The Funding of Abortion through EU Development Aid

An Analysis of EU’s Sexual and Reproductive Health Policy
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QUESTION CONSIDERED

The objective of this report is to document how two world’s largest abortion providers - International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI) have been receiving, and continue to receive funding from the European Union’s Development Aid and Public Health budgets for projects related to “sexual and reproductive health” (SRH).

The term “sexual and reproductive health” as defined by the EU excludes abortion explicitly. Both organizations, however, are known to consider abortion to be a core service related to “sexual and reproductive health” – a service which they have made it their mission to offer on a large scale worldwide.

This raises questions: are the EU’s budgets for Development Aid and Public Health used to finance abortions in developing countries? Is this attributable to negligence, or is it done deliberately? If done deliberately: is this legal? If a result of negligence: what are the consequences for such a misuse of European budgets and what could be done to prevent such misuse in the future?

I. THE EU - GLOBAL PARTNER ON SEXUAL AND REPRODUCTIVE HEALTH

The European Commission has also been an active member of the Reproductive Health Supplies Coalition (RHSC) since it was set up in 2004 and is a member of the coalition’s 13-seat executive committee. The Reproductive Health Supplies Coalition (RHSC) is a high-level global partnership of public, private, and non-governmental organisations of reproductive health supply donors and stakeholders dedicated to increasing resources, strengthening systems and ensuring that people in low-income and middle-income countries have access to and use affordable, high quality supplies for better reproductive health. The coalition brings together more than 100 member organisations (including Marie Stopes International and International Planned Parenthood Federation) with critical roles in providing reproductive health supplies.

European Commission, UNFPA and a number of partners from the supplies coalition helped develop a mechanism called AccessRH to expedite procurement and increase the availability of reproductive health commodities in developing countries. AccessRH - UNFPA-managed reproductive health procurement and information service that aims to improve access to quality, affordable sexual and reproductive health (RH) commodities - procures the medical and surgical instruments to perform abortions such as MVA (manual vacuum aspiration) kits and aspirators. AccessRH is co-founded by the EU, the German Federal Ministry for Economic Cooperation and Development (BMZ), the United States Agency for International Development (USAID) and UNFPA. EU contribution accounts for €24,3 million (for 30 months starting in June 2011).
I.1. Official EU Position on Sexual and Reproductive Health

A. EU Law

The legal basis for funding the Sexual and Reproductive Health programmes in developing countries is the Regulation on aid for policies and actions on reproductive and sexual health and rights in developing countries (2003)\(^4\) which states in Article 1 that:

“1) The Community shall support actions to improve reproductive and sexual health in developing countries and to secure respect for the rights relating thereto.

2) The Community shall provide financial assistance and appropriate expertise with a view to promoting a holistic approach to, and the recognition of, reproductive and sexual health and rights as defined in the ICPD Programme of Action, including safe motherhood and universal access to a comprehensive range of safe and reliable reproductive and sexual health care and services.”

More importantly, Article 16 states clearly:

“No support should be given under this Regulation to incentives to encourage sterilization or abortion, or to improper testing of contraception methods in developing countries. When cooperation measures are implemented, the decisions adopted at the ICPD, in particular point 8.25 of the ICPD Programme of Action, according to which, inter alia, abortion should in no case be promoted as a method of family planning, must be rigorously observed.”

Regulation 1905/2006 – the second relevant EU regulation, which is based on the first - states\(^5\) that one purpose of the funding of health-related projects under the DCI is to “improve maternal and child health and sexual and reproductive health and rights as set out in the Cairo Agenda of the International Conference on Population and Development (ICPD), addressing poverty diseases, in particular HIV/AIDS, tuberculosis and malaria.”\(^6\) The Regulation, as many other regulations and actions adopted by the Commission relative to “sexual and reproductive health and rights” (SRHR) have done, upholds as the definition of that term the definition established by the International Conference on Population and Development in Cairo in 1994, meaning that “SRHR” must be defined within ICPD’s. Therefore, one must examine the ICPD definition of “SRH” to ascertain the Commission’s legal definition.

