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REPORT

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

Committee on Women's Rights and Gender Equality

Rapporteur: Edite Estrela

PR_INI

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on Sexual and Reproductive Health and Rights

(2013/2040(INI))

The European Parliament,

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

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

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

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

– having regard to the Declaration and Programme of Action of the United Nations International Conference on Population and Development (Cairo, 13 September 1994), to the outcome documents of its review conferences, to the resolution of the special session of the United Nations General Assembly (ICPD+5) in June 1999, and to the United Nations General Assembly Resolution 65/234 on the follow-up to the International Conference on Population and Development beyond 2014 (December 2010),

– having regard to the Beijing Declaration and Platform for Action, adopted by the Fourth World Conference on Women on 15 September 1995 and to Parliament's resolutions of 18 May 2000 on the follow-up to the Beijing Action Platform[1], of 10 March 2005 on the follow-up to the Fourth World Conference on Women – Platform for Action (Beijing+10)[2] and of 25 February 2010 on Beijing +15 – UN Platform for Action for Gender Equality[3],

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

– having regard to the parliamentary statements of commitment on 'the Implementation of the ICPD Programme of Action' from Ottawa (2002), Strasbourg (2004), Bangkok

[1] OJ C 59 E, 23.2.2001, p. 133.
[2] OJ C 320 E, 15.12.2005, p. 12.
[3] OJ C 348 E, 21.12.2010, p. 11.

(2006), Addis Ababa (2009), and Istanbul (2012),

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

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

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

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

– having regard to the Report of the United Nations High Commissioner for Human Rights of 17 November 2011 on ‘Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity’ (A/HR/C/19/41),

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

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

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

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

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

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

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

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

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

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

– having regard to the Council conclusions on the EU role in Global Health adopted at the 3011th Foreign Affairs Council meeting of 10 May 2010,

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

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

– having regard to Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European Centre for Disease Prevention and Control[3],

– having regard to its resolutions of 29 September 1994 on the outcome of the Cairo International Conference on Population and Development[4], and 4 July 1996 on the follow-up to the Cairo International Conference on Population and Development[5],

– having regard to its resolution of 3 July 2002 on sexual and reproductive health and rights[6],

– having regard to its resolution of 10 February 2004 on the proposal for a European Parliament and Council regulation establishing a European Centre for Disease Prevention and Control[7],

– having regard to its resolution of 4 September 2008 on Maternal Mortality ahead of the UN high-level event on the millennium development goals held on 25 September 2008[8],

– having regard to its resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women[9],

– having regard to its resolution of 13 March 2012 on equality between women and men in the European Union – 2011[10],

– having regard to the report of the United Nations High Commissioner for Human Rights on ‘Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity’ (A/HR/C/19/41),

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[1] OJ L 224, 6.9.2003, p.1.
[2] OJ L 403, 30.12.2006, p.9.
[3] OJ L 142, 30.4.2004, p.1.
[4] OJ C 305, 31.10.94, p. 80.
[5] OJ C 211, 22.7.1996, p.31.
[6] OJ C 271, 12.11.2003, p.219.
[7] OJ L 142, 30.4.2004, p.1.
[8] OJ C 295, 4.12.2009.
[9] OJ C 296 E, 2.10.2012, p. 26.
[10] OJ C 251 E, 31.8.2013, p. 1.

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

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

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

B. whereas Article 8 of the Treaty on the Functioning of the European Union (TFEU) states that in all its activities the Union shall aim to eliminate inequalities and to promote equality between men and women;

C. whereas sexual and reproductive health and rights touch every human being at every stage of life and are therefore a lifelong concern both for women and men; whereas sexual and reproductive health and rights (SRHR) programmes need to be tailored to the different needs and challenges which people face at different times in their life;

D. whereas Article 168 TFEU states that the Union shall act in accordance with a high level of human health protection and to improve public health;

E. whereas women and men, regardless of age, sex, race, ethnicity, class, caste, religious affiliation, marital status, occupation, disability, HIV (or STI) status, national origin, immigration status, language, sexual orientation and gender identity, have the right to make their own informed and responsible choices as regards their sexual and reproductive health, and all the corresponding methods and possibilities should be available to them;

F. whereas gender inequality is a key cause of the non-fulfilment of women's and adolescents' sexual and reproductive health; whereas stereotyped perceptions about femininity and masculinity in general, and perceptions about girls' and women's sexuality in particular, are profound obstacles to the fulfilment of SRHRs;

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

H. whereas unintended and unwanted pregnancies are still a problematic reality for many women in the EU, including teenage girls;

I. whereas in almost one third of Member States contraceptives are not covered under public health insurance, which is a serious barrier to access for certain groups of women, including low-income women, adolescents and women living in violent relationships;

J. whereas women are disproportionately affected by a lack of SRHRs due to the nature of human reproduction, and the gender-based social, legal and economic context in which it occurs;

K. whereas comprehensive, age-appropriate, evidence-based, scientifically accurate and non-judgemental sexuality education, quality family planning services and access to contraception help to prevent unintended and unwanted pregnancies, reduce the need for

abortion and contribute to the prevention of HIV and STIs; whereas teaching young people to take responsibility for their own sexual and reproductive health has long-term positive effects, lasting throughout their lifetime and having positive impact on society;

