insurance, which covers psychological and psychiatric counselling, medical tests for determining hormone therapy and counselling with an endocrinologist ⁽²⁴²⁾.

In **Poland**, costs related to the reconstruction of organs range from PLN 3,000 to PLN 30,000 (EUR 700-7,000), with an average expense of PLN 12,958 (around EUR 3,000). Costs associated with the removal of gonads and other internal genital organs range from PLN 2,500 (around EUR 584) to PLN 14,022 (around EUR 3,300), with an average expense of PLN 5,037 (around EUR 1,200). These prices make the service inaccessible for people from disadvantaged socioeconomic backgrounds.

Quality

No mechanisms are in place to effectively assess the quality of these services across the six Member States. Because of this, there is no comprehensive data that allows to assess the quality of sex reassignment surgeries across the countries at the core of this study.

In **Italy**, a 2014 investigation noted the presence of high risks for transgender people accessing sex reassignment surgery, due to a lack of experience of medical professionals, among other factors. At that time, at least 13 cases had been opened by transgender women, suing several hospitals and surgeons for malpractice ⁽²⁴³⁾.

Equal treatment

A lack of literature in the specific context of transgender people and access to healthcare was noted in the research across the Member States. However, transphobia and discrimination are reported as issues in other Member States as well. Additional research would be necessary to effectively assess equal

²⁴¹ [Transgender Europe, Overdiagnosed but Underserved, 2017](#)

²⁴² Transbalkan, Trans Health Croatia, available at: <http://www.transbalkan.org/zdravstvo/hrvatska/>

²⁴³ L'Espresso, Transgender, sono troppi I rischi per chi vuole operarsi in Italia, 2014 <http://espresso.repubblica.it/visioni/scienze/2014/03/19/news/trans-troppi-rischi-per-chi-si-opera-in-italia-1.157773>

treatment and access to healthcare by transgender people, particularly in the context of sex reassignment surgery and the broader context of SRH.

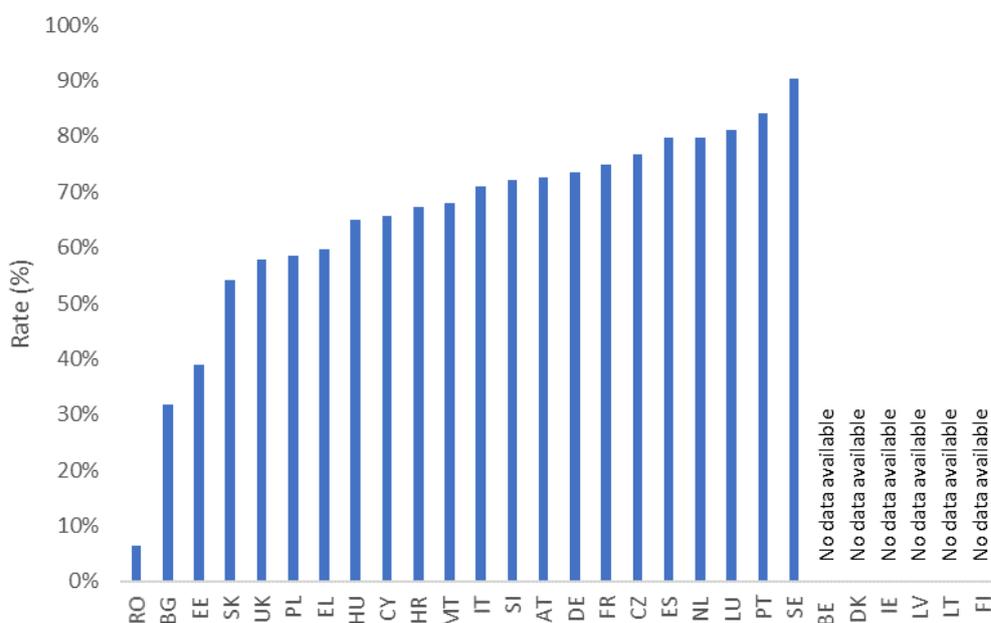
For example, according to the report 'Transgender and healthcare in Poland' (Trans-Fuzja Foundation, 2015⁽²⁴⁴⁾), one of the main barriers for effective access to quality SRH services for transgender people in the health sector is discrimination from medical professionals. This is manifested through language not corresponding to gender identity and preferred form, as well as loud, malicious and unkind comments (on appearance or documents), surprised looks and awkward questions. However, a lack of intimacy and privacy during the visit was also reported, as were a lack of gender neutral bathrooms and specific harmful practices such as pressing drugs into the mouths of patients by force.

3.2.7. Breast cancer and cervical screening

Availability

Eurostat publishes a range of data relating to breast cancer and cervical screening in the EU ⁽²⁴⁵⁾. Some of these data are self-reported across Member States, such as for last breast examinations by X-ray or cervical test among women, which can then be disaggregated by age, educational attainment level and degree of urbanisation. Survey data are also available to indicate the rates of breast cancer and cervical screening across the majority of EU Member States. Figure 11 below displays the rates of women having mammography screening for breast cancer for 2014 across Europe using survey data (2015 and 2016 data is only available for Turkey, Netherlands and Italy). The percentage attributed to each Member State is calculated as the number of women aged 50-69 who have received a bilateral mammography within the past two years (or according to the specific screening frequency recommended in each country) divided by the number of women aged 50-69 answering survey questions on mammography.

Figure 12: Mammography screening rates across Europe for women aged 50-69 (Eurostat, 2014)



²⁴⁴ Trans-Fuzja Foundation, Transgender and healthcare in Poland, 2015, available at: http://transfuzja.org/download/publikacje/transplciowosc_a_opieka_zdrowtona_w_polsce.pdf.

²⁴⁵ Data available from Eurostat table: h1th_ps_scre

The data show that **Sweden** excels for breast cancer screening (90.4 %). In the **Czech Republic**, the rates amount to around 75 %.

According to the Eurostat data, in **Croatia**, the rates of women having mammography screenings for breast cancer in 2014 are around 65 %. Data show access to cervical screening tests for 88.4 % women aged between 30-34 and 57.7% women aged 65-69. Of women in urban areas, 80.4 % had access to cervical screening test in the last three years, compared to 72.5 % women in rural areas. Women with higher education undertake cervical screening more frequently. Around 60 % of women with low incomes had access to cervical screening test in the three years prior to the survey. ⁽²⁴⁶⁾.

In **Italy**, the coverage of breast cancer and cervical screening services is assessed annually by the *Osservatorio Nazionale Screening* (ONS). In fact, the data present the relationship between the numbers of women invited to both breast cancer and cervical screening. The report also takes into consideration screening for colon and rectal cancer. The most recent report found that, in 2016, 40.5 % of women who received an official invitation for a free cervical screening accepted and accessed the service, with 56 % of women doing the same for free breast cancer screening ⁽²⁴⁷⁾.

In **Poland**, the rate of uptake in the breast cancer prevention programme in 2016 was 42.11 %, compared to a recommended optimal level of 70 %. According to the data published by the Ministry of Health, in 2017, over 1,000,000 women benefited from the programme. The rate of uptake of the cervical cancer prevention programme in 2016 was 20.86 %. According to data published by the Ministry of Health, in 2017 almost 460,000 women benefited from the programme.

In **Portugal**, the Breast Cancer Screening Programme (developed by the Portuguese League Against Cancer, in collaboration with Primary Health Care) has complete coverage of the central region of the country (78 counties), some districts in the Alentejo, the North and the Algarve (in this geographical area with the Algarve Oncological Association). In the districts of Porto, Lisbon and Setúbal coverage is partial (covering only some counties in each district) ⁽²⁴⁸⁾, according to information on the website of the Portuguese League (as at 14 September 2018). In 2014 the total population coverage rate was 73.1 % for the Portuguese mainland ⁽²⁴⁹⁾.

Affordability

In **Italy**, cervical screening is provided for free by family planning and counselling centres. Breast cancer screening is also covered by the national health systems within hospitals.

The cost of screening for the **Czech Republic, Croatia, Portugal, Poland** and **Sweden** are covered by national health insurance systems. In **Poland**, specifically, mammography tests are not limited and are covered by the state budget (for women aged 50-69, without referral).

Quality

The study found no comprehensive information about the quality of these services at national level within the six Member States.

²⁴⁶ European Health Interview Survey, Health Care Usage in Croatia 2014-2015, Croatian Institute of Public Health, 2017, available at: https://www.hzjz.hr/wp-content/uploads/2017/09/EHIS_02.pdf_FINAL_za-web.pdf

²⁴⁷ Osservatorio nazionale screening (2017). Rapporto 2017 <https://www.osservatorionazionalecreening.it/sites/default/files/allegati/ons%20rapporto%202017.pdf>

²⁴⁸ The territory of Portugal (Mainland) has 278 counties or municipalities (local public administration unit); 308 in total.

²⁴⁹ Miranda, N. & Portugal, C., Programa Nacional para as Doenças Oncológicas. Relatório 2014: Avaliação e Monitorização dos Rastreios Oncológicos Organizados de Base Populacional de Portugal Continental. Direção-geral da Saúde, 2015. Disponível em <https://www.dgs.pt>

In **Italy**, ONS reports provide information about the quality of the services, using indicators such as waiting times between the different breast cancer screening. The 2017 report found that programmes across the country still need to improve these services ⁽²⁵⁰⁾.

In **Portugal**, in the Cancer Monitoring and Evaluation Report for 2014 ⁽²⁵¹⁾, the Directorate-General for Health identified constraints to all population-based cancer screening programmes at national level, chiefly the financial sustainability of screening programmes, and decisions on the contractual model to guarantee service delivery. It concluded that 'there are many difficulties in the maintenance, extension and implementation of new screening by the regional health administration, related to organisational, logistical reasons and lack of human and financial resources. The situation is particularly critical in the case of screening for cervical cancer and colon and rectal cancer' (p.44).

Equal treatment

Equal treatment in access to breast cancer and cervical screening is not systematically reported in **Croatia**, the **Czech Republic**, **Italy**, **Poland**, **Portugal** and **Sweden**. Overall, these screenings must by law be accessible to all women, with some specific recommendations for women from certain age ranges, as outlined in Section 2.2.1. Particular challenges may relate to location and distance from medical infrastructure, as well as residency status, which might affect migrant women and refugees.

For example, in **Italy** cervical screening is provided within family planning and counselling centres. Again, not all family planning and counselling centres across the territory are fully operational, given staff and funding constraints. This might constitute a barrier for women in rural areas and far from such infrastructures. The 2017 ONS report noted differences in the provision of the service across the different regions, with additional barriers in the south of the country ⁽²⁵²⁾. In **Croatia**, as previously noted, differences might depend on whether women are in urban or rural areas, and some differences were recorded in relation to their education status. In **Poland**, in order to reach women living in rural areas and more isolated towns, there are special so-called 'mammo-buses' (mobile breast screening units) which travel across the country ⁽²⁵³⁾. The timetable of bus stops is published and updated on the Ministry of Health's website. Mobile units offering mammography are also found in **Portugal** at national level and **Italy** at municipal level, depending on the local health board.

3.2.8. Provision of SRH-related information

Availability

One way to assess the extent to which age-specific information is available is to look at data which indicates healthcare organisations' use of social media, with which younger generations are more likely to engage. The WHO Regional office for Europe published data on healthcare organisations' use of social media for the following:

- patient appointments;
- emergency announcements;

²⁵⁰ Osservatorio nazionale screening, Rapporto 2017

<https://www.osservatorionazionale screening.it/sites/default/files/allegati/ons%20rapporto%202017.pdf>

²⁵¹ Miranda, N. & Portugal, C., Programa Nacional para as Doenças Oncológicas. Relatório 2014: Avaliação e Monitorização dos Rastreios Oncológicos Organizados de Base Populacional de Portugal Continental. Direção-geral da Saúde, 2015. Disponível em:

<https://www.dgs.pt.p.44>

²⁵² Osservatorio nazionale screening, Rapporto 2017

<https://www.osservatorionazionale screening.it/sites/default/files/allegati/ons%20rapporto%202017.pdf>

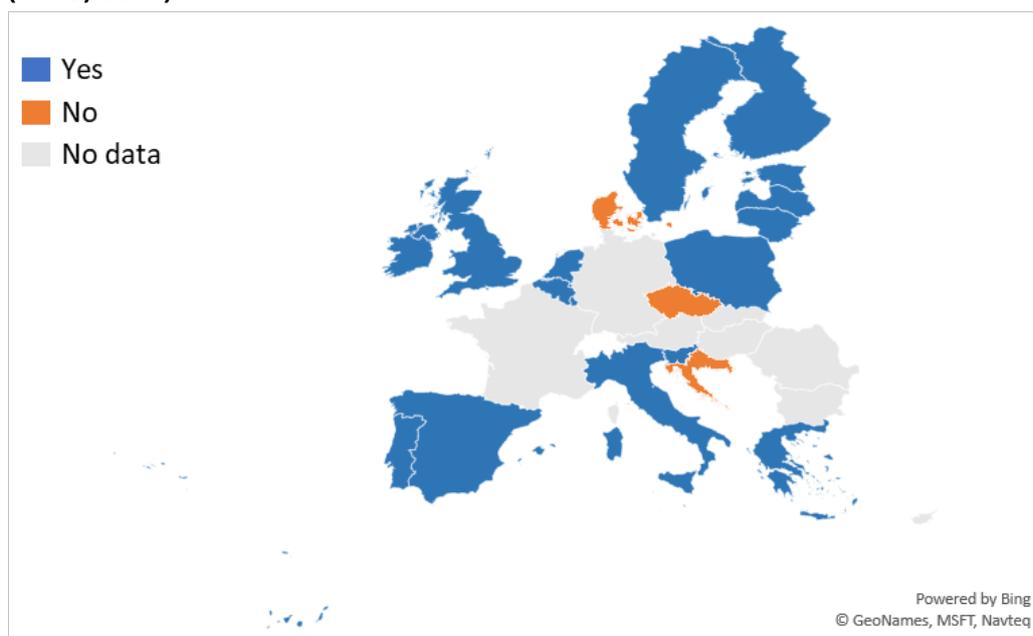
²⁵³ <http://www.nfz.gov.pl/dla-pacjenta/mammobusy>.