The EU development policy in the field of sexual and reproductive health is based on the ‘Programme of Action’ of the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 and ‘ICPD +5 Key Actions’ for further implementation of the ICPD Programme of Action (1999). At its meeting on 23 November 2004, the General Affairs and External Relations Council adopted ‘Cairo/ICPD+10 Council Conclusions’ where it reiterated:

\(\)\(^5\) Art. 5,2 (b)(i)
“its full and broad support for the entire agenda of the International Conference on Population and Development (ICPD) and the key actions adopted at ICPD+5, as well as the need to achieve its mutually supportive goals (...)

and

“reaffirmed the agreement reached to shift towards a rights based approach, which puts the well-being and free choice of the individual at the centre of its concern, and the need for a strong EU leadership in the prompt implementation of the ICPD Program of action in the context of the Millennium Declaration, approved in September 2000.”

Moreover, sustained improvement of the health and well-being of the populations of developing countries is one of the major objectives of development. Improving reproductive and sexual health and protecting reproductive and sexual rights are important aspects of this objective. The word “improving” connotes the positive application of the regulation.  

B. ICPD Cairo 1994 Definition and International Treaties

The ICPD definition of “sexual and reproductive health,” as quoted in its entirety in note 8, neither mentions nor makes any allusion as to encompassing abortion, either medical or surgical, within the bounds of SRH. Indeed, it is a well-known fact that the issue of abortion was controversially discussed at the Conference and that, in its Programme of Action, the ICPD refrained from promoting abortion in the definition of SRH. The only time that abortion is mentioned, it is accompanied by strict limitations, explicitly stating that abortion was not a legitimate means of “family planning,” that it should only be available where already legal, and that it should not be a promoted course of action for women. Also, the definition specifically requires that any changes related to abortion law “can only be determined at the national or local level according to the national legislative process.”

Indeed, the European Commission itself declared that abortion was not included in the ICPD definition of SRH:

“The term ‘reproductive health’ was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development. All Member States of the Union endorsed the Programme of Action adopted at


1 Report of the International Conference on Population and Development, Cairo, U.N., ch. VII, ¶ 3. Sept. 13, 1994, Sales No. E.95.XIII.18 (“Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth... All countries are called upon to strive to make reproductive health accessible through the primary health-care system to all individuals of appropriate age as soon as possible and no later than 2015. Such care should include, inter alia: family planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion as specified in paragraph 8.25; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counseling on human sexuality, reproductive health and responsible parenthood.”); Id. 8.25 (“In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion (defined in a footnote) as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.”).
Cairo. The Union has never adopted an alternative definition of ‘reproductive health’ to that given in the Programme of Action, which makes no reference to abortion.”

Likewise, the Council has at various occasions declared that abortion lay without the reaches of the definition of SRH. Among the many statements in this regard, the answer given to two questions asked by Members of the European Parliament at Question Time on 4 December 2003 was of particular significance. This answer was formulated as follows:

“The European Community’s development policy with regard to sexual and reproductive health is based on the action programme of the UN International Conference on Population and Development held in Cairo in 1994 and on the key measures, known as ‘Cairo + 5’, adopted in 1999 by the UN XXI General Assembly. Those programmes and key measures stipulate that reproductive health should cover: (...) prevention of abortions performed under dangerous conditions and appropriate treatment for complications caused by such abortions; treatment of infections of the reproductive organs, of sexually transmitted diseases and of other conditions affecting reproductive health…”

One MEP then asked a follow-up question:

“Does the term ‘reproductive health’ include the promotion of abortion, yes or no?”

The representative of the Council Presidency answered:

“No.”

It seems thus clear, and indeed both the Council and the Commission officially agree with the statement, that the ICPD definition of “sexual and reproductive health” was constructed to exclude abortion from its reaches.

C. Abortion Cannot Logically Be Included in the ICPD Definition

As abortion is not explicitly included in the ICPD definition of “sexual and reproductive rights,” some NGOs and Committees for UN Treaties, for example the Committee on the Elimination of Discrimination against Women (CEDAW), have argued that abortion must be implicitly included in the term “sexual and reproductive health”. This argument is ill-founded. In order for a service to be implicitly included in the term “sexual and reproductive health”, it must be included in the plain meaning of the words actually enacted, or it must be essential in order to achieve the delineated purpose of the phrase. Neither is the case for the ICPD Programme of Action.

