**The protection of sexual and reproductive health**

**in European human rights law:**

**Perspectives from the Council of Europe**

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Abstract

The recent recognition of a ‘right to sexual and reproductive health’ in human rights law and the volatility of national legal safeguards on such issues (as highlighted by recent events in Europe), call for a discussion on how sexual and reproductive health is currently protected in European human rights law. This article will thus, explore whether and how human rights bodies of the Council of Europe protect individuals’ sexual and reproductive health through their monitoring procedures. It will analyse the case-law of the European Court of Human Rights and that of the European Committee of Social Rights since 2000, to finally conclude whether or not these indirectly enable the recognition of a right to sexual and reproductive health in the future of the Council of Europe.

**Key words:** sexual and reproductive health, human rights, right to health, Council of Europe, European Court of Human Rights, European Committee of Social Rights.

# Introduction

In recent years, supranational human rights bodies have increasingly recognised a right yet inexistent in treaty law: that to “sexual and reproductive health” (SRH). Whether at the international level in the UN,[[1]](#footnote-1) or at the regional level in Africa, the Americas or Europe,[[2]](#footnote-2) all human rights systems seem to recognise that individuals are entitled to a right to SRH, which states ought to realise. The recognition of such a right in human rights law, and its consecration in 2016 by the UN Committee on Economic, Social and Cultural Rights, in General Comment No. 22, comes as no surprise.[[3]](#footnote-3) Not only does it reflects the intersection of two growing sets of rights in this field: reproductive rights and the right to health,[[4]](#footnote-4) it also reflects the importance of SRH to realise human dignity and equality (cornerstones of human rights law).

However, the recent recognition of a right to SRH calls for closer examination of how SRH is currently protected in human rights case-law, for its interpretation on paper can only start becoming meaningful through adjudication. While I will only use the right to SRH to contextualise the protection of SRH in human rights law, its content must first be clarified to delineate the scope of my paper. Such a content should be principled and evidence-led to ensure an adequate protection of individuals’ SRH, which necessitates using expertise from human rights law *and* public health. The content of the right to SRH will thus, rely on concepts identified as key to SRH by recent landmark documents in each discipline. These are: the 2016 General Comment 22 on the right to SRH, drafted the UN Committee on Economic, Social and Cultural Rights (UNCESCR GC22);[[5]](#footnote-5) and the 2004 Reproductive Health Strategy of the UN World Health Organization,[[6]](#footnote-6) recently updated by the 2018 Guttmacher-Lancet Commission report on SRH and rights (altogether referred to as ‘the WHO strategy’).[[7]](#footnote-7) UNCESCR GC22 particularly emphasises the concepts of choice, vulnerability and access to care, when defining the right to SRH.[[8]](#footnote-8) Furthermore, the WHO strategy identifies several key components of SRH (in which such concepts may apply): maternal and new-born health services; family planning services; safe abortion services; prevention and treatment of sexually transmitted infections and reproductive cancers; and promotion of sexual health.[[9]](#footnote-9) As a result, this article understands the right to SRH as everyone’s right to access key SRH services and information that facilitate their ability to make free choices over their SRH. Such a definition is narrower than that attributed to SRH rights, since it focuses on access to healthcare, choices, and vulnerability to coercion, violence and discrimination. As a result, I will not discuss discrimination based on gender or sexual orientation unless it explicitly involves access to healthcare. I will not discuss either access to assisted reproduction or surrogacy, due to space constraints.

This research is particularly significant because it focuses on Europe, where states’ protection of individuals’ SRH is often – wrongly – perceived as a given. On the contrary, recent events such as the 2018 Irish referendum on abortion demonstrate that the protection of SRH through national policies is uncertain, in the face of conservative religious and political movements in power.[[10]](#footnote-10) It is therefore crucial that human rights law minimises such legal uncertainty, in order to protect everyone’s right to access key SRH services and information, as well as everyone’s autonomy to make free choices over their SRH. By analysing to what extent European human rights case-law protects individuals’ SRH, this article directs human rights bodies, practitioners and victims towards avenues worth considering (or improving on).

This article will focus on the key human rights system of the region, i.e. the Council of Europe, and the two bodies before which SRH matters can be adjudicated: the European Court of Human Rights (ECtHR) and the European Committee of Social Rights (ECoSR). First, I will rigorously assess how individuals’ SRH is protected through the monitoring procedure of the ECtHR, by analysing all the SRH Merits Judgments held by the ECtHR since 2000. The review builds upon the recent findings of Oja and Yamin with regard to the case-law of the ECtHR on reproductive rights.[[11]](#footnote-11) Second, I will analyse all the Conclusions and Merits Decisions formulated by the ECoSR since 2000. However, no prior literature is available regarding the SRH jurisprudence of the ECoSR, since this is a novel area of research.

This article will also fill important gaps left by legal scholarship regarding the protection of SRH in European human rights law, especially in the light of the recent recognition of a comprehensive ‘right to SRH’. Research exploring the case-law of the ECtHR regarding SRH matters tends to view each issue in isolation of each other, and to focus on abortion.[[12]](#footnote-12) Furthermore, no research to date has discussed how the ECoSR protects SRH matters. Therefore, this article provides original contributions to the existing literature on SRH and human rights. By asking whether the human rights bodies of the Council of Europe can protect individuals’ SRH adequately through their monitoring procedures, it will conclude whether they can indirectly enable the recognition of a right to SRH in the future.

# Attempts of the European Court of Human Rights to protect sexual and reproductive health

This section starts to assess how European human rights law protects individuals’ SRH by studying the potential of the ECtHR to do so through its monitoring procedure (i.e. the complaints procedure). It is worth noting that the judgments of the ECtHR are legally binding and that their execution is supervised by the Committee of Ministers of the Council of Europe,[[13]](#footnote-13) who can use various coercive measures to ensure states’ compliance.[[14]](#footnote-14) Therefore, this reinforces the Court’s ability to protect individuals’ SRH in its complaints procedure. In order to examine the case-law of the ECtHR on SRH, I used a key word search on the online case-law database of the Court (HUDOC),[[15]](#footnote-15) selecting Merits Judgments in the English language. As of May 2018, the words ‘reproductive health’ resulted in 39 entries. However, the words ‘sexual health’ resulted in 560 entries, so I narrowed the search to ‘sexuality, health’, resulting in 28 entries. In order to guarantee a comprehensive account of the Court’s case-law, I also verified the relevance of cases listed in pertinent Court’s factsheets. Those are: ‘Reproductive rights’, ‘Health’, ‘Violence against women’, ‘Gender equality’, ‘Gender identity’, ‘Homosexuality: criminal aspects’, ‘Sexual orientation issues’, ‘Prisoners’ health-related rights’, and ‘Persons with disabilities and the ECHR’.[[16]](#footnote-16) Finally, I chose to only discuss Merits Judgments since 2000, to analyse recent developments; and cases fitting this paper’s definition of SRH, to contextualise the recent recognition of a ‘right to SRH’. It is worth reminding the reader that such a definition encapsulates rights to access key SRH services and information that facilitate everyone’s ability to make free choices over their SRH (especially those vulnerable to violence, coercion and discrimination).[[17]](#footnote-17) Key services are understood as: maternal and new-born health services; family planning services; safe abortion services; prevention and treatment of sexually transmitted infections and reproductive cancers; and promotion of sexual health.[[18]](#footnote-18) The cases studied through that lens, therefore, shed a light on a rich jurisprudence of the ECtHR on SRH, emanating mainly from Articles 3 and 8 of the European Convention on Human Rights (ECHR) – thus, focus of this section.[[19]](#footnote-19)

## Article 3 ECHR: access to SRH and vulnerability

Following this methodology and this paper’s definition of SRH, I have identified two types of cases emanating from Article 3 ECHR: forced sterilisations and abortion cases. Both categories shed an interesting light on the Court’s interpretation of individuals’ vulnerability in SRH, notably women. Article 3 ECHR recognises that ‘*No one shall be subjected to torture or to inhuman or degrading treatment or punishment*’. [[20]](#footnote-20) At a first glance, the non-derogable and absolute status of this provision in international law,[[21]](#footnote-21) as well as the positive obligations it imposes on states, seem to provide a strong protection to applicants who successfully allege a breach of this provision in SRH cases.[[22]](#footnote-22) While this is true in the case-law of the Court relevant to forced sterilisations, it is unfortunately not always true in abortion cases.

### ***Protecting vulnerability in forced sterilisations cases: integrity***

Since 2000, the Court held three Merits Judgments concerning allegations of forced sterilisation procedures on Romani women in Slovakia, under Article 3 ECHR. Such procedures were carried out after the applicants had given birth and in the absence of consent or justifiable medical emergency.[[23]](#footnote-23) In all three cases, the ECtHR found a violation of Article 3, on the basis that forced sterilisations procedures violated the applicants’ integrity, as well as their right to autonomy and choice as patients.[[24]](#footnote-24) Notions of patients’ integrity, autonomy and choice do not appear in the text of the ECHR but are crucial to SRH, as clearly asserted by UNCESCR GC22.[[25]](#footnote-25) This is particularly true in maternal health services, a key component to SRH according to the WHO strategy,[[26]](#footnote-26) considering the fragility of women in the midst of labour. Therefore, the Court’s reference to such notions in relation to Article 3 ECHR is to be celebrated, since it contributes to protecting vulnerable individuals in SRH care, and incorporates well-recognised elements of healthcare law.[[27]](#footnote-27) Furthermore, the Court clearly recognised the victims’ suffering when justifying its findings of non-conformity, by highlighting their feelings of ‘*fear, anguish and inferiority*’, their ‘*lasting suffering*’,[[28]](#footnote-28) or the fact they had been ‘*debased and humiliated*’.[[29]](#footnote-29) However, and as argued by Oja and Yamin or by Patel, the ECtHR failed to highlight the discriminatory aspect of such procedures against the applicants.[[30]](#footnote-30) The Court referred to international concerns regarding forced sterilisation procedures on Roma women in Slovakia.[[31]](#footnote-31) Nevertheless, it held that there was not enough evidence to prove that the medical professionals had acted in bad faith, as part of an organised policy, or with intentional racially-led motives.[[32]](#footnote-32) Furthermore, the Court consistently decided that there was ‘*no need to examine separately the complaint under Article 14 of the Convention*’ (which prohibits discrimination).[[33]](#footnote-33) These judgments fail to recognise the vulnerability of (Roma) women to forced sterilisations, contrarily to UNCESCR GC22, which declares that such procedures violate the right to SRH and often reflect intersectional discrimination.[[34]](#footnote-34) The Court’s failure to identify and protect individuals vulnerable to SRH violence, coercion or discrimination by using Article 3, is even more apparent in abortion cases.

