SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE

PROGRESS AND CHALLENGES

Follow-up report | to the 2017 Issue Paper

COMMISSIONER FOR HUMAN RIGHTS
COMMISSAIRE AUX DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE PROGRESS AND CHALLENGES

Follow-up report to the 2017 Issue Paper
by the Council of Europe
Commissioner for Human Rights

Council of Europe

Issue papers and their follow-up reports are published by the Commissioner for Human Rights to contribute to debate and reflection on important current human rights issues. Many of them also include recommendations by the Commissioner for addressing the concerns identified.

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Acknowledgements:

This follow-up report was prepared by Adriana Lamačková and Keina Yoshida, with assistance from Camille Gervais, Leah Hoctor, Laura Mirahver and Katrine Thomasen, from the Europe Program at the Center for Reproductive Rights.

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Introduction

Universal access to quality sexual and reproductive health care and the ability to exercise sexual and reproductive autonomy and decision making are integral components of human rights and gender equality. Council of Europe member states have international human rights obligations to respect, protect and fulfil these rights.

In 2017, the Council of Europe Commissioner for Human Rights' predecessor published an Issue paper on *Women's sexual and reproductive health and rights in Europe* ("the 2017 Issue Paper").[1] The 2017 Issue Paper set out key international human rights standards relating to women's sexual and reproductive health and rights and described a series of key concerns, challenges, and deficits pertaining to women's and girls' sexual and reproductive health and rights in Council of Europe member states. The Issue Paper also outlined recommendations for action by member states to ensure the full enjoyment of sexual and reproductive health and rights.

Since 2017, member states have taken important steps towards the implementation of these recommendations. Many countries have adopted legal and policy reforms, upgraded their programmatic, investment and health system responses, enhanced the levels of technical guidance and training provided to health care workers, and improved oversight, accountability, and monitoring mechanisms. These developments have increased access to contraception and abortion care, improved the quality of obstetric care and advanced the provision of comprehensive sexuality education in schools, amongst other things.

However, despite many notable achievements, pervasive challenges and deficits in sexual and reproductive health and rights continue across Europe and there is an ongoing need for robust member state action to ensure the full enjoyment of sexual and reproductive health and rights for everyone. As the Commissioner has outlined in numerous reports, statements, and comments published since 2017, the following problems still persist: human rights violations continue to occur in the sphere of sexual and reproductive health; retrogression has taken place in some member states; multiple and intersectional discrimination continues to impede the full realisation of sexual and reproductive health and rights of marginalised groups; and

human rights defenders working to advance sexual and reproductive health and rights still face considerable challenges in parts of the region.

In light of the new landscape in the Council of Europe region following the COVID-19 pandemic, the full-scale invasion of Ukraine by the Russian Federation in 2022 and the related cost-of-living crisis, this new report, which includes the Commissioner's follow-up recommendations, reiterates the importance of adopting an inclusive approach in the design and implementation of sexual and reproductive health policies. It stresses the need to pay special attention to women and girls in all their diversity* as well as non-binary people and other persons with relevant needs, such as transgender (trans) men, who may be at risk of, or exposed to, intersecting forms of discrimination, and who might face increased vulnerabilities.

This report is a follow-up to, and complements, the 2017 Issue Paper and is intended to assist member states with their ongoing efforts to improve the enjoyment of sexual and reproductive health and rights.

The report highlights some of the concerns in certain areas of sexual and reproductive health and rights and provides a concise overview of important recent developments in relevant international human rights standards and international public health and technical guidelines. It draws on the Commissioner's country work, expert meetings with civil society organisations and dialogue with member states.

Section 1 focuses on the provision of comprehensive sexuality education (CSE) in Council of Europe member states. It highlights some of the prevailing concerns and deficits in relation to the provision of CSE and points to recent developments in international human rights standards and technical guidelines.

Section 2 addresses access to contraception services and information, and outlines some of the progress and ongoing challenges and recent developments in international human rights standards.

Section 3 considers the state of access to abortion care and information in the region and discusses developments in international human rights law and public health standards on abortion. It identifies the important progress made by many Council of Europe member states since the 2017 Issue Paper whilst also highlighting the impact of remaining barriers and restrictions that continue to undermine access to quality abortion care.

Section 4 addresses mistreatment and abuse in reproductive health care.

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* This publication, when using "women and girls", refers to all women and girls regardless of their age, disability, gender identity, gender expression, racial or ethnic origin, religion or belief, sex characteristics, sexual orientation, or other characteristics or status.

It outlines important developments in international human rights law and public health standards and provides a brief overview of the main issues and concerns that continue to impede the delivery of respectful and dignified obstetric and gynaecological care in many member states.

Section 5 addresses the need for urgent action to ensure that women and girls can fully enjoy their sexual and reproductive health and rights free from all forms of discrimination. It illustrates the way in which intersectional discrimination continues to affect the sexual and reproductive health and rights of many marginalised groups across Europe, with a particular focus on women and girls with disabilities, Roma women and girls, older women, refugees, asylum seeking and migrant women, LGBTI people and sex workers.

Section 6 highlights the vital role of human rights defenders, civil society organisations and health care providers working to advance sexual and reproductive health and rights and summarises some of the challenges and risks they are facing due to their work.

This follow-up report is followed by the Commissioner's recommendations to all Council of Europe member states in the areas of sexual and reproductive health and rights addressed in the report.

Chapter 1
Comprehensive sexuality education

Comprehensive sexuality education (CSE) plays a vital role in promoting the health and wellbeing of children and young people and preparing them for safe, fulfilling lives.[2] Ensuring that children and young people have access to age-appropriate CSE is a central component of states' obligations to guarantee sexual and reproductive health and rights. Data and evidence clearly outline that good quality, curriculum-based CSE enables children and young people to develop age-appropriate knowledge, attitudes, and skills that contribute to safe, healthy, and positive relationships.[3]

In recent years, some member states have made important progress towards ensuring the provision of age-appropriate, evidence-based CSE in school settings. However, in many parts of the region, deficits and challenges in CSE programming and implementation persist, and harmful misconceptions about CSE remain at play, depriving many children and young people of access to this important form of education.