First, abortion certainly does not fall within the plain meaning of the term “SRH,” nor do the actions of the signatories give that implication. The plain meaning of “SRH” includes the physical health of a person’s sexual organs and that person’s capacity to procreate. Even taking into account that the

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The purpose of “sexual health” is defined as “the enhancement of life and personal relations,” the plain meaning might possibly include pleasurable sexual intercourse; however, on its face, access to abortion has nothing to do with the act of intercourse, the pleasure that results, or the “enhancement of life and personal relations,” as all are possible while a woman is pregnant. Also, “reproductive health” on its face means that reproduction is occurring and is occurring in a healthy manner. Abortion terminates the process of reproduction. In plain meaning, abortion is antithetical to the “reproductive health” of the mother and, even more so, of the offspring that is eliminated.

Second, the signatories of the Programme of Action very clearly excluded abortion from “SRH.” The signatories mentioned abortion only in the negative, either that it was not part of “family planning” or that it should not be promoted on the international level. Indeed, as it was the overt goal of ICPD under the agreement to promote and win universal support for “sexual and reproductive health” on the international level, it was clear that that objective was only attainable if abortion was excluded from the meaning of “sexual and reproductive health.”

Third, abortion could only be considered as “implicitly included” in the concept of “SRH” if it were impossible to attain “SRH” without having recourse to abortion. But that is clearly not the case. Abortion is not an essential service that must be provided in order for the “SRH” of patients to be improved. A pleasurable and fulfilling sexual life is certainly attainable without abortion being available. Pregnancy does not diminish the ability to have intercourse or the pleasure experienced thereby. The only inhibition on sexual activity occurs after birth, but the same is also true after having an abortion as in both cases there is a requisite waiting period before resuming vaginal intercourse. Much more prohibitive to sexual health are those infirmities enumerated by the ICPD definition, such as sexually transmitted diseases and HIV/AIDS. Reproductive health, on the other hand, refers to the ability of a healthy mother to bring a healthy child into life through birth. The family planning aspect of this element, as delineated by the ICPD, does not include abortion, meaning that the ICPD seeks to encourage a mother’s ability to plan the timing and spacing of her offspring by using contraception but not to encourage the mother to terminate under the rubric of family planning the life of a child she has already conceived. The remainder of the services listed in ICPD’s definition refers to those health services that must be provided to bring and nurture a healthy baby into independent life. The implicit inclusion of abortion in this term is absurd on its face as an aborted baby cannot be a healthy baby.

Indeed, abortion is not only unnecessary for good “reproductive health,” but recent studies have shown abortion to be detrimental to the “reproductive health” and of the mother. Besides terminating the life of the child aborted, a large number of recent studies on abortion have shown that women who have had an abortion have a 35% increased risk of premature birth in subsequent pregnancies, and the risk increases further by 75% after a second abortion. A large number of studies in the past ten years have also shown that women who have had an abortion have an increased risk of breast cancer. Not only physical health is at stake. In 2011 British Journal of Psychiatry published a report on the effects of abortion on mental health.

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published the findings of one of the largest studies of its kind on abortion - "Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009" - showing that almost 10% of all mental health problems are directly linked to abortion. Overall, when compared to all women who carried to term, the increased risk of experiencing mental health problems ranged from 55% to 138%.

Additionally, the denial of abortion does not automatically cause a high mortality rate as many nations prohibiting abortions – Chile, Ireland, and Poland among them – have some of the lowest maternal mortality rates in the world. It seems clear that abortion is not an essential element of “sexual and reproductive health”.

The argument that international law requires the provision of abortion under SRH is also unfounded. There exists no global UN treaty that includes the word “abortion” as a part of SRH, nor can a “right” to abortion be inferred from the plain meaning of any of the treaties. Indeed, no treaty even mentions the word “abortion.” Only one UN treaty, the Convention on the Rights of Persons with Disabilities, even mentions the term SRH. Even in that instance, when signing the treaty, fifteen nations made interpretive statements on the term SRH, noting that it did not include abortion, and no other nation contradicted that interpretation.

In October 2011 a group of 31 experts in international law, international relations, international organizations, public health, science/medicine and government. The signers include law professors, philosophers, Parliamentarians, Ambassadors, human rights lawyers, and delegates to the UN General Assembly provided an expert document (The San José Articles) that shows that there is no international right to abortion. No UN treaty makes abortion an international human right. Specifically, San José Article 5 reaffirms:

“There exists no right to abortion under international law, either by way of treaty obligation or under customary international law. No United Nations treaty can accurately be cited as establishing or recognizing a right to abortion.”