L. whereas according to the United Nations Population Fund (UNFPA), as well as the World Health Organisation (WHO), 287 000 women die every year as a result of complications linked to pregnancy and childbirth;

M. whereas an estimated five million young people aged between 15 and 24, and two million adolescents aged between 10 and 19 are living with HIV[1], and typically failing to access and utilise sexual and reproductive health and HIV services, as such services rarely meet the unique sexual and reproductive health needs of young people in a comprehensive way;

N. whereas, despite international commitments, there are disparities in the standard of sexual and reproductive health between and within Member States, and whereas there is also inequality as regards the sexual and reproductive rights enjoyed by women in Europe, including in terms of access to reproductive health services, contraception and abortion, depending on the country of residence, income, age, migration status and other factors;

O. whereas adolescent mothers are less likely to complete secondary education and more likely to live in poverty;

P. whereas migrant, refugee and undocumented women face insecure economic and social situations, where concerns about sexual and reproductive health are often minimised or ignored;

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

R. whereas SRHRs are key factors for gender equality, poverty elimination, economic growth and development;

S. whereas women and men should bear equal responsibility for preventing unwanted pregnancies; whereas contraceptives are mainly used by women;

T. whereas preventing unwanted pregnancy is not only about contraceptive services and information but also includes the provision of comprehensive sexuality education as well as material and financial assistance for pregnant women in need;

U. whereas access to safe abortion is banned, except in very narrow circumstances, in three EU Member States (Ireland, Malta and Poland); whereas in several Member States abortion remains legal but is increasingly difficult to access due to regulatory or practical barriers, such as the abuse of conscientious objection, mandatory waiting periods and biased counselling, and whereas other Member States are even considering restricting access to abortion services;

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[1] UNICEF report entitled ‘Opportunity in crisis: preventing HIV from early adolescence to young adulthood’, 2011.

V. whereas socio-economic and job-related circumstances make it difficult for many women and young couples to become parents;

W. whereas maternal mortality remains a concern in some Member States and a challenge for European development policy;

X. whereas sexual violence is a serious human rights violation and has a devastating impact on the sexuality, dignity, psychological wellbeing, autonomy and reproductive health of women and girls; whereas harmful traditional practices, such as female genital mutilation/cutting, and early and forced marriage have a damaging effect on personal well-being and self-esteem, sexual relations, pregnancies and childbirth and are a lifelong risk to women's health, as well as to communities and society as a whole;

Y. whereas violence against women, particularly domestic violence and rape, is widespread and rising numbers of women are at risk of contracting AIDS and other STIs as a result of high-risk sexual behaviour on the part of their partners; whereas such violence is also perpetrated against pregnant women, thereby increasing the likelihood of miscarriage, stillbirth or abortion;

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

AA. whereas budget cuts in public health further restrict access to healthcare and services;

AB. whereas women and girls who are engaged in prostitution or drug use are most at risk of contracting STIs, including HIV, and whereas the SRHR needs of such women and girls are often neglected,

AC. whereas studies have shown that comprehensive sexuality education and high-quality family planning services increase the likelihood of responsible, safe and respectful behaviour upon initial and subsequent sexual activity;

AD. whereas lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons continue to face discrimination, violence, and judgemental portrayals of their sexuality and gender identities in all Member States today;

AE. whereas attention should be devoted not only to terminating unwanted pregnancies, but also particularly to preventing them; whereas preventing unwanted pregnancies is not only about the provision of contraceptive methods and information, but also includes the provision of comprehensive sexuality education as well as material and financial assistance for pregnant women and couples in need;

AF. whereas young people are widely exposed, from an early age, to pornographic content, especially through access to the internet, whether at home or at school;

AG. whereas unsafe abortions seriously endanger women's physical and mental health and may place their lives in danger;

AH. whereas the sexualisation of young girls in the media is a phenomenon that affects the emotional development and the sex life both of women and men and helps to perpetuate gender stereotyping and various forms of discrimination and sexual violence;

AI. whereas the practice of forced or coerced sterilisation of Roma and disabled women, as well as transgender persons, still occurs in some Member States;

AJ. whereas the sharing of best practices among Member States offers a means of identifying optimal solutions and more effectively safeguarding the interests of all EU citizens;

AK. whereas there are examples of Member States combining the liberal legislation of abortion with effective sexuality education, high-quality family planning services and the availability of different contraceptives which combine lower abortion rates and higher birth rates;

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

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

2. Stresses that violations of SRHRs have a direct impact on women's and girls' lives, on women's economic independence, on women's enjoyment of social services, on women's access to decision-making and participation in public life, on women's vulnerability to male violence, on women's access to education and on the enjoyment of private life, and therefore such violations affect society as a whole;

3. Stresses that the empowerment of women and girls is key to breaking the cycle of discrimination and violence and for the promotion and protection of human rights, including sexual and reproductive health;