- general health announcements;
- to promote health messages as a part of health promotion campaigns;
- to seek feedback on services.

There are no data on access to SRH services specifically.

Figure 12 below explores data on healthcare organisations using social media to make general health announcements. Across the EU, the use of social media to communicate general health announcements appears to be very widespread, having been reported for all countries for which data is available (except Denmark, the Czech Republic and Croatia). However, this was observed in the context of general health announcements, and not necessarily specifically on issues related to SRH goods and services.

Figure 13: Healthcare organisations using social media to make general health announcements (WHO, 2017)



A lack of information on SRHR for all age groups and for vulnerable groups has been reported across the six Member States examined here.

In **Italy**, information on access to SRH goods and services is generally available within the public family planning clinics, within hospitals or within the website of the Ministry of Health. However, most information does not address specific age groups or vulnerable groups. It appears that no additional efforts are made to reach specific vulnerable groups, with some exceptions at local level. Sex education is not implemented at national level, but some initiatives have been implemented at local or institution-level, often thanks to the active participation of civil society organisations.

In the **Czech Republic**, SRH education is not mandatory in schools ⁽²⁵⁴⁾. Some campaigns are conducted by civil society organisations.

In **Croatia**, stakeholders pointed to a lack of data on the use of contraceptives hinders access and fosters misperceptions and a lack of knowledge about these methods. Meetings and conferences of

²⁵⁴ IPPF, Barometr dostupnosti moderních možností antikoncepce pro ženy v 16 zemích EU, 2015.

professional societies (often sponsored by the producers/manufacturers of contraceptives) are improving access to information among gynaecologists on the contraceptive goods available.

According to a UNICEF (2015) study on children and youth in Croatia ⁽²⁵⁵⁾, one-third of adolescents have difficulties in discussing sexuality, STIs and contraception with their doctors. Adolescent girls express the same concerns about pregnancy and gynaecological problems, as well. Education on SRHR is not part of all school curricula: the lack of information and knowledge on SRHR increases the risk of unwanted pregnancies among minors ⁽²⁵⁶⁾.

In **Poland**, there are no guides or information campaigns on access to SRH goods and services for different age groups and vulnerable groups. Information on access to SRH should be available to young people through sex education, but this is practically non-existent in Poland. Sex education is limited to preparing for family life, which could theoretically convey information about family planning but this does not happen in practice. Doctors are another potential source of information, as patients of all ages have access to information.

In **Portugal**, information on access to goods and services is available to everyone. The delegations of the Family Planning Association (Alentejo, Algarve, Centre, Lisbon, Autonomous Region of Madeira and North) provide services for children, young people and adults, and offer consultations in multiple specialties of SRH ⁽²⁵⁷⁾. Immigrants or non-speakers of Portuguese can access a permanently available translation service guaranteed by the public administration body with responsibility for the integration of immigrants. People with disabilities do not have specific materials (e.g. in Braille for people with visual impairment), nor are professionals prepared to deal with the particular needs of people with cognitive disabilities.

Promising practices from civil society organisations: information on SRH

Some of the best examples of the provision of SRH-related information are offered by civil society organisations.

In **Croatia**, CESI organised a social network campaign entitled 'My issue - my choice - it is time to learn more' (*Moja stvar, moj izbor – Vrijeme je da saznaš više*). The campaign aimed to inform young people about SRH and encourage greater involvement of young people in discussions and activities related to their SRH. The Facebook page has 7,750 users, and direct actions are organised in Zagreb, Karlovac and Rijeka. CESI produced three video blogs that were shown under the common name 'Like a cat around hot porridge' (*Kao mačka oko vruće kaše*). These video blogs have more than 8,500 views on YouTube ⁽²⁵⁸⁾.

In **Italy**, the portal *Vita di Donna* (Woman's life) provides comprehensive information on SRH goods and services in the country. As a non-profit organisation, *Vita di Donna* offers free counselling and assistance on the phone for any health-related issue. In particular, they provide information on where to effectively access SRH services such as abortions, family planning, contraception, obstetric, pre-natal and post-natal care ⁽²⁵⁹⁾.

²⁵⁵ UNICEF, Opinions and attitudes of children and youth in Croatia, (*Mišljenja i stavovi djece i mladih u Hrvatskoj*), 2015, available at: <https://www.unicef.hr/wp-content/uploads/2015/09/StavovidjeceimladihuHrvatskoj.pdf>

²⁵⁶ Grujić, J., Younger poor women are most affected by the reduction of right to abortion, Lupiga, (*Redukcijom prava na pobačaj najviše će biti pogođene mlade siromašne žene*), Lupiga, 2015, available at: <https://lupiga.com/intervju/intervju-pravo-na-pobacaj>

²⁵⁷ <http://www.apf.pt/servicos>

²⁵⁸ Video blog on contraception, CESI, available at: <http://www.cesi.hr/hr/novosti/1811-kao-macka-oko-vruce-kase/> and <http://www.cesi.hr/hr/novosti/1794-moja-stvar-moj-izbor-vrijeme-je-da-saznas-vise-1794/>

²⁵⁹ Vita di Donna, <https://www.vitadidonna.it/>

In the **Czech Republic**, AVON Pochod (AVON March) or [zdravaprsa.cz](https://www.zdravaprsa.cz) ([healthybreasts.cz](https://www.healthybreasts.cz)) aims to raise awareness about breast cancer and its prevention ⁽²⁶⁰⁾. A march has taken place every year since 2000 in order to achieve these goals. This campaign tries, for example, to fundraise for NGOs working in the area.

In **Sweden**, SRH education is mandatory in primary and secondary schools ⁽²⁶¹⁾. Specialist clinics also distribute tailored information for people of different age groups and vulnerability. For people with disabilities, the Support and Service Law for certain disabilities (*Stöd och service till vissa funktionshindrade, LSS*) ⁽²⁶²⁾ provides for the individual to live as good and independent a life as possible. This includes the right to work, study or have meaningful employment. Any support under this law, including advice, personal assistance etc. is offered free of charge. The policy places equal value on all people, and, as such, access to information and goods and services should occur on an equal footing. This is captured in the outreach work of organisations such as Funkis, which work to highlight SRHR needs of those who are differently abled and to apply the LSS law in these cases ⁽²⁶³⁾. A 2018 study by the National Board of Health and Welfare found that only 3 % of over 65-year olds do not access healthcare for financial reasons, and the vast majority of relatives are satisfied with the level of care their older family members receive ⁽²⁶⁴⁾.

Affordability

The issue of affordability is less relevant in the provision of SRH-related information, which typically comes in the form of communication campaigns, active involvement of civil society organisation, or through online campaigns and information provided in specific websites. These information campaigns do not necessarily have a cost per se, but a certain media presence is required. Campaigns might also be conducted through radio and TV programmes, which would offset issues of affordability further.

Quality

In **Italy**, the website of the Ministry of Health provides an overview of the family planning offices registered in the national territory, region by region. However, stakeholders highlighted that the information provided is not accurate, as many of these registered centres do not actually provide the full umbrella of services, due to being under-staffed, under-funded and, in some cases, affiliated with the Catholic Church. No additional information on the actual status and operation of the family planning office is provided in the website.

No monitoring and evaluation mechanisms for the implementation of information campaigns were identified across the six Member States.

Equal treatment

People from disadvantaged socioeconomic backgrounds might be excluded by information initiatives and campaigns, as may groups from rural areas, as they are less likely to have Internet access. As these

²⁶⁰ AVON Zdravá prsa, available at: <https://www.zdravaprsa.cz/>

²⁶¹ SKOLFS 2010:37, Preschool, basic school and school-based activities (*läroplan för grundskolan, förskoleklass och fritidshemmet*), 2010; SKOLFS 2011:144, High school teaching (*Gymnasieskolan*), 2011.

²⁶² Law 1993:387 Support and Service to the disabled (*Stöd och service till vissa funktionshindrade*), 27 May 1993, Updated 2018:571.

²⁶³ Funkis Projektet, About the Project (*Om Projektet*), 2018, available at <http://www.funkisprojektet.se/om-projektet/>

²⁶⁴ The National Board of Health and Welfare (*Socialstyrelsen*) (2018), Care and support for the elderly (*Vård och omsorg om äldre*), available at: <https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/20857/2018-2-7.pdf>

campaigns are in some cases run by family planning and counselling offices, as well as departments within hospitals, people living far from such infrastructure might not necessarily be reached. Radio and TV campaigns might have the value to offset these issues.

Women and other groups with disabilities might face additional barriers in accessing relevant information. A certain lack of attention to different groups was reported by interviewed stakeholders. This is the case both in terms of content, and in the way in which these information campaigns are carried out. For example, it would be necessary to provide information that is accessible by people with visual and hearing impairments.

Research has found that 'experiences of trans people in healthcare situations are precarious, and information and knowledge from healthcare providers is often lacking' ⁽²⁶⁵⁾.

Of the six Member States, only **Sweden** appears to demonstrate targeted provision of information for SRH-related issues.

3.3. Identified barriers to practical access and driving factors

Despite progress across Europe in terms of SRHR legislation and practice, 'women in Europe continue to face widespread denials and infringement of their sexual and reproductive health and rights' ⁽²⁶⁶⁾. In recent years, anti-choice movements, in many cases led by religious organisations, have grown in strength, as has their presence within political parties. At the same time, stigmatisation and social norms regarding women's sexuality and gender role still apply to many dimensions of women's lives ⁽²⁶⁷⁾.

This section provides an overview of the barriers identified in the six Member States in the context of access to SRH goods and services, specifically looking at:

- access to information on relevant SRH goods and services;
- accessibility of services, in terms of:
 - availability;
 - affordability;
 - quality;
 - equal treatment and specific barriers for marginalised and vulnerable groups.

Availability

The study identified barriers to accessing SRH goods and services at national level. These can be grouped into a number of categories, which relate variously to the six Member States. These barriers are particularly evident in access to contraceptives and access to abortion services, as well as sex-reassignment surgeries.

²⁶⁵ Transgender Europe, *Overdiagnosed but Underserved*, 2017.

²⁶⁶ Council of Europe, *Women's sexual and reproductive health and rights in Europe*. Issue paper, 2017. <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-paper/168076dead>, p. 5.

²⁶⁷ Council of Europe, *Women's sexual and reproductive health and rights in Europe*. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-paper/168076dead>, p. 5.

Barriers may be **legal**, due to restrictive laws and/or provisions that ignore SRHR. For example, **Poland's** restrictive anti-abortion law results in the criminalisation of many medical staff, while the conscientious objection clause is not well-regulated (²⁶⁸). There is frequently a gap between de jure protections of SRHR and de facto enjoyment of these entitlements and rights.

Barriers may be **procedural**, for example related to waiting times for abortion services. While in some cases these involve appropriate and medically justified steps, in others they imply the imposition of unnecessary preconditions on those intending to access the service. WHO guidelines state that mandatory waiting periods, for example, do not fulfil a medical purpose, but rather delay women's access to timely abortion care (²⁶⁹). An example of a procedural barrier is found in **Italy**, where RU486 for medical abortion can be administered only up to 50 days (seven weeks), while in most countries it can be administered up to 63 days.

Barriers might be **cultural**. In **Croatia, Italy, Portugal** and **Poland**, researchers reported a deep stigma in society as a whole, especially for services such as abortion, as well as provision of contraceptives. Individuals may not have high awareness of their reproductive rights. In **Croatia**, in 2012, the Internet portal 'Clinic for abortion' appeared, providing selective information on abortion services, mostly highlighting high health risks related to abortion, for the purposes of intimidation (²⁷⁰). Women who wish to terminate their pregnancy are subjected to serious psychological pressure (²⁷¹).