Additionally Article 6 states:

“The Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee) and other treaty monitoring bodies have directed governments to change their laws on abortion. These bodies have explicitly or implicitly interpreted the treaties to which they are subject as including a right to abortion. Treaty monitoring bodies have no authority, either under the treaties that created them or under general international law, to interpret these treaties in ways that create new state obligations or that alter the substance of the treaties. Accordingly, any such body that interprets a treaty to include a right to abortion acts beyond its authority and contrary to its mandate. Such ultra vires acts do not create any legal obligations for

states parties to the treaty, nor should states accept them as contributing to the formation of new customary international law.”

I.2. IPPF and MSI Definition of “Sexual and Reproductive Health”

Although the 1994 Cairo definition has been adopted by many other international organizations and agreements, including the World Health Organization and the Convention on the Elimination of Discrimination against Women, neither IPPF nor MSI have followed the international norm or indeed the European standard when formulating their definitions of “sexual and reproductive health.” Both organizations claim to work for and support “SRH,” but both explicitly include the provision of abortion and post-abortive care in the list of services they provide under that rubric.

Marie Stopes International in its “Global Impact Report 2010” describes specifically the following strategies:

1) Increasing access to both surgical and medical abortion where permitted and
2) Providing training to mid-level providers in medical abortion and manual vacuum aspiration techniques.

Marie Stopes International states in the report that over 99% of its impact occurred in developing countries of which over 50% was in South Asia. In the report it affirms its role as a world’s leading abortion provider:

“In 2010 “an estimated 1 million or more women accessed MSI services for a safe abortion or for treatment of complications relating to an unsafe abortion”.

IPPF is even bolder in its statement in the Annual Report 2007/2008 (the last one published on their website) when stating that:

“Access to safe legal abortion is a public health and human rights imperative”.

Specifically IPPF goal stipulates:

“A universal recognition of a woman’s right to choose and have access to safe abortion, and a reduction in the incidence of unsafe abortion.”

In 2007, the total number of abortion related services provided by Member Associations of IPPF were almost three times the number of services provided in 2005. The most common types of abortion-related services provided are post-abortion counselling, pre-abortion counselling, and induced surgical abortion.

21 Marie Stopes International- Notes to the financial statements for the year ended 31 December 2008
MSI’s and IPPF’s definitions stand in obvious conflict with the EU’s publicly stated understanding of SRH.

I.3. COMPETENCE OF THE EUROPEAN COMMISSION

The support of abortion as a part of foreign policy and the definition of when life begins are not the competence of the European Commission according to the principles of conferral and subsidiarity, the statements made by the Commission itself, and the requirement of consensus in the Council on foreign policy matters.

A. Principles of Conferral and Subsidiarity

In Article 5, paragraphs 2 and 3, of the Treaty on the European Union (TEU), the relationship between the Member States and the Union is defined in the following terms:

“2. Under the principle of conferral, the Union shall act only within the limits of the competences conferred upon it by the Member States in the Treaties to attain the objectives set out therein. Competences not conferred upon the Union in the Treaties remain with the Member States.

3. Under the principle of subsidiarity, in areas which do not fall within its exclusive competence, the Union shall act only if and insofar as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level.”

The competence of the Union is restricted to those competences that the Member States conferred upon it, and its exercise subject to the principle of subsidiarity. The Member States have certainly never conferred abortion policy to the Union, nor have they empowered the Union to incorporate abortion into its foreign policy. Not all Member States face the same demographic issues nor do they have the same moral values which they wish to export to the world, and for this reason abortion is deemed to be a policy issue falling within the exclusive competence of Member States.

B. Statements of the European Commission and the Council

The Commission has repeated on innumerable occasions that abortion is outside the competence of the EU and therefore remains the competence of each individual Member State. Of those statements, this report will only include a small selection of quotes that, in the given context, appear to be of particular significance.

First, in response to a question posed on March 26, 2007 regarding Latin American countries and their legislation on abortion, the Commission responded:

23 See Reply of the Commission, H-0239/07, April 26, 2007 (EC).
24 As asserted, there are innumerable quotes from various members or staff of the Commission at all levels asserting that the EU has no competency over abortion. Abortion is an oft debated topic in the EU and many questions are posed by Members of the European Parliament to the Commission regarding abortion policy both within the Community and in foreign affairs. The typical response is like those cited in the text.
“The Commission does not assume any positions in favor or against abortion, due to the fact that there is no community legislation in this respect.”