4. Recognises that SRHRs are an essential element of human dignity, which need to be addressed in the broader context of structural discrimination and gender inequalities; calls on the Member States to safeguard SRHRs through the Fundamental Rights Agency and the European Institute for Gender Equality (EIGE), not least by providing for reproductive health programmes and services, including the types of care and medicines essential for voluntary family planning and maternal and newborn health, and by maintaining vigilance on policies and/or legislation which may infringe upon sexual and reproductive health and rights;

5. Calls on the Member States to provide quality sexual and reproductive health services adapted to the needs of specific groups without any discrimination, fears of judgment (to young people and vulnerable groups, for example); underlines that such services must equally target and facilitate the active role of men and boys in sharing responsibility for sexual behaviour and its consequences;

6. Emphasises that EU and Member State policies must ensure that they respect, protect and fulfil SRHRs for all by fostering an understanding of human sexuality as a positive aspect of life and creating a culture of acceptance, respect, non-discrimination and non-violence;

7. Stresses that within the EU and where relevant in its external policies, the EU must ensure that laws and policies are amended, enacted or repealed to respect and protect sexual and reproductive health and rights and enable all individuals to exercise them without discrimination on any grounds;

8. Emphasises that reproductive choices and fertility services should be provided within a non-discriminatory framework;

9. Emphasises that surrogate motherhood represents a commodification of both women's bodies and children;

10. Stresses that forced or coerced sterilisation of any person represents a breach of that person's human rights and bodily integrity, and calls on the Member States to abolish any existing law that imposes sterilisation;

11. Deeply regrets the fact that the proposal for a new 'Health for Growth Programme 2014-2020' does not mention SRHRs and urges the Commission to include SRHRs in its next EU Public Health Strategy;

12. Calls on the Member States to ensure a geographically adequate distribution of quality health service points and quality and safe transportation options in order to guarantee equal access for the whole population, including women and girls living in rural areas;

13. Notes that even though it is a competence of Member States to formulate and implement policies on SRHRs, the EU can exercise policy-making competence in relation to strategies and initiatives integrating issues related to SRHRs in the areas of public health and non-discrimination, so as to support better implementation and awareness-raising of sexual and reproductive rights legislation and policies and to promote the exchange of best practices between Member States;

14. Calls on the Member States to provide access to sexual and reproductive health services through a rights-based approach and without any discrimination on the grounds of ethnic origin, housing status, migration status, age, disability, sexual orientation, gender identity, health or marital status;

15. Calls on the governments of the Member States and the candidate countries to develop a high-quality national policy on sexual and reproductive health, in cooperation with pluralist civil society organisations, providing comprehensive information concerning effective and responsible methods of family planning, ensuring equal access to a range of high-quality contraceptive methods as well as fertility awareness;

16. Calls on the EU and its Member States to compile and monitor more comprehensive data and statistics regarding sexual and reproductive health indicators (STIs, abortion and contraception rates, unmet needs for contraception, adolescent pregnancy, etc.), disaggregated at least by gender and age;

17. Expresses concern about the restrictions on access to sexual and reproductive health services and contraceptives in the accession countries; calls on the governments of those countries to adopt legislation and policies that ensure universal access to sexual and

reproductive health services, and systematically to gather the necessary data to improve the situation as regards sexual and reproductive health;

18. Calls on the Member States to guarantee sustainable funding to public services and civil society organisations providing services in the field of sexual and reproductive health;

19. Calls on the Member States to work with the Commission, the EIGE and civil society to design a European strategy for the promotion of SRHRs, and support the elaboration and implementation of comprehensive national strategies for sexual and reproductive health; suggests that the EIGE be empowered to collect, analyse and compile Europe-wide data and best practices, in order to better understand the obstacles to the integration of sexual and reproductive health prevention and treatment programmes into the basic healthcare systems;

20. Stresses that the current austerity measures have a detrimental impact, particularly for women, in terms of quality, affordability and accessibility on public health services, information and programmes related to sexual and reproductive health, and in terms of quality and accessibility, as well as on family planning and support organisations, on NGO service providers, and on women's economic independence; points out that the Member States should take the necessary steps to ensure that access to sexual and reproductive health services is not jeopardised;

21. Calls on the Member States to develop an SRHR strategy with an allocated budget, implementation plan and monitoring system associated to it;

22. Stresses that it is vitally important that women have access to annual gynaecological check-ups and mammograms, and that it is therefore unacceptable for Member States to reduce such services on the pretext of the crisis and budget cuts;

23. Encourages the Member States to share their best practices and measures packages in the field of sexual and reproductive health policy;

24. Urges the Member States and the candidate countries, in view of the impact of the financial and economic crisis on the public health sector, to provide – free of charge or in a manner that is financially accessible – adapted contraceptive information and services and other sexual and reproductive health services, such as annual gynaecological check-ups and mammograms, as well as measures for the prevention, diagnosis and treatment of STIs, which include high-quality professional advice and counselling, to all sections of the population, including women in rural areas, young people, ethnic minorities, migrants, people with disabilities, and the socially excluded;

25. Stresses that SRHRs are basic rights for women and men which should not to be restricted on religious grounds, for example by concluding concordats;