### ***Protecting vulnerability in abortion cases: suffering***

Since 2000, the Court held four Merits Judgments under Article 3 ECHR, concerning allegations of insufficient access to abortion services in Poland and in Ireland (the two states parties to the ECHR with the most restrictive abortion laws).[[35]](#footnote-35)

In the two earlier abortion cases, the ECtHR found that there was no violation of Article 3, even though severe suffering was reported by the applicants. In *Tysiac v. Poland* (2007)[[36]](#footnote-36) the applicant had requested a therapeutic abortion on the ground that her pregnancy would worsen her severe myopia but she was refused access to this procedure and became severely disabled following the birth of her child. The Court incomprehensibly dismissed the applicant’s allegations of ill-treatment based on the anguish, distress and loss of eyesight she had suffered from, by succinctly declaring: *‘[i]n the circumstances of the instant case, the Court finds that the facts alleged do not disclose a breach of Article 3’*.[[37]](#footnote-37) This is particularly surprising since the Court recognised, in that same assessment, that states’ failure to provide adequate medical treatment could lead to a violation of Article 3.[[38]](#footnote-38) The Court also dismissed applicants’ suffering in the case *A. B. C. v. Ireland* (2010), in which three women who were unable to access legal abortion services in Ireland had to travel to the United Kingdom to terminate their pregnancies.[[39]](#footnote-39) While the ECtHR recognised the arduous aspect of travelling abroad to obtain an abortion, it held that such circumstances did not reach the minimum level of severity necessary to trigger Article 3.[[40]](#footnote-40) Such a position denies evidence highlighting the significant impact of these travels on women’s mental health and on their access to post-abortion care, aimed at preventing complications.[[41]](#footnote-41) Furthermore, such a position goes against a more recent decision of the UN Human Rights Committee, which held that women having to travel abroad from Ireland to terminate their pregnancies were subject to ‘*conditions of intense physical and mental suffering*’ likely to contribute to a breach of their freedom from inhuman treatment.[[42]](#footnote-42) The ECtHR’s desire to avoid controversial topics such as abortion is a failure to recognise women’s particular vulnerability to SRH discrimination and to protect them from suffering, including that caused by unsafe abortions. This is all the more problematic since the Court also refused to assess applicants’ allegations of Article 14 violations, by declaring that this provision did not trigger separate issues,[[43]](#footnote-43) which is incorrect.

In the two later abortion cases involving an alleged breach of Article 3 ECHR, the ECtHR found a breach, but failed to strongly protect women’s SRH. In *R. R. v. Poland* (2011),[[44]](#footnote-44) a pregnant woman was told by health professionals that her foetus was likely to suffer from malformation, but she was denied access to genetic tests until it was too late for her to undergo an abortion; she gave birth to a severely-ill child.[[45]](#footnote-45) The ECtHR held that the applicant’s suffering, before and after obtaining the results of genetic tests that were available all along, met the threshold set by Article 3.[[46]](#footnote-46) It highlighted the applicant’s ‘*great’* vulnerability, ‘*deep*’ distress and ‘*acute*’ anguish, caused by weeks of uncertainty and her inability to make an informed decision on the continuation or legal abortion of her pregnancy.[[47]](#footnote-47) The protection of women’s SRH through Article 3 in an abortion case is certainly a first for the ECtHR, which should be applauded on that basis. However, the Court’s recognition of the applicant’s suffering under Article 3 does not seem motivated by the fact that the applicant was *de facto* forced to continue a pregnancy which she did not desire to pursue. Instead, it seems conditioned by the fact that the applicant was prevented from accessing a procedure she was *legally* entitled to undergo, dependent upon genetic tests. (Her situation fell under one of the few exceptions to Poland’s abortion restrictive laws: her foetus was likely to develop incurable life-threatening ailment).[[48]](#footnote-48) This distinction, nonetheless, is particularly important for cases involving countries (such as Poland) which laws impede women’s access to abortion, since it is unclear whether the ECtHR would have recognised a breach of Article 3 if the applicant had not been legally entitled to undergo an abortion. This concern remains present in the case of *P. and S. v. Poland* (2012).[[49]](#footnote-49) In this case, a teenager who had become pregnant after being raped, was denied access to abortion services due to delays caused by the medical staff. Furthermore, her and her mother were harassed by a priest (and anti-abortion activists) contacted by the medical staff; and they were denied assistance from the police. The ECtHR declared that the ‘*deplorable manner*’ with which the authorities treated the young applicant had caused her severe suffering, therefore breaching Article 3.[[50]](#footnote-50) Furthermore, the Court linked explicitly the applicant’s suffering to the authorities’ obstruction since in this case, the applicant wished to undergo an abortion immediately (and not dependent on genetic tests). However, like in *R.R. v. Poland*, the Court recognised the applicant’s suffering by focusing on the fact that she was unable to undergo an abortion she was legally entitled to,[[51]](#footnote-51) rather than by focusing on the fact that she needed it to alleviate her suffering. Moreover, the Court assessed the existence of an inhuman and degrading treatment based on the vulnerability of the victim (i.e. her young age and her status as rape victim), and on the deplorable manner with which authorities dealt with her. Therefore, it is unclear whether the ECtHR considers that denying women legal access to abortion services represents an inhuman and degrading treatment as such, regardless of these factors. The Court should, in the future, incorporate evidence-led reports stressing the significant vulnerability, suffering and discrimination experienced by women denied legal access to abortion,[[52]](#footnote-52) in order to interpret coherently Article 3. This would also align with recommendations formulated by both UNCESCR GC22 and the WHO strategy on the need to prevent unsafe abortions.[[53]](#footnote-53)

The recent use of Article 3 ECHR in SRH cases is limited to cases involving women, giving the Court an opportunity to protect their particular vulnerability to violence, coercion and discrimination in SRH. The ECtHR has consistently held a breach of their freedom from cruel and inhuman treatment in cases involving forced sterilisation procedures. Furthermore, it has been more willing to recognise applicant’s suffering in recent abortion cases, by reviewing thoroughly allegations of violations and by holding findings of non-conformity. However, the Court’s SRH case-law under Article 3 highlights a conservative position. One that strongly protects women’s SRH in their decisions to reproduce; but weakly protects it in their decisions to *not* reproduce, for it conditions the recognition of women’s suffering to a political deference for states’ abortion laws.

## Article 8 ECHR: access to SRH and autonomy

The most used provision of the ECHR regarding SRH cases is Article 8 on the right to private (and family) life. The methodology discussed above and this paper’s definition of SRH enabled me to identify six types of case reviewed under Article 8: forced sterilisations, obstetric and gynaecologic malpractice, access to abortion, medical assistance in homebirths, access to gender reassignment surgery, and rights over one’s own SRH medical data. It is interesting to note that the ECtHR clearly protects rights over one’s own SRH medical data,[[54]](#footnote-54) as well as transgender persons’ rights to access gender reassignment surgery.[[55]](#footnote-55) However, this article will focus on the former four categories, for they give a particularly interesting insight into the Court’s reading of individuals’ autonomy in SRH, focusing on women. Article 8 ECHR protects everyone’s ‘*right to respect for his private and family life, his home and his correspondence*’.[[56]](#footnote-56) Despite the possibility for states to legally restrict this right for reasons that traditionally interfere with individuals’ SRH (‘*the protection of health or morals, or* […] *the protection of the rights and freedoms of others*’[[57]](#footnote-57)), the jurisprudence of the ECtHR has been relatively protective of individuals’ SRH under this provision.

### ***Protecting autonomy in forced sterilisation cases: informed consent***

Since 2000, the Court held four Merits Judgments under Article 8 ECHR involving Roma women who had been subject to forced sterilisations in Slovakia, following a caesarean section. However, this article will only study *V.C. v. Slovakia* (2011), *N.B. v. Slovakia* (2012), and *I.G. and others v. Slovakia* (2012),[[58]](#footnote-58) for *K.H. and others v. Slovakia* (2009) concerns a different aspect of SRH not discussed in this article: the right to access one’s medical records.[[59]](#footnote-59) In the first three cases (discussed in subsection 1.1.1), the ECtHR held not only a breach of Article 3, but also a breach of Article 8. In these cases, the Court emphasised the importance of informed consent on two accounts. Firstly, it consistently justified its findings of non-conformity with Article 8 by referring to the applicants’ lack of informed consent in medical decisions affecting significantly their SRH.[[60]](#footnote-60) The clear protection of informed consent by the ECtHR is a welcome addition to its jurisprudence on SRH, for it indirectly upholds patients’ autonomy, both key SRH principles recognised by UNCESCR GC22.[[61]](#footnote-61) Secondly, the ECtHR repeatedly recognised a breach of Slovakia’s ‘*positive obligations*’ on the ground that it had failed to take sufficient safeguards to protect applicants’ reproductive health (by combatting non-consensual sterilisations).[[62]](#footnote-62) It did so by using diverse sources indicating the particular vulnerability of Roma women to non-consensual sterilisation procedures, partly due to public negative perceptions towards birth rates among this community. [[63]](#footnote-63) The Court’s recognition of states’ positive obligations under Article 8 through an evidence-led reasoning represents a positive development in its SRH case-law. Positive obligations highlight the construction of a better rights framework, guaranteeing effective rights, as argued by Dickson.[[64]](#footnote-64) They enable the ECtHR to extend its protection to instances where states should have actively protected individuals’ SRH, whether by granting them access to SRH information or by implementing measures taking into account the specific SRH needs of vulnerable groups. Such needs, however, can only be known through data collection, making the Court’s evidence-led reasoning crucial. The use of Article 8 to promote autonomy also protects individuals’ SRH in cases involving obstetric and gynaecologic malpractice.

### ***Protecting autonomy in obstetric and gynaecologic malpractice: procedural guarantees***

Since 2000, the Court held three Merits Judgments under Article 8 ECHR involving women subject to obstetric and gynaecologic malpractice. In all cases, the ECtHR held a breach of Article 8 on the basis that procedural guarantees were inadequate, thus protecting women’s SRH. In *G.B. and R.B. v. the Republic of Moldova* (2012) and *Csoma v Romania* (2013), the applicants had been victims of medical errors due to doctors’ negligence, impeding their ability to reproduce (and creating long-term health issues, or endangering their life).[[65]](#footnote-65) Not only did the Court recognise a serious interference with both applicants’ right to private life, it also protected procedural aspects of Article 8 fundamental to the protection of their SRH. In *Csoma v Romania*, the Court highlighted that the applicant’s inability to obtain redress, partially due to an inadequate case-law on hospitals’ liability for medical acts, represented a breach of the state’s ‘*positive obligations*’ under Article 8.[[66]](#footnote-66) In *G.B. and R.B. v. the Republic of Moldova*, the Court stressed that the low compensation obtained by the applicant (700 euros) did not constitute sufficient just satisfaction, considering the ‘*devastating effect’* of the medical error.[[67]](#footnote-67) In these cases, the ECtHR expects national courts to protect (women) victims of obstetric and gynaecologic malpractice, through adequate remedy avenues and compensation. Such expectations reflect those set by UNCESCR GC22, which recognises that the right to SRH must be *‘fully justiciable at the national level’*, and that victims must be able to access adequate remedies.[[68]](#footnote-68) While neither case refers explicitly to the notion of patients’ autonomy, they both connect the notion of consent to that of integrity.[[69]](#footnote-69)

In *Carvalho Pinto de Sousa Morais v Portugal* (2017),[[70]](#footnote-70) the Court extended its protection to women’s sexual health, a topic often overshadowed by that of reproductive health. In this case, the applicant had undergone a gynaecological surgery during which a medical error occurred, leaving a nerve permanently damaged, which caused her pain, loss of sensation in the vagina, incontinence, as well as difficulty walking, sitting and in having sexual relations.[[71]](#footnote-71) The Portugese Supreme Administrative Court, however, had reduced the applicant’s compensation on the ground that her sexuality was ‘not as important’ because she was fifty years old and had two children.[[72]](#footnote-72) The ECtHR stressed the sharp contrast of this court’s jurisprudence with similar cases involving men, and held in a strong statement: *‘[t]hat assumption reflects a traditional idea of female sexuality as being essentially linked to child-bearing purposes and thus ignores its physical and psychological relevance for the self-fulfilment of women as people’*.[[73]](#footnote-73) The decision of the ECtHR to review and hold a breach of Article 14 (on non-discrimination) in conjunction with Article 8 is a welcome addition to its jurisprudence on SRH.[[74]](#footnote-74) By combating stereotypes that perpetuate SRH discrimination and by promoting sexual health, the ECtHR incorporates elements considered fundamental to SRH by UNCESCR GC22 and the WHO strategy.[[75]](#footnote-75) The use of the principle of non-discrimination enables the Court to assess women’s autonomy more comprehensively and thus, to protect their SRH more effectively. However, as noted below, its protection under Article 8 is weaker in the presence of a foetus.