Second, when the Commission was asked yet again if the term “sexual and reproductive health” would in future and forthcoming regulations include abortion or population control, the Commission responded:

“(The Commission) does not provide incentives to encourage sterilization or abortion in developing countries.”

Both quotations show that the EU’s lack of competence for policy related to abortion affects not only situations where the domestic policy of Member States would be concerned, but also prohibits the EU from assuming any positions in favor of or in opposition to abortion in a foreign policy context.

Finally, in a 2011 letter written on the behalf of Vice President of the Commission Viviane Reding (concerning the Commissioner’s statement that Hungary’s using of EU funds to finance a publicity campaign to persuade women that, in case of an unwanted pregnancy, they should let their child live and release it for adoption, rather than having abortion), her Head of Cabinet reaffirmed this position by stating:

“I would like to underline the fact that the EU has no competence regarding abortion. This means that the EU cannot promote or condemn abortion; that is why the Commission considers that the use of EU money for an anti-abortion campaign is not in line with EU competence.”

Likewise, the Council has at various occasions declared that abortion lies outside the competence of the EU. When posed a written question by Emilio Menéndez del Valle regarding the “right to abortion” in Latin America, the Council responded by declaring:

“Concerning the right to abortion, the Council would inform the Honorable Member that the issue of abortion from a legal point of view falls under the competence of the individual Member States.”

Logically, it follows that the use of EU money to promote or perform abortions would also not be in line with the EU competence.

It seems clear both the Commission and the Council have publicly declared that abortion lies without EU competence.

C. Lack of Consensus on a Matter of Foreign Policy

The provision of abortion through development aid is a matter of Common Foreign and Security Policy (CFSP). Article 239 of the Treaty on the Functioning of the European Union (TFEU) requires
unanimity from the Member States in the Council in order for the European Union to pursue a particular foreign policy as the Common Foreign and Security Policy (CFSP). Each Member State remains free to independently pursue its own foreign policy, but the Union’s foreign policy is restricted to the areas on which the European Council can reach consensus.

The Council has not reached a consensus on funding abortion services via development aid as a part of foreign policy. In fact, this remains one of the most contested issues within the organs on the Community level. At current, there are several Member States that directly contribute from their national budgets to organizations that openly administer abortions abroad as part of their services, among them Denmark, Sweden and the United Kingdom. On the other hand, there are several that have adopted strong national legislation promoting the protection of the life of a fetus, refraining from funding abortion services, with Poland, Ireland, and Malta among them. The current foreign policy landscape is divided, certainly not unanimous.

As there is no unanimity among Member States on policies related to abortion, the EU’s development policy would risk being turned into a highly controversial matter if the European Commission used money from its development aid budget, taxed inter alia from Member States where abortion is illegal and from citizens who consider abortion immoral, and committed it to NGOs who use it to provide abortions. The allocation of funds is policy put into action, and the Commission inherently takes a stance on a policy outside of its competence if it funds NGOs perpetrating abortion throughout the world. It was for this reason, as repeated by Vice President Reding in the letter quoted above, that the Commission abruptly rescinded its support for an information campaign in Hungary which had displayed a poster advocating adoption rather than abortion. If an organization were discovered to be using Commission funding to perpetrate abortions abroad, it would only be logical that the Commission would take a position consistent with the strong statement made regarding the Hungarian project. The fact that abortion is legal in a country benefiting from development aid does not make it legal for the Commission to fund and promote abortion in that country just as the legality of the anti-abortion campaign in Hungary did not make it legal for the Commission to fund that campaign in Hungary.