26. Insists that enabling the fundamental freedom of women, girls and couples to take decisions about their sexual and reproductive life, including whether and when to bear children, creates opportunities to pursue activities such as education and employment, something which contributes to gender equality, poverty reduction, and inclusive and sustainable development; notes that being able to choose to have fewer children, with

more time between births, potentially enables families to invest more in each child's education and health;

Unintended and unwanted pregnancy: access to contraception and safe abortion services

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

28. Emphasises that voluntary family planning contributes to preventing unintended and unwanted pregnancies and reduces the need for abortion;

29. Calls on the Member States to refrain from preventing pregnant women seeking abortion from travelling to other Member States or jurisdictions where the procedure is legal;

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

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

32. Stresses that the Member States should implement policies and measures aimed at preventing people from having abortions for social or economic reasons and providing support to mothers and couples in difficulty;

33. Recommends that, as a human rights and public health concern, high-quality abortion services should be made legal, safe, and accessible to all within the public health systems of the Member States, including non-resident women, who often seek these services in other countries because of restrictive abortion laws in their country of origin, and to avoid clandestine abortions that seriously endanger women's physical and mental health;

34. Underlines that even when legal, abortion is often prevented or delayed by obstacles to the access of appropriate services, such as the widespread use of conscientious objection, medically unnecessary waiting periods or biased counselling; stresses that the Member States should regulate and monitor the use of conscientious objection in the key professions, so as to ensure that reproductive healthcare is guaranteed as an individual's right, while access to lawful services is ensured and appropriate public referrals systems of good quality are in place; stresses that the right to conscientious objection is an individual right and not a collective policy, and that advice and counselling must be confidential and non-judgmental; is concerned that medical staff are coerced into refusing SRHR services in religion-based hospitals and clinics throughout the EU;

35. Urges the Member States to take targeted action to meet the specific needs of vulnerable people who are at risk of marginalisation and social and economic exclusion, in particular young women in rural areas, who may find it difficult to gain access to modern means of contraception as a result of economic and social problems, in particular during the current economic crisis;

36. Calls on all Member States to ensure that healthcare professionals who perform abortion

and abortion-related services are not prosecuted or penalised under any criminal law instruments on the grounds of having provided these services;

37. Calls on the governments of the Member States and the candidate countries to refrain from prosecuting women who have undergone illegal abortions;

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

As regards comprehensive sexuality education and youth-friendly services

39. Calls on the Member States to ensure universal access to comprehensive SRHR information, education and services; urges them to ensure that this information covers a variety of modern methods of family planning and counselling, skilled birth attendance, and the right to access gynaecological and obstetric emergency care, and that it is non-judgmental and scientifically accurate about abortion services;

40. Stresses that the participation of young people, in cooperation with other stakeholders, such as parents, in the development, implementation and evaluation of the programmes is vital for comprehensive sexuality education to be effective; encourages the use of peer educators in sexuality education as a good way to lead to empowerment, and calls on the Member States and candidate countries to make use of various other methods in reaching out to young people, such as publicity campaigns, social marketing for condom use and other methods of contraception, and initiatives such as confidential telephone helplines;

41. Calls on the Member States to make sexuality education classes compulsory for all primary and secondary school children and to ensure that space is made available for this subject in school curricula; stresses the importance of regularly reviewing and updating the teaching of sexuality education and of placing special emphasis on respect for women and on gender equality;

42. Stresses that sexuality education must be designed and implemented in a holistic, rights-based and positive way, emphasising the development of life skills and including both the psycho-social and bio-medical aspects of sexual and reproductive health and rights;

43. Underlines that the sexual and reproductive health needs of adolescents differ from those of adults; calls on the Member States to ensure that adolescents have access to user-friendly services where their concerns and rights to confidentiality and privacy are duly taken into account;

44. Calls on the Member States to provide adolescent-friendly sexual and reproductive health services which are in accordance with age, maturity and evolving capacities, which do not discriminate on the grounds of gender, marital status, disability, or sexual orientation/identity, and which are accessible without the consent of parents or guardians;

45. Calls on the Member States to ensure compulsory, age-appropriate and gender-sensitive sexuality and relationship education, provided in a mixed-sex setting, for all children and

adolescents;

46. Calls on the Member States to devise and introduce post-graduate education and training programmes and courses on issues relating to sexual health and reproductive rights for medical students and heath care workers, with a view to ensuring that women and couples are provided with high-quality guidance, based on their state of health and personal and career requirements, on how large a family to have;

47. Urges the Member States to take measures to remove all barriers hindering the access of adolescent girls and boys to safe, effective, affordable methods of contraception, including condoms, and to provide clear information on contraceptives;

48. Reminds the Member States that they must ensure that children and young people can enjoy their right to seek, receive and impart information related to sexuality, including sexual orientation, gender identity and gender expression, in an age-appropriate and gender-sensitive manner;

49. Insists that Member States draw up measures providing for work with young and under-age mothers and expectant mothers to support them in coping with the problems of early motherhood and to prevent cases of new-born babies being killed;

50. Stresses that sexuality education must include the fight against stereotypes, prejudices, all forms of gender violence and violence against women and girls, shed light on and denounce discrimination on the grounds of gender and sexual orientation, as well as structural barriers to substantive equality, in particular equality between women and men, and emphasise mutual respect and shared responsibility;