1.1 Developments in international human rights standards and technical guidelines

International human rights law requires member states to guarantee access to age-appropriate CSE for all children and young people and to prevent retrogressive initiatives that would restrict or remove access to CSE.[4]

In recent years, human rights mechanisms have continued to emphasise the importance of comprehensive, evidence-based, scientifically accurate, age-appropriate and quality sexuality education.[5] They have made it clear that international human rights law requires member states to ensure that comprehensive sexuality education is non-discriminatory and inclusive.[6] They have outlined that CSE must promote human rights, gender equality, respect, autonomy, consent and diversity by supporting the development of skill sets that will enable young people to: exercise informed decision

making about sexuality; protect themselves from sexual and gender-based violence, sexually transmitted infections and early pregnancy; and build healthy and respectful relationships.[7] They have underscored that member states must address information accessibility in digital environments, including guidance on how to identify trusted sources of information, and they must also ensure that CSE teachers are trained on digital safeguards.[8] In addition, human rights mechanisms have underlined that states should integrate age-appropriate, gender-sensitive and accessible CSE into mandatory school curricula at all levels of education and provide systematic training to teachers.[9]

New *International technical guidance on comprehensive sexuality education* has also been published in recent years, which outlines a new definition of CSE and contains key considerations and recommendations for member states regarding CSE.[10] The guidance has defined CSE as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realise their health, wellbeing and dignity; develop respectful social and sexual relationships; consider how their choices affect their own wellbeing and that of others; and understand and ensure the protection of their rights throughout their lives."[11]

1.2 Deficits in establishing and delivering CSE

Although there has been some important progress, shortcomings in compliance with international standards and guidelines on CSE continue across Europe. Concerns persist regarding limited access to CSE in schools in many member states. Data indicates that several member states still have not integrated CSE into mandatory school curricula.[12]

Even where sexuality education is mandatory and supportive legislative or policy frameworks exist, there are still notable variations in the quality of curricula, teacher training, and delivery methods.[13] School curricula on sexuality education often falls short of international standards, with a strong focus on the biological aspects of sex and reproduction, and far less content on gender equality, sexuality, consent, human rights and digital media.[14] Gaps also persist in addressing social norms and gender stereotypes, including those around toxic masculinity, and men and boys must be included in efforts towards gender equality and eliminating all forms of discrimination, sexism, misogyny, and violence.[15] Children and young people are rarely involved in developing and evaluating CSE curricula and delivery.[16]

Support for teachers on the delivery of sexuality education continues to be insufficient in most countries[17] and teachers continue to lack access to adequate training materials and tools and report a lack of confidence when it comes to addressing diverse topics, including gender norms, or in the use of interactive teaching methods.[18]

Inadequate resource allocation to CSE programming and monitoring and evaluation also remains a serious concern in most countries, and CSE implementation is often dependent on local authorities or individual schools.[19]

1.3 Misconceptions and opposition to CSE

In some member states, misconceptions and disinformation about CSE persist and public campaigns have sometimes sought to disseminate harmful and inaccurate information about CSE, wrongfully describing it as "sexual abuse," or "paedophilia," or so-called "propaganda in favour of homosexuality." These campaigns also often claim that CSE is intended to spread so-called "gender ideology," and that mandatory CSE in school curricula violates the rights of parents to educate their children in accordance with their values and beliefs.[20]

In a small number of countries, policy makers have pursued efforts to roll back CSE programming or block the introduction of inclusive non-discriminatory CSE in schools. For example, in 2021, legislation was adopted in Hungary prohibiting or limiting children's access to any LGBTI content in the public sphere, including in schools and the media.[21]

Chapter 2
Access to contraceptive services and information

In recent years, several Council of Europe member states have made progress in removing barriers that impede access to affordable contraceptive services and information. Yet, for many across Europe, access to a choice of affordable modern contraceptive methods remains a challenge. The COVID-19 pandemic and associated measures aggravated pre-existing access barriers and at times created new ones, such as service disruptions, stock outages, increased costs, and limited access to medical consultations for prescription refills.[22]

Although some member states such as Belgium, France, Ireland, and Luxembourg have expanded entitlements to free contraception in recent years,[23] in many member states financial barriers and the failure to cover contraception under public health insurance or reimbursement schemes continue to undermine access for many women and girls.

Other ongoing barriers include the restricted availability of certain contraceptive options, prescription requirements, and the lack of access to evidence-based accessible information on a wide-range of contraceptive options. In many member states, myths and misconceptions about modern contraception persist due notably to insufficient training for health professionals and the lack of evidence-based public awareness campaigns.[24]

Women and girls from marginalised groups, including women and girls living in poverty, rural women and girls, women and girls with disabilities, ethnic minorities, refugees, asylum seekers and migrants, particularly those in an irregular situation, face specific challenges when it comes to gaining access to contraception. Laws and policies still prevent many adolescents in the region from gaining access to prescriptions for contraceptives since some member states still require parental consent for adolescents under the ages of 16 or 18 years. Limited engagement of men and boys as both users and supporters of contraception and family planning in a way that

promotes gender equality and supports women's sexual and reproductive decision making and autonomy also continues to be of concern across Europe.[25]

Although most member states have now legalised the sale of emergency contraception over the counter in pharmacies, without prescription, some still require a prescription for emergency contraception causing significant delays in access to time-sensitive medication.[26]

International human rights law requires member states to ensure access to evidence-based comprehensive contraceptive services and information, on the basis of non-discrimination and equality.[27] In recent years, human rights mechanisms have expanded on the content of these obligations, calling on member states to make the full range of modern contraception, including emergency contraception, readily available and accessible to everyone, including by covering them under national health insurance schemes or providing them free of charge.[28] They have underlined the importance of effective measures to disseminate comprehensive, evidence-based information on all modern contraceptive options in accessible formats, including through comprehensive sexuality education,[29] and have stressed that member states should "conduct awareness-raising programmes to promote the understanding that contraception is a responsibility that women and men share."[30] They have also addressed the need to ensure that women and girls with disabilities are supported, where needed, in decision making concerning their use of contraception and that this must always be based on their free and informed consent, respecting their dignity and autonomy.[31]

Chapter 3
Access to abortion care and information

Following decades of legal and policy reforms intended to expand access to abortion care and improve service provision, abortion is now legal in almost all Council of Europe member states.

Since the publication of the 2017 Issue Paper, Cyprus, Finland, Iceland, Ireland, Northern Ireland and San Marino have legalised abortion on request,[32] meaning that doctors or other professionals are not required to attest to, or certify, the existence of a particular reason or justification for the abortion. Over the same period, many places in Europe, including Belgium, France, Lithuania, Moldova, the Netherlands, North Macedonia, Spain, as well as England, Scotland and Wales have undertaken reforms designed to remove some of the harmful procedural or regulatory barriers that have obstructed access to abortion care in practice, such as mandatory waiting periods, third-party authorisation requirements and restrictions on medication abortion.[33] Similar law reform processes that have the potential to remove other harmful barriers and restrictions are currently under way in numerous member states, including Belgium, Denmark, France, Germany, Ireland, the Netherlands, Norway, Poland, and the United Kingdom.[34]

However, there is sizeable room for improvement. Laws and policies on abortion continue to fall short of international human rights standards and public health guidance. Meanwhile, rollbacks on entitlements to abortion have occurred in a small number of countries and retrogressive threats continue to pose a risk to member states' commitments under international human rights law.