A number of Member States retain policies on abortion and contraception that are founded on presumptions that motherhood should be women's predominant social role. This is the case where legislation excludes legal abortion and contraception services from public health insurance or reimbursement schemes (²⁷²).

Barriers might also be driven by **religious factors**. This is an element that sustains the exercise of conscientious objection, explored in Section 4 of this report. Countries like **Croatia, Italy** and **Poland** continue to be particularly exposed to considerable influence from the Catholic Church in public and political discourse, and this can have an impact on the protection of SRHR. In **Croatia**, stakeholders noted that prayer sessions are organised by anti-choice religious movements in front of hospitals to specifically discourage women from accessing abortion services.

These barriers are exacerbated by a **lack of political support**, especially in **Croatia**, the **Czech Republic, Italy, Poland** and **Portugal**. Legislation and policy initiatives have demonstrated a general lack of attention to SRHR issues, which is even more pronounced with respect to inequality in access to SRHR. Stakeholders in **Italy** and **Croatia**, for example, point to a lack of funds targeting SRH within wider health budgets.

²⁶⁸ See section 4 for further details on the conscientious objection clause and its impact.

²⁶⁹ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>; WHO (2012), "Safe abortion: technical and policy guidance for health systems (2nd ed).

²⁷⁰ Cesar, S., Conscience-based refusal in reproductive medicine, CESI, 2017, available at: http://www.cesi.hr/attach/_c/conscienceobjection-eng~2.pdf

²⁷¹ Lupiga, False abortion clinics mushroom in Croatia and scare women that abortion leads to suicide or death ('Lažne klinike za abortus: Niču po Hrvatskoj i plaše žene da će se ubiti ili umrijeti nakon pobačaja'), 2014, available at: <https://lupiga.com/vijesti/lazne-klinike-za-abortus-koliko-smo-daleko-od-tog-mokrog-sna-nasih-ljubitelja-srednjeg-vijekaj>; interviews with stakeholders

²⁷² Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

In **Croatia**, the Ministry of Health has set out no standardised procedure providing information on termination of pregnancy or a standard procedure for gynaecological examination of a woman who opts for an abortion. Procedures vary depending on the hospital (some include waiting times and mandatory dissuasive counselling, or counselling by a social worker, psychologist or a nun) ⁽²⁷³⁾. The full autonomy of healthcare providers in terms of provision of termination of pregnancy represents an issue of public health as it has resulted in limited availability and legal and medical uncertainty for women ⁽²⁷⁴⁾.

A number of countries across the EU (including five of the Member States examined here) in which conscientious objection is an option, have failed to adopt adequate regulatory frameworks and enforcement measures, for example when it comes to enforcing an obligation to refer to another doctor. This element is further explored in Section 4 of the report.

Affordability

Financial concerns are a significant obstacle, with contraceptives being quite expensive in most countries, apart from some exceptions, as outlined above. This is particularly problematic for vulnerable groups, particularly for women from disadvantaged backgrounds. Public health insurance does not always cover important SRH goods and services. For example, in the Czech Republic and Poland, contraceptives are not covered. This means that women can face financial difficulty in accessing contraceptives, in particular long-acting reversible contraceptives and contraceptive pills.

Affordability of other goods, such as medicines for SRH-related illnesses, and SRH services, is mostly ensured across the six Member States through their national health systems.

Quality

In the specific context of contraceptives and medicines for SRH-related illnesses, such as STIs, quality is most often assured by national pharmaceutical agencies, in cooperation with the Ministries of Health.

An obstacle in terms of the quality of services is the lack of training for health professionals. Such training is often implemented on a case-by-case basis, depending on the commitment of municipalities, regions, or hospitals and clinics themselves. The lack of monitoring mechanisms does not allow for effective evaluation of the quality of services. Finally, pockets of **regional good practice are not always rolled out nationally**, as is the case in Italy.

Equal treatment

Challenges and barriers in availability, affordability and quality have stronger or distinct implications for marginalised and vulnerable groups ⁽²⁷⁵⁾. These barriers are often guided by stigma and preconceptions related to sexuality and reproduction. For example, 'women with disabilities, adolescents, older women, unmarried women and lesbian, bisexual and transgender people may face particular discriminatory presumptions of favour of asexuality, residual social opprobrium attached to sex outside of marriage, related expectations that young women should "protect their virginity", and

²⁷³ Portal novosti, Please, have an abortion elsewhere (2018).

²⁷⁴ Gender Equality Ombudsperson, Research: Practice of Health Institutions in Croatia to Ensure the Availability of Legally Induced Abortion (*Istraživanje: praksa zdravstvenih ustanova u Hrvatskoj po pitanju osiguranja dostupnosti legalno induciranog pobacaja*), 2014, available at: https://www.prs.hr/attachments/article/1555/05_ISTRA%C5%BDIVANJE%20-%20Praksa%20zdravstvenih%20ustanova%20u%20RH.pdf

²⁷⁵ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

prevailing homophobia and transphobia' (²⁷⁶). Undocumented women face additional challenges as well.

In **Poland**, national researchers have highlighted additional barriers for the following groups:

- unmarried and single women, due to discrimination on the grounds of marital status;
- sex workers, who become invisible in the system due to the lack of a coherent or uniform regulation;
- ethnic minorities, victims of trafficking and women with migrant backgrounds, due to discrimination, prejudice, socioeconomic disadvantage, lack of health insurance, and insecure residence status;
- older women, particularly due to the lack of a specific targeted approach in the context of SRHR;
- rural women, because of digital, territorial and economic exclusion, lack of medical infrastructure, and often lack of access to appropriate information;
- LGBTI people, due to discrimination and the lack of a targeted approach, which makes them invisible within the system.

These groups are also particularly vulnerable in the other Member States, as demonstrated by research at national level and confirmed by the stakeholders interviewed. These and other groups in Europe 'face intersectional discrimination on the grounds of sex, combined with other grounds in the realisation of their sexual and reproductive health and rights' (²⁷⁷).

In **Sweden**, only a few youth clinics are open at the weekend. For trans people, boys and men are under-represented in visits to these clinics. The National Board of Health and Welfare is rolling out strategies to try to tackle this shortfall. The lack of attention to LGBTI issues in **Italy** was reported by one of the stakeholders interviewed, who noted a particular lack of knowledge and training of health professionals both in the public and private sector.

A 2015 shadow report from the Czech Women's Lobby noted that **Czech Republic** has not taken measures to eliminate discrimination against migrants in access to public health insurance. This affects migrants' access to SRH. The same report noted direct discrimination of women in same-sex partnerships, who cannot legally request artificial insemination (²⁷⁸). Finally, harmful stereotypes underlie certain coercive practices, such as forced sterilisation of Roma women (²⁷⁹).

In **Croatia**, the lack of sufficient equipment for services for women with disabilities is reported. In 2016, there were around 67,000 women living with a disability in Croatia, and they are facing barriers to access to SRHR services. For example, there are 242 examination tables adapted to the needs of women with disabilities. Of 137 health facilities, 37 had no adapted table (including both private and public facilities). Around 26 % of adapted tables are found in private clinics, only some of which have agreements with the national institute for public health which ensure that their services are covered

²⁷⁶ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-paper/168076dead>

²⁷⁷ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-paper/168076dead>

²⁷⁸ https://czlobby.cz/sites/default/files/news_download/2015-czl_shadow_report_cedaw_final.pdf

²⁷⁹ ERRC (2016), 'Coercive and cruel: sterilisation and its consequences for Romani women in the Czech Republic (1966-2016)'.

by the mandatory health insurance. Medically assisted reproduction is not available to single women. Roma women face various constraints in access to healthcare, as a result of multiple discrimination and social exclusion based on ethnicity affiliation, gender and social status. Available data indicate that 21 % of Roma women have never had any health insurance, with the exception of pregnant women who access public support for expectant mothers ⁽²⁸⁰⁾.

In **Portugal**, one of the interviewees noted that girls under 16 face specific problems in accessing abortion services because they need an authorisation signed by a parent or legal guardian. There is also a certain difficulty for women in the Autonomous Regions of Açores and Madeira when they are on the mainland, because the autonomous regions health systems are not integrated into the national health system.

While there is a certain level of awareness about the added barriers for vulnerable groups, especially among health professionals operating in the field, policies and legislation largely overlook the issue of equal treatment and do not specifically target groups that might be particularly struggling to access SRH goods and services.

Another issue that particularly affects equal treatment is the **lack of information on SRH goods and services** for all age groups and vulnerable groups. As noted above, a particular lack of comprehensive information about SRHR was reported in **Croatia, Czech Republic, Italy** and **Poland**. This was not an issue in **Sweden**, where SRH education is mandatory in schools both at primary and secondary level, and where specialist clinics distribute information tailored for people of different age groups and vulnerabilities.

Information on relevant SRH services and the provision of SRH goods faces two challenges. Firstly, it might be particularly difficult to access relevant information, or the information available might not be age-specific or tailored to vulnerable groups. This was raised as a concern in **Portugal**. Similarly in **Italy**, information provided at national level is neither age-specific nor specific to vulnerable groups. The particular 'invisibility' of LGBTI people and their access to SRH has been noted.

Language presents another potential barrier, particularly for migrants and refugees. While in some cases translation services are provided (e.g. in **Sweden** and locally in **Italy**) these are not widespread practices.

²⁸⁰ OHCHR, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia, A/HRC/35/21/Add.2 (2016), available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/107/70/PDF/G1710770.pdf?OpenElement>

4. CONSCIENTIOUS OBJECTION LAW AND PRACTICE IN THE EUROPEAN UNION

KEY FINDINGS

- Conscientious objection is recognised internationally mainly via UN instruments and the ECHR. It is widely recognised by UN treaty bodies that the **right to conscientious objection is not absolute** and can be restricted in key circumstances.
- The ICESCR held that the exercise of **conscientious objection must not be a barrier** to accessing SRH services and the CEDAW Committee called upon State Parties to establish an effective mechanism of referral if health service providers refuse to perform reproductive health services for women based on conscientious objection.
- Under the ECHR, conscientious objection is guaranteed under the right to freedom of thought, conscience and religion, but **must be balanced** against respect for privacy and family life (which serves as the basis for many SRH rights). Both rights can be limited to protect 'health and morals' or the rights of others.
- Relevant ECtHR rulings established that applicants cannot use their religious beliefs to justify refusing to sell contraceptive methods to certain individuals, and that governments are obliged to ensure that the exercise of freedom of conscience does not block patients from accessing services to which they are legally entitled.
- There is **no clear competence under the EU** mandate to regulate the harmonisation of the right to conscientious objection in access to SRH goods and services.
- The EU's **Employment Equality Directive** (Directive 2000/78/EC) protects healthcare employees from discrimination due to their religion or beliefs in relation to employment conditions. However, a restriction could be applied on the freedom of religion or belief when it results from a genuine occupational requirement, the objective is legitimate, and the requirement is proportionate.
- **22 of the 28 Member States provide for a right to conscientious objection** in relation to the provision of abortion ⁽²⁸¹⁾. In the six Member States in this study, all but Sweden have a conscientious objection clause in their legislation. Croatia, the Czech Republic and Poland have broad provisions that do not explicitly cover SRH services and goods. Italy and Portugal have specific conscientious objection clauses in relation to the provision of SRH services and, in particular, abortions and related procedures. Czech Republic, Italy, Poland and Portugal establish some limitations to the application of conscientious objection. Most commonly, these prevent conscientious objection from being invoked where it will cause a serious danger to a patient's life.
- There are key gaps in the legislation on conscientious objection, for example **limited right of appeal**, a **lack of obligation to refer** to other medical practitioners and a **failure to pay specific attention to vulnerable groups**.
- There is a **lack of data** on the extent of conscientious objection in the six Member States. The impact of conscientious objection on access to SRH goods and services has not been

²⁸¹ Belgium, Czech Republic, Denmark, Germany, Estonia, Ireland, Greece, Spain, France, Croatia, Italy, Latvia, Luxembourg, Hungary, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, United Kingdom.

effectively monitored and measured. However, it appears that to constitute an additional barrier for women in accessing healthcare and SRHR specifically.

The driving factors behind the exercise of conscientious objection and the resulting limited access to SRH services are: a **strong religious background and culture** has affected the understanding of services such as abortion; **anti-choice movements**, as well as movements with a specific interest in subverting advancements in gender equality, have grown across Europe in the past 10 years; **work-place culture**, which encourages the practice of conscientious objection and often actively discourages the provision of abortion services; the **stigma** of abortion; **lack of information and sufficient training**

Access to SRH at times comes into conflict with freedom of thought, conscience and religion. Freedom of conscience is a fundamental right guaranteed within the EU, thus the right to conscientious objection was formulated at national and international level, in particular in regard to performing abortion. However, its unregulated or unlimited exercise may lead to serious violations of SRHR in the form of restrictive access to abortion or prescribing, selling or advising on contraceptive methods, which may affect people's SRHR, particularly women's rights.