51. Underlines that sexual education must include non-discriminatory information and convey a positive view of LGBTI persons, in order to underpin and protect in an effective manner the rights of young LGBTI people;

52. Emphasises in this regard that sexuality education is particularly necessary, as young people have access, from an early age, to pornographic and degrading content, especially via the internet; emphasises, therefore, that sexuality education must be part of a broader supportive approach to young people’s emotional development so as to enable them to form mutually respectful relationships; encourages the Member States to introduce campaigns directed at parents and at adults who work with young people, to raise their awareness about the harmful effects of pornography on adolescents;

53. Asks the Member States, also, to address the fundamental need for comprehensive sexuality education that includes the emotional aspects of relationships, given the phenomenon of sexualisation of young girls in audiovisual and digital content to which young people have access;

54. Asks the Member States, in the context of sexuality education, to focus on the prevention of sexually transmitted infections (STIs), including HIV, by encouraging safe sexual behaviour and facilitating access to means of protection;

As regards STI prevention and treatment

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

56. Calls on the Member States to maintain and increase the quality and the level of information made available to the general public and to strengthen their policies for raising awareness on STIs, particularly HIV/AIDS, based on the latest medical developments and practices, on the ways in which diseases are transmitted, as well as prevention methods, and also to avoid unwanted pregnancies;

57. Calls on the Member States to provide prevention activities besides voluntary counselling and testing;

58. Calls on the Commission and the Member States to address the specific SRHRs of people living with HIV/AIDS, with a focus on the needs of women and at-risk populations, including persons in prostitution, prisoners, migrants and injection-drug users, notably by integrating access to testing and treatment and reversing the underlying socio-economic factors, such as gender inequality and discrimination, contributing to the risk to women and populations at risk of contracting HIV/AIDS;

59. Calls on the EU to promote and invest in research and development of new and improved acceptable, affordable, accessible, high-quality prevention technologies, diagnostics and treatments, targeting HIV and AIDS and other STIs, as well as neglected tropical diseases, in order to reduce the burden of these diseases on maternal and child health;

60. Calls on the Member States to put in place effective, inclusive strategies for HIV prevention, and to remove regulations and laws that penalise and stigmatise people living with HIV/AIDS, as these laws have been deemed ineffective and even counter-productive to HIV prevention;

61. Urges the Commission and the Member States to make it easier to gain access to information, vaccines and treatment in order to protect babies against HIV infection during pregnancy and to ensure that appropriate post-natal treatment is provided without delay in the event of infection;

As regards violence related to sexual and reproductive rights

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

63. Recommends that the Member States ensure that women and men of all social and ethnic groups give their fully informed consent to all medical services and procedures, such as contraceptive services, sterilisation and abortion; calls on the Member States to establish procedures that guarantee freedom from inhuman and degrading treatment in reproductive healthcare settings, with a particular focus on detention centres, prisons, and mental health and elderly care institutions;

64. Recalls that sexual violence or sexual control over women, such as rape, including marital

rape, female genital mutilation (FGM), sexual abuse, incest, sexual exploitation, sexual harassment and forced early/child marriage, have a damaging long-term impact on women's and girls' sexual and reproductive health, as well as on their self-esteem and empowerment; calls on the Member States to address the need to protect women and girls from these abuses, and provide services to victims, with the support of educational programmes at both national and community level, and to focus on measures to do so which incorporate severe penalties for perpetrators of abuse, including the criminalisation of sexual coercion;

65. Calls on the Member States to sign and ratify the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence;

66. Calls on the Member States and the candidate countries to guarantee that a woman who has become pregnant as a result of rape, as well as women in cases where there is a serious risk to their health or life, can undergo an abortion with full health and legal safeguards, without restrictions of any kind;

67. Insists that SRHRs need to be rooted in existing international human rights instruments and key political consensus documents; regrets that the EU position formulated in preparation for the UN Conference on Sustainable Development (Rio+20), which recognised SRHRs as a cross-cutting issue key to other aspects of development, was not reflected in the final UN document due to the absence of a unified EU voice;

68. Calls on the Member States to ensure the integration of the ICPD+20, Beijing+20 and Rio+20 processes into the post-2015 framework;

As regards SRHRs and official development assistance (ODA)

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

70. Stresses the importance of education and awareness-raising in the area of sexual and reproductive health as an integral part of the women's health agenda in developing countries;

71. Asks the Commission to allow a specific line on SRHRs under the thematic lines of the Development Cooperation Instrument, as well as sufficient funding for the broad SRHR agenda in all appropriate instruments;

72. Recalls the urgent need for trained health workers in developing countries, as well as the need to prevent the brain-drain of trained health professionals by means of financial incentives and training support; underlines the importance of integrated health services relating to HIV and SRHRs, as well as of involving civil society, local authorities, communities, public health non-profit organisations and volunteers organisations at all levels when setting up health services; insists, in particular, on the need to facilitate access to SRHR-related healthcare in rural and remote areas;

73. Supports Recommendation 1903 (2010) of the Council of Europe Parliamentary

Assembly to allocate 0.7 % of gross national income to ODA; calls for the EU to maintain this commitment through the financing and implementation of the 2014-2020 European external actions instruments and European Development Fund;