3.1 Developments in international human rights standards and public health guidelines

Guaranteeing access to quality abortion care is a critical component of states' obligations to respect and ensure the human rights of women and

other persons in need of such care, and human rights mechanisms have long recognised that the criminalisation of abortion and restrictive laws, policies and practices undermine access to safe abortion care and impose burdens on those seeking care, all of which can jeopardise their health and lives.[35]

In recent years, human rights mechanisms have continued to articulate the content of member states' obligations to decriminalise abortion, repeal restrictive abortion laws, and guarantee access to abortion care in practice. They have urged states to guarantee "adequate access to safe abortion and post-abortion services to ensure full realisation of rights of women, their equality and their economic and bodily autonomy to make free choices about their reproductive rights"[36] and made it clear that any regulation of abortion must not subject women and girls who need abortion care to physical or mental pain or suffering, discriminate against them, arbitrarily interfere with their privacy or force them to resort to unsafe abortion.[37]

To this end they have specified that member states must:

- ✓ Legalise abortion, reform highly restrictive abortion laws that limit access to specific situations and decriminalise abortion in all circumstances, and repeal provisions that criminalise abortion and related assistance to which a pregnant person has given free and informed consent.[38]
- ✓ Remove access barriers such as mandatory waiting periods, mandatory counselling, and third-party authorisation requirements and ensure that abortion services are confidential and non-judgmental.[39]
- ✓ Guarantee universal and equal access to abortion care for everyone across their jurisdiction.[40] This should include covering abortion care, including abortion on request, under public health insurance schemes or providing it free of charge,[41] and ensuring that "sufficient numbers of adequately trained medical professionals are available to perform abortions and reduce regional disparities in this regard."[42]
- ✓ Guarantee the availability of medication abortion and ensure it is provided based on non-discrimination and equality.[43]
- ✓ Refrain from imposing new barriers in access to abortion care and ensure there is no retrogression in entitlements to care.[44]

Human rights mechanisms have addressed refusals of abortion care by medical professionals.[45] For example, in two 2020 decisions, the European Court of Human Rights considered complaints by two midwives against Sweden alleging that their right to freedom of thought, conscience and religion under Article 9 of the European Convention on Human Rights had

been violated when they were denied employment within the Swedish health system following refusals to assist in abortion care due to their personal, religious faith. The Court dismissed their claims as manifestly ill-founded, outlining that the denial of employment, "pursued the legitimate aim of protecting the health of women seeking an abortion," and was necessary in a democratic society and proportionate because, "Sweden provides nationwide abortion services and therefore has a positive obligation to organise its health system in a way as to ensure that the effective exercise of freedom of conscience of health professionals in the professional context does not prevent the provision of such services."[46]

Similarly, human rights mechanisms have recognised that those seeking or providing abortion care may face stigmatisation and harassment due to state failures to address the actions of individuals and groups who oppose abortion care. They have called on states to "[s]trengthen efforts to prevent the stigmatisation and trauma of women and girls who seek abortion, including through the provision of "safe access zones" in all concerned health services in a timely manner."[47] They have also stressed the importance of measures to "enable health-care providers to undertake their work without undue interference, intimidation or restrictions."[48]

Public health guidelines on abortion care have also evolved in recent years. Drawing on international human rights standards and public health evidence, the World Health Organization (WHO) issued its Abortion Care Guideline in 2022, updating and replacing the recommendations in previous WHO guidelines on abortion care.[49] The Guideline explains that an enabling environment – which includes respect for human rights including a supportive framework of law and policy, the availability and accessibility of information, and a supportive, universally accessible, affordable and well-functioning health system – is the foundation of quality comprehensive abortion care.[50] The Guideline points out that legal, policy and regulatory restrictions, including limiting access to abortion by grounds and gestational limits, as well as other barriers, can make it difficult or impossible to access quality abortion care, which can have numerous harmful consequences for women's health and lives and undermine their human rights.[51]

The Guideline outlines a series of recommendations for member states on good practice in the areas of law and policy, clinical services, and service delivery. The recommendations are based on human rights law and public health evidence and, together with the best practices described in the Guideline, they aim to enable evidence-based decision making with respect to quality abortion care.[52]

The recommendations include the following and are intended to:

- ✓ Reform laws to fully decriminalise abortion.[53]
- ✓ Legalise abortion on request and remove requirements that mandate third party authorisation by any individual, body, or institution.[54]
- ✓ Repeal laws and regulations that restrict abortion by grounds, prohibit abortion based on gestational limits, and require mandatory waiting periods.[55]
- ✓ Ensure access to medication abortion including the option of self-management without the direct supervision of a trained health worker and the option of telemedicine in early pregnancy.[56]
- ✓ End regulations that limit who can provide and manage abortion care that are inconsistent with WHO guidance.[57]
- ✓ Guarantee that access to and continuity of comprehensive abortion care be protected against barriers created by health workers' refusals of care.[58]

3.2 Highly restrictive abortion laws

Currently five Council of Europe member states – Andorra, Liechtenstein, Malta, Monaco, and Poland – retain highly restrictive abortion laws.[59] These laws have myriad harmful consequences for women and girls and other persons in these countries who need access to abortion care. By restricting the legality of abortion to specific exceptions or grounds, such laws exclude most people who need abortion care from the possibility of legal access. As a result, they are forced to seek abortion care outside of legal pathways or to travel to other jurisdictions, if they have the means to do so. For those who are unable to access abortion in their home country or travel to other countries, they may be forced to continue a pregnancy against their will.[60]

3.3 Criminalisation of abortion

Although most member states have legalised abortion on request, in most cases abortion is still regulated in part through criminal law. In several cases – such as in Belgium, Cyprus, Iceland, Italy, Liechtenstein, Portugal, and San Marino – these laws criminalise women who undergo abortion outside the scope of the law.[61] However, more commonly, member states' laws criminalise the actions of health care providers or others who assist people to access abortions that are not lawful.

Such laws treat abortion care differently from all other forms of health care and can cause significant harm to the health and wellbeing of those

seeking abortion care. They also exert a chilling effect on health care workers' provision of legal abortion care, which can delay access to care and lead to denial of life-saving treatment.[62] Women denied abortion care due to criminalisation have reported experiencing severe physical and mental anguish, extreme vulnerability, stigma, and isolation.[63]

For example, in Poland, the tightening of already highly restrictive law through a regressive ruling of the country's Constitutional Tribunal, issued in 2020, has resulted in denials of life-saving treatment to several women in obstetric emergencies. It has been accompanied by an increase in the number of criminal investigation proceedings initiated against persons suspected of assisting with access to abortion care outside the narrow scope of the law.[64]

3.4 Access barriers

In most member states, a range of regulatory, policy and practical barriers continue to hinder access to abortion care in practice. These include medically unnecessary restrictions such as short time limits for abortion on request, third-party authorisation requirements, restrictions on access to medication abortion, and restrictions on who can provide and manage abortion that are inconsistent with WHO guidance. In several countries – namely Albania, Armenia, Belgium, Georgia, Germany, Hungary, Ireland, Italy, Latvia, Luxembourg, Portugal, and Slovakia – abortion laws impose mandatory waiting periods. Some countries, including Albania, Armenia, Georgia, Germany, Hungary, Italy, Lithuania, and Slovakia maintain mandatory counselling or information requirements that are sometimes intended to dissuade women from accessing abortion care. For instance, laws in Germany and Hungary require directive counselling explicitly intended to influence decision making.[65] In addition, some member states – such as Croatia, Czechia, Lithuania, Romania and Slovakia – still do not include abortion on request in public health insurance schemes, meaning that those seeking abortion on request have to pay for it out of their own pockets.[66] Lack of competency-based training for health workers on the provision of quality abortion care is also of concern in several member states.