This section reviews the existing international and EU framework in relation to conscientious objection and how the legal frameworks attempt to address the issue of conflict between two fundamental rights, i.e. the right to health and the right to freedom of religion, thought and conscience. It also presents an overview of the situation in Member States in law and practice, as well as the challenges and driving factors.

4.1. International and European framework

4.1.1. International legal and policy framework

Conscientious objection is recognised at the international level through two main avenues: UN instruments and within the CoE ECHR framework.

The UN

International human rights conventions and mechanisms recognise conscientious objection under provisions on the right to freedom of thought, conscience and religion. Article 18 of the **ICCPR** is dedicated to the latter, in granting everyone the freedom to express their religion and not be subject to coercion that would potential impair that freedom. The Human Rights Committee, in its General Comment No 22, confirmed that conscientious objection falls within the scope of Article 18 of the ICCPR ⁽²⁸²⁾. However, the ICCPR recognises that the freedom to exercise individual beliefs 'may be subject to such limitations' prescribed by law and necessary to protect fundamental rights and freedoms of others (Article 18, para. 3) ⁽²⁸³⁾. Thus, the right **is not absolute**.

In its General Comment No 28, the Human Rights Committee reflects that 'States Parties should ensure that traditional, historical, religious or cultural **attitudes are not used to justify violations of women's right** to equality before the law and to equal enjoyment of all Covenant rights' ⁽²⁸⁴⁾.

Article 12 ICESCR guarantees the right to health, which include the right to SRH. In its General Comment No 22 on the right to SRH, the Committee on Economic Social and Cultural Rights (**CESCR**) specifies

²⁸² Human Rights Committee, [CCPR General Comment No. 22: Article 18](#) (Freedom of Thought, Conscience or Religion), 1993.

²⁸³ Article 18, para. 3 ICCPR.

²⁸⁴ Human Rights Committee, [General Comment No. 28 Article 3](#) (The equality of rights between men and women), 2000.

that the exercise of **conscientious objection must not be a barrier** to accessing health services. State Parties have an obligation to ‘appropriately regulate this practice’ to guarantee that it does not restrict access to SRH care - for example by requiring that **referrals** are made to accessible providers in a position to provide the services in question – and that it does not stop services from being performed during emergencies. In addition, State Parties must ensure an adequate number of healthcare providers willing and able to provide such services within reasonable geographical reach ⁽²⁸⁵⁾.

The Human Rights Committee, in the sixth periodic report for Poland, expressed concerns about women’s access to reproductive health services, including contraception counselling, pre-natal testing and abortion. The document explicitly links said access and inappropriate application of the ‘conscience clause’ ⁽²⁸⁶⁾. The ICESCR ⁽²⁸⁷⁾ specifically calls for state regulation of conscientious objection clauses, including the legal obligation of healthcare providers to implement a mechanism of systematic referral ⁽²⁸⁸⁾.

CEDAW affirms the right to reproductive choice, guaranteeing women’s right ‘to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights’ (Article 16 (e)). The CEDAW Committee, in General Recommendation no. 24, called on State Parties to establish an **effective mechanism of referral**, if health service providers refuse to perform certain reproductive health services for women based on conscientious objection ⁽²⁸⁹⁾. In a statement on SRHR beyond 2014 ICPD, the CEDAW Committee declared that State Parties should organise ‘health services so that the exercise of conscientious objection does not impede **their effective access to reproductive healthcare services**, including abortion and post-abortion care’ ⁽²⁹⁰⁾.

A number of UN bodies have called for exercise of conscientious objection in a way that is **compatible with the exercise of SRHR**. The Office of the UN High Commissioner for Human Rights (OHCHR) calls for states to ensure that the claim to conscientious objection by health professionals does not prevent women from accessing health services ⁽²⁹¹⁾. This issue concerns different groups and particular attention should be paid to vulnerable and disadvantaged groups, which include adolescents, unmarried people, socioeconomically disadvantaged people, people living with HIV, people with disabilities, LGBTI people, drug users and people engaged in sex work (as defined by the 2016 WHO Europe Action Plan for sexual and reproductive health ⁽²⁹²⁾). For example, the UN Committee on the Rights of the Child has explicitly called for Member States to ensure that ‘adolescents are not deprived of any sexual and reproductive health information or services due to providers’ conscientious objections’ ⁽²⁹³⁾.

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health specifically states that a health system should provide a

²⁸⁵ Committee on Economic, Social and Cultural Rights, [General comment No. 22 \(2016\) on the right to sexual and reproductive health](#) (Article 12 of the International Covenant on Economic, Social and Cultural Rights), paras.14 and 43.

²⁸⁶ Human Rights Committee, Concluding Observations: Poland, para. 12, U.N. Doc. CCPR/C/ POL/CO/6 (2010).

²⁸⁷ Committee on Economic, Social and Cultural Rights, Concluding Observations: Poland, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009).

²⁸⁸ Zampas, C. & Andión-Ibañez, X., Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice. *European Journal of Health Law* 19, 2012, p. 234.

²⁸⁹ Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 (women and health), (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies* (Vol. II), at 358, para. 11, U.N. Doc. A/HRI/GEN/1/Rev.9 (2008).

²⁹⁰ Committee on the Elimination of Discrimination against Women, [Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review, 2014](#).

²⁹¹ Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to the eliminate preventable maternal mortality and morbidity, A/HRC/18/27 (2011), para. 30.

²⁹² WHO, [Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind, 2016](#).

²⁹³ General comment 15, on the Right of the child to the enjoyment of the highest attainable standard of health, 2013, , ra 69.

continuum of prevention and care, where 'the absence of an effective referral system is inconsistent with the right to the highest attainable standard of health' (294).

As outlined in Section 2.1.1, the 2016 **WHO European Action Plan for Sexual and Reproductive Health** (295) specifically tackles SRHR, paying particular attention to Europe. The Action Plan presents three main goals and 14 related objectives. Under Goal 2, to ensure that all people can enjoy the highest attainable standard of sexual and reproductive health and wellbeing, the document addresses the specific objective to attend to everyone's concerns and needs related to SRHR. It is in this context that it calls for states to ensure that the exercise of conscientious objection does not jeopardise people's access to services related to SRHR. On the provision of safe abortions, the WHO clearly states that individual healthcare providers have a right to conscientious objection, but that this right should not entitle them to impede or deny access to lawful abortion services because of the risk posed by delayed care to women's health and life (296). The WHO again stresses the importance of referral mechanisms, adding that where referral is not possible, 'the healthcare professional who objects must provide safe abortion to save the woman's life and to prevent serious injury to her health' (297).

The Council of Europe

Conscientious objection is guaranteed under **Article 9 ECHR** on the right to freedom of thought, conscience and religion. This must be balanced with Article 8 on the right to respect for private and family life. As noted in Section 2.1.1, 'private life' is understood by the ECtHR to encompass the right to personal autonomy, and to include topics such as gender identity, sexual orientation, sexual life, physical and psychological integrity of individuals and decisions on having children. According to the Convention, both rights can be subject to limitations 'for the protection of health and morals, or for the protection of the rights and freedoms of others'. This demonstrates the complexity in balancing the right of health providers to conscientious objection with the right of people, especially women, to access SRHR.

The European Court of Human rights (ECtHR) has made a number of rulings interpreting the scope of Article 9 in relation to the right to conscientious objection in the context outside military service. The ECtHR has held that the right to **conscientious objection may be restricted** on the ground of public interest in ensuring equal treatment for all users (298). Two cases are particularly relevant in the context of conscientious objection, namely *Pichon and Sajous v. France (2001)*, and *R.R v. Poland (2011)*.

In *Pichon and Sajous v. France (2001)*, the applicants were the joint owners of a pharmacy in Salleboeuf, France. Both refused to supply contraceptives to three women who provided regular prescriptions, for religious reasons (299). The ECtHR ruled that 'the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere' (300).

In the *R.R v. Poland case (2011)*, in relation to the right of physicians and medical practitioners to refuse certain services based on conscience clauses, the Court noted an obligation for states to

²⁹⁴ Report to the Human Rights Council of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2008, A/HRC/7/11, para. 55.

²⁹⁵ WHO, [Action for Sexual and Reproductive Health: Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind](#), 2016.

²⁹⁶ WHO, [Safe abortion: technical and policy guidance for health systems](#). Second edition, 2012.

²⁹⁷ WHO, [Safe abortion: technical and policy guidance for health systems](#). Second edition. 2012, p. 69.

²⁹⁸ ECtHR, *Eweida and Others v. the United Kingdom*, § 105. See ECtHR, [Guide on Article 9 of the European Convention on Human Rights: Freedom of thought, conscience and religion](#), 2018.

²⁹⁹ Nawrot, O., Conscientious objection and European vision of Human Rights. *Prog Health Sci* 2016, Vol 6, No 1, 2016.

³⁰⁰ ECtHR *Pichon and Sajous v France*.

ensure that effective exercise of the freedom of conscience of health professionals does not constitute an obstacle for patients' access to services to which they are legally entitled ⁽³⁰¹⁾. More specifically, the Court ruled that there had been a violation of Article 3 of the ECHR, namely the prohibition of inhuman and degrading treatment, and a violation of Article 8, on the right to respect for private and family life ⁽³⁰²⁾.

In ***Pichon and Sajous v. France (2001)***, the applicants were the joint owners of a pharmacy in Salleboeuf, France. Both refused to supply contraceptives to three women who provided regular prescriptions, for religious reasons ⁽³⁰³⁾. The ECtHR ruled that 'the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere' ⁽³⁰⁴⁾.

In the ***R.R v. Poland case (2011)***, in relation to the right of physicians and medical practitioners to refuse certain services based on conscience clauses, the Court noted an obligation for states to ensure that effective exercise of the freedom of conscience of health professionals does not constitute an obstacle for patients' access to services to which they are legally entitled ⁽³⁰⁵⁾. More specifically, the Court ruled that there had been a violation of Article 3 of the ECHR, namely the prohibition of inhuman and degrading treatment, and a violation of Article 8, on the right to respect for private and family life ⁽³⁰⁶⁾.

Claims to conscientious objection which would have limited access to SRHR to different groups, including LGBTI people, have been unsuccessful. In 2013, the ***Ladele and McFarlane v. the United Kingdom*** case saw two applicants appeal to the ECtHR after having their employment contracts terminated, complaining of a violation of Article 9 on freedom of thought, conscience and religion, and Article 14, on the prohibition of discrimination, specifically on the grounds of religion. The first applicant was a registrar of births, deaths and marriages who refused to preside at same-sex civil partnership ceremonies, while the second was a sex therapy and relationship counsellor who refused to counsel same-sex couples. Both applicants explained their actions on the grounds of religious beliefs. The ECtHR rejected both appeals.

Resolution 1763 (2010) of the Council of Europe tackles the right to conscientious objection in lawful medical care. In particular, it comprises four main points. First, it states that no person, hospital or institution shall be coerced or discriminated against because of its refusal to perform or assist an abortion, miscarriage, or euthanasia. Second, it emphasises the need to balance the right to conscientious objection with state responsibility to ensure people's access to lawful medical care. The Parliamentary Assembly expressed its concern 'that the unregulated use of conscientious objection may disproportionately affect women, notably those with low incomes or living in rural areas' ⁽³⁰⁷⁾. Third, it underlines the adequate regulation of the practice of conscientious objection across the Member States of the Council of Europe itself. Finally, the Resolution calls for clear and comprehensive regulations on conscientious objection in lawful medical care ⁽³⁰⁸⁾. The adopted Resolution does not

³⁰¹ ECtHR R.R v Poland case, para 206.

³⁰² European Court of Human Rights, [Reproductive rights, Factsheet](#).

³⁰³ Nawrot, O., Conscientious objection and European vision of Human Rights. Prog Health Sci 2016, Vol 6, No 1, 2016.

³⁰⁴ ECtHR *Pichon and Sajous v France*.

³⁰⁵ ECtHR R.R v Poland case, para 206.

³⁰⁶ European Court of Human Rights, [Reproductive rights, Factsheet](#).

³⁰⁷ Council of Europe, Parliamentary Assembly, The right to conscientious objection in lawful medical care (2010), <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909&lang=en>

³⁰⁸ Council of Europe, Parliamentary Assembly, The right to conscientious objection in lawful medical care (2010), <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909&lang=en>

contain specific restrictions or regulations for conscientious objection ⁽³⁰⁹⁾. It should be noted that while Parliamentary Assembly resolutions may be used for the purposes of interpretation, they are not binding ⁽³¹⁰⁾.