74. Highlights the fact that the epidemics suffered in certain developing countries which are partners of the EU, including the HIV epidemic, significantly impede development;

75. Urges the organisations receiving EU funds for HIV/AIDS and/or health protection to develop a clear, concise and transparent strategy as to how they can incorporate SRHRs and primary HIV prevention into their interventions;

76. Urges the EU to ensure that European development cooperation adopts a human-rights-based approach and that it has a strong and explicit focus, and concrete targets on SRHRs, paying particular attention to family planning services, maternal and infant mortality, safe abortion, contraceptives, prevention of and the fight against HIV/AIDS and other sexually transmitted diseases and the elimination of practices such as female genital mutilation, early and/or forced marriage, gender-biased sex selection and forced sterilisation;

77. Calls on EU delegations to work with the relevant governments to elaborate and implement policies that focus on fostering the value of women and girls in society, in order to fight gender inequality, discrimination against women and girls, and the social norms that govern son preference, which constitute the root causes of prenatal sex-selection, female infanticide and the abortion of female foetuses, as well as early forced marriage and female genital mutilation; emphasises that efforts to limit sex selection must not hamper or limit the right of women to have access to legitimate sexual and reproductive health technologies and services;

78. Urges that the provision of EU humanitarian aid and that of its Member States should be effectively excluded from the restrictions on humanitarian aid imposed by the USA or other donors, in particular by ensuring access to abortion for women and girls who are victims of rape in armed conflicts;

79. Urges the Commission and the European External Action Service (EEAS), in human rights dialogues, to address the barriers people face when trying to access reproductive health services and exercise their sexual and reproductive rights;

80. Notes that the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), adopted in Cairo in 1994, recognised that sexual and reproductive health and rights are fundamental to achieving sustainable development;

81. Urges the Commission, in this context, to maintain in its development priorities the removal of all barriers to access to quality, affordable, acceptable and accessible SRHSs, prenatal and maternal healthcare services, including voluntary family planning, access to contraception and safe abortion, and youth-friendly services, while combating gender discrimination leading to sex-selective and involuntary abortions, forced sterilisation and sexual violence, as well as ensuring the provision of sexual and reproductive health supplies, prenatal and maternal healthcare supplies, and HIV prevention, treatment, care

and support, without discrimination;

82. Urges the EU and its Member States to ensure that the ICPD+20 operational review process results in a comprehensive review of all aspects related to the full enjoyment of sexual and reproductive rights, that it reaffirms a strong and progressive approach to sexual and reproductive rights for all that is consistent with international human rights standards, and that it increases the accountability of governments for achieving the agreed objectives; calls, in particular, on the EU and its Member States to ensure that the review process is conducted in a participatory manner and that it provides an opportunity for different stakeholders, including civil society as well as women, adolescents and young people, to participate in a meaningful manner; recalls that the framework for such a review must be based on human rights and have a specific focus on sexual and reproductive rights;

83. Asks the Commission and the EEAS, and in particular EU delegations on the ground, to be fully aware of SRHRs and prenatal and maternal healthcare as important factors for inclusive and sustainable development in the context of human development, governance, gender equality and human rights, and economic empowerment of young people and women at country level, and as important factors for the current EU programming process for the period 2014-2020;

84. Urges the EU to ensure that population dynamics, inclusive and sustainable development linkages and SRHRs are a priority in shaping the post-2015 global development framework, where all individuals can realise their human rights, including SRHRs, regardless of social status, age, sexual orientation, gender identity, race, ethnicity, disability, religion or belief; insists that the EU must speak with a unified, coherent and leading voice on the issue;

85. Recalls that women worldwide who have unwanted pregnancies should have ready access to reliable information and counselling; recalls that quality and comprehensive healthcare services and assistance should also be offered;

86. Calls on the EU and its Member States to honour their commitments to the full and effective implementation of the Programme of Action of the International Conference on Population and Development and the outcomes of the review conferences;

87. Urges the Commission and the EEAS to support ownership and leadership on the part of national governments, local authorities and civil society as regards the provision and promotion of SRHRs, which are universal and must be based on shared responsibilities;

88. Asks Parliament to address SRHR violations in Parliament’s annual report on human rights and democracy in the world and the European Union’s policy on the matter;

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

EXPLANATORY STATEMENT

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

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

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

This report comes at a very important timing. The current political and economic context threatens the respect of the SRHRs. Due to the current financial crisis and economic downturn and the related cuts in the public budgets there is a tendency among MS to accelerate the privatisation of health services and decrease access to and quality level of health services[3]. Additionally, very conservative positions regarding SRHRs have arisen all around Europe. As clearly manifested in countries such as Spain and Hungary, and in regional forums such as the Parliamentary Assembly of the Council of Europe, the European Committee on Social Rights, and even at the EP, the anti-choice opposition is becoming stronger and more vocal. Given these attacks, it is more critical than ever that the EP stands up for sexual and reproductive rights as human rights and provides a useful summary of the current state of play of SRHRs at the European level.