These barriers delay access to abortion care and may force women to seek abortion care outside of legal frameworks, travel to another country for care, or continue a pregnancy against their will. These barriers disproportionately impact marginalised groups, such as women living in poverty or facing financial hardship, rural women, and adolescent girls, who may not always be able to comply with these regulatory requirements.[67]

In addition, many member states still have not established adequate mechanisms to ensure that refusals of abortion care on the grounds of conscience or religion by medical providers do not hinder timely access to care. In several places, laws and policies regulating refusals of care are inadequate, and effective monitoring and oversight mechanisms to ensure compliance are lacking. As a result, in Croatia, Italy, Northern Ireland, Poland, Romania, and Slovakia, for example, widespread refusals of care are imposing significant burdens on those who need abortion care and are leading to delays in care, thereby endangering the health and life of patients.[68] The authorities' failure to take effective measures to ensure service provision also impacts the health and wellbeing of medical professionals who do provide abortion care and can sometimes lead to career limitations and discrimination.[69] Similarly, the failures of some member states to ensure those seeking and providing abortion care are effectively protected from harassment and intimidation also continue to be of concern, as is abortion stigma that remains pervasive across the region.[70]

3.5 Access to evidence-based information

Although some improvement has been made in the availability of evidence-based information on abortion and its regulation, easy access to such information continues to be a challenge in some member states. Only a small number of countries provide information on abortion care on government-run websites[71] and some member states still maintain laws that prohibit public dissemination of some or all forms of evidence-based information.[72]

Furthermore, websites providing false and misleading information about abortion designed to dissuade people from accessing abortion care have spread across Europe and new organisations have been established with the purpose of providing misleading and biased information and counselling on abortion.[73] There have also been attempts to mandate the provision of biased information about abortion by health professionals and to ban the public provision of evidence-based information on abortion.[74]

3.6 Retrogression

In a small number of member states, highly concerning efforts to roll back entitlements to abortion have advanced in recent years, as policy makers have pursued legislative and judicial initiatives seeking to remove grounds for legal abortion and introduce new access barriers.[75]

The most egregious example of retrogression took place in Poland between 2020 and 2021 when legal provisions allowing abortion in situations of severe or fatal foetal impairment were repealed following a regressive ruling by the Constitutional Tribunal.[76] Since then, the already severe impact of the country's highly restrictive abortion law has increased even further, leading many women to experience anxieties about becoming pregnant.[77] Several women have died in Polish hospitals in recent years, reportedly because they were denied life-saving care during obstetric emergencies in connection with the chilling effect of the retrogressive restrictions on abortion access.[78] In December 2023, the European Court of Human Rights held that rollbacks on legal entitlements to abortion, following the ruling of the Constitutional Tribunal involving judges appointed by a severely irregular procedure that did not meet rule of law requirements, violated a woman's right to respect for private life under the European Convention on Human Rights.[79]

Retrogression also occurred in Hungary in 2022, when new regulations were introduced requiring patients to listen to the foetal ultrasound prior to obtaining abortion care.[80] In 2023, Georgia also adopted further restrictive measures, including the requirement to include a psychologist and a social worker in the provision of mandatory counselling before abortion care.[81] Attempts to restrict access to abortion have also taken place in other member states in recent years – notably in Italy, Lithuania, and Slovakia.[82]

Retrogression that leads to the removal of pre-existing entitlements to abortion or the introduction of new restrictions on access to abortion care is contrary to international human rights law.[83] Human rights mechanisms have repeatedly urged states to refrain from adopting retrogressive proposals seeking to restrict or undermine access to abortion care.[84]

Chapter 4
Obstetric and gynaecological care

In recent years, some Council of Europe member states have made advancements towards ensuring standards of care and access to quality reproductive health care. Yet, important public health, human rights, equality, and structural concerns persist across Europe that continue to undermine equal access to quality obstetric and gynaecological care. Research into the experiences of women in reproductive health care settings, particularly during facility-based childbirth, has highlighted instances of disrespectful, abusive, and discriminatory treatment across Council of Europe member states. The COVID-19 pandemic and associated measures compromised the provision of quality obstetric care in some settings as restrictions were placed on the presence of birth companions and visitors, mandatory caesarean delivery was imposed for those who tested positive with COVID-19, and newborns were often separated following birth.[85] In some member states, the legacy of these measures persists and pandemic-related restrictions have not been fully removed in obstetric care settings.

4.1 Developments in international human rights standards and public health guidelines

International human rights mechanisms have underlined that disrespectful, abusive, and discriminatory treatment during obstetric care and in other reproductive health services gives rise to violations of human rights and they have called for reforms to ensure respect for free and informed consent and the provision of respectful care. In recent years, they have increasingly addressed the content of states' obligations to guarantee respectful care during pregnancy and childbirth, free of discrimination, coercion, and violence.[86]

For example, the United Nations Special Rapporteur on Violence against Women, its Causes and Consequences has underlined that violations of

informed consent, restrictions on decision making, and disrespect and mistreatment in reproductive health services and during childbirth is systematic in nature and is part of "a continuum of the violations that occur in the wider context of structural inequality, discrimination and patriarchy, and are also the result of a lack of proper education and training, as well as a lack of respect for women's equal status and human rights."[87] The Special Rapporteur specified that mistreatment and violence against women in obstetric care and other reproductive health care settings results in physical and psychological suffering that violates numerous human rights, including the rights to freedom from torture and ill-treatment, life, health, privacy, information and freedom from discrimination.[88] She also recognised that the conditions and constraints of the health system and power dynamics in the provider-patient relationship are the root causes of mistreatment and violence against women during childbirth, and that these constraints are aggravated by discriminatory laws or practices and harmful gender stereotypes regarding women's decision-making competence, their role in society and motherhood.[89] The Special Rapporteur has urged states to respect, protect and fulfil women's human rights during reproductive health care services and childbirth, free from mistreatment and gender-based violence, and ensure women receive dignified and respectful reproductive health care and obstetric care, free from discrimination and violence, and allocate sufficient budgetary resources needed to provide quality, accessible reproductive and maternal health care.[90]

Similarly, in three recent cases, the United Nations Committee on the Elimination of Discrimination against Women found that violations of women's human rights occurred in situations where pregnant women were subjected to multiple vaginal examinations, where episiotomies or caesarean sections were carried out without their informed consent, and where their consent was not sought for feeding choices for newborns.[91] The Committee found that obstetric care must be provided in a way that ensures informed consent, respects dignity, guarantees confidentiality and is sensitive to the pregnant women's needs and perspectives.[92] It outlined that pregnant women "have the right to receive full information about recommended treatments so that they can make well-considered and informed decisions" and that medical professionals must be provided with professional training on women's human rights.[93]