4.1.2. EU legal and policy framework

4.1.2.1. EU legal framework on conscientious objection

The EU has **no clear competence** to regulate the harmonisation of the right to conscientious objection in access to SRH goods and services or to take legislative action to prevent its application to restrict access to goods and services.

Under Articles 10 and 19 TFEU, the EU is empowered to define and implement policies to combat discrimination based on religion or belief. To date, the EU has adopted a legal measure in relation to non-discrimination based on religion or belief in the employment sector: Employment Equality Directive (Directive 2000/78/EC).

The **Employment Equality Directive** aims to guarantee equal treatment irrespective of religion and belief (among other grounds) in employment and occupation in both the public and private sectors. The Directive prohibits direct and indirect discrimination, instructions to discriminate, harassment and victimisation. Accordingly, healthcare employees are protected from discrimination due to their religion or belief in relation to employment conditions, including promotion, and working conditions. As a result, a medical or health professional cannot be dismissed or refused promotion for having exercised their right to freedom of religion or belief in the form of a conscientious objection.

Article 4(1) of the Directive provides, however, that a difference of treatment based on religion or belief does not constitute discrimination 'where, by reason of the nature of the particular occupational activities concerned or of the context in which they are carried out, such a characteristic constitutes a genuine and determining occupational requirement, provided that the objective is legitimate, and the requirement is proportionate'. Arguably, a health care professional could thus be prevented from exercising conscientious objection ⁽³¹¹⁾. Courts would apply the **proportionality test** to determine whether such derogation pursues a legitimate aim that is necessary and proportionate. This assessment would take into account the nature of the services/goods provided as well as any disproportionate burden placed on the employer and on the rights and freedoms of others, as a result of the objection.

In the case C-157/15 (Achbita), the CJEU held that the pursuit of a legitimate aim allows a restriction to be imposed on the freedom of religion, within certain limits ⁽³¹²⁾. In this case, the CJEU balanced freedom of religion (including the right to manifest it) with freedom to conduct business. It considered that an employer's wish to project an image of neutrality towards customers is in principle a legitimate aim. The CJEU applied a similar test to that adopted by the ECtHR. Limitations to freedom of thought, conscience and religion may therefore occur when this right is balanced with other rights, and a proportionality test is conducted.

³⁰⁹ Commentary – Conscientious Objection and the Council of Europe, the right to conscientious objection in lawful medical care Resolution 1763 (2010).

³¹⁰ ECtHR, Demir and Baykara v. Turkey, para 74

³¹¹ Bribosia, E. & Rorive, I., In search of a balance between the right to equality and other fundamental rights, European Network of Legal Experts in the Non-Discrimination Field, 2010.

³¹² Case C-157/15 Judgment of the Court (Grand Chamber) of 14 March 2017 ECLI:EU:C:2017:203 para. 39.

As the right to freedom of religion and belief is not absolute, guaranteeing the right in relation to SRHR can be a balancing act and has led to **conflict between both rights**. Tensions have arisen where healthcare professionals exercised their conscientious objection, on one hand, and when healthcare professionals expressed their support for abortion on the other hand. The former is exemplified by the ECtHR Pichon and Sajous case, where two pharmacists were criminally convicted as a result of their refusal to sell the contraceptive pill, on the basis of their religious beliefs. The ECtHR noted that the freedom of religion and conscience does not 'always guarantee the right to behave in public in a manner governed by [one's] belief'. The Court found that their religious beliefs could not justify their refusal to sell contraceptives. It follows that conscientious objection cannot lead to the restriction of the rights and freedoms of another person. In another case, a Swedish midwife who refused to participate in abortions or prescribe contraceptives (both part of midwives' responsibilities) was prevented from being employed by three clinics. The Swedish Ombudsman and District Court both ruled against her claim of discrimination⁽³¹³⁾.

In countries with healthcare facilities traditionally organised under a **religious ethos**, the question arises whether healthcare professionals expressing strong beliefs in favour of SRHR which conflict with the religious views of the organisation may be prevented from being employed or made redundant as a result of their beliefs. In fact, the Employment Equality Directive allows public or private organisations with ethos based on religion or belief to 'require individuals working for them to act in good faith and with loyalty to the organisation's ethos'. In the Lombardi v. Italy case, a professor was denied employment due to his views in favour of abortion. The ECtHR ruled that the University's interest in dispensing teaching based on Catholic doctrine did not justify the interference with the applicant's freedom of expression and had not been 'necessary in a democratic society'⁽³¹⁴⁾. In line with this case law, a healthcare professional should not be excluded from a particular employment as a result of their views in favour of SRHR.

The **Charter of Fundamental Rights of the European Union** recognises the right to freedom of thought, conscience and religion and specifically guarantees the right to conscientious objection 'in accordance with the national laws governing the exercise of this right' (Article 10)⁽³¹⁵⁾. The right to conscientious objection should, however, be balanced with the right to healthcare laid down in Article 35 of the Charter. In addition, the Charter provides that the scope and meaning of the guaranteed rights are determined not only by the text of the Charter, but also by the case law of the ECtHR and CJEU. The EU may only guarantee a higher level of protection than the ECHR, thus the right to conscientious objection under EU law should be interpreted in the same manner as the case law of the ECtHR.

Lastly, since all Member States have ratified the ECHR, the limitations to conscientious objection imposed by the CoE apply to Member States. In addition, EU law⁽³¹⁶⁾ and EU jurisprudence⁽³¹⁷⁾ confirmed that fundamental rights as guaranteed by the ECHR are considered general principles of EU law and the meaning and scope of the rights contained in the Charter must be the same as those laid down by the ECHR. The CJEU has ruled accordingly, confirming that EU fundamental rights should correspond to the rights guaranteed by the ECHR. EU legislation should thus be interpreted in light of the body of law and case law developed under the ECHR.

³¹³ International Campaign for Women's Right to Safe Abortion, [Sweden: Where conscientious objection to abortion is not recognised in law](#), 2017.

³¹⁴ ECHR case Lombardi Vallauri v Italy [2011] ECHR 1636.

³¹⁵ Charter of Fundamental Rights of the European Union, <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012P/TXT&from=EN>

³¹⁶ Article 6 of the TEU and Article 52(3) of the EU Charter of Fundamental rights.

³¹⁷ Case C-294/16 PPU Judgment of the Court (Fourth Chamber) of 28 July 2016 ECLI:EU:C:2016:610 para. 50

In an opinion on the right to conscientious objection, the EU Network of independent experts on fundamental rights observed that the right to religious conscientious objection 'should be regulated in order to ensure that, in circumstances where abortion is legal, **no woman shall be deprived from having effective access to the medical service of abortion**'⁽³¹⁸⁾. As a result, States must ensure:

1. effective remedy to challenge any refusal to provide abortion;
2. an obligation on the healthcare practitioner exercising the right to conscientious objection to refer to another qualified healthcare practitioner who will agree to perform the abortion;
3. ensure that another qualified healthcare practitioner will be available, including in rural or remote areas.

4.1.2.2. EU policy framework on conscientious objection

As a result of its limited competence, the EU has not adopted policy actions directly addressing conscientious objection, with policy instruments focusing on EU external action. One of such example is the EU Guidelines on the promotion and protection of freedom of religion and belief adopted by the Council of the European Union in 2013⁽³¹⁹⁾. The Guidelines state that '*As opposed to the freedom to have a religion, to hold a belief or not to believe, the freedom to manifest one's religion or belief may be subject to limitations, but only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others*'. According to the EU Council, limitations on the freedom to manifest one's religion should be authorised if they are necessary to protect public health. The institution adds that these limitations must be in accordance with international standards.

The 2001 European Parliament Resolution on sexual and reproductive health and rights⁽³²⁰⁾ called on Member States and accession countries to undertake a range of actions with regard to contraception, prevention of unwanted pregnancy and abortion, and adolescent SRH and sexuality education. On unwanted pregnancies and abortion, the Resolution called upon governments to ensure, in cases of legitimate conscientious objection of the provider, referral to other service providers⁽³²¹⁾.

4.2. Member States' legal frameworks and practices

4.2.1. National legal approaches to conscientious objection in access to SRH services and goods

22 of the 28 Member States provide for a right to conscientious objection in relation to the provision of abortion.

Member States with conscientious objection

Belgium, Czech Republic, Denmark, Germany, Estonia, Ireland, Greece, Spain, France, Croatia, Italy, Latvia, Luxembourg, Hungary, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, United Kingdom

Source: 2018 WHO [Global Abortion Policies Database](#)

³¹⁸ EU Network of independent experts on fundamental rights, [OPINION N° 4-2005: The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy see](#), 14 December 2005.

³¹⁹ [EU Guidelines on the promotion and protection of freedom of religion or belief](#), 24 June 2013.

³²⁰ Resolution on sexual and reproductive health and rights, Eur. Parl. Assemb. 2001/2128(INI) (2002).

<http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+REPORT+A5-2002-0223+0+DOC+XML+V0//EN>

³²¹ Resolution on sexual and reproductive health and rights, Eur. Parl. Assemb. 2001/2128(INI) (2002), para 10

Within those allowing for the exercise of conscientious objection in relation to abortion, Member States vary in their regulation. Some explicitly impose limits on the exercise of that right, such as in emergency situations, while others require an obligation to refer. This section presents a more in-depth overview of the legal framework and practical application of conscientious objection in the six Member States covered by this study.

4.2.1.1. Conscientious objection in six Member States

Research on the legal frameworks of the six Member States examined in this study found that most countries, except **Sweden**, have a conscientious objection clause in their legislation in relation to health services and specifically SRH services and goods. In terms of **scope**, **Croatia**, the **Czech Republic** and **Poland** have **broad provisions** that do not explicitly cover SRH services and goods. **Italy** and **Portugal** have **specific conscientious objection clauses** in relation to the provision of SRH services and, in particular, abortion and related procedures.

- In **Croatia**, the right to conscientious objection is guaranteed for doctors and paramedical staff (e.g. nurses), as well as pharmacists. According to the legal framework, health professionals can invoke conscientious objection on the grounds of moral, ethical or religious attitudes and beliefs, and refuse to provide diagnoses, medical care and rehabilitation of patients ⁽³²²⁾.
- In **Czech Republic**, a conscientious objection clause was added to the Act on Health Services no. 372/2011. The legislation notes that medical staff may refuse health services to a patient if this contradicts their conscience or religion ⁽³²³⁾. This clause refers to health services but makes no mention of the provision of goods.
- In **Italy**, conscientious objection is covered by Article 9 of the 1978 Law no. 194 on the social protection of motherhood and the voluntary termination of pregnancy ⁽³²⁴⁾, and it is guaranteed for doctors and health professionals. No definition of conscientious objection is provided here but is, however, defined by Law n.772 from 1972, which relates to the military service, where conscientious objection is based on 'strong and profound religious or philosophical or moral reasons'.
- In **Poland**, physicians, nurses and midwives may refuse to provide medical services that conflict with their conscience, according to the so-called 'conscience clause', regulated by Article 39 of the Act on the Physicians' and Dentists' Professions ⁽³²⁵⁾. This clause is universally formulated and does not refer directly to any aspect of reproductive rights.
- In **Portugal**, the right to conscientious objection allows a citizen not to fulfil certain legal obligations by virtue of convictions of a religious, moral, humanistic or philosophical nature. Conscientious objection specifically in cases of voluntary termination of pregnancy is regulated by Law no. 16/2007. Accordingly, doctors and other health professionals can invoke the right to conscientious objection in relation to any act relating to voluntary termination of pregnancy.
- In **Sweden**, the legislation does not recognise the right to conscientious objection in the provision of SRH services and goods. The Healthcare Act, the Patient Safety Act and the

³²² C izmic , Right of health workers to conscientious objection (Pravo zdravstvenih radnika na 'priziv savjesti'), University of Split, 2016, available at: <https://hrcak.srce.hr/file/237854>.

³²³ Act on Health Services No. 372/2011 Coll., <https://www.zakonyprolidi.cz/cs/2011-372#cast5>

³²⁴ Legge 22 maggio 1978, n. 194 Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza. Available at: http://www.salute.gov.it/imgs/C_17_normativa_845_allegato.pdf; in English: http://www.columbia.edu/itc/history/degrazia/courseworks/legge_194.pdf

³²⁵ Act of 5 December 1996 on the medical and dentist professions, Journal of laws 2011, Nr 277, item 1634 with further changes. <http://prawo.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU19970280152>

Abortion Act make it clear that the needs and rights of the patient are placed above those of the healthcare provider. If a patient wishes to have an abortion and it is within the first 18 weeks, the healthcare provider cannot refuse to provide the service.

Croatia, Czech Republic, Italy, Poland and Portugal also establish some legal **conditions and limitations** to the application of conscientious objection.