I.4. Questionable Partnerships between EU and MSI and IPPF

Two of the major beneficiaries EU funds allocated to SRH have been and continue to be International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI). MSI received at least some €3.5 million in support for its new projects in 2007 and more than €9 million for the years 2005 and 2009. This is a minimum figure, as this sum was calculated on the basis of the MSI reports to

29 The Treaty on European Union, July 29, 1992, 1993 O.J. (C 191) (recognizing the existence of a European Community development policy and providing it a legal foundation by defining the common objectives of the Community’s external assistance and by referring explicitly to the need for enhancing coordination, complementarity and policy coherence).
30 Consolidated Version of the Treaty on the Functioning of the European Union art. 239, § 2, Sep. 5, 2008, 2008 O.J. (C 115) 47 (hereinafter TFEU) (“The common foreign and security policy is subject to specific rules and procedures. It shall be defined and implemented by the European Council and the Council acting unanimously, except where the Treaties provide otherwise.”).
32 These totals were calculated based upon the annual project reports submitted to the European Commission from MSI. These reports were made available via a document request under Commission Regulation 1049/01, 2001 O.J (L145) 43 (EC). The description of the action for each of MSI’s funded projects necessarily includes the amount of support granted to the project by the Commission. This figure is a simple sum of all of the support listed in the reports. This, however, is a minimum figure because, as explained below, the Commission withheld some of the reports for “commercial interests” reasons. Therefore, it is possible that the European Commission is involved in even more projects of MSI and IPPF than were determined through the Document Request submitted to the Commission under the authority of Commission Regulation 1049/01.
the Commission that are discussed in detail below. However, the European Commission appears to have financed many more MSI projects on “SRH” but refused to disclose information on those projects, citing MSI’s “commercial interests” as a justification for this refusal. This reaction of the European Commission is surprising given that Marie Stopes International is not a commercial entity but a UK based charity registered by Charity Commission for England and Wales under the number 265543 with an income of £129,86 million in 2010.33

A list of relevant documents in the possession of the European Commission is included in Appendix1. Marie Stopes International in its financial statements reports the following ‘grant income’ from the European Union.

It amounts to £15.8 million for the years 2005 and 2009 which is more than double of the base of the MSI reports made available by the European Commission.

<table>
<thead>
<tr>
<th>Year</th>
<th>Grant Income (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>707,000</td>
</tr>
<tr>
<td>2009</td>
<td>5,573,000</td>
</tr>
<tr>
<td>2008</td>
<td>4,540,000</td>
</tr>
<tr>
<td>2007</td>
<td>2,551,000</td>
</tr>
<tr>
<td>2006</td>
<td>1,365,000</td>
</tr>
<tr>
<td>2005</td>
<td>1,822,000</td>
</tr>
</tbody>
</table>

Information: Marie Stopes International Financial Statements34

IPPF has also received considerable funding, but an accurate figure on the total amount is impossible to provide, given that only four reports for IPPF were disclosed by the Commission (see below). In the projects discussed below, awards to both IPPF and MSI for individual projects ranged from €750,000 to €2.5 million.

33 http://www.charity-commission.gov.uk
34 http://www.charity-commission.gov.uk
The clear and unambiguous conclusion drawn from the evidence presented by the following reports is that both IPPF and MSI are openly perpetrating abortions on projects receiving European Commission funding. A Document Request to the European Commission for all documents and communications between the Commission and IPPF or MSI resulted in the disclosure of multiple reports from both organizations. Those reports provide direct evidence to the fact that MSI and IPPF are perpetrating medical and surgical abortions in multiple countries throughout the world, including through “SRH” programs funded by the EU. Reports submitted to the European Commission by both organizations clearly indicate that these activities are part of the programs funded by the EU, but the Commission has not rescinded its funding from either. The following is first a description of the document request process in relation to this particular report and second a demonstration of the contents of those documents.

II.1. Document Request from the European Commission

In accordance with the transparency requirements of the European Union, a request was made for all correspondence between the Commission and MSI, IPPF, and the Center for Reproductive Rights (CRR) from 2005 to 2010. This request was to include all correspondences, including funding requests, grants, and email correspondences.

After a lengthy process regarding the disclosure of the documents, some documents from IPPF and MSI were supplied by the Commission. Most of the documents themselves were complete, but sev-

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36 The document request and the subsequent email correspondences between the Commission and the requesting party endured for a period of five months before any documents were supplied. The Commission would promise the documents in 15 days, and after both missing the deadline and receiving another
eral were clearly missing sections and attachments. In addition, some documents were withheld under the exception of Article 4(2) of Regulation 1049/2001. (See lengthy list in Appendix 1). Also, there were no reports for numerous projects that received Commission funding during the specified time period, nor was there any notification that the reports from these projects were legally withheld from disclosure. In light of these reasons, the search results seem rather rudimentary and cursory. It is only possible to analyze a limited number of documents; yet, even those documents suffice to reveal the use of EU budgets to fund abortions in developing countries. However, it would be necessary for the Commission to provide full access to all relevant documents in order to identify the full scale of those activities and the total amount of EU funds involved.