### ***Protecting autonomy in abortions cases: positive obligations***

Since 2000, the ECtHR held four Merits Judgments concerning women’s access to abortion, all of which were discussed at length in subsection 1.1.2., in the context of Article 3. However, it is worth noting that, subject to two key criticisms, the Court’s jurisprudence on this issue seems more protective under Article 8 than it is under Article 3.

In *Tysiac v. Poland* (2007), *R. R. v. Poland* (2011), and *P. and S. v. Poland* (2012), the ECtHR found a violation of Article 8 on the ground that Polish authorities had failed to comply with their positive obligations to respect the applicants’ right to private life.[[76]](#footnote-76) As discussed in the context of forced sterilisations, the development of positive obligations by the ECtHR is a step in the right direction, since it enables the Court to protect SRH rights effectively. In *Tysiac v. Poland*, the Court stressed that the state ought to allow timely access to abortions in order to protect women’s health (sometimes damaged by late abortions),[[77]](#footnote-77) and that this included clarifying the legal conditions governing access to abortion.[[78]](#footnote-78) In other words, there is no point in having ‘theoretical or illusory’ rights to access abortion procedures if those rights are not ‘practical and effective’.[[79]](#footnote-79) Therefore, the Court affirmed that the state was under a ‘*positive obligation to create a procedural framework enabling a pregnant woman to effectively exercise her right of access to lawful abortion*’;[[80]](#footnote-80) and later in *A.B.C. v. Ireland* (2010), that the latter should be ‘*shaped in a coherent manner*’.[[81]](#footnote-81) The doctrine of positive obligations has also enabled the ECtHR to recognise states’ accountability when health professionals’ conscientious objection prevented women from accessing lawful abortions, in *R.R. v. Poland* and in *P. and S. v. Poland*.[[82]](#footnote-82) Therefore, the use of positive obligations under Article 8 has increased the Court’s protection of women’s ability to make meaningful decisions regarding their SRH and thus, their autonomy – which UNCESCR GC22 consistently links with access to abortion.[[83]](#footnote-83)

However, two key criticisms should be expressed in this regard. Firstly, while the Court requires that states’ legal frameworks on access to abortion be coherent, it does not specify in what sense (a legal framework can be coherent whether it allows or prohibits abortion). Could total bans on abortion be considered compliant with Article 8 as long as their legal frameworks are ‘coherent’? Similar concerns were formulated when reviewing this case-law through the prism of Article 3, since the Court conditioned its recognition of women’s suffering to their ability to lawfully access abortion. Secondly, the Court’s use of the test of proportionality in abortion cases is unsatisfactory on various aspects. On one hand, the ECtHR admits only using this test in abortion cases involving ‘negative obligations’ (*A.B.C. v. Ireland*),[[84]](#footnote-84) but not in cases involving ‘positive obligations’ (*Tysiac v Poland*, *R. R. v. Poland*, and *P. and S. v. Poland*).[[85]](#footnote-85) This dichotomy, however, does not encapsulate accurately or comprehensively states’ obligations.[[86]](#footnote-86) In all the cases discussed in this sub-section, applicants complained that the state did not provide sufficient access to abortion, thus indicating a positive obligation. The difference lies instead in what applicants challenged: the law itself (*A.B.C. v. Ireland*); or its application (*Tysiac v Poland*, *R. R. v. Poland*, and *P. and S. v. Poland*), the former requiring more audacity to criticise than the latter. On the other hand, the ECtHR applies the test of proportionality incoherently. In *A.B.C. v. Ireland*, the Court recognised that prohibiting abortion for reasons of health or well-being represented an interference with women’s right to private life.[[87]](#footnote-87) Therefore, it considered that such interference could only be lawful if it was prescribed by law (here, the Irish Constitution),[[88]](#footnote-88) pursued legitimate aims (here, ‘the protection of morals’),[[89]](#footnote-89) and was necessary in a democratic society. When assessing this last criterion, not only did the Court examine the European consensus on access to abortion,[[90]](#footnote-90) thus relying on cultural relativist arguments rather than protecting women’s autonomy, it also contradicted itself. It started by stating that states’ margin of appreciation was normally restricted when a *‘particularly important facet of an individual’s existence’* was at stake,[[91]](#footnote-91) which is clearly relevant to decisions whether to pursue a pregnancy. The ECtHR, nevertheless, noted that if there was no European consensus on how to protect important facets of individuals’ existence, states’ margin of appreciation would be wider.[[92]](#footnote-92) It is unclear why a human rights body mandated to supervise a treaty to which states have consented, should prioritise states’ consensus over the protection of individuals’ rights. The Court yet recognised that there was, indeed, a wide European consensus towards allowing abortion on broader grounds than under Irish law, but it incomprehensibly decided to dismiss it.[[93]](#footnote-93) It favoured, instead, ‘*the profound moral views of the Irish people as to the nature of life*’; by highlighting the importance of striking a balance between applicants’ right to private life and the ‘*rights invoked on behalf of the unborn*’.[[94]](#footnote-94) Therefore, the ECtHR found that Ireland had not exceeded its margin of appreciation (except for the applicant whose pregnancy was jeopardising her health and life, for whom a violation of Article 8 was reached).[[95]](#footnote-95) This (political) decision disregards principles upheld by UNCESCR GC22 such as the promotion of choice and the prohibition of coercion, violence and discrimination.[[96]](#footnote-96) Furthermore, it does not contribute to preventing the risk of unsafe abortions, which the WHO considers key to SRH.[[97]](#footnote-97) It will be interesting, nonetheless, to assess future case-law in the light of the 2018 Irish referendum. To conclude, while the ECtHR is willing to protect women’s autonomy in cases where the implementation of abortion laws is restrictive, its courage does not stretch to cases where the law itself is being challenged. Interestingly, homebirth cases also reflect the shyness of the Court in protecting women’s SRH autonomy when a foetus is at stake.

### ***Protecting autonomy in homebirth cases: choice***

Since 2000, the Court held two Merits Judgments under Article 8 ECHR involving women planning to give birth at home who could not obtain medical assistance. In those cases, the ECtHR upheld women’s autonomy unevenly, by shifting its jurisprudence to favour states’ margin of appreciation over women’s choices. In the case of *Ternovszky v. Hungary* (2010), the applicant alleged a breach of Article 8 because the uncertainty of Hungarian law dissuaded health professionals from assisting her in giving birth at home.[[98]](#footnote-98) Upon study of WHO guidelines highlighting that low-risk pregnant women can give birth at home,[[99]](#footnote-99) the ECtHR concluded that Article 8 had been infringed, referring to the applicant’s ‘*right to choice in matters of child delivery*’.[[100]](#footnote-100) The Court thus, clearly protected pregnant women’s autonomy (recognising it as a ‘*fundamental principle*’ under Article 8),[[101]](#footnote-101) and guided its reasoning with evidence-led findings. However, in the similar case of *Dubská and Krejzová v the Czech Republic* (2016),[[102]](#footnote-102) the ECtHR ruled differently. In this case, the applicants also claimed that the domestic legislation dissuaded health professionals from assisting them in giving birth at home, resulting in a breach of Article 8. However, the ECtHR did not hold a violation of their right to private life*.*[[103]](#footnote-103)The Court studied the findings of the International Study Group of the World Association of Perinatal Medicine, which stressed that homebirths involved ‘*unnecessary, preventable increased risks to the newborn and the mother*’, and were often coupled with transportation to the nearest hospital.[[104]](#footnote-104) By doing so, the Court legitimately attempted to assess whether the interference with applicants’ right to private life was proportionate to the aim pursued, i.e. the protection of their health.[[105]](#footnote-105) While this article does not necessarily criticise the outcome of this decision, it highlights various deficiencies in the Court’s rationale. Firstly, the ECtHR regularly refers to the ‘child’ in its decision, and even assesses provisions of the UN Convention on the Rights of the Child regarding children’s best interests and right to health.[[106]](#footnote-106) While labour is the crucial moment following which the unborn becomes the new-born, it is unclear at which stage the ECtHR considers human rights to be relevant. Secondly, the Court uses health considerations and health rights to prioritise women’s and the unborn’s health, over women’s choices regarding their own SRH.[[107]](#footnote-107) Considering that SRH encompasses maternal and new-born care according to the WHO strategy,[[108]](#footnote-108) this raises a fundamental question: to what extent should maternal health prevail over women’s choices? Finally, the ECtHR refers to the absence of a European consensus in order to justify its decision to grant the authorities a wider margin of appreciation.[[109]](#footnote-109) The Court’s reliance on a cultural relativist approach is deeply problematic in the light of its capacity as human rights body and protector. This particularly calls into question its ability to protect SRH, an aspect of health often facing challenges embedded in religious, cultural and societal values. However, it is worth noting that neither the WHO strategy nor UNCESCR GC22 consider that women’s choice to give birth at home is core to SRH.

Most of the Court’s SRH case-law under Article 8 ECHR involves (cis) women, with the exception of several cases involving transgender persons’ rights to access gender reassignment surgery. This has given the ECtHR an opportunity to protect women’s particular needs regarding their SRH autonomy. The ECtHR has consistently held a breach of their right to private life in cases involving forced sterilisations or obstetric and gynaecological malpractice. However, it has been more hesitant in cases involving abortions and homebirths, by prioritising states’ margin of appreciation and European consensus over women’s choices. Therefore and alike the Court’s SRH case-law under Article 3, the jurisprudence of the Court under Article 8 remains conservative. It strongly protects women’s SRH in their decisions to reproduce, but is more hesitant when a foetus is at stake.

# Attempts of the European Committee of Social Rights to protect sexual and reproductive health

This section continues to assess how European human rights law protects individuals’ SRH, by examining the potential of the ECoSR to do so in its monitoring procedures (i.e. reporting and collective complaints procedures). It is worth noting that the comments formulated by the Committee through both procedures are not legally binding. The Committee of Ministers of the Council of Europe can take recommendations when states do not comply with the ECoSR’s Conclusions (reporting procedure),[[110]](#footnote-110) or with the ECoSR’s Merits Decisions (collective complaints procedure).[[111]](#footnote-111) However, no coercive measures seems available to ensure states’ compliance. These element weaken the Committee’s ability to protect individuals’ SRH in its case-law, but they also strengthen its ability to conduct a constructive dialogue with states. In order to examine the jurisprudence of the ECoSR on SRH, I focused on its interpretation of Article 11 of the European Social Charter (ESC) on the right to health,[[112]](#footnote-112) for it is a key right in SRH,[[113]](#footnote-113) and the most informative provision in this regard. In order to carry out this analysis, I examined all the Committee’s Conclusions formulated through its reporting procedure on Article 11, in the English language and since the procedure began in 1969. As of May 2018, this represented 1,003 entries on HUDOC, the online case-law database of the Committee.[[114]](#footnote-114) I then focused on comments relevant to this paper’s definition of SRH, to contextualise the recent recognition of a ‘right to SRH’. While this article focuses on findings post 2000, previous research has allowed me to study the ECoSR’s Conclusions from 1969 to 2015,[[115]](#footnote-115) thus bringing an interesting historical perspective on its review of SRH. I also examined all the Committee’s Merits Decisions held through its collective complaints procedure on Article 11, in the English language. As of May 2018, this corresponded to 12 entries on HUDOC, all dated post 2000. However, only four are relevant to SRH as defined in this paper. Such a definition encompasses rights to access key SRH services and information that facilitate everyone’s ability to make free choices over their SRH (especially those vulnerable to violence, coercion and discrimination).[[116]](#footnote-116) Key services are understood as: maternal and new-born health services; family planning services; safe abortion services; prevention and treatment of sexually transmitted infections and reproductive cancers; and promotion of sexual health.[[117]](#footnote-117) The findings studied through the dual monitoring system of the Committee on Article 11 ESC stress a richer approach to SRH in the reporting procedure, due to the nature of this mechanism.