- In **Croatia**, Article 20 of the Law on medical doctors ⁽³²⁶⁾ provides that conscientious objection can be invoked to refuse to undertake diagnosis, treatment and rehabilitation of a patient if this does not interfere with the rules of the profession and 'if this does not cause permanent consequences for health or endanger the life of the patient'. The doctor must inform the patient promptly, as well as his/her supervisor or employer. However, the extent of interference with the rules of the profession is not explicitly explained.
- In **Czech Republic**, the legislation specifies that conscientious objection cannot be invoked 'if it threatens the patient's life or if it is a serious threat to his or her health' ⁽³²⁷⁾.
- In **Italy**, conscientious objection can be invoked exclusively in relation to abortion, but not for any care before or after the procedure. The objection cannot be invoked if the pregnant woman in question is in serious danger and it is necessary to intervene to save her life. The legislation also states that if someone is registered as an objector, this status will be revoked if the health professional conducts abortion and related procedures at any point.
- In **Poland**, conscientious objection cannot be invoked if the delay in providing the service would cause risk to life and serious damage to the woman's health. The health professional may rely on conscientious objection on the condition that he/she provides grounds for its application in the specific case. Health practitioners are required to include a note of the conscientious objection in the medical file of the patient, as well as to inform their supervisor in writing.
- In **Portugal**, Law no. 16/2007 establishes that conscientious objection cannot be invoked when there is a danger to life or a serious threat to the woman's health. The legislation specifies that if a health professional is a conscientious objector, this has to be followed in the public sector and private sector alike, since it is grounded on personal convictions that do not change according to the type of service.

Some reference to the possibility to file complaints or to **appeal** is mentioned in the legislation of **Poland**. In the case of refusal to issue a prescription for contraceptive pills (including for emergency contraception), to refer for prenatal tests or to issue a certificate on the medical grounds for abortion, a patient is entitled to file a complaint on lack of access to the health service to the regional office of the National Health Fund and to the Commissioner for Patients' Rights and Commissioner for Professional Liability. In **Croatia**, patients have the right to appeal before a hospital board, order of doctors and administrative court. However, there are no known records of appeals. A right to appeal is not explicitly recognised in the legislation of the Czech Republic, Italy and Portugal, although usual administrative procedures would apply.

Legislation in **Croatia** and the **Czech Republic** includes requirements for the conscientious objector to refer the patient to another doctor. **Referrals to other medical practitioners** are not a requirement in the legislation of **Italy, Poland and Portugal**. In the specific case of **Poland**, until 2015, doctors

³²⁶ (Zakon o liječnicima), OG 121/03,117/08

³²⁷ Act on Health Services No. 372/2011 Coll., <https://www.zakonyprolidi.cz/cs/2011-372#cast5>

refusing a particular service were obliged to refer the patient to another practitioner or institution where the required service could be provided. In 2015, the Polish Constitutional Court held this requirement unconstitutional, by arguing that it should be the state's duty, not the doctor's, to provide information to the patient about the possibility to have the service carried out.

Table 6 below provides an overview of regulation of the conscientious objection clause across the six Member States.

Table 6. Regulation of the conscientious objection clause in six Member States

Member State	CO clause	Scope of the clause	Limitations/ conditions	Right to appeal	Obligation to refer
Croatia	X	Health services broadly	<ul style="list-style-type: none"> • Permanent consequences for the health of the patient • Threat to life of the patient • Interference with the rules of the profession 	Right to appeal before a hospital board, order of doctors and administrative court	Obligation to refer to other medical practitioners is a requirement in the legislation
Czech Republic	X	Health services broadly	<ul style="list-style-type: none"> • Threat to patient's life • Serious threat to patient's health 	No reference to right to appeal	Obligation to refer to other medical practitioners is a requirement in the legislation
Italy	X	Specific to abortion	<ul style="list-style-type: none"> • Only for the procedure of abortion, not for care before and/or after • Threat to patient's life • Serious threat to patient's health 	No reference to a right to appeal	No reference to referrals
Poland	X	Health services broadly	<ul style="list-style-type: none"> • Threat to patient's life • Serious threat to patient's health 	Right to file a complaint on access to the health service	No reference to referrals
Portugal	X	Specific to SRHR	<ul style="list-style-type: none"> • Threat to patient's life • Serious threat to patient's health 	No reference to a right to appeal	No reference to referrals
Sweden		N/A	N/A	N/A	N/A

The stakeholders interviewed highlighted the following gaps in the legislation in the context of conscientious objection:

- the **right for patients to appeal** when the provision of a specific service is refused by medical professionals and/or pharmacists is not effectively guaranteed by the legislations in the six Member States;
- the **obligation to refer** to other medical practitioners where conscientious objection is invoked is not explicitly indicated as a requirement in Italy, Poland and Portugal;
- no specific attention is paid to the impact of conscientious objection on **vulnerable groups**. The intersecting nature of inequalities, in terms of gender, socioeconomic background, sexual orientation, gender identity and other factors often makes it difficult to establish exactly how such inequalities interact and play a role in someone's life. However, acting to address one of these dimensions can have a corresponding positive influence on other inequalities⁽³²⁸⁾. For example, policies that specifically target gender inequality in access to healthcare may constitute a starting point to address such inequalities, with specific attention paid to people from migrant backgrounds, the socioeconomically disadvantaged, etc.
- no reliable monitoring or evaluation mechanisms are in place to ensure that conditions are respected and enforced, and to monitor the numbers of health professionals that refuse abortion care and to consequently guarantee the provision of services⁽³²⁹⁾

While the Member States have adopted legal frameworks regulating conscientious objection to ensure that it would not endanger the lives of women and to safeguard access through referral, the next section looks at the practice and application of conscientious objection in order to better understand how these pieces of legislation is actually implemented in Croatia, Czech Republic, Italy, Poland, Portugal and Sweden.

4.2.2. Conscientious objection in practice at national level: challenges, driving factors and good practices

Existing data

The research encountered a **lack of data** on the extent of conscientious objection across the EU, including in the six Member States analysed for this study. 'While the existing evidence suggests widespread use of conscience claims in healthcare, the data are not sufficient to capture the breadth and depth of this phenomenon'⁽³³⁰⁾.

In **Croatia**, the Croatian Institute for Public Health (CIPH) does not routinely collect statistics on conscientious objection. The exact number of conscientious objectors is unknown, with some estimates amounting to 70 % of doctors. Several hospitals in Croatia are no longer providing abortions and, in Zagreb, doctors from the Sveti Duh Hospital are reportedly all conscientious objectors: this reflects the scope of application in practice in the country⁽³³¹⁾.

As shown in Table 6 below, in the **Czech Republic, Poland** and **Portugal** there are no data that can provide a specific picture of the numbers of conscientious objectors in the country or the numbers of

³²⁸ UNFPA, 2017, <http://www.aidos.it/wp-content/uploads/2017/10/RAPPORTO-UNFPA-2017.pdf>, p. 80.

³²⁹ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

³³⁰ International Womens' Health Coalition, [Unconscionable when providers deny abortion care](https://www.ihc.org/2018/01/unconscionable-when-providers-deny-abortion-care/), 2018, p. 12.

³³¹ Desk research suggests that these hospitals were almost collectively invoking conscientious objection since the last research was done in 2014 (see Ombudsperson for Gender Equality research) and the situation is the same in 2018; Grujić, J. (2015). Younger poor women are most affected by the reduction of right to abortion, (*Redukcijom prava na pobač aj najviše c e biti pogođene mlade siromašne žene*), Lupiga, available at: <https://lupiga.com/intervjui/intervju-pravo-na-pobacaj>

objections invoked. In **Croatia**, there are some estimates but data is not effectively collected at national level.

Table 7. Numbers of conscientious objectors and objections invoked

Country	Data on Conscientious objection	Year
Croatia	Estimates amounting to 70 % of doctors invoking conscientious objection	Not specified
Czech Republic	No data	N/A
Italy	70.9 % of gynaecologists, 48.8 % of anaesthetists and 44 % of non-medical personnel	2016
Poland	No data	N/A
Portugal	2009 data found that 80 % of gynaecologists refused to perform abortions ⁽³³²⁾	2009
Sweden	N/A	N/A

In **Poland**, there is a lack of information and data on the use of conscientious objection by medical practitioners. The Commissioner for Human Rights urged the Supreme Medical Council to gather the necessary data on how the use of conscientious objection works in practice, after the 2015 Constitutional Court judgment. On May 2016, the Supreme Medical Council replied, stating that no information had been gathered or analysed in this regard, despite the fact that the law requires conscientious objection to be recorded in medical files and notifications to objectors' supervisors. The so-called 'declaration of faith' provides the names of 4,000 doctors of different professions and students, including gynaecologists, who would rely on conscientious objection in the provision of SRHR services. The present Minister of Health has also signed this declaration. It has provoked an ongoing debate on the application of conscientious objection by doctors and other professionals. This does not constitute a comprehensive source of data.

In **Italy**, data on conscientious objection were collected between 2005 and 2016, and subsequently explored in the 2017 national report on the implementation of Law 194/78. The report provides an overview of the distribution of conscientious objectors across the different regions of Italy, as shown in Table 7 below. In the specific case of gynaecologists, for example, in 2016 numbers varied from 17.6 % of objectors in the region of Valle d'Aosta to 96.9 % in the region of Molise. This has implications for access to services for residents of specific Italian regions. The report specifies that the number of abortions has decreased in the country, suggesting that conscientious objection does not have a particular impact on access to services because the demand is also lower. However, data on the actual demand of services versus the extent of the provision would be needed in order to verify this statement. As noted by the president of the Laiga association ⁽³³³⁾ in an interview earlier in 2018 ⁽³³⁴⁾, the data should actually be interpreted differently, noting that **illegal abortions are common practice**, even if there is no specific data to monitor their extent. This was confirmed by the stakeholders interviewed for this study. The 2017 report offers an overview of the number of hospitals and clinics that provide abortion services across the country, by region. The report shows that an average of 60.4 % of the hospitals and clinics with a gynaecology department perform abortions.

³³² Heino, A. et al., 2013; Oliveira da Silva, M., Reflections on the legislation of abortion in Portugal. *Eur J Contracept Reprod Health Care*, 14: 2009, pp. 245-8.

³³³ Free Association of Italian Gynaecologists for the implementation of the Law 194/78, <http://www.laiga.it/>

³³⁴ <http://www.lastampa.it/2018/05/22/italia/troppe-obiettori-tornano-gli-aborti-clandestini-20aOfmycta2YBmipxwDBRJ/pagina.html>

However, these numbers go from a registered 24.1 % of structures in the Region of Campania, to 100 % in the Region of Liguria. However, stakeholders noted that these might be overestimated, as at a practical level the service is not provided by practitioners that use 'non-official' reasons to justify refusal of the service.

Stakeholders in Italy noted that there are more objectors in practice than indicated in the 2017 report, since a large number of doctors might object more 'informally', not officially recording their objection. Even if not officially objecting and even if it is not allowed by legislation, doctors might find ways to refuse other services, such as, for example, inserting the intrauterine contraceptive device (IUD). The experts interviewed noted that in some cases, this is justified to the patients without a solid medical reason and is often driven by conceptions of this contraceptive method as a form of abortion.

In **Croatia**, the practice of conscientious objection is reportedly inconsistent across the country. A number of doctors invoke conscientious objection during working hours in public health facilities while actually providing abortion services in private practice, fraudulently keeping the fees. In rural areas, abortion is almost entirely unavailable as the majority of doctors invoke conscientious objection, obliging women to seek the service in private clinics. Doctors do not issue receipts for abortions and are causing material damage to the facilities as well. There are cases in which abortions are performed in non-authorised facilities, with women reported to health institutions only in the case of complications. No official complaints have been submitted to the Croatian medical chamber⁽³³⁵⁾.

Figure 14: Percentage of gynaecologists, anaesthetists and non-medical personnel invoking conscientious objection in Italy in 2016, by region

REGIONE	GINECOLOGI		ANESTESISTI		PERS. NON MEDICO	
	N	%	N	%	N	%
ITALIA SETTENTRIONALE	1541	63.9	1524	40.1	3491	33.4
Piemonte	282	64.2	218	36.0	365	25.0
Valle d'Aosta	3	17.6	4	25.0	4	6.8
Lombardia	540	71.1	578	45.8	1511	46.5
Bolzano	65	84.4	88	68.8	271	69.0
Trento	27	58.7	23	25.3	266	14.9
Veneto	253	72.1	295	40.6	516	46.0
Friuli Venezia Giulia	59	50.9	40	26.7	143	27.8
Liguria	87	63.5	73	36.7	80	20.1
Emilia Romagna	225	48.2	205	32.8	335	22.9
ITALIA CENTRALE	688	70.1	674	47.0	1745	32.7
Toscana	209	60.1	131	25.8	271	21.3
Umbria	77	73.3	119	64.7	187	58.8
Marche	110	70.1	122	47.3	645	27.7
Lazio	292	78.7	302	62.4	642	45.1
ITALIA MERIDIONALE	838	83.5	765	66.1	3110	75.7
Abruzzo	98	85.2	117	60.3	284	65.7
Molise	31	96.9	37	92.5	86	94.5
Campania*	288	81.8	156	65.5	481	72.8
Puglia	327	86.1	314	65.7	2008	83.2
Basilicata	37	88.1	44	71.0	64	24.3
Calabria	57	69.5	97	66.9	187	75.1
ITALIA INSULARE	542	77.7	569	67.1	1039	71.7
Sicilia	446	84.6	496	76.9	782	84.2
Sardegna	96	56.1	73	36.0	257	49.4
ITALIA	3609	70.9	3532	48.8	9385	44.0

*Data for the Region of Campania are from 2013.