Human rights mechanisms have also emphasised the importance of ensuring the individual's free and informed consent for other reproductive health care procedures and interventions.[94] They have found rights violations where medical procedures such as abortion or intra-uterine contraception were performed without the patient's free and informed consent.[95]

Updated public health guidelines have also been issued setting out guidance for member states. For example, in 2018, the World Health Organization published comprehensive and consolidated guidelines on intrapartum care for a positive childbirth experience, highlighting the importance of woman-centred care to optimise the experience of labour and childbirth for women and their babies through a holistic, human rights-based approach.[96]

4.2 Disrespectful care and mistreatment

In many member states, failures to ensure adequate standards of care and respect for the dignity and autonomy of women in obstetric care persist. Women across the region report experiences of mistreatment, humiliation, verbal, psychological and physical abuse, and neglect in the context of facility-based childbirth. These include restrictions on movement, fundal pressure, denial of adequate pain relief, condescension, scolding, mocking and other forms of verbal disrespect.[97] Experiences of neglect, delays, denial of care, inadequate pain relief, sexual violence, humiliation, verbal abuse, judgmental and sexist remarks, and violations of privacy have also been reported in gynaecological care settings.[98] Although these practices frequently affect women from all backgrounds, reports indicate that women from marginalised groups including women living in poverty, migrants, women from ethnic minorities, as well as other persons who might require relevant care, such as non-binary people and trans men, face exacerbated harm.[99]

The impact of such disrespectful and abusive practices on women's emotional and mental health and wellbeing can be severe. Abusive and disrespectful obstetric care has been associated, for example, with postpartum depression, post-traumatic stress disorder, and negative implications for sexuality and sexual expression. It has also been associated with exacerbated risks of complications during childbirth and decreased trust in the health system leading to increased unwillingness to seek medical care.[100]

These practices are often connected with structural problems and systemic conditions that significantly impact the provision of obstetric care and other reproductive health services, including the lack of adequate health system investment, staff and equipment shortages, poor working conditions for health care staff, and lack of adequate and clear policies, guidelines, and training.[101] Harmful gender stereotypes, stigma, and discriminatory attitudes also play a role in shaping the treatment of women in obstetric care and other reproductive health care settings.

4.3 Informed consent and decision making

Allegations of disregard for women's autonomy and decision-making capacity during childbirth, and related failures to ensure women's full and informed consent prior to medical interventions, continue to be common in obstetric care settings in many member states. Women report a lack of clear and complete information about the decisions made by medical staff during childbirth and report that sometimes procedures are performed despite their explicit disapproval and lack of consent, such as episiotomies and vaginal examinations. Women also indicate that sometimes procedures are performed in the presence of students without their consent.[102]

Additionally, concerns regarding involuntary sterilisation, contraception and abortion, as well as other medical procedures performed without the free and informed consent of women with disabilities persist across the region, despite the fact that such acts are specifically prohibited under the Council of Europe Convention on preventing and combating violence against women and domestic violence, often referred to as the 'Istanbul Convention' and the Convention on the Rights of Persons with Disabilities.[103]

Chapter 5
Access to sexual and reproductive health and rights without discrimination

In all member states, intersectional discrimination continues to impede the full realisation of sexual and reproductive health and rights of marginalised groups who face the brunt of ongoing shortfalls, restrictions, and inequalities in sexual and reproductive health and rights. Multiple and intersecting inequalities in the enjoyment of the social determinants of health - including income security and social protection, adequate living conditions, education and employment conditions - also affect sexual and reproductive health equity and outcomes.[104] National level data on sexual and reproductive health indicators often mask extreme disparities in health outcomes amongst different groups of people within a country, and marginalised groups of women and girls are still regularly excluded from policy development and evaluation processes.

5.1 Developments in international human rights standards

Under international human rights law, states are obliged to eliminate all forms of discrimination in the enjoyment of sexual and reproductive health and rights.[105] In recent years, human rights mechanisms have provided more guidance to member states on the content of this obligation, by urging them to address and combat multiple and intersecting forms of discrimination and to mitigate the aggravating effects of such discrimination on the enjoyment of sexual and reproductive health and rights through legislation, administrative, policy changes and special measures.[106]

For instance, they have elaborated on member states' obligations to ensure that women with disabilities can fully enjoy their sexual and reproductive health and rights, by taking effective measures to enable women with disabilities to make autonomous decisions about their sexual and

reproductive health and to ensure their access to sexual and reproductive health services, including abortion care, free from coercion and any form of discrimination.[107] They have also urged member states to eliminate the practice of segregation of Roma women in reproductive health care settings, to bring an end to different forms of racist verbal, physical and psychological violence that Roma women often face in these health care contexts, and to ensure non-discriminatory and adequate access to sexual and reproductive health care for Roma women.[108] They have also called on states to ensure equal access to sexual and reproductive services for LGBTI persons and to address stigma they experience when seeking these services.[109] Human rights mechanisms have also underlined that member states are required to ensure that all refugees, asylum seekers and migrants, particularly those in an irregular situation, and stateless persons can access affordable quality sexual and reproductive health care, regardless of their migration status[110] and they have also specified that pregnant and breastfeeding women should not be subjected to administrative detention.[111] In addition, they have emphasised the importance of guaranteeing access to comprehensive sexual and reproductive health care in conflict- and crisis- settings and mitigating the impact of climate change on the realisation of sexual and reproductive health and rights.[112]

5.2 Challenges and deficits

Across the region, marginalised groups continue to face discrimination when it comes to the enjoyment of their sexual and reproductive health and rights. Specific challenges are faced by, amongst others, women and girls living in poverty, rural women and girls, women and girls with disabilities, ethnic minorities including Roma women and girls, adolescents, older women, unmarried and single women, women living with HIV, sex workers, women and girls affected by conflict situations, victims of human trafficking, refugees, asylum seekers, migrant women in an irregular situation, and LGBTI people.[113]

The Council of Europe Commissioner for Human Rights has repeatedly called on Council of Europe member states to guarantee the right to health, including the right to sexual and reproductive health, of persons belonging to specific groups facing intersecting forms of discrimination, including women with disabilities, Roma women, migrant women and LGBTI people.[114]

By way of example, in much of the region **Roma women and girls** continue to face deeply entrenched racism and discrimination, including in relation to the social determinants of health, which undermines their sexual and reproductive health and rights.[115] In some member states,

they are subjected to segregation, racial harassment and abuse in reproductive health care settings.[116] In some cases, Roma women survivors of forced sterilisations continue to be deprived of effective remedies, and comprehensive mechanisms to address their situation are still needed.[117] In other cases, mechanisms have been developed that aim to provide survivors of forced sterilisation with reparations for the harm they endured, although problems in implementation raise questions about the extent to which these are currently able to provide for effective remedies.[118] Roma women who have other intersecting identities often face huge barriers as well as forms of discrimination in the access and provision of sexual and reproductive health care services.[119]