## Protection of SRH in the reporting procedure

The ECoSR reviews the implementation of the ESC through two monitoring procedures: the reporting procedure and the collective complaints procedure. In the reporting procedure, the Committee periodically receives states reports (as well as NGOs reports) describing the implementation of the Charter in a given state party.[[118]](#footnote-118) After having examined these reports, the ECoSR declares in documents called ‘Conclusions’ whether such a description complies or not with each article of the Charter, and justifies why. This also applies to the right to health, enshrined in Article 11 ESC.[[119]](#footnote-119) The methodology and this paper’s definition of SRH enabled me to identify a change over the years in how the ECoSR reviewed SRH under Article 11, and how this affected its protection.

### 1969-2000: little to no monitoring of SRH matters

From 1969 to 2000, the ECoSR reviewed states’ compliance with Article 11 ESC relatively randomly in its reporting procedure, thus leaving the monitoring of SRH issues to chance. For instance, when discussing Norway’s compliance with the right to health in 1981, the Committee highlighted the availability of maternal health services and that of family planning courses for health personnel.[[120]](#footnote-120) However, it did not monitor the availability of these services for any other country that same year, thus failing to establish consistent standards and expectations under Article 11.[[121]](#footnote-121) Furthermore, when discussing Norway’s next report during the 1984 reporting cycle, the Committee did not refer again to these services, thus failing to monitor Norway’s progress.[[122]](#footnote-122) What must also be outlined with regard to the reporting procedure of the ECoSR from 1969 to 2000, is how rarely it referred to SRH issues when monitoring states’ compliance with the right to health. Aside from a couple of comments regarding states’ efforts to provide medical check-ups for pregnant women,[[123]](#footnote-123) and to combat sexually transmitted diseases,[[124]](#footnote-124) it almost never monitored SRH under Article 11 of the Charter. Therefore, the ECoSR did not protect individuals’ SRH adequately during that period of time.

### 2001-2009: consistent monitoring of SRH matters

From 2001 to 2009, the ECoSR started using the same thematic health indicators for every state and in every reporting cycle. These enabled the Committee to develop more specific legal standards under Article 11 of the ESC,[[125]](#footnote-125) including on SRH matters. Thanks to indicators such as ‘*infant and maternal mortality’, ‘health education in schools’, ‘counselling and screening for pregnant women, children and adolescents’, and ‘counselling and screening for the rest of the population’*, the ECoSR systematically monitored the availability of maternal health services, as well as that of sex education and measures to combat diseases affecting the reproductive system, during that period of time.[[126]](#footnote-126) Both the WHO strategy and UNCESCR GC22 consider that such issues are fundamental to SRH,[[127]](#footnote-127) highlighting the importance of them being reviewed regularly.

From 2001 to 2009, the Committee monitored the availability of maternal health services in all states parties to the Charter by systematically reviewing maternal mortality rates and the availability of screening services for pregnant women. More specifically, the ECoSR kept outlining that states should take measures to bring maternal deaths down to zero risk,[[128]](#footnote-128) especially countries with highly developed healthcare systems.[[129]](#footnote-129) It also repeatedly declared that counselling and screeningservices for pregnant women should be provided free of charge, regularlyand throughout the country.[[130]](#footnote-130) As a result, the reporting procedure of the Committee explicitly protected access to adequate maternal health services at the time, through the right to health as enshrined in Article 11 ESC. This position clearly aligns with the recommendations formulated by the WHO strategy and UNCESCR GC22, since both consider that states’ efforts to improve maternal health services are crucial for SRH.[[131]](#footnote-131) It also goes beyond the review operated by the ECtHR regarding obstetric care, as the latter is restricted to rulings against forced sterilisations, obstetric and gynaecological malpractice, homebirths, and rights over one’s own SRH medical data.

Another SRH matter consistently monitored under the right to health from 2001 to 2009 was that of sex education to school pupils (and, sometimes, sex education to the overall population). In its reporting procedure at the time, the ECoSR repeatedly requested that health education be included in school curricula, that it be provided during the entire period of schooling, and that it covered sexual and reproductive education.[[132]](#footnote-132) The Committee also consistently required that awareness-raising campaigns targeted at the general population addressed public health priorities, including sex education.[[133]](#footnote-133) Therefore, the Committee did not simply focus on the ‘curative’ aspect of SRH from 2001 to 2009, but it also addressed its ‘promotional’ aspect. This position, again, echoes recommendations formulated by the WHO strategy and UNCESCR GC22, since both stress the importance of high quality family planning services and sexual health promotion, including SRH education for all.[[134]](#footnote-134) It also corresponds to the approach developed by the ECtHR in its case-law on SRH education under Article 2 of Protocol 1 of the ECHR, despite it not being studied in this paper.[[135]](#footnote-135)

Finally, when monitoring states’ compliance with Article 11 ESC in its reporting procedure from 2001 to 2009, the ECoSR also reviewed SRH by regularly expecting states to combat diseases affecting the reproductive system. The Committee kept requiring, in particular, that states demonstrate their ability to cope with infectious diseases via prophylactic measures, including special treatment for patients suffering from AIDS.[[136]](#footnote-136) The ECoSR also monitored the availability of screening services regarding breast, cervical or prostate cancer, though irregularly.[[137]](#footnote-137) However, no further monitoring was developed on this aspect. Therefore, the Committee’s review is mainly in line with recommendations of the WHO strategy and UNCESCR GC22, which emphasise the necessity for states to take measures combatting sexually transmitted infections and reproductive cancers.[[138]](#footnote-138) It also goes beyond the ECtHR’s review since the latter has not developed any case-law yet in that respect.

Nevertheless, various limits should be highlighted regarding the monitoring and thus, protection of SRH from 2001 to 2009 by the ECoSR. Firstly, the use of indicators to monitor human rights such as the right to health can be controversial. How many indicators should be used, and who should design them, considering these tend to delineate the legal content of the right in question?[[139]](#footnote-139) Secondly, the Committee’s use of indicators under Article 11 ESC is not entirely satisfactory in the context of SRH, since they do not facilitate the review of important topics such as the availability of contraception and abortion services. Both the WHO strategy and UNCESCR GC22 consider that high quality family planning services and measures combating unsafe abortion are crucial to individuals’ SRH.[[140]](#footnote-140) Studies explicitly reveal that the use of contraception lowers abortion prevalence (including that of unsafe abortion procedures).[[141]](#footnote-141) Similarly, the lack of access to safe abortion services is often coupled with high rates of clandestine abortions, a procedure threatening women’s health and lives.[[142]](#footnote-142) Therefore, the focus of the ECoSR on maternal health services embraces a conservative approach to women’s SRH, despite efforts to monitor sex education: one associated with maternity rather than with women’s autonomy. These comments, regrettably, resemble those made when analysing the ECtHR’s SRH case-law in section 1.

### Since 2010: ups and downs in the monitoring of SRH matters

Since 2010, the ECoSR has bundled the thematic health indicators developed between 2001 and 2009 into fewer indicators. These new indicators, nonetheless, maintain the same coherence across the themes reviewed under Article 11 ESC and make little to no difference in how the Committee reviews SRH. The Conclusions of the ECoSR in its 2013 and 2017 reporting procedures on Article 11 highlight that similar issues are reviewed, similar standards are applied and similar protection is provided, with regard to SRH. The difference mainly lies in the name of the new indicators, those relevant to SRH being: ‘measures to ensure the highest possible standard of health’, ‘counselling and screening’, ‘education and awareness raising’, as well as ‘immunisation and epidemiological monitoring’.

It is worth noting that during its (short) 2015 reporting cycle, the ECoSR incomprehensibly stopped using thematic health indicators. When reviewing states’ compliance with Article 11 ESC, the Committee consequently failed to monitor SRH systematically, coherently or in depth. It reviewed the availability of maternal health services only three times;[[143]](#footnote-143) the teaching of sex education, only once;[[144]](#footnote-144) and the availability of measures combatting diseases affecting the reproductive system, six times.[[145]](#footnote-145) It becomes now apparent that without any indicators, whether between 1969 and 2000 or in 2015, the Committee’s protection of individuals’ SRH drops significantly. Therefore, to maintain a consistent, in-depth monitoring and thus, protection of SRH, the ECoSR should review Article 11 through thematic health indicators (relevant to key SRH issues).

Despite this ‘glitch’, the Committee’s protection of SRH has progressed since 2010, for it started reviewing an additional SRH issue in its 2013 and 2017 reporting cycles on Article 11 ESC: transgender persons’ SRH. The ECoSR regularly verifies that states provide access to gender reassignment surgery when needed, and that they do not require sterilisation procedures to recognise a new gender identity. While such review was ad hoc in 2013,[[146]](#footnote-146) it has become almost systematic in 2017,[[147]](#footnote-147) thanks to the NGO International Lesbian and Gay Association seemingly providing regular shadow reports.[[148]](#footnote-148) For instance, the Committee criticised Turkey for the stringent criteria imposed upon transgender persons to access gender reassignment surgeries, by referring to the case *Y.Y. v. Turkey* held by the ECtHR on the same matter.[[149]](#footnote-149) Such monitoring thus, clearly protects transgender persons’ access to healthcare supporting key aspects of their sexuality, as it is partially the case in the ECtHR’s case-law. However, neither the WHO strategy nor UNCESCR GC22 consider gender reassignment surgeries (or even hormone therapies) as key aspects of SRH.[[150]](#footnote-150) The absence of recommendations in that respect ignores the evidence highlighting the significant relief these procedures provide to individuals suffering from gender dysphoria, and the improvement they make to transgender persons’ sexual health.[[151]](#footnote-151) However, significant progress remains to be made in the Committee’s review and thus, protection of (cis) women’s SRH. Its Conclusions remain largely silent on access to contraception and abortion, and no relevant legal standards have therefore emanated from its reporting procedure. For instance, in its 2017 reporting procedure on Article 11, the ECoSR never reviewed individuals’ access to contraceptives and it only monitored once women’s ability to access abortion services, across 35 states.[[152]](#footnote-152) As a result, the Conclusions of the ECoSR, alike the judgments of the ECtHR, fail to fully align with recommendations formulated by the WHO strategy or UNCESCR GC22 in that respect.[[153]](#footnote-153)

To conclude, the use of indicators by the ECoSR to monitor states’ realisation of the right to health in its reporting procedure, has clearly enabled it to consistently monitor and follow up key aspects of SRH, as defined by the WHO strategy and UNCESCR GC22.[[154]](#footnote-154) These include: the availability of maternal health services, the teaching of sex education, and the implementation of measures to combat diseases affecting the reproductive system. However, the same indicators have also restricted the ECoSR to a rigid understanding of SRH, one that fails to embrace more contentious questions such as access to abortion and to family planning services.