Source: *Relazione del Ministro della Salute sulla attuazione della legge contenente norme per la tutela sociale della maternità e per l'interruzione volontaria di gravidanza (Legge 194/78), 2017.*

³³⁵ Abortion in Croatia: What lies behind official statistical data? Conference: All for peace, health and education, nothing for armament, (*Abortus u Hrvatskoj: Što se krije iza službenih statističkih podataka?, konferencija: Sve za mir, zdravlje i znanje – ništa za naoružanje*), Belgrade, 2005.

In **Sweden**, even if conscientious objection is not recognised by the legislation, there is one documented case where it was invoked in court. In 2014, a Swedish midwife refused to participate in abortions or prescribe contraceptives and was turned down for multiple positions in clinics in the region of Jönköping. She sued for discrimination before Sweden's Discrimination Ombudsman and appealed to the District Court. Both ruled against her claims of discrimination in 2015, with the District Court ordering her to pay the authority's legal costs. She then appealed to the Labour Court (arbetsdomstolen). Her anti-abortion lawyers argued on human rights grounds that her freedom of religion and freedom of conscience have been breached and that she had been discriminated against. The judgment in the Labour Court, which could not be appealed, came on 12 April 2017, with a ruling in favour of the employer. The Federation of Catholic Families in Europe (FAFCE) presented a collective complaint against Sweden to the European Committee of Social Rights⁽³³⁶⁾, arguing that Sweden fails to protect the right to health and the right to non-discrimination⁽³³⁷⁾. The Committee stated that the rights of pregnant women and patients are to be protected ahead of the interests of healthcare providers. A particularly important finding from this case is that the Committee 'does not impose on states a positive obligation to provide a right to "conscientious objection" for healthcare workers'.

Impact of conscientious objection

The impact of conscientious objection on access to SRH goods and services has not been effectively monitored and measured across these countries. However, the experts and researchers consulted noted that **access to SRH goods and services is in practice greatly limited because of conscientious objection**. The high numbers of conscientious objectors recorded in countries such as Italy and Croatia clearly indicate limitations in the provision of services, particularly to the access to abortion and contraception. In particular, conscientious objection constitutes an additional barrier for women in accessing healthcare and SRHR specifically, such as discrimination, stigma, financial burden, lack of information, transportation difficulties, and 'limited autonomy to make decisions about their own bodies'⁽³³⁸⁾.

In the specific context of abortion, women who cannot access SRH services may resort to **clandestine, unsafe abortion and services**. In view of the legal consequences, women who resort to clandestine abortions do not follow up and seek post-abortion care in the case of complications⁽³³⁹⁾. They may also be forced to seek another provider, for example abroad, which can be **costly**. This has a clear impact on women from **vulnerable groups**, since they 'frequently face financial barriers and restrictions on freedom of movement that further hinder access to abortion services'⁽³⁴⁰⁾. This might reportedly cause other health problems, such as mental health issues, pregnancy complications or economic hardship leading to additional health problems⁽³⁴¹⁾.

- In **Italy**, the data show that some regions might have **almost no access** to abortion services, and access might be particularly complex for women in rural areas. The IPPF EN v. Italy⁽³⁴²⁾ and CGIL v. Italy cases

³³⁶ Federation of Catholic Families in Europe (FAFCE) v. Sweden, No. 99/2013 (European Committee of Social Rights March 17, 2015) https://www.coe.int/en/web/turin-european-social-charter/processed-complaints/-/asset_publisher/5GEFkMh2bYG/content/no-99-2013-federation-of-catholic-family-associations-in-europe-fafce-v-sweden?inheritRedirect=false

³³⁷ https://iwhc.org/wp-content/uploads/2018/06/IWHC_CO_Report-Web_single_pg.pdf

³³⁸ https://iwhc.org/wp-content/uploads/2018/06/IWHC_CO_Report-Web_single_pg.pdf, p. 11

³³⁹ Council of Europe (2017). Women's sexual and reproductive health and rights in Europe. Issue paper. <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

³⁴⁰ Council of Europe (2017). Women's sexual and reproductive health and rights in Europe. Issue paper. <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

³⁴¹ Fiala, C. & Arthur, J.J. (2017). There is no defence for 'conscientious objection' in reproductive healthcare. *Eur J Obstet Gynecol Reprod Biol*, Sep 216, pp. 254-258.

³⁴² Council of Europe, European committee of Social Rights, Decision on the merits of complaint no.87/2012, International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, <https://hudoc.esc.coe.int/eng/#%22ESCDIdentifier%22:%22cc-87-2012-dmerits-en%22>

⁽³⁴³⁾ found that conscientious objection amounts to violation of a number of rights, namely the right to protection of health, the principle of non-discrimination, the right to work and the right to dignity of work. The *Associazione Luca Coscioni per la liberta' di ricerca scientifica* declared, as reported in the *CGIL v. Italy* case, that 'there is a significant regional disparity in the provision of abortion services due to the lack of non-objecting medical practitioners, which means that women need to rely on private service providers or have an abortion in other geographical areas'. This clearly has an impact on specific groups of women, such as women from rural areas and/or those from a disadvantaged socioeconomic background.

Stakeholders noted that the negative impact of conscientious objection on women's access to abortion services could be limited if medical abortions (through the administration of RU486) were encouraged, through changes to the current regulations. This would entail extending the possibility to access RU486 up to 63 days (as in most countries) and limiting the hospitalisation requirement of three days (which has already been done in some parts of the country at regional level (e.g. in Emilia Romagna and in Piedmont)).

- In **Poland**, researchers have noted that it is not only the right to legal abortion that is limited by conscientious objection but that limitations could also cover **access to prenatal tests and information which violates the right** of women to health services which should be guaranteed for all under the public health scheme. The ECtHR has pointed out the limiting character of the legal provisions on conscientious objection and the illusory right to a legal abortion (see *Tysi c v. Poland* ⁽³⁴⁴⁾, *R. R. v Poland* ⁽³⁴⁵⁾ and *P. and S. v. Poland* ⁽³⁴⁶⁾). In the 2011 case **of R.R. v. Poland**, a woman was denied access to timely prenatal genetic examinations, in part due to conscience-based refusal, after potentially severe foetal abnormalities were discovered during an ultrasound. The additional examination results would have informed her decision on whether or not to terminate her pregnancy. Despite being legally entitled to those tests under Polish law, doctors and hospital administrators **repeatedly denied her these diagnostic tests**, until the pregnancy was too advanced for abortion to be a legal option.

In the 2012 case of **P. and S. v. Poland**, a 14-year old became pregnant as a result of rape, but encountered numerous barriers to obtaining an abortion to which she was legally entitled, in part due to the use of conscientious objection. She was subjected to **coercive and biased counselling** by a priest and was removed from the custody of her mother, who supported her decision to have an abortion. She also discovered that confidential information about her pregnancy had been divulged to the press.

The famous **case of Dr Chazan** illustrates the impact of conscientious objection on access to SRHR services, particularly access to abortion. In 2014, a 22 weeks pregnant woman whose foetus was diagnosed with multiple, severe and irreversible malformations, was denied a legal abortion by Dr Bogdan Chazan, Director of the public Holy Family Hospital in Warsaw. The timeline for prenatal testing and procedures were extended so as to prevent the woman from seeking an abortion elsewhere and she was not referred to another doctor despite the fact that it was required by Polish law at the time. The child born as a result of Chazan's decision died after 10 days. Prenatal diagnosis was fully confirmed and there was no chance of its survival. The National Health Fund imposed a penalty of PLN 70,000 (EUR 19,600) on the hospital for violation of patient's rights and failure to act according to current

³⁴³ Council of Europe, European Committee of Social Rights, Decision on the merits of complaint no. 91/2013. *Confederazione Generale Italiana del Lavoro (CGIL) v. Italy*, <https://hudoc.esc.coe.int/fre/#!%22ESCDIdentifier%22:%22cc-91-2013-dadmissandmerits-en%22>

³⁴⁴ ECtHR Judgment of 20 March 2007, application no 5410/03.

³⁴⁵ ECtHR Judgment of 26 May 2011, application no 27617/04.

³⁴⁶ ECtHR Judgment of 30 October 2012, application no 57375/08.

provisions. Later that month, Mayor of Warsaw dismissed Dr Chazan from the position of director of the Holy Family Hospital in Warsaw. Dr Chazan appealed his dismissal before the Labour Court, with Polish bishops openly expressing their support for his actions. In the aftermath of the Chazan scandal, one district in Mazovia voivodship changed its provisions concerning a local hospital, stating that its work was fully based on the principle of protection of human life. The woman victim of Dr Chazan's decision demanded compensation for personal damages caused by his abuse of conscientious objection, and the case is still pending. Meanwhile, Dr Chazan was nominated for the position of regional gynaecology and obstetrics consultant, a position which he obtained despite objections from the Federation for Women and Family Planning, together with 64 other organisations ⁽³⁴⁷⁾.

Driving factors

Similar driving factors underpin the exercise of conscientious objection across the countries under investigation. These factors are not extensively researched by literature at national level but interesting insights were gained from the practical experience of the stakeholders interviewed for this study.

In countries such as **Italy, Portugal and Poland**, a **strong religious background and culture** has affected the understanding of services such as abortion. Stakeholders in these countries highlighted the strong role of the Catholic Church in public and political discourse.

Anti-choice movements, as well as movements with a specific interest in derailing advancements in gender equality, have grown across Europe in the past 10 years. In Italy, anti-abortion movements have been at the frontline of opposition to gender equality. Since 2013, an increasing number of conferences driving the anti-abortion agenda have been recorded ⁽³⁴⁸⁾. These movements oppose abortion services, as well as contraception ⁽³⁴⁹⁾.

The stakeholders noted that conscientious objection is most often not invoked based on actual religious beliefs. Fiala & Arthur (2017) state that it is 'inappropriate and impossible for courts or governments to "decide" whether someone's religious beliefs are valid or sincere' ⁽³⁵⁰⁾. At a practical level, conscientious objection might be invoked because of specific **workplace cultures, which encourages the practice of conscientious objection**. Doctors and medical practitioners might invoke conscientious objection in order to escape certain obstacles posed to their careers. Stakeholders in Italy have reported that it might 'be easier' for a doctor or a health professional to be an objector. In fact, since the majority of doctors in a given hospital might indeed invoke conscientious objection, it is often practically not convenient for one or two doctors to be the only ones providing the service, as this has a certain impact on their professional and personal lives. Stakeholders also reported that a **lack of information and sufficient training** to the profession within the higher educational system affects the extent of conscientious objection in the country.

In **Portugal and Italy**, legislation does not allow for entire institutes and hospitals to invoke conscientious objection. However, at a practical level, many hospitals are owned and/or funded by the Catholic Church and have a workplace environment where conscientious objection is the norm, even if it is not formalised.

³⁴⁷ Objection of NGOs and other organisation against Dr Chazan's nomination, see [here](#).

³⁴⁸ Avanza, M., *Mobilisations anti 'idéologie du gender' et milieux catholiques pro-life en Italie*, 2015. In Paternotte, D., van der Dussen, S. & Piette, V. *Habemus Gender! Déconstruction d'une risposte religieuse* (pp. 207-221). Brussels: Editions de l'Université de Bruxelles.

³⁴⁹ Paternotte, D., van der Dussen, S. & Piette, V., *Habemus Gender! Déconstruction d'une risposte religieuse*. Brussels: Editions de l'Université de Bruxelles, 2015.

³⁵⁰ <https://www.sciencedirect.com/science/article/pii/S0301211517303573>

In **Poland**, public school religion classes integrate the anti-abortion agenda into the curriculum, including making the pupils watch the 1984 anti-abortion movie 'The Silent Scream'. This strongly contributes to **the stigma of abortion** within Polish society. Among doctors there is fear and pressure from peers and the medical authorities. Doctors prefer not to be associated with the abortion procedure ⁽³⁵¹⁾. Legal provisions are far from being precise and unequivocal, which evokes doubts as regards the use of conscientious objection by medical professionals, with patients often deprived of basic services guaranteed under the public health insurance scheme ⁽³⁵²⁾.