Sexual and Reproductive Health

The WHO states that 'reproductive health addresses the reproductive processes, functions and system at all stages of life. [*It*] therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.'[4]
Sexual health is defined as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual

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1 UN Development Fund (2011). Human Development Report 2011: Sustainability and Equity: A Better Future for All, Technical Note 3.

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

health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'[1]

Sexual and Reproductive Rights

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

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

Maternal Mortality

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

Data collection

Many MS do not collect the necessary data to fully measure reproductive and sexual health. For example over two-thirds of MS have no information on the percentage of pregnant women who have received at least one antenatal visit and over one-quarter of MS have no

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[1] WHO (2006). Defining sexual health: Report of a technical consultation on sexual health; 28–31 January 2002, Geneva.

[2] Yamin, A. E. (Ed.), 2005, Learning to dance: Advancing women's reproductive health and well-being from the perspectives of public health and human rights, Cambridge, Harvard University Press.

[3] It is assumed that 'countries with 1–10 deaths per 100,000 births are performing at essentially the same level and that differences are random', see footnote 1.

[4] UN Maternal Mortality Estimation Inter-agency Group (2012). Trends in maternal mortality 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank estimates.

data on the percentage of births attended by a skilled healthcare professional.[1] While compiling such data may be considered redundant by some highly developed countries, they are nevertheless important indicators that allow the consistent monitoring of reproductive health standards. It is necessary that the MS compile and monitor more comprehensive data and statistics regarding sexual and reproductive health indicators (STIs, abortion and contraception rates, unmet need for contraception, adolescent pregnancy...), disaggregated at least by gender and age. In order to get a better overview of the situation in the whole Union, the European Institute for Gender Equality should therefore be empowered to ensure the collection and analysis of data and best-practices.

Sexuality education

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

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

Although the general trend is that sexuality education programmes are slowly improving, the sharing of common goals and best practices among EU states would serve to facilitate the harmonisation of sexuality education standards and to contribute to more equal sexual and reproductive health for all European youth.

Adolescent Birth Rates and Unwanted Pregnancy

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

Despite encouraging trends in some MS, the stark disparity between the Netherlands' adolescent birth rate of 5, UK's 26, and Bulgaria's 44, indicates that much of the EU's youth still lacks the necessary skills and knowledge to make responsible sexual and reproductive

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

choices.

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

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

Abortion

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

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

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

standards.[1]

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

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

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

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

Sexually Transmitted Infections

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

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

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

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

Violence related to sexual and reproductive rights

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

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

SRHRs in Official development assistance

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

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

MS should contribute to accelerate the progress in order to achieve Millennium Development Goal 5 and its two targets by addressing reproductive, maternal, newborn and child health in a

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

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

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

MINORITY OPINION

Of Anna Zaborska

This non-binding resolution violates the EU Treaty and cannot be used to introduce right to abortion, or against the full implementation of ECI(2012)000005. No international legally binding treaty nor the ECHR nor customary international law can accurately be cited as establishing or recognizing such right. All EU institutions, bodies and agencies must remain neutral on the issue of abortion. The ECJ confirms (C-34/10) that any human ovum after fertilization constitutes a human embryo which must be protected. The UN Declaration of the Rights of the Child states that every child has the right to legal protection before as well after birth. Union assistance should not be provided to any authority or organisation which promotes, supports or participates in the management of any action which involves abortion. The human right of conscientious objection together with the responsibility of the state to ensure that patients are able to access medical care in particular in cases of emergency prenatal and maternal healthcare must be upheld. No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to practices which could cause the death of a human embryo.

10.7.2013

OPINION OF THE COMMITTEE ON DEVELOPMENT

for the Committee on Women's Rights and Gender Equality

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

Rapporteur: Michael Cashman

SUGGESTIONS

The Committee on Development calls on the Committee on Women's Rights and Gender Equality, as the committee responsible, to incorporate the following suggestions into its motion for a resolution:

1. Insists that universal access to sexual and reproductive health and rights (SRHRs) is a fundamental human right and asks the Commission to ensure that development cooperation and the future global development framework adopt a human rights and gender-based approach and have a strong and explicit focus, concrete targets and measurable indicators on SRHRs, while prioritising women and young people's empowerment and gender equality;

2. Urges the Commission, in this context, to maintain in its development priorities the removal of all barriers to allow access to quality, affordable, acceptable and accessible sexual and reproductive health services (SRHSs), prenatal and maternal healthcare services, including voluntary family planning, access to contraception and safe abortion, and youth-friendly services, while combating gender discrimination leading to sex-selective and involuntary abortions, forced sterilisation and sexual violence, as well as ensuring the provision of SRH supplies, prenatal and maternal healthcare supplies, HIV prevention, treatment, care and support, without discrimination;

3. Asks the Commission to allow a specific line on SRHRs under the Development Cooperation Instrument thematic lines, as well as sufficient funding for the broad SRHR agenda in all appropriate instruments;

4. Calls on the Member States to ensure the integration of the ICPD+20, Beijing+20 and Rio+20 processes within the post-2015 framework;

5. Recognises that universal access to quality healthcare and services, including SRHSs,

prenatal and maternal healthcare, and education contributes to inclusive and sustainable development and to the reduction of infant, child and maternal mortality, as well as to the empowerment of women and young people and that, therefore, this is a highly cost-effective public health and development strategy;