II.2. MSI Reports to the European Commission on Funded Projects

The majority of the reports that were disclosed, with the most pertinent analyzed below, consisted of at least one report for each annual year and also another document listing the amount of funding requested. The Commission did not disclose all projects in all cases, and indeed some projects were missing reports for entire calendar years, but this list of documents is the most discernable pattern of exchange between NGO and the Commission for each project. Some requests, such as one application from MSI for the Bangladesh Project 112309, are actually labeled as a “Block Grant Request.” This raises the question whether in those cases the Commission is extending money to these organizations for any and all purposes, without requesting them to use the funds provided for any particular project. The findings are as follows.

a. Cambodia Project ONG – PVD/2006/119-302

MSI reported in an interim report from its Cambodia Project, a project that began in 2006, that MSI-run clinics in four provinces had succeeded in performing some 6,807 abortions. While it is true that the abortion laws of Cambodia allow a doctor to administer an abortion until the twelfth week of pregnancy, at which point an abortion is stipulated upon the health of the mother or a genetic defect of the fetus, MSI is taking a front-runner approach, actually administering the abortions itself in its own clinics. Again, the Commission’s competence to fund abortion abroad seems highly questionable, regardless of whether or not the abortion is legal in the project country.

b. South Africa Project - Sante/2006/104 – 975

Although the meaning of both terms is not completely clear, the logical conclusion is that MSI provided multiple methods of induced abortion in South Africa, particularly as abortion on demand is legal according to South African law. At minimum, the report should give the Commission a very strong reason to suspect MSI is perpetrated abortions as a part of its South African project.
Grant beneficiary - Marie Stopes South Africa (MSSA) as it states in the Interim Report in August 2010 “continues to play a key role in supporting the DoH (Department of Health) on policy and technical issues around abortion. Medical staff received training (...) on the provision of both medical and surgical abortion.”

c. Bangladesh Project - ONG-PVD/BD/2005/112170

This project began in 2005 and received some €743,877 in support from the European Commission. In the final report for the project, MSI reported that it had reached 93% of its goal for the number of “menstrual regulations” it had hoped to perform as it had successfully provided “menstrual regulation[s]” to some 12,278 patients.44 (See Appendix 4). Abortion remains illegal in Bangladesh except to save the life of the mother; however, many “SRH” providers have been performing “menstrual regulations” for years, MSI among them.

What is meant by “menstrual regulation”? MSI never defines the term in its reports, but a further investigation on the meaning of the term is undertaken in Section IV below.

d. Papua New Guinea Project ONG-PVD/2005/113-681

The project in Papua New Guinea began in 2005 and was supported by €730,000 from the European Commission, a sum representing 85% of the total costs of the project.45 As a part of the services provided in Papua New Guinea, a country where abortion is legal only to save the life of the mother,46 MSI reported that it was providing training to individuals to perform induced, surgical abortions. MSI’s precise language is as follows: “Recruitment, Training and Maintenance of Reproductive Health Clinic (RHC) teams”: “This consisted of in-depth train-the-trainer training in...medical procedures such as manual vacuum aspiration ... and emergency contraception.”47 (See Appendix 5) Even if the abortions were not actually being performed in MSI’s own clinics or were being done truly only when the life of a mother was at stake, MSI was unabashedly training individuals in regards to the proper techniques of administering abortions through manual vacuum aspiration. (See Appendix 7 and 8). Also, emergency contraception is undefined and likely refers to the provision of abortifacients to patients.