Similarly, in most member states, **women and girls with disabilities** are often subjected to serious violations of their sexual and reproductive health and rights.[120] Many women and girls with disabilities undergo involuntary sterilisation, contraception and abortion without their free and informed consent.[121] Substitute decision-making systems, where a guardian or a judge is empowered to make life-altering decisions for persons with disabilities, against their will and preferences, are common in many European countries.[122] Women with disabilities also face huge barriers in access to sexual and reproductive health care and evidence-based information.[123]

The provision of appropriate sexual and reproductive health care services and information for **older women** is also lacking in some countries. Older women face increased risks of violence, abuse, and neglect as well as harmful gender stereotypes, assumptions, and stigma in relation to sexuality and sexual and reproductive health. Health care policy and service provision often fails to prioritise the specific sexual needs of women related to, and following, the menopause, and age-related financial barriers often restrict older women's access to comprehensive quality care. Older women in care settings are especially vulnerable to sexual violence or other serious violations of their personal and bodily integrity.[124]

Across Europe, refugees, asylum seeking and **migrant women,** especially women in an irregular situation, also face serious forms of discrimination and exclusion in relation to their enjoyment of sexual and reproductive health and rights. In many member states, laws and policies directly or indirectly prevent migrant women in an irregular situation, refugees, and asylum seekers from accessing affordable sexual and reproductive health care, including during pregnancy and childbirth.[125] For many migrant women, being in an irregular situation, fear of being reported to immigration authorities, and a lack of effective separation — or "firewalls" — between health services and immigration controls and enforcement prevents them

from accessing sexual and reproductive health care, sometimes placing their health and lives at risk.[126] In administrative detention settings or transit zones, women can face barriers accessing adequate and appropriate sexual and reproductive health care.[127]

Although there have been important positive developments in many member states, **LGBTI people** continue to experience diverse forms of intersectional discrimination in the sphere of sexual and reproductive health and rights.[128] In some countries, discrimination on the basis of marital status, health status, sex, sexual orientation, gender identity and expression, as well as sex characteristics, continues to limit the rights of LGBTI people to access essential sexual and reproductive health services. In some parts of the region, LGBTI people still face practices that violate their sexual and reproductive health and rights, such as so-called "conversion therapies",[129] sterilisation of trans people,[130] medically unnecessary "normalising" treatments on intersex children without their prior, free, and informed consent[131] and discriminatory restrictions on access to assisted reproduction.[132]

Sex workers across Europe also face significant obstacles to securing equal and unhindered access to their sexual and reproductive health and rights.[133] Stigma and discrimination towards them in health care settings is particularly widespread. This may result in denial of care, disrespectful and abusive language and treatment, confidentiality breaches and a lower quality of care, and some sex workers avoid seeking health care altogether. They sometimes lack access to social protection, health insurance and health care subsidisation schemes. Barriers are often exacerbated for sex workers who face intersecting forms of discrimination, including on the basis of age, disability, sexual orientation, gender identity and expression, sex characteristics, migration status, and health status.[134]

Chapter 6
Human rights defenders working to advance sexual and reproductive health and rights

Continued progress in sexual and reproductive health and rights in Europe would not be possible without the tireless work, resolve, and courage of the human rights defenders and civil society organisations that are working across the region to advance these rights. Council of Europe member states have clear international human rights obligations to protect human rights defenders and create an enabling environment in which they can conduct their work, free from hindrance and insecurity.[135]

However, despite these obligations, human rights defenders and civil society organisations working to promote and protect sexual and reproductive health and rights in some parts of Europe face various concerning challenges and risks. In some member states, recent rollbacks on sexual and reproductive rights and gender equality, alongside efforts to undermine the rule of law, have exacerbated these threats. Some human rights defenders are facing threats to their personal safety and liberty, as well as different forms of intimidation and harassment. In some countries, civil society organisations working on sexual and reproductive health and rights face severe financial and operational uncertainty and insecurity.[136] In some contexts, medical professionals who provide sexual and reproductive health care are also facing similar threats and challenges.[137]

Human rights mechanisms have expressed increasing concern about the threats and challenges faced by human rights defenders and organisations working in Europe. They have recognised that women human rights defenders and women's rights organisations, that are often at the front lines of providing direct support and assistance to those in need of sexual and reproductive health care, may be exposed to gender-specific forms of persecution and discrimination because of their human rights work. They have urged states to take effective measures to ensure safe and favourable environments for human rights defenders working on sexual

and reproductive health and rights and to support them in discharging their role.[138]

6.1 Risks to personal safety and fear of prosecution and judicial harassment

In some Council of Europe member states, human rights defenders report receiving threats to their personal safety because of their advocacy and efforts to promote and protect sexual and reproductive rights.

They have reported experiencing incidents and threats of physical attack and violence, including sexual violence and death threats, stigmatisation, smear campaigns, hate speech, defamation, and harassment, both online and offline.[139]

In some countries, human rights defenders have also faced legal consequences or harassment because of their work.[140] For example, in 2023, Justyna Wydrzyńska was convicted by a district court in Poland for helping a woman access abortion medication.[141] In Andorra, Vanessa Mendoza Cortés faced criminal charges, including on counts of a "crime against the prestige of the institutions", for her work in 2019 voicing concern to the United Nations Committee on the Elimination of Discrimination against Women and in the media about women's human rights and Andorra's abortion ban. In January 2024, she was acquitted by the Tribunal de Corts in Andorra.[142]

Human rights defenders who have exercised their right to freedom of assembly are also facing legal consequences. For example, in Poland, peaceful demonstrators who gathered to protest against rollbacks on abortion rights reported being subjected to intimidation and excessive use of force by law enforcement forces and some of them faced criminal charges related to their role in these demonstrations.[143]

The use of criminal investigation and prosecution as a form of reprisal against human rights defenders for their work to protect human rights not only causes substantial harm to the individuals concerned but can also have a broader chilling effect. In some member states, human rights defenders working to advance sexual and reproductive health and rights report increasing levels of fear that they will be targeted through legal channels by the state authorities.

6.2 Unfavourable and hostile working environments

Many human rights defenders and civil society organisations working to advance sexual and reproductive rights in Europe also face challenges

related to their working environment. In several member states, there are concerns about increasing restrictions on civil society space and clampdowns on the legitimate activities of human rights defenders and civil society organisations through legislative attempts to place unjustified restrictions on the activities and funding sources of civil society organisations.[144]

A sustained lack of funding, including sources of state support, is another challenge faced by many civil society organisations working in Europe to advance sexual and reproductive health and rights. Long-term financial insecurity has negatively impacted organisations' ability to respond to retrogression and to proactively protect sexual and reproductive health and rights. In some member states, there are concerning reports of state funding being diverted to anti-SRHR (anti-Sexual and Reproductive Health and Rights) or anti-LGBTI organisations.[145]

A rise in stigmatising political rhetoric and attacks on sexual and reproductive health and rights and gender equality also compounds the challenges faced by human rights defenders and civil society organisations working in this field. The ability of human rights defenders to continue their work towards advancing sexual and reproductive rights, women's rights and gender equality is often undermined as they must dedicate considerable time and resources towards halting initiatives that seek to rollback sexual and reproductive health and rights.[146]

The Commissioner's recommendations

The Commissioner for Human Rights calls on Council of Europe member states to fully implement their human rights obligations in the field of sexual and reproductive health and rights.