In all six Member States, researchers, literature and stakeholders all highlighted a strong **lack of support from policy makers** towards SRH, with the exception of Sweden, which has shown a more targeted approach to the issue. No attention is paid to these issues, as demonstrated by the lack of comprehensive legislation. In some cases, such as in Italy and Poland, active opposition to the provision of certain services is explicitly expressed by the political parties in power.

A number of countries across the EU, including five of the Member States analysed here (with the exception of Sweden) where conscientious objection is an option, have failed to adopt adequate regulatory frameworks and enforcement measures 'to ensure that women can still access legal abortion services in practice when medical professionals refuse care on grounds of conscience' ⁽³⁵³⁾. **Monitoring and evaluation mechanisms are missing.** The legislation itself does not provide sufficient limitations and conditions or a clear framework for the exercise of conscientious objection. No monitoring mechanism is in place at national, regional and/or local level to effectively evaluate the extent to which conscientious objection constitutes an obstacle to access to SRH services and goods, especially for women and vulnerable groups.

³⁵¹ Allies or Opponents, Medical doctors in the debate on women's right to abortion in Poland, 2018, Foundation for Equality and Emancipation STER.

³⁵² Anna Jacek: CO in the medical profession, Institute of nursery and obstetrics of the University in Rzeszów.

³⁵³ Council of Europe, Women's sexual and reproductive health and rights in Europe. Issue paper, 2017, <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

The present study explored **sexual and reproductive health and rights** (SRHR) in Europe, paying particular attention to six Member States, namely **Croatia, Czech Republic, Italy, Poland, Portugal** and **Sweden**. Through researching the policy and legal framework at international, European and national level, and of the state of play in the six countries, the research looked at existing barriers to the access to SRH goods (e.g. medicines, contraceptives) and services (e.g. safe abortions), by highlighting commonalities and differences across the selected Member States. It also considered **inequalities** in terms of access to these goods and services, especially for vulnerable groups. Moreover, the study highlighted the role of conscientious objection, and the extent to which this practice exercises an impact on the access to SRHR. The policy and legal framework at **international and European level** provide for a **right to sexual and reproductive healthcare**, as a fundamental aspect of the right to health, and encompassing strongly inter-connected rights such as the right to family planning, the right to equal access to services, freedom from violence and the right to life. The research found some gaps in this context. For example, non-discrimination and equal treatment are fundamental EU principles, but they are not explicitly addressed in provisions relating to SRH.

At **Member States' level**, and particular in the six countries at the core of the present study, the research revealed a broad range of differences when it comes to SRHR. For example, only Portugal and Croatia explicitly protect a right to SRH in legislation. Moreover, the national health systems and public insurance do not always cover SRH goods and services, such as contraception and abortion services. Furthermore, a particular identified gap is the absence of effective monitoring and evaluation mechanisms that could effectively assess the implementation of legal requirements for SRH. Specific needs of **vulnerable groups** are especially overlooked by legislation and policies.

Practical access to SRH goods and services varies significantly across the EU. A lack of literature and data on access to SRH goods and services, particularly versus the demand of such goods and services was evident throughout this investigation. Interviewed stakeholders contributed to have a clearer picture of the state of play in the six Member States. The research identified a wide range of barriers and challenges that can operate to restrict access to SRH goods and services.

These **barriers** might be legal, procedural, cultural, driven by religious factors, and supported by a lack of political will and commitment to issues of SRHR and gender equality. Financial concerns are a significant obstacle, particularly for groups with a disadvantaged socio-economic background.

Despite the legal protections for different groups at international and EU level, **particular groups may be disadvantaged in their access to quality, appropriate SRH goods and services.**

In the specific context of **conscientious objection**, 22 Member States recognise a right to conscientious objection, in particular in relation to the provision of abortion ⁽³⁵⁴⁾.

The right to conscientious objection, requires a balancing of the rights of health providers to express their beliefs with states' responsibility to ensure people's access to their SRHR, specifically access to related services and goods ⁽³⁵⁵⁾. Investigation in the countries at the core of this study showed that,

³⁵⁴ Belgium, Czech Republic, Denmark, Germany, Estonia, Ireland, Greece, Spain, France, Croatia, Italy, Latvia, Luxembourg, Hungary, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, United Kingdom.

³⁵⁵ Council of Europe's Parliamentary Assembly, Resolution 1763, The right to conscientious objection in lawful medical care, 2010

where health providers have the possibility to exercise their right to object, this balance is most often not attained. In this context, a number of gaps were identified, such as the **lack of monitoring and evaluation mechanisms** that could ensure that this balance is respected. Other key gaps are **limited right of appeal**, a **lack of obligation to refer** to other medical practitioners and a **failure to pay specific attention to vulnerable groups**. Moreover, there is an evident lack of data on the extent of conscientious objection in the six Member States.

Based on these findings and in order to address the identified gaps, section 5.2 presents recommendations targeted to European institutions and Member States to foster and strengthen access to SRH goods and services in the EU.

5.2. Recommendations

The recommendations presented below provide key avenues for the European Parliament, the European Commission and Member States to strengthen SRHR in the EU. They focus on improving access to SRH goods and services, as well as the exercise of conscientious objection in a manner compatible with SRHR.

5.2.1. Ensuring full access to SRH goods and services

- **EU to strengthen legal framework on equal access to SRH goods and services**

The **European Commission** should confirm the application of Directive 2004/113/EC to SRH goods and services and recognise that limits and barriers to access SRH goods and services constitute discrimination based on sex, as they disproportionately affect one sex (women) or vulnerable groups (e.g. trans people) in their exercise of their right to access health goods and services.

In light of the particularity of SRH goods and services (which by nature target one particular sex), the European Commission should adopt guidelines for Member States to ensure equal access to SRH goods and services in line with EU law and ECtHR jurisprudence.

The **European Parliament** should be fully engaged in monitoring the implementation of Directive 2004/113/EC on equal treatment in the access to and supply of goods and services. Its monitoring should pay particular attention to access to SRH goods and services. It should also request the Commission to collect data and information on access to these types of goods and services.

The European Parliament should play a proactive role in calling for the adoption of guidelines to ensure equal access to SRH goods and services in line with international standards.

- **EU to include SRH in its gender equality commitments**

The **European Commission** should include key actions to improve access to SRH goods and services as part of its next Strategy on gender equality (2020 and beyond). The policy actions should also support the implementation of Directive 2004/113/EC and the recommended guidelines in the area. They should target supporting Member States in their efforts to improve access to SRH goods and services and close monitoring of national measures in the area. Additional actions could include the collection of comparable EU-wide data on access to SRH goods and services.

The **European Parliament** should call on the Commission to include key actions on access to SRH goods and services in its new Strategy on Gender Equality post-2019, and to monitor the

implementation of those actions. The European Parliament could also set up a working group to formulate a general strategy in the area and to gather views on how the EU could better align legislation and practice with international standards in the area.

- **EU to support awareness-raising and training through its funding programmes**

The **European Commission** should support better access to SRH goods and services by raising awareness and training healthcare professionals on:

- specific SRH needs of vulnerable groups (e.g. LGBTI people);
- importance of individualised counselling as part of SRH services;
- general awareness of SRHR and modern contraceptive choices;
- legal requirements to ensure equal access and referrals.

The European Commission should also support initiatives to raise awareness among individuals of their reproductive rights, through funding campaigns or setting up information websites, as well as promoting tolerance for individuals exercising their SRHR. Better informed individuals will make more informed decisions.

The **European Parliament** should also contribute to raising awareness and supporting training for healthcare professionals. It has a crucial role to play in promoting more and better recognition of the importance of SRHR compatible with international standards.

- **Member States to conduct comprehensive research at national level to assess the provision of SRH goods and services**

Member States should conduct research and case studies at national level in order to verify if SRH goods and services are being provided as per the legislation. This will allow for the identification of specific gaps and will inform the development and revision of existing legislation and policy. This would be particularly useful in better addressing the needs of vulnerable groups, which are most often overlooked.

- **Member States to ensure access (availability, affordability, quality and equal treatment)**

Availability: **Member States** should implement effective legislation to address access to SRH goods and services. Structures should be implemented across different regions, allowing for medical infrastructure to be reached regardless of geographical location. In order to effectively implement legislation, Member States should implement monitoring and evaluation mechanisms for assess access to SRH goods and services within the country.

Affordability: Member States should make sure that SRH goods and services are covered by the national health insurance systems.

Quality: Requirements for the quality of SRH services should be established at national level. For example, Member States should foster education and training of medical professionals in certain specialisations, both within their formal higher education and through professional development training.

Equal treatment: Member States should develop and update existing policies in order to target vulnerable groups. As defined by the 2016 WHO Europe Action Plan for sexual and reproductive health

(356), these groups include adolescents, unmarried people, the socioeconomically disadvantaged, people living with HIV, people with disabilities, LGBTI people, drug users and people engaged in sex work.

5.2.2. Ensuring the exercise of conscientious objection in a manner compatible with respect of SRHR

- **EU to clarify the application of the Employment Equality Directive 2000/78/EC and ensure its compatibility with SRHR**

The **European Commission** should ensure that in applying the Employment Equality Directive, the right to freedom of religion and belief of healthcare employees and the religious ethos of health institutions do not create barriers to access to SRH goods and services.

To this end, the European Commission should ensure that international standards, including those stemming from international conventions and ECtHR jurisprudence, are applied in the context of the implementation of both Directive 2004/113/EC and Directive 2000/78/EC. Those standards include:

- an individual's belief cannot lead to the restriction of the rights and freedoms of another person ⁽³⁵⁷⁾;
- the right to conscientious objection may be restricted by the ground of public interest in ensuring equal treatment for all users ⁽³⁵⁸⁾;
- conscientious objection must not be a barrier to accessing health services. States have an obligation to appropriately regulate this practice to guarantee that it does not restrict access to SRH care ⁽³⁵⁹⁾;
- where abortion is legal at national level, states must fulfil a range of procedural requirements to ensure that the right to abortion is upheld in a practical and effective manner ⁽³⁶⁰⁾;
- states must establish an effective mechanism of referral where health service providers refuse to perform certain reproductive health services for women based on conscientious objection. The referrals must be made to accessible providers in a position to provide the services in question. In addition, conscientious objection should not stop services from being performed during emergencies ⁽³⁶¹⁾.

The **European Parliament** should be fully engaged in monitoring the implementation of Directive 2000/78/EC (paying close attention to whether or not its application conflicts with SRHR), calling for any appropriate legislative changes to ensure effective implementation, and ensuring that the EU legal framework is fully aligned with international standards.

³⁵⁶ WHO, Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind, 2016, http://www.euro.who.int/_data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf?ua=1

³⁵⁷ ECtHR *Pichon and Sajous v. France*.

³⁵⁸ ECtHR, *Eweida and Others v. the United Kingdom*, § 105. See ECtHR, [Guide on Article 9 of the European Convention on Human Rights Freedom of thought, conscience and religion](#), 2018.

³⁵⁹ Committee on Economic, Social and Cultural Rights, [General comment No. 22 \(2016\) on the right to sexual and reproductive health](#) (article 12 of the International Covenant on Economic, Social and Cultural Rights), paras.14 and 43.

³⁶⁰ ECtHR, *Tysiąc v. Poland*, 20 March 2007.

³⁶¹ Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 (women and health), (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies* (Vol. II), at 358, para. 11, U.N. Doc. A/HRI/GEN/1/Rev.9 (2008). EU Network of independent experts on fundamental rights, [OPINION N° 4-2005: The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy see](#), 14 December 2005.

The European Parliament should take the lead in exchanging best practice in legislative and policy changes to align with international standards in the area.

- **Member States to ensure effective referrals and sufficient non-objectors service providers (at a minimum) to meet necessary demands, in line with international standards**

Member States should explicitly indicate the requirements for effective referrals from objectors to structures where the specific SRH services can be accessed. In the case of barriers derived from geographical distribution of medical infrastructures (e.g. in specific regions and in rural areas), the legislation should ensure a minimum number of professionals that can provide the required services.

In order to ensure the implementation of such mechanisms, monitoring and evaluation instruments need to be in place. An example could be to integrate the effective provision of SRH services as one of the criteria included in the systematic evaluation of the functioning and success of individual hospitals and their management.

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This study was commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee. It aims to provide a comparative overview of the situation in the European Union, with particular focus on six selected Member States, in terms of access to sexual and reproductive healthcare goods (such as medicines) and services (such as abortion and family planning), from both legal and practical perspectives. The study looks at the extent to which conscientious objection affects access to sexual and reproductive rights (SRHR). The study will contribute to formulating a clear framework for the improvement of access to sexual and reproductive healthcare goods and services in the EU.

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