## Protection of SRH in the complaints procedure

The ECoSR reviews the implementation of the European Social Charter through a dual monitoring system: the reporting procedure and the collective complaints procedure. In the collective complaints procedure, created in 1995, the Committee receives complaints from NGOs or trade unions alleging a violation of the ESC by a given state party.[[155]](#footnote-155) After having examined the arguments of both parties, the ECoSR declares in a Merits Decision whether or not the state has complied with the ESC, and why. While this procedure favours the review of specific situations rather than general states of affairs, which is the role of the reporting procedure, both often feed into each other. The methodology and this paper’s definition of SRH have narrowed down the number of relevant Decisions held under Article 11 ESC to four. One of them concerns the teaching of sex education; and three concern access to abortion in the context of conscientious objection.

### Sex education case

In *Interights v. Croatia* (2009), the ECoSR received a complaint from a human rights NGO alleging a breach of Article 11 ESC on the right to health.[[156]](#footnote-156) In its complaint, Interights alleged that Croatian schools did not provide comprehensive or adequate SRH education for children and young people.[[157]](#footnote-157) In response, the Committee found a breach of Article 11 and required that the state take action on various aspects identified as problematic by the complaint. The Committee asked that SRH education be part of the ordinary school curriculum; that Croatian schools allocate sufficient time and resources to SRH education; and that the substance of SRH education be relevant, culturally appropriate, objective, based on contemporary scientific evidence, and not censored.[[158]](#footnote-158) It also required that Croatia set up a procedure enabling SRH education to be adequately monitored and evaluated.[[159]](#footnote-159) Three positive aspects arise from this Merits Decision. Firstly, by examining in depth the different aspects under which Croatian schools failed to provide adequate SRH education, the Committee developed comprehensive SRH standards under the right to health. Those standards, fully in line with recommendations from the WHO strategy and UNCESCR GC22 on family planning services and sexual health promotion,[[160]](#footnote-160) allowed the Committee to recognise school pupils’ right to receive an adequate SRH education more effectively. Secondly, the Committee adopted an evidence-led reasoning since it used SRH parameters such as incidence of sexually transmitted infections, birth rate and use of the pill among teenage girls, to assess the impact of inadequate sex education in schools.[[161]](#footnote-161) This enabled the ECoSR to assert its use of public health parameters in the collective complaints procedure, and to acknowledge the particular needs of individuals vulnerable to SRH discrimination. Thirdly, while the Committee granted Croatia a margin of appreciation, it confined this to minor aspects of SRH education, and conditioned this to compliance with the standards it had set.[[162]](#footnote-162) This application of states’ margin of appreciation, prioritising individuals’ SRH over states’ interests, should inspire the ECtHR when ruling on abortion cases. However, one concern must be raised when reading this case: the Committee’s use of European averages to put Croatia’s SRH indicators into perspective.[[163]](#footnote-163) Like the use of the European consensus by the ECtHR, this reasoning can shift the Committee’s focus on what states do (sometimes badly) rather than on what they ought to do to effectively protect individuals’ SRH.

While the Committee, overall, strongly protects individuals’ right to access SRH education in this case, its position is less decisive regarding individuals’ right to access abortion services in its three other SRH Merits Decisions.

### Abortion cases

In the case *International Planned Parenthood Federation European Network (IPPF EN) v. Italy* (2013),[[164]](#footnote-164) the ECoSR received a complaint from an NGO specialised in family planning, who alleged a breach of Article 11 ESC on the right to health, together with a breach of Article E on the prohibition of discrimination. In its complaint, the NGO IPPF declared that the number of medical practitioners who conscientiously objected to performing abortion procedures was so high that it rendered the national legislation allowing women to access such services, ineffective.[[165]](#footnote-165) The Committee accepted that access to abortion services be associated with the right to health, and even referred to key UN documents in this respect, when examining relevant international law.[[166]](#footnote-166) More importantly, it recognised that Article 11 imposed positive obligations upon states, including the obligation to provide ‘*appropriate and timely health care on a non-discriminatory basis, including services relating to sexual and reproductive health’*, and the obligation to care for ‘*the specific health needs of women*’.[[167]](#footnote-167) The ECoSR, therefore, held that Italy was responsible for not implementing adequately Article 11 ESC since the measures taken to guarantee women’s access to abortion services were insufficient. This decision is welcome as an attempt by the Committee to protect women’s access to abortion services under the right to health, by reference to UN standards. It also reflects an implicit alignment with recommendations formulated by the WHO strategy and UNCESCR GC22 regarding access to abortion and conscientious objectors.[[168]](#footnote-168) Lastly, the recognition of positive obligations – whether in the Committee or the ECtHR’s case-law on abortion, allows further protection of women’s SRH.

However, in *IPPF v. Italy*, the ECoSR relies heavily on the fact that the state has legalised access to abortion to avoid making a more assertive ruling regarding women’s SRH. It even justifies the relevance of the right to health in this case on the ground that ‘*national legislation has classified [abortion] as a form of medical treatment that relates to the protection of health and individual well-being*’.[[169]](#footnote-169) It is, therefore, unclear whether the connection between access to abortion and the right to health reflects a definite human rights norm or whether it is conditioned by states’ abortion laws. In the latter hypothesis, the Committee could potentially find states with restrictive abortion laws in compliance with Article 11 ESC, as long as women’s access to abortion remains guaranteed in the very few exceptions allowed by the national legislation. Such an approach, reminding that of the ECtHR in its abortion case-law, would fail to sufficiently protect women’s SRH in states with restrictive abortion laws such as Poland. Nevertheless, in *IPPF v. Italy* the ECoSR expressed concern regarding women who had to travel to health facilities across Italy or abroad to terminate their pregnancy. It also expressed concern regarding women who had to terminate their pregnancy without the assistance of competent health authorities. It considered that these situations involved ‘*considerable risks for the health and well-being of the women concerned*’.[[170]](#footnote-170) Such a statement is promising, since it can potentially be formulated against states with restrictive abortion laws. It also moves towards what the WHO strategy and UNCESCR GC22 consider essential in SRH: combatting policies increasing the risk of unsafe abortions.[[171]](#footnote-171) However, a complaint needs to be brought on that basis and a decision, held, for this to be clarified.

Two years later, the ECoSR took a similar standing in the case *Confederazione Generale Italiana del Lavoro (CGIL) v. Italy* (2015), based on a complaint and facts akin to the case *IPPF v. Italy*.[[172]](#footnote-172) In its Merits Decision, the Committee drew comparisons with *IPPF v. Italy* in order to declare that the steps taken by Italy had been insufficient and the situation, not remedied. However, the case of *CGIL v. Italy* did not clarify the Committee’s approach to women’s access to abortion services as a human rights standard under Article 11 ESC.

In *Federation of Catholic Families in Europe (FAFCE) v. Sweden* (2015),[[173]](#footnote-173) the ECoSR received a complaint from an NGO alleging a breach of Article 11 ESC by Sweden. That time, however, the complaint criticised the state’s failure to establish a clear legal framework governing the practice of conscientious objection by healthcare providers in the context of abortion procedures. The NGO FAFCE also alleged a breach of the right to heath on the basis that Sweden had failed to prevent sex selective abortions, eugenic abortions, abortions of viable foetuses, and abortions among minors without parental consent.[[174]](#footnote-174) The Committee, nevertheless, found no breach of Article 11. In its first rationale, the ECoSR rejected the association between a right to conscientious objection for healthcare workers and the right to health. It specifically stated that ‘*Article 11 of the Charter is primarily concerned with the guaranteeing access to adequate health care, and this means in cases of maternity that the primary beneficiaries are the pregnant women*’.[[175]](#footnote-175) In this statement, the Committee clearly protected women’s SRH under Article 11 ESC over the right to conscientious objection of health practitioners. Furthermore, in its third rationale, the ECoSR declared that Sweden had not breached the right to health due to the allegedly high number of abortions sought by young people. It found no evidence proving that such a number was manifestly high, or that it resulted from an insufficient access to contraception and to SRH education.[[176]](#footnote-176) However, it did mention that states’ failure to provide such services could legitimately jeopardise states’ compliance with Article 11. Such declarations thus, promote elements considered as key to the realisation of SRH by the WHO strategy and UNCESCR GC22: family planning services, safe abortion services, and promotion of sexual health.[[177]](#footnote-177) Nevertheless, some concern should be expressed regarding the Committee’s second rationale. In its second rationale, the ECoSR refused to widen the scope of Article 11 ESC to the unborn, in response to claims that Sweden had failed to prevent sex-selective and eugenic abortions. However, it did so by issuing a confusing statement. The ECoSR declared that states parties to the ESC benefited from a wide margin of appreciation in deciding when life began and that, as a result, they could freely determine the extent to which a foetus had a ‘right to health’.[[178]](#footnote-178) It thus, stated that Sweden had not exceeded its margin of appreciation since its legislation was striking an ‘*appropriate balance between the rights of the woman and the right to health of the foetus*’.[[179]](#footnote-179) This declaration not only contradicts the Committee’s own refusal to apply Article 11 ESC to the unborn, it also contradicts the jurisprudence of the ECtHR, which refuses to apply human rights to the unborn.[[180]](#footnote-180) More importantly, this declaration jeopardises the protection of women’s SRH in human rights law.

It is difficult to draw a clear conclusion on how the ECoSR protects SRH in its complaints procedure since it has reviewed very few cases relevant to that topic until now. So far, the Committee has clearly required that sex education taught in schools be comprehensive and objective; and it has consistently protected women’s access to abortion services over potential rights of conscientious objectors. It would, nonetheless, be interesting to know how the ECoSR would approach complaints issued from countries in which abortion services are not legally available, and how it would approach other key components to SRH in the future.

# Conclusion

This article explored whether human rights bodies of the Council of Europe could protect individuals’ SRH adequately through their monitoring procedures, to contextualise the recent recognition of a right to SRH.

Part 1 focused on the adjudication of SRH matters before the ECtHR. It highlighted that most of the Court’s recent case-law under Articles 3 and 8 ECHR on SRH as defined in this article, involved (cis) women. It also emphasised that the Court had been given the opportunity to give a protective reading of vulnerability under Article 3, and of autonomy under Article 8. However, its protection of individuals’ SRH is uneven under both provisions, depending on whether or not a foetus is at stake (strong SRH protection regarding forced sterilisations, obstetric and gynaecological malpractice; but weak protection regarding abortions and homebirths). To conclude, such a conservative and political position perpetuates SRH discrimination against women and thus, fails to comply with recommendations formulated by key human rights and global health bodies.

Part 2 focused on the adjudication of SRH matters before the ECoSR. It stressed that the Committee interprets Article 11 ESC on the right to health as requiring that states provide access to a wide number of SRH services. These include: access to maternal health services, sex education, prevention and treatment of diseases affecting the reproductive system (through its reporting procedure); as well as access to abortion services when lawfully available (through its complaints procedure). Such protection echoes well recommendations formulated by key human rights and global health bodies. To conclude, the Committee protects individuals’ SRH more consistently and comprehensively than the ECtHR, thanks to its reporting procedure and the use of indicators. However, it has not yet taken a clear stand on a more contentious but key aspect of SRH: women’s access to abortion; and its findings do not have the same legal force than the Court’s.