The recommendations outlined below complement the comprehensive recommendations to member states set out by the Commissioner in the 2017 Issue Paper on *Women's sexual and reproductive health and rights in Europe* and provide guidance for member states on actions required of them to guarantee compliance with international human rights law and standards.

The Commissioner for Human Rights recommends that Council of Europe member states:

Guarantee the provision of comprehensive sexuality education:

- implement and mainstream mandatory comprehensive sexuality education (CSE) across the education system, including into ordinary school curricula, and ensure that CSE is age-appropriate and developmentally appropriate and provided in line with international human rights law and public health guidelines
- ensure the comprehensive nature of sexuality education curricula, including topics related to sexual and reproductive autonomy, gender equality, sexual orientation and gender identity, gender-based violence, consent, diversity, and healthy and respectful relationships
- reform laws and policies to ensure the mandatory nature of age appropriate CSE in school curricula and consult children and young people in the design, implementation, and evaluation of CSE programming
- provide teachers and education professionals with sufficient specialised training and support on an ongoing basis and guarantee adequate financial and human resources to allow for the delivery of high-quality CSE

- establish CSE programmes for out-of-school children and young people

Guarantee the availability and accessibility of affordable contraceptive services and evidence-based information on contraception:

- ensure the affordability of the full range of modern contraceptive methods and cover them under public health insurance or subsidisation schemes, as well as ensure that coverage extends to all people of reproductive age and all methods of modern contraception
- include all modern contraceptive methods in national lists of essential medicines and ensure their practical availability across rural and urban areas
- disseminate evidence-based, accurate information on contraception, in accessible formats and languages, and establish awareness-raising programmes and strategies to tackle and dispel misconceptions
- repeal residual legal and policy barriers that impede access to contraceptive services and information, such as prescription requirements for emergency contraception or third-party authorisation requirements, including for adolescents and women with disabilities
- provide regular, specialised and evidence-based training for health care workers on the delivery of contraceptive education, information and services

Guarantee access to quality abortion care including evidence-based information on abortion:

- repeal laws and policies that criminalise abortion, so as to remove all criminal penalties for consensual abortion, including for anyone who undergoes abortion, assists with access to abortion or provides abortion care
- repeal highly restrictive abortion laws and legalise abortion on request, as well as remove all regulatory barriers for access to abortion care in line with international human rights standards and the World Health Organisation abortion care guidelines
- disseminate accessible and evidence-based information on abortion care and related legal entitlements and reform laws and policies to ensure that abortion counselling is never mandatory, biased, or directive

- ensure the availability of medication abortion and allow self-management of abortion medication in accordance with the World Health Organization guidelines
- guarantee timely access to abortion care in practice, including by ensuring that:
  - it is provided free of charge or covered under public health insurance
  - there are enough fully trained providers of abortion care throughout the country
  - access to abortion is not obstructed by refusal of care on the part of health care workers
  - measures are in place to protect from harassment, intimidation, and stigmatisation those seeking and providing care

Ensure dignified and respectful gynaecological and obstetric care, free from discrimination and violence:

- ensure that all forms of gynaecological and obstetric care are provided in line with human rights standards, including the principle of non-discrimination and respect for the dignity, autonomy, integrity, and decision-making capacity of those requiring gynaecological and obstetric care
- ensure that full and effective informed consent policies and protocols are applied to all forms of reproductive health care, including obstetric care
- repeal laws and policies that directly or indirectly restrict individuals' decision making in relation to their sexual and reproductive health, and ensure that everyone can benefit from the presence of a skilled birth attendant and a companion of their choice during childbirth, without discrimination on any grounds
- eradicate medically unnecessary and harmful practices that undermine autonomy and decision making during and post-childbirth
- conduct information and awareness-raising campaigns on patients' rights, including on preventing and combating sexism and gender-based violence in gynaecological and obstetric care
- prohibit and sanction disrespect, mistreatment, and abuse in gynaecological and obstetric care

Establish effective measures to tackle intersecting forms of discrimination that limit the equal enjoyment of sexual and reproductive health and rights:

- repeal discriminatory laws and policies, and end discriminatory practices that curtail access to sexual and reproductive health care for certain groups, including on the grounds of age, disability, ethnicity, gender identity and expression, nationality or migration status, relationship status, sex, sex characteristics, sexual orientation, and socio-economic status
- establish effective public information and awareness-raising campaigns and training programmes designed to eradicate multiple and intersectional discrimination in the sphere of sexual and reproductive health and rights, particularly in health care settings
- ensure that persons with disabilities are not denied their right to autonomy in respect of their sexual and reproductive health care and for this purpose ensure that no medical intervention is performed without their prior, free, and informed consent
- ensure a life course approach in the provision of sexual and reproductive health services, from early childhood and throughout old age, and combat ageism within health care settings
- eradicate practices of segregation on the grounds of ethnicity in sexual and reproductive health care settings and ensure that Roma women can access quality care, free from discrimination, disrespect, and abuse
- ensure that all survivors of sexual violence, including those in conflict zones, victims of human trafficking, asylum seekers and refugees, and migrants in administrative detention can access comprehensive sexual and reproductive health services, including emergency contraception, abortion care and HIV post-exposure prophylaxis
- guarantee sex workers' rights to be free from violence, stigma, and discrimination in health care settings, as well as to quality sexual and reproductive health care

Ensure there is no retrogression in the protection of sexual and reproductive health and rights and enable the work of human rights defenders acting to advance sexual and reproductive health and rights:

- prevent the erosion of existing protections in the field of sexual and reproductive health and rights; reject measures and initiatives that seek to roll back established entitlements and repeal any retrogressive measures
- refrain from rhetoric and discourse that are contrary to human rights principles and that undermine commitments to women's rights, gender equality and sexual and reproductive health and rights or that stigmatise and delegitimise human rights defenders working in this field
- promote men's and boys' engagement and accountability in matters relating to sexism, misogyny, violence, and toxic masculinity, as well as sexual and reproductive health and rights of women and girls in all their diversity
- reform laws and policies that undermine the operation of human rights defenders, civil society organisations, and health care providers acting to advance sexual and reproductive health and rights, whilst also eradicating, preventing and sanctioning violence, hate speech, smear campaigns, harassment, and intimidation which target these actors
- ensure that civil society organisations working to advance sexual and reproductive health and rights have access to public funds in a non-discriminatory and transparent manner and that they effectively enjoy the freedom to solicit and receive funds from institutional or individual donors in other countries
- engage systematically human rights defenders and civil society organisations that are working to advance sexual and reproductive health and rights in the development, implementation, monitoring, evaluation and continuing improvement of law, policy and practice relating to sexual and reproductive health and rights

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Concluding Observations: Poland, CRC/C/POL/CO/5-6 (2021), para. 36(d); HRC, General comment No. 36 - Article 6: right to life, CCPR/C/GC/36 (2019), para. 8; Concluding Observations: Ireland, CCPR/C/IRL/CO/5 (2023), para. 26(a).