II.3. IPPF Reports to the European Commission on Funded Projects

a. Bolivia, Guatemala, and Peru Project 100-428 (Budget line 21.020703)

During the course of this project, a project began in 2005 to which the EU provided more than €1,700,000 in financial support, IPPF and its member organizations distributed 1,102 “emergency contraception units.” 48 IPPF never defined what were the precise contents of these units and what it meant by “emergency contraception”, but the terms likely include such abortifacients as progestin, mifepristone, and misoprostol pills. All three of these countries have strict abortion laws, outlawing

43 Interim Narrative Report Marie Stopes International / Marie Stopes South Africa AUGUST 2010 pt 3, p.22
44 Marie Stopes Int’l, Improved Access to and Utilization of Affordable, Quality Sexual Reproductive Health (SRH) Services and Information among Underserved and Low Income Women, Men and Young People of the Hard to Reach Areas of Shariatpur, Bhola, and Barisal Districts in Bangladesh, Annual Report, Commis- sion Contract 112170, 8 (EC).
45 Id.
abortions except for health reasons. 49 However, all of them, to different extents, also require evidence of the abortion to be presented in order to prosecute. 50 The evidence is simply impossible to recover from the heavy menstrual bleeding which abortifacients cause in order to induce an abortion, making prosecution de facto impossible. The reports submitted by IPPF do not provide any evidence that the “emergency contraception” it provided was in line with the applicable laws of the project countries; in particular, it is not clear what kind of “health reasons” would warrant the use of those abortion methods described by IPPF as “emergency contraception.”

b. Bangladesh Project - SANTE-2004-080-420

During the course of its Bangladesh project, a project begun in 2005 with €1.48 million of funding from the Commission, IPPF reported that it also freely provided “menstrual regulation” services to many of the clients who came to its clinics seeking assistance. 51 (See Appendix 6). As described in further detail below, this procedure is performed on a woman suspected to be pregnant with a manual vacuum aspirator, the instrument of choice for modern induced abortions throughout the world. Indeed Family Planning Association of Bangladesh (FPAB), one of the member organizations that worked with IPPF and was also funded by the Commission, included on its website that one of the objectives of the project was to “increase access to safe abortion for 80% of the beneficiaries of the program operation areas of FPA Bangladesh.” 52 Whether FPAB rightfully included “menstrual regulation” as abortion or had another service in mind when publicizing its objectives, perhaps a service not included in the report given by IPPF to the European Commission, is unclear.

II.4. “Menstrual Regulation”

a. Definition and Preponderance

The meaning of “menstrual regulation”, although initially unclear, can be quickly elucidated through reviews of IPPF’s and MSI’s websites. According to IPPF, a “menstrual regulation” is a process that empties a uterus, in which an embryo has likely already implanted, by use of a manual vacuum aspirator. 53 (See Appendix 7). In the eyes of IPPF and MSI, this differs from a surgical abortion because it is performed intentionally before the official administration of a pregnancy test, meaning the pregnancy is never verified. 54

The actual process of a “menstrual regulation” is completed when an administrator, usually a doctor or midwife but also at times a family member of the woman, inserts the cannula of a manual vacuum aspirator through the dilated cervix of the woman and pulls back on the piston in order to create high-powered suction inside the uterus. (See Appendix 8). The suction created is so violent that it normally empties the uterus of all of its contents including the fetus, placenta, and uterine lining. Typically, before 12 weeks, the fetus is sufficiently soft and the suction sufficiently violent as to completely dismember and deconstruct the fetus, enabling it to pass through the very narrow cannula, leaving only a mass of unidentifiable, bloody tissue in the piston. (See Appendix 9. Warning:

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49 See e.g., World Abortion Policies 2011, supra note 36.
50 Id.
54 Id.
graphic nature). This is the same process that is termed a “surgical abortion” by the medical field except that a “menstrual regulation” is performed on a woman who “suspects” rather than “knows” she is pregnant, the latter woman having been informed of the pregnancy via a pregnancy test.

The Guttmacher Institute estimates that “menstrual regulations” account for more than half of all abortions in Bangladesh,55 and that more than 730,000 abortions occur annually in the country.56 According to MSI’s own website, MSI performs more than 50,000 “Menstrual Regulations” every year,57 and many of those, as this report shows, were administered using Commission funding.

Obviously, the Guttmacher Institute does not hesitate to count “menstrual regulations” as abortions. More remarkably, MSI is also attuning to equating its “menstrual regulation” services to abortion. In one table on its website, MSI compared the rate of abortion provided in 8 recipient countries (see Appendix 10). Bangladesh was the second of the eight, showing that MSI provided a steadily increasing percentage of the abortions in the country, reaching 15% in 2010. A small asterisk after the name of the country clarified that MSI had tabulated “menstrual regulations” in Bangladesh but “abortions” in every other country. If MSI