It is, therefore, apparent that both human rights bodies protect relatively well SRH in their recent case-law, which represents a positive step towards the recognition in practice of a right to SRH in the Council of Europe. Nevertheless, they both fail to protect women’s access to abortion, thus reflecting a lack of ambition from the Council of Europe as to what SRH entails in human rights law. This clearly compromises the full recognition in practice of a right to SRH in European human rights law, in the light of recommendations enshrined in UNCESCR GC22 and the WHO strategy. The ECtHR’s judges and the ECoSR’s members must align their understanding of SRH to well-recognised UN standards. This would enable them to protect everyone’s rights to access key SRH services and information facilitating their ability to make free choices over their SRH (especially those vulnerable to violence, coercion and discrimination).

1. UNCESCR, ‘General Comment No. 22: Right to Sexual and Reproductive Health (Art. 12)’ (2016) UN Doc. E/C.12/GC/22. See also premises of this recognition in: UNCESCR, ‘General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)’ (2000) UN Doc. E/C.12/2000/4, paras 8, 11, 14, 16, 21, 23, 34, 36. [↑](#footnote-ref-1)
2. In the African Union, the African Commission on Human and Peoples’ Rights clearly connected women’s right to health to SRH (see African Commission on Human and Peoples’ Rights, ‘General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa’ (2014), Preface). In the American Organization of American States, the Inter-American Commission on Human Rights explicitly referred to a ‘*right to health and reproductive health*’ (see Inter-American Commission on Human Rights, ‘Report on the Status of Women in the Americas’ (1998) OEA/Ser.L/V/II.100 Doc. 17, Chapter III, Section C, Item 3). It also discussed interactions between the right to health and SRH (Inter-American Commission on Human Rights, ‘Report on Access to Information on Reproductive Health from a Human Rights Perspective’ (2011) OEA/Ser.L/V/II. Doc. 61, paras 5, 33–35, 60). As for the Council of Europe, its Parliamentary Assembly recognised an autonomous right to SRH, resulting from interactions between SRH and the right to health (see CoE Parliamentary Assembly, ‘Resolution 1399, European Strategy for the Promotion of Sexual and Reproductive Health and Rights’ (2004), paras 1 and 2). Its Commissioner for Human Rights also emphasised the importance of SRH in human rights law, including that of the right to SRH (see CoE Commissioner for Human Rights, ‘Human Rights Comment: Protect Women’s Sexual and Reproductive Health and Rights’ (2016) <https://www.coe.int/en/web/commissioner/-/protect-women-s-sexual-and-reproductive-health-and-rights?desktop=true> accessed 26 June 2018; and CoE Commissioner for Human Rights, ‘Issue Paper: Women’s Sexual and Reproductive Health and Rights in Europe’ (2017), 5, 17, 47–50, 56, 58 <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead> accessed 26 June 2018. [↑](#footnote-ref-2)
3. UNCESCR, ‘General Comment 22’ (n 1) para 1.: ‘*The right to sexual and reproductive health is an integral part of the right to health’.* [↑](#footnote-ref-3)
4. See literature using the right to health to exemplify interactions between SRH and human rights: Bharati Sadasivam, ‘The Rights Framework in Reproductive Health Advocacy - A Reappraisal’ (1997) 8 Hastings Women’s Law Journal 313; Rebecca J Cook, ‘Developments in Judicial Approaches to Sexual and Reproductive Health’ (2002) 21 Medicine and Law 155; Ebenezer Durojaye, ‘Monitoring the Right to Health and Sexual And Reproductive Health at the National Level: Some Considerations for African Governments’ (2009) 42 Comparative and International Law Journal of Southern Africa 227; Ilise L Feitshans, ‘Is There a Human Right to Reproductive Health’ (1998) 8 Texas Journal of Women and the Law 93; Lance Gable, ‘Reproductive Health as a Human Right’ (2009) 60 Case Western Reserve Law Review 957; Sofia Gruskin, Mindy Jane Roseman and Laura Ferguson, ‘Reproductive Health and HIV: Do International Human Rights Law and Policy Matter’ (2007) 3 McGill International Journal of Sustainable Development Law and Policy 69; Aart Hendricks, ‘Promotion and Protection of Women’s Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women’s Convention’ (1995) 44 American University Law Review 1123; Paul Hunt and Gillian McNaughton, ‘A Human Rights-Based Approach to Health Indicators’, *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007); Charles G Ngwena, ‘Conscientious Objection to Abortion and Accommodating Women’s Reproductive Health Rights: Reflections on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective’ (2014) 58 Journal of African Law 183; Wanda Nowicka, ‘Sexual and Reproductive Rights and the Human Rights Agenda: Controversial and Contested’ (2011) 19 Reproductive Health Matters 119, 119. [↑](#footnote-ref-4)
5. UNCESCR, ‘General Comment 22’ (n 1). [↑](#footnote-ref-5)
6. WHO Department of Reproductive Health and Research, ‘Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets’ (2004) UN Doc. WHO/RHR/04.8, 21 para 35 <http://apps.who.int/iris/bitstream/handle/10665/68754/WHO\_RHR\_04.8.pdf;jsessionid=88D66713F41FB041EBC159A78A51644D?sequence=1> accessed 26 June 2018. Such ‘core components’ are widely referred to in other important global health documents: e.g. UNFPA, ‘Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights’ (2010) 13 <https://www.unfpa.org/sites/default/files/pub-pdf/uarh\_report\_2010.pdf> accessed 26 June 2018; UNFPA, The Danish Institute for Human Rights and OHCHR, ‘Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions’ (2014) UN Doc. HR/PUB/14/6, 24 <http://www.unfpa.org/sites/default/files/pub-pdf/NHRIHandbook.pdf> accessed 26 June 2018. [↑](#footnote-ref-6)
7. Ann M Starrs and others, ‘Accelerate Progress – sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission’ (2018) The Lancet <https://www.sciencedirect.com/science/article/pii/S0140673618302939> accessed 26 June 2018. (This report was launched in May 2018 during the 71st WHO Health Assembly, see <http://www.who.int/reproductivehealth/news/wha71/en/> accessed 26 June 2018). [↑](#footnote-ref-7)
8. UNCESCR, ‘General Comment 22’ (n 1) para 5: the right to SRH is defined as ‘*the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health [and] […] unhindered access to a whole range of [SRH] facilities, goods, services and information*’. [↑](#footnote-ref-8)
9. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8 (this report also suggests SRH interventions regarding ‘*subfertility and infertility*’, as well as ‘*sexual and gender-based violence*’, but these tend to correspond to SRH rights more than a right to SRH as defined in this article). [↑](#footnote-ref-9)
10. Republic of Ireland, Thirty-sixth Amendment of the Constitution Bill 2018 (Bill No. 29 of 2018). See also recent attempts to restrict access to abortion in Poland and in Spain. [↑](#footnote-ref-10)
11. E.g. Liiri Oja and Alicia Ely Yamin, ‘Woman in the European Human Rights System: How Is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women’s Citizenship’ (2016) 32 Columbia Journal of Gender and Law 62. [↑](#footnote-ref-11)
12. E.g. Chiara Cosentino, ‘Safe and Legal Abortion: An Emerging Human Right? The Long-Lasting Dispute with State Sovereignty in ECHR Jurisprudence’ (2015) 15 Human Rights Law Review 569; Gregor Puppinck, ‘Abortion and the European Convention on Human Rights’ (2013) 3 Irish Journal of Legal Studies 142; Johanna Westeson, ‘Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights’ (2013) 122 International Journal of Gynecology & Obstetrics 173; Elizabeth Wicks, ‘A, B, C v Ireland: Abortion Law under the European Convention on Human Rights’ (2011) 11 Human Rights Law Review 556. [↑](#footnote-ref-12)
13. (European) Convention for the Protection of Human Rights and Fundamental Freedoms (as amended) 1950 (ECHR), Article 46. [↑](#footnote-ref-13)
14. CoE Committee of Ministers, ‘Rules of the Committee of Ministers for the Supervision of the Execution of Judgments and of the Terms of Friendly Settlements (as Amended on 18 January 2017)’ <https://rm.coe.int/16806eebf0> accessed 26 June 2018. [↑](#footnote-ref-14)
15. The HUDOC database (for the ECtHR) can be found on <https://hudoc.echr.coe.int/eng> accessed 26 June 2018. [↑](#footnote-ref-15)
16. The factsheets of the ECtHR can be found on <https://www.echr.coe.int/Pages/home.aspx?p=press/factsheets&c=> accessed 26 June 2018 (all factsheets mentioned above were compiled in 2018, except one which was compiled in 2014). [↑](#footnote-ref-16)
17. See UNCESCR, ‘General Comment 22’ (n 1) para 5. [↑](#footnote-ref-17)
18. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-18)
19. Since 2000, the Court has developed a limited SRH case-law under other ECHR provisions, which this article will thus, not discuss. While this article focuses on Merits Judgments, it is worth noting that the Court held several Admissibility Decisions under Article 9 ECHR and Article 2 of Protocol 1 of the ECHR, in which it protects access to family planning services such as contraception and SRH education, over religious beliefs. (See *Pichon and Sajous v France* App no. 49853/99 (Admissibility Decision) (ECtHR, October 2001); *Jiménez Alonso and Jiménez Merino v Spain* App no. 51188/99 (Admissibility Decision) (ECtHR, 25 May 2000); and *Dojan and others v Germany* App no. 319/08 (Admissibility Decision) (ECtHR, 13 September 2011)). The Court has also held a couple of Merits Judgments under Article 10 ECHR regarding access to information about abortion, but these do now allow to draw conclusions on the Court’s position. See *Women on waves and others v Portugal* App no. 31276/05 (ECtHR, 3 February 2009); *Annen v Germany* App no. 3690/10 (ECtHR, 26 November 2015). [↑](#footnote-ref-19)
20. ECHR (n 13), Article 3. [↑](#footnote-ref-20)
21. ibid, Article 15. [↑](#footnote-ref-21)
22. To be successful, applicants must demonstrate that their ill-treatment has attained a minimum level of severity, usually dependant on the circumstances of the case. (See the landmark case *Ireland v the United Kingdom* [1978] Series A no. 25). [↑](#footnote-ref-22)
23. *KH and others v Slovakia* App no. 32881/04 (ECtHR, 28 April 2009); *VC v Slovakia* App no. 18968/07 (ECtHR, 8 November 2011); *NB v Slovakia* App no. 29518/10 (ECtHR, 12 June 2012); *IG and others v Slovakia* App no. 15966/04 (ECtHR, 13 November 2012). [↑](#footnote-ref-23)
24. Such statement was first held in *VC v Slovakia* (n 23) paras 116–120; and referred to in *NB v Slovakia* (n 23) paras 77–81; as well as in *IG and others v Slovakia* (n 23) paras 118, 122–126. [↑](#footnote-ref-24)
25. UNCESCR, ‘General Comment 22’ (n 1) paras 5, 8, 10, 25, 28, 29, 34, 42, 48. [↑](#footnote-ref-25)
26. See WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-26)
27. E.g. Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (7th edition, OUP USA 2013) ch 4. [↑](#footnote-ref-27)
28. *VC v Slovakia* (n 23) para 118; *NB v Slovakia* (n 23) para 80. [↑](#footnote-ref-28)
29. *IG and others v Slovakia* (n 23) para 123. [↑](#footnote-ref-29)
30. Oja and Yamin (n 11) 88; Priti Patel, ‘Forced Sterilization of Women as Discrimination’ (2017) 38 Public Health Reviews 15. [↑](#footnote-ref-30)
31. *VC v Slovakia* (n 23) paras 145–149 (part of the ECtHR’s assessment under Article 8). [↑](#footnote-ref-31)
32. ibid paras 177–179; *NB v Slovakia* (n 23) paras 121–122; *IG and others v Slovakia* (n 23) paras 165–166. [↑](#footnote-ref-32)
33. *VC v Slovakia* (n 23) para 6 of the ruling; *NB v Slovakia* (n 23) para 7 of the ruling; *IG and others v Slovakia* (n 23) para 8 of the ruling. [↑](#footnote-ref-33)
34. UNCESCR, ‘General Comment 22’ (n 1) paras 30, 57–59. [↑](#footnote-ref-34)
35. Center for Reproductive Rights, ‘The World’s Abortion Laws 2018’ <http://worldabortionlaws.com/map/> accessed 26 June 2018. [↑](#footnote-ref-35)
36. *Tysiac v Poland* App no. 5410/03 (ECtHR, 20 March 2007). [↑](#footnote-ref-36)
37. ibid paras 62–66 (quote in para 66). [↑](#footnote-ref-37)
38. ibid para 66. [↑](#footnote-ref-38)
39. *A, B and C v Ireland* App no. 25579/05 (ECtHR, 16 December 2010). [↑](#footnote-ref-39)
40. ibid paras 160–165. [↑](#footnote-ref-40)
41. Amnesty International, ‘She Is Not a Criminal: The Impact of Ireland’s Abortion Law’ (2015) 55-58 and 84-86 <https://www.amnesty.org.uk/files/she\_is\_not\_a\_criminal\_report\_-\_embargoed\_09\_june.pdf> accessed on 26 June 2018. [↑](#footnote-ref-41)
42. *Amanda Jane Mellet v Ireland* UN Doc. CCPR/C/116/D/2324/2013 (Human Rights Committee, 31 Mars 2016) para 7.4: ‘*Many of the negative experiences described that she went through could have been avoided if the author had not been prohibited from terminating her pregnancy in the familiar environment of her own country and under the care of the health professionals whom she knew and trusted, and if she had been afforded the health benefits she needed that were available in Ireland, were enjoyed by others, and could have been enjoyed by her, had she continued her non-viable pregnancy to deliver a stillborn child in Ireland*.’ [↑](#footnote-ref-42)
43. *Tysiac v Poland* (n 36) para 5 of the ruling; *A, B and C v Ireland* (n 39) para 6 of the ruling. [↑](#footnote-ref-43)
44. *RR v Poland* App no. 27617/04 (ECtHR, 26 May 2011). [↑](#footnote-ref-44)
45. ibid. [↑](#footnote-ref-45)
46. Ibid paras 153–162. [↑](#footnote-ref-46)
47. ibid para 159. [↑](#footnote-ref-47)
48. Family Planning, Protection of the Human Foetus and Conditions Permitting Pregnancy Termination Act 1993 (Poland), s 4(a)(1) [↑](#footnote-ref-48)
49. *P and S v Poland* App no. 57375/08 (ECtHR, 30 October 2012). [↑](#footnote-ref-49)
50. ibid paras 168–169. [↑](#footnote-ref-50)
51. ibid para 167. [↑](#footnote-ref-51)
52. David A Grimes and others, ‘Unsafe Abortion: The Preventable Pandemic’ (2006) 368 The Lancet 1908; M Antonia Biggs and others, ‘Women’s Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study’ (2017) 74 JAMA psychiatry 169; Diana Greene Foster and others, ‘Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States’ (2018) 108 American Journal of Public Health 407. [↑](#footnote-ref-52)
53. See UNCESCR, ‘General Comment 22’ (n 1) paras 28, 49(e); WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-53)
54. The ECtHR interprets Article 8 as protecting the right to access one’s medical records following suspicion of non-consensual sterilisation (see *KH and others v Slovakia* (n 23)); and the right for one’s SRH medical records to be treated confidentially (see *P and S v Poland* (n 49); *Radu v the Republic of Moldova* App no. 50073/07 (ECtHR, 15 April 2014); and *Mockutė v Lithuania* App no. 66490/09 (ECtHR, 27 February 2018). [↑](#footnote-ref-54)
55. The ECtHR interprets Article 8 as protecting transgender persons’ right to access gender reassignment surgery without obstruction from state authorities (see *L v Lithuania* App no. 27527/03 (ECtHR, 11 September 2007); and *YY v Turkey* App no. 14793/08 (ECtHR, 8 January 2009)); and without obstruction from private health insurers (see *Van Kück v Germany* App no. 35968/97 (ECtHR, 12 June 2003); and *Schlumpf v Switzerland* App no. 29002/06 (ECtHR, 8 January 2009)). [↑](#footnote-ref-55)
56. ECHR (n 13), Article 8. [↑](#footnote-ref-56)
57. ibid, Article 8(2). [↑](#footnote-ref-57)
58. *VC v Slovakia* (n 23); *NB v Slovakia* (n 23); *IG and others v Slovakia* (n 23). [↑](#footnote-ref-58)
59. *KH and others v Slovakia* (n 23). [↑](#footnote-ref-59)
60. *VC v Slovakia* (n 23) paras 138–155; *NB v Slovakia* (n 23) paras 92–99; *IG and others v Slovakia* (n 23) paras 135–146. [↑](#footnote-ref-60)
61. UNCESCR, ‘General Comment 22’ (n 1), see para 5 which defines SRH; and see the words ‘autonomy’, ‘free’, ‘coercion’, ‘vulnerability’, ‘violence’ and ‘discrimination’, appearing multiple times in this document. [↑](#footnote-ref-61)
62. *VC v Slovakia* (n 23) para 154; *NB v Slovakia* (n 23) paras 97–98; *IG and others v Slovakia* (n 23) paras 144–145. [↑](#footnote-ref-62)
63. See in particular *VC v Slovakia* (n 23) paras 145–149, highlighting findings from the Council of Europe Commissioner for Human Rights, the European Commission against Racism and Intolerance, the UN Committee on the Elimination of Discrimination against Women, and the Slovakian Ministry of Health. [↑](#footnote-ref-63)
64. Brice Dickson, ‘Positive Obligations and the European Court of Human Rights Special Issue: Positive Obligations and the European Court of Human Rights’ (2010) 61 Northern Ireland Legal Quarterly 203, 204–205. It is worth noting, nevertheless, that the UN promotes an even more comprehensive account of states’ obligations through the tripartite typology ‘respect, protect, fulfil’, e.g. UNCESCR, ‘General Comment 22’ (n 1) paras 39–48. [↑](#footnote-ref-64)
65. *GB and RB v the Republic of Moldova* App no. 16761/09 (ECtHR, 18 December 2012); *Csoma v Romania* App no. 8759/05 (ECtHR, 15 January 2013). [↑](#footnote-ref-65)
66. *Csoma v. Romania* (n 65) paras 62–68. [↑](#footnote-ref-66)
67. *GB and RB v the Republic of Moldova* (n 65) para 32. [↑](#footnote-ref-67)
68. UNCESCR, ‘General Comment 22’ (n 1) para 64. [↑](#footnote-ref-68)
69. *GB and RB v the Republic of Moldova* (n 65) paras 29–30; *Csoma v. Romania* (n 65) paras 42 and 48. [↑](#footnote-ref-69)
70. *Carvalho Pinto de Sousa Morais v Portugal* App no. 17484/15 (ECtHR, 25 July 2017). [↑](#footnote-ref-70)
71. ibid para 48. [↑](#footnote-ref-71)
72. ibid paras 16 and 49. [↑](#footnote-ref-72)
73. ibid para 52. [↑](#footnote-ref-73)
74. ibid paras 30–56. [↑](#footnote-ref-74)
75. UNCESCR, ‘General Comment 22’ (n 1) paras 6 and 35; WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-75)
76. *Tysiac v Poland* (n 36) paras 114–130; *RR v Poland* (n 44) paras 192–214; *P and S v Poland* (n 49) paras 100–112. [↑](#footnote-ref-76)
77. *Tysiac v Poland* (n 36) para 118. [↑](#footnote-ref-77)
78. ibid para 124. [↑](#footnote-ref-78)
79. ibid para 113. This statement was initially made in *Airey v Ireland* Series A no 32 (ECtHR, 9 October 1979) para 24, in the context of legal aid. It was reiterated in *RR v Poland* (n 44) para 191; and in *P and S v Poland* (n 49) para 99. [↑](#footnote-ref-79)
80. This is how *RR v Poland* (n 44) para 200 and *P and S v Poland* (n 49) para 99, summarise (and refer to) the assessment of the Court in *Tysiac v Poland* (n 36) paras 116–124. [↑](#footnote-ref-80)
81. *A, B and C v Ireland* (n 39) para 249. See also *RR v Poland* (n 44) para 187; and *P and S v Poland* (n 49) para 99. [↑](#footnote-ref-81)
82. *RR v Poland* (n 44) para 206; *P and S v Poland* (n 49) paras 106–107. [↑](#footnote-ref-82)
83. UNCESCR, ‘General Comment 22’ (n 1) paras 10, 25, 34. [↑](#footnote-ref-83)
84. *A, B and C v Ireland* (n 39) paras 216–218. [↑](#footnote-ref-84)
85. *Tysiac v Poland* (n 36) para 108; *RR v Poland* (n 44) para 188; *P and S v Poland* (n 49) para 98. [↑](#footnote-ref-85)
86. Dickson (n 64) 203. Furthermore, such a dichotomy does not reflect the tripartite typology of states’ obligations adopted by the UN, e.g. UNCESCR, ‘General Comment 22’ (n 1) paras 39–48. [↑](#footnote-ref-86)
87. *A, B and C v Ireland* (n 39) para 214. This statement was avoided in *Tysiac v Poland* (n 36) para 108; but it was reiterated in *RR v Poland* (n 44) para 188; and *P and S v Poland* (n 49) para 96. [↑](#footnote-ref-87)
88. *A, B and C v Ireland* (n 39) paras 219–221. [↑](#footnote-ref-88)
89. ibid para 227. [↑](#footnote-ref-89)
90. See also a criticism of this decision in Daniel Regan, ‘European Consensus: A Worthy Endeavour for the European Court of Human Rights’ (2011) 14 Trinity College Law Review 51, 62. [↑](#footnote-ref-90)
91. *A, B and C v Ireland* (n 39) para 232. [↑](#footnote-ref-91)
92. ibid. [↑](#footnote-ref-92)
93. ibid paras 235-241. [↑](#footnote-ref-93)
94. ibid para 241. [↑](#footnote-ref-94)
95. ibid paras 243–268. [↑](#footnote-ref-95)
96. UNCESCR, ‘General Comment 22’ (n 1) para 5. [↑](#footnote-ref-96)
97. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-97)
98. *Ternovszky v Hungary* App no. 67545/09 (ECtHR, 14 December 2010). [↑](#footnote-ref-98)
99. ibid para 11. [↑](#footnote-ref-99)
100. ibid paras 23–27. [↑](#footnote-ref-100)
101. ibid para 22. [↑](#footnote-ref-101)
102. *Dubská and Krejzová v the Czech Republic* App no. 28859/11 and 28473/12 (ECtHR, 15 November 2016). [↑](#footnote-ref-102)
103. ibid para 191. [↑](#footnote-ref-103)
104. ibid paras 140, 142. [↑](#footnote-ref-104)
105. ibid paras 172–173. [↑](#footnote-ref-105)
106. ibid paras 64 and 74 (para 74: when reviewing the arguments of the Chamber). [↑](#footnote-ref-106)
107. ibid paras 180, 185, 187. [↑](#footnote-ref-107)
108. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-108)
109. *Dubská and Krejzová v the Czech Republic* (n 102) paras 183–184. [↑](#footnote-ref-109)
110. European Social Charter 1961 (ESC 1961), Article 29. [↑](#footnote-ref-110)
111. Additional Protocol to the European Social Charter providing for a system of collective complaints 1995, Article 9. [↑](#footnote-ref-111)
112. ESC 1961 (n 110), Article 11; European Social Charter (as amended) 1996 (ESC 1996), Article 11. Both versions of the Charter currently coexist but the wording of Article 11 is almost identical in both. [↑](#footnote-ref-112)
113. UNCESCR, ‘General Comment 22’ (n 1) para 1: ‘*The right to sexual and reproductive health is an integral part of the right to health*’. [↑](#footnote-ref-113)
114. The HUDOC database (for the ECoSR) can be found on <http://hudoc.esc.coe.int/eng/> accessed 26 June 2018 (One entry corresponding to the Committee’s Conclusions on the implementation of each of the three paragraphs of Article 11 ESC, by each state, during each reporting cycle) [↑](#footnote-ref-114)
115. Claire Lougarre, ‘What Does the Right to Health Mean? The Interpretation of Article 11 of the European Social Charter by the European Committee of Social Rights’ (2015) 33 Netherlands Quarterly of Human Rights 326. [↑](#footnote-ref-115)
116. See UNCESCR, ‘General Comment 22’ (n 1) para 5. [↑](#footnote-ref-116)
117. See WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8. [↑](#footnote-ref-117)
118. Procedure created by ESC 1961 (n 110), Articles 21 to 24. [↑](#footnote-ref-118)
119. ibid, Article 11; ESC 1996 (n 112), Article 11. [↑](#footnote-ref-119)
120. ECoSR, ‘Conclusions VII (1981)’ on Article 11(1) ESC, Norway. [↑](#footnote-ref-120)
121. ibid on Article 11(1) ESC, all other countries. [↑](#footnote-ref-121)
122. ECoSR, ‘Conclusions VIII (1984)’ on Article 11(1) ESC, Norway. [↑](#footnote-ref-122)
123. ECoSR, ‘Conclusions VII (1981)’ on Article 11(1) ESC, Norway; ECoSR, ‘Conclusions IX-2 (1985-1986), Addendum’ on Article 11(1) ESC, Spain; ECoSR, ‘Conclusions X-2 (1987-1990)’ on Article 11(1), Spain; ECoSR, ‘Conclusions XI-2 (1991-1992)’ on Article 11(1), France; ECoSR, ‘Conclusions XII-2 (1991-1992)’ on Article 11(1), France. [↑](#footnote-ref-123)
124. ECoSR, ‘Conclusions XI-1 (1991-1992)’ on Article 11(3), Sweden; ECoSR, ‘Conclusions XII-1 (1991-1992)’ on Article 11(3), Iceland; ECoSR, ‘Conclusions XII-2 (1991-1992)’ on Article 11(3), Italy and Spain. [↑](#footnote-ref-124)
125. Lougarre (n 115) 330–336. [↑](#footnote-ref-125)
126. ibid 332–334. [↑](#footnote-ref-126)
127. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) (maternal healthcare in paras 10, 18, 28 and 45; sex education in paras 9, 28, 47, 49(f) and 63; sexually transmitted diseases in paras 13, 18, 44, 45 and 51). [↑](#footnote-ref-127)
128. Standard first established in ECoSR, ‘Conclusions XV-2 (2001)’ on Article 11(1), Belgium. [↑](#footnote-ref-128)
129. Standard first established in ECoSR, ‘Conclusions 2003’ on Article 11(1), France (this standard was expressed in more ‘formal’ terms in reporting cycles XIX-2 (2009) and 2009). [↑](#footnote-ref-129)
130. Standard first established in ECoSR, ‘Conclusions 2005’ on Article 11(2), Moldova. [↑](#footnote-ref-130)
131. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 10, 18, 28 and 45. [↑](#footnote-ref-131)
132. Standard first established in ECoSR, ‘Conclusions XV-2 (2001)’ on Article 11(2), Belgium. [↑](#footnote-ref-132)
133. Standard first established in ECoSR, ‘Conclusions 2005’ on Article 11(2), Moldova. [↑](#footnote-ref-133)
134. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 9, 18, 19, 28, 47, 49(f), 63. [↑](#footnote-ref-134)
135. The ECtHR clearly protected the teaching of SRH education in schools over religious beliefs in *Jiménez Alonso and Jiménez Merino v. Spain* (n 19); and *Dojan and others v. Germany* (n 19). [↑](#footnote-ref-135)
136. Standard first established in ECoSR, ‘Conclusions XVII-2 (2005)’ on Article 11(2), Latvia. [↑](#footnote-ref-136)
137. For instance, see ECoSR, ‘Conclusions 2009’ and ECoSR, ‘Conclusions XIX-2 (2009)’ on Article 11(2) ESC: the ECoSR reviewed the availability of screening services for breast cancer in 7 countries out of 39 (Andorra, Belgium, Cyprus, Estonia, Ireland, Italy, Slovenia); and it reviewed the availability of screening services for prostate cancer in 2 countries out of 39 (Hungary, Latvia). [↑](#footnote-ref-137)
138. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 13, 18, 44, 45 and 51. [↑](#footnote-ref-138)
139. Lougarre (n 115) 346–349. [↑](#footnote-ref-139)
140. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) (access to contraception in paras 13, 18, 28, 41, 44, 45, 57, 58 and 62; access to abortion in paras 10, 13, 18, 21, 28, 34, 40, 41, 45, 49(e), 57 and 59). [↑](#footnote-ref-140)
141. WHO ‘Safe Abortion: Technical and Policy Guidance for Health Systems (2nd Edition)’ (2012) 22–23 <http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434\_eng.pdf> accessed 26 June 2018. [↑](#footnote-ref-141)
142. ibid 19–21. [↑](#footnote-ref-142)
143. ECoSR, ‘Conclusions 2015’ on Article 11(2), Romania and Turkey; ECoSR, ‘Conclusions XX-4 (2015)’ on Article 11(2), Greece. [↑](#footnote-ref-143)
144. ECoSR, ‘Conclusions 2015’ on Article 11(2), Ukraine. [↑](#footnote-ref-144)
145. ibid on Article 11(2), Georgia, Lithuania, Moldova, Portugal and Turkey; ECoSR, ‘Conclusions XX-4 (2015)’ on Article 11(2), Greece. [↑](#footnote-ref-145)
146. ECoSR, ‘Conclusions 2013’ on Article 11(1), Turkey, Ukraine, Denmark, Malta and Moldova. [↑](#footnote-ref-146)
147. Review operated for 25 states out of 34, in ECoSR, ‘Conclusions XXI-2 (2017)’ on Article 11(1); and ECoSR, ‘Conclusions 2017’ on Article 11(1). [↑](#footnote-ref-147)
148. Most documents submitted through the reporting procedure can be found on: <https://www.coe.int/en/web/turin-european-social-charter/national-reports#{%2213417429%22:[20]}> accessed 26 June 2018. [↑](#footnote-ref-148)
149. ECoSR, ‘Conclusions 2017’ on Article 11(1), Turkey; (ECtHR) *YY v Turkey* (n 55). [↑](#footnote-ref-149)
150. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1). [↑](#footnote-ref-150)
151. Griet De Cuypere and others, ‘Sexual and Physical Health After Sex Reassignment Surgery’ (2005) 34 Archives of Sexual Behavior 679. [↑](#footnote-ref-151)
152. ECoSR, ‘Conclusions 2017’ on Article 11(1), Austria. See a slightly more satisfactory review of this issue in ECoSR, ‘Conclusions 2013’ on Article 11(1), Portugal; ECoSR, ‘Conclusions 2013’ on Article 11(2), Sweden; and ECSR, ‘Conclusions XX-2 (2013)’ on Article 11(2), Macedonia (in which the Committee highlights the availability of advice on contraception and the number of maternal deaths related to abortion procedures). [↑](#footnote-ref-152)
153. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1). [↑](#footnote-ref-153)
154. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 18 and 44. [↑](#footnote-ref-154)
155. Procedure created by Additional Protocol ESC 1995 (n 111). [↑](#footnote-ref-155)
156. *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia* Complaint No. 45/2007 (ECoSR, 30 March 2009). [↑](#footnote-ref-156)
157. ibid paras 25–32. [↑](#footnote-ref-157)
158. ibid paras 47, 51–54, 58–66. [↑](#footnote-ref-158)
159. ibid para 47. [↑](#footnote-ref-159)
160. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 18 and 19. [↑](#footnote-ref-160)
161. *INTERIGHTS v Croatia* (n 156) paras 55–56. [↑](#footnote-ref-161)
162. ibid paras 52 and 59 (the margin of appreciation granted to Croatia concerned the organisational structure and cultural appropriateness of SRH education). [↑](#footnote-ref-162)
163. ibid paras 55–56. [↑](#footnote-ref-163)
164. *International Planned Parenthood Federation European Network (IPPF EN) v Italy* Complaint No. 87/2012 (ECoSR, 10 September 2013). [↑](#footnote-ref-164)
165. ibid para 12. [↑](#footnote-ref-165)
166. ibid paras 37–38 (the ECoSR referred to Article 12 of the International Covenant on Economic, Social and Cultural Rights and to General Comment No. 14 of the Committee on Economic, Social and Cultural Rights). [↑](#footnote-ref-166)
167. ibid para 66. [↑](#footnote-ref-167)
168. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 14 and 43. [↑](#footnote-ref-168)
169. *IPPF EN v Italy* (n 164) para 161. [↑](#footnote-ref-169)
170. ibid para 175. [↑](#footnote-ref-170)
171. WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1) paras 10, 13, 18, 21, 28, 34, 40, 41, 45, 49(e) and 59. [↑](#footnote-ref-171)
172. *Confederazione Generale Italiana del Lavoro (CGIL) v Italy* Complaint No. 91/2013 (ECoSR, 12 October 2015). [↑](#footnote-ref-172)
173. *Federation of Catholic Families in Europe (FAFCE) v Sweden* Complaint No. 99/2013 (ECoSR, 17 March 2015). [↑](#footnote-ref-173)
174. ibid paras 36–46. [↑](#footnote-ref-174)
175. ibid paras 69–72. [↑](#footnote-ref-175)
176. ibid paras 76–79. [↑](#footnote-ref-176)
177. See WHO, ‘Reproductive Health Strategy’ (n 6) 21, para 35; Report of the Guttmacher–Lancet Commission (n 7) 8; UNCESCR, ‘General Comment 22’ (n 1). [↑](#footnote-ref-177)
178. *FAFCE v Sweden* (n 173) para 73. [↑](#footnote-ref-178)
179. ibid paras 74–75. [↑](#footnote-ref-179)
180. E.g. *VO v France* App no. 53924/00 (ECtHR, 8 July 2004) para 80: ‘*the unborn child is not regarded as a “person” directly protected by Article 2 of the Convention and that if the unborn do have a “right” to “life”, it is implicitly limited by the mother’s rights and interests*’. [↑](#footnote-ref-180)