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46. European Court of Human Rights, *Grimmark v. Sweden*, Application No. 43726/17, decision of 11 February 2020, paras. 25-26; *Steen v. Sweden*, Application No. 62309/17, decision of 11 February 2020, paras. 20-21.

47. HRC, Concluding Observations: Ireland, CCPR/C/IRL/CO/5 (2023), para. 26(e). See also Human Rights Committee (HRC), General comment No. 36 - Article 6: right to life,

CCPR/C/GC/36 (2019), para. 8; PACE, *Access to abortion in Europe: stopping anti-choice harassment*, Resolution 2439 (2022) and Explanatory memorandum by Ms Margreet De Boer, rapporteur, Doc. 15459, 21 Feb. 2022.

48. Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions, Agnes Callamard*, Saving lives is not a crime*, A/73/314 (2018), para. 89(h).
49. World Health Organization (WHO), Abortion care guideline (2022). See also WHO, Clinical practice handbook for quality abortion care (2023).
50. Ibid., p. xx.
51. Ibid., pp. xx, 21-29.
52. Ibid., p. xxi.
53. Ibid., pp. 24-25.
54. Ibid., pp. 26-27, 42-44.
55. Ibid., pp. 26-29, 41-42.
56. Ibid., pp. 95-100.
57. Ibid., p. 59.
58. Ibid., pp. 60-61.
59. Andorra does not allow abortion at all. Recent legislation in Malta provides for access to abortion only when the life of a pregnant woman is at risk. Liechtenstein and Poland allow abortion only when a pregnant woman's life or health is at risk, or the pregnancy is the result of sexual violence. In Monaco, abortions are legal only when a pregnant woman's life or health is at risk, the pregnancy is the result of sexual violence or involves a severe fetal impairment. See Andorra: Llei 9/2005, del 21 de febrer, qualificada del Codi penal, Arts. 107-109 (Law 9/2005, 21 February, acting as Penal code, Arts. 107-109); Malta: KODIĊI KRIMINALI, KAPITOLU 9, 243B (Criminal Code, Chapter 9, Art. 243B); Liechtenstein: Strafgesetzbuch vom 24. Juni 1987 (StGB), Abschnitt 2 (Criminal Code of 24 June 1987 (StGB), Sec. 2); Poland: USTAWA z dnia 7 stycznia 1993 r. o planowaniu rodziny, ochronie płodu ludzkiego i warunkach dopuszczalności przerywania ciąży (Act on Family Planning, Protection of the Human Fetus, and Conditions for Pregnancy Termination of 7 Jan. 1993); Monaco: Code pénal, Article 248 (Penal code, Article 248).
60. CEDAW, *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, CEDAW/C/OP.8/GBR/1 (2018), paras. 22, 64; WHO, Abortion care guideline (2022), page 26-27.
61. Belgium: Loi relative à l'interruption volontaire de grossesse, abrogeant les articles 350 et 351 du Code pénal et modifiant les articles 352 et 383 du même Code et modifiant diverses dispositions législatives, 15 octobre 2018, Article 3 (Law on the voluntary termination of pregnancy, repealing articles 350 and 351 of the penal code and amending articles 352 and 383 of the same code and amending various legislative provisions, 15 October 2018, Article 3), available at http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2018101503&table_name=loi; Cyprus: Ο περί Ποινικού Κώδικα Νόμος (ΚΕΦ.154) Ν. 23(Ι)/2018 ΝΟΜΟΣ ΠΟΥ ΤΡΟΠΟΠΟΙΕΙ ΤΟΝ ΠΟΙΝΙΚΟ ΚΩΔΙΚΑ, 168 (Penal Code, Chapter 154 as modified by Law 23(I)/2018 amending the penal code, Article 168), available at http://cylaw.org/nomoi/enop/ind/0_154/section-scf87db566-babb-4f92-9d6b-b3d3303615c3.html; Iceland: Almenn hegningarlög, 216. gr. (General Criminal law, Article 216), available at https://www.althingi.is/lagas/nuna/1940019.html; Italy: Legge 22 maggio 1978, n. 194, Norme per la tutela sociale della maternita' e sull'interruzione volontaria della gravidanza, Gazzetta Ufficiale della Repubblica Italiana No. 140 (22 maggio 1978) (Law No. 194 of May 22,

1978, Provisions on the Social Protection of Maternity and the Voluntary Interruption of Pregnancy, Official Gazette No. 140 (May 22, 1978), available at https://www.antonellapedone.com/leggi/legge-194-1978-05-22#:~:text=Legge%20n.194%20del%2022%20maggio%201978%20Norme%20per,e%20tutela%20la%20vita%20umana%20dal%20suo%20inizio; Liechtenstein: Article 96 para 3 of the Criminal Code of Liechtenstein, 24 June 1987, available at https://www.gesetze.li/konso/html/1988037000?version=53&search_text=&search_loc=#par:96; Portugal: Código Penal, Decreto-Lei No. 48/1995, versão consolidada (Penal Code, Decree-Law no. 48/95 as amended), Articles 140-142, available at https://diariodarepublica.pt/dr/legislacao-consolidada/decreto-lei/1995-34437675; San Marino: Legge 7 settembre 2022 n.127 - Regolamentazione dell'interruzione volontaria di gravidanza, articolo 16 che modifica l'articolo 153 del Codice penale (Law no. 7 of 2022 September 127 - Regulation of the voluntary interruption of pregnancy, Article 16 amending Article 153 of the Criminal Code), available at https://www.consigliograndeegenerale.sm/on-line/home/archivio-leggi-decreti-e-regolamenti/scheda17177841.html.

62. See, e.g., WHO, Abortion care guideline (2022), pp. 22, 24-25.

63. CEDAW, *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, CEDAW/C/OP.8/GBR/1 (2018), paras. 30, 33-42, 83.

64. See, e.g., FEDERA, SRHR and FEDERA Overview – June-July 2023**,** available at https://en.federa.org.pl/srhr-and-federa-overview-june-july-2023/; *Komentarz FEDERY do postawienia zarzutów dr Marii Kubisie*, 27.11.2023, available at https://federa.org.pl/wp-content/uploads/2023/11/DrKubisa_stanowisko_FEDERY.pdf; *Communication from NGOs (Foundation for Women and Family Planning and the Center for Reproductive Rights) (18/04/2023) in the cases of R.R., TYSIAC and P. and S. v. Poland (Applications No. 27617/04, 5410/03, 57375/08)*, 1468th meeting (June 2023) (DH), available at https://hudoc.exec.coe.int/?i=DH-DD(2023)525E.

65. See Center for Reproductive Rights, *European Abortion Laws: A Comparative Overview* (Sept. 2023), available at https://reproductiverights.org/european-abortion-laws-comparative-overview/.

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69. See, e.g., WHO, Abortion care guideline (2022), p. 61.

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