6. Insists that SRHRs need to be rooted in existing international HR instruments and key political consensus documents; regrets that the EU position formulated in preparation for the UN Conference on Sustainable Development (Rio+20), which recognised SRHRs as a cross-cutting issue key to other aspects of development, was not reflected in the final UN document, due to the absence of a unified EU voice;

7. Urges the EU to ensure that population dynamics and inclusive and sustainable development linkages, and SRHRs are a priority in shaping the post-2015 global development framework, where all individuals can realise their human rights, including SRHRs, regardless of their social status, age, sexual orientation, gender identity, race, ethnicity, disability, religion or belief; insists that the EU must speak with a unified, coherent and leading voice on the issue;

8. Insists that enabling the fundamental freedom of women, girls and couples to take decisions about their sexual and reproductive life, including whether and when to bear children, creates opportunities to pursue activities such as education and employment, which contributes to gender equality, poverty reduction, and inclusive and sustainable development; notes that being able to choose to have fewer children, with more time between births, potentially enables families to invest more in each child's education and health;

9. Calls on the EU and its Member States to keep their commitments to the full and effective implementation of the Programme of Action of the International Conference on Population and Development and the outcomes of their review conferences;

10. Asks the Commission and the European External Action Service (EEAS), and in particular EU delegations on the ground, to be fully aware of SRHRs as well as prenatal and maternal healthcare as important factors for inclusive and sustainable development, in the context of human development, governance, gender equality and human rights, economic empowerment of young people and women at country-level, as well as important factors for the current EU programming process for the period 2014-2020;

11. Calls on EU delegations to work with relevant governments to elaborate and implement policies that focus on fostering the value of women and girls in society, in order to fight gender inequality, the discrimination of women and girls, and the social norms that govern son-preference which constitute the root causes of prenatal sex-selection, female infanticide and the abortion of female foetuses, as well as early forced marriage and female genital mutilation; emphasises that efforts to limit sex-selection must not hamper or limit the right of women to have access to legitimate sexual and reproductive health technologies and services;

12. Urges the organisations receiving EU funds for HIV/AIDS and/or health protection to develop a clear, concise and transparent strategy how they can integrate SRHRs and primary HIV prevention in their interventions;

13. Urges the Commission and the EEAS to support the ownership and leadership of national governments, local authorities and civil society on the provision and promotion of SRHRs, which are universal and must be based on shared responsibilities;

14. Calls on the EU to promote the research and development of new and improved acceptable, affordable and accessible prevention technologies, diagnostics and treatments, targeting SRHRs and poverty -related and neglected tropical diseases (PRNDs) which heavily impair SRHRs in low- and middle-income families, and which taken together are among the leading causes of maternal and child mortality;

15. Asks Parliament to address SRHRs violations in Parliament's annual report on 'human rights and democracy in the world and the European Union's policy on the matter';

16. Recalls that women worldwide who have unwanted pregnancies should have ready access to reliable information and counselling; recalls that quality and comprehensive healthcare services and assistance should also be offered.

RESULT OF FINAL VOTE IN COMMITTEE

Date adopted	9.7.2013
Result of final vote	+: 18 –: 6 0: 0
Members present for the final vote	Thijs Berman, Michael Cashman, Véronique De Keyser, Nirj Deva, Leonidas Donskis, Mikael Gustafsson, Miguel Angel Martínez Martínez, Gay Mitchell, Norbert Neuser, Bill Newton Dunn, Maurice Ponga, Jean Roatta, Michèle Striffler, Keith Taylor, Ivo Vajgl, Anna Záborská, Iva Zanicchi
Substitute(s) present for the final vote	Emer Costello, Santiago Fisas Ayxela, Enrique Guerrero Salom, Edvard Kožušník, Isabella Lövin, Cristian Dan Preda
Substitute(s) under Rule 187(2) present for the final vote	Jan Kozłowski

RESULT OF FINAL VOTE IN COMMITTEE

Date adopted	26.11.2013
Result of final vote	+: 19 –: 15 0: 0
Members present for the final vote	Regina Bastos, Andrea Češková, Tadeusz Cymański, Edite Estrela, Iratxe García Pérez, Zita Gurmai, Mikael Gustafsson, Mary Honeyball, Sophia in ‘t Veld, Silvana Koch-Mehrin, Rodi Kratsa-Tsagaropoulou, Constance Le Grip, Astrid Lulling, Barbara Matera, Elisabeth Morin-Chartier, Angelika Niebler, Siiri Oviir, Antonyia Parvanova, Marc Tarabella, Britta Thomsen, Marina Yannakoudakis, Anna Záborská, Inês Cristina Zuber
Substitute(s) present for the final vote	Iñaki Irazabalbeitia Fernández, Kent Johansson, Nicole Kiil-Nielsen, Doris Pack, Zuzana Roithová
Substitute(s) under Rule 187(2) present for the final vote	Birgit Collin-Langen, António Fernando Correia de Campos, Jill Evans, María Irigoyen Pérez, Miroslav Mikolášik, Ewald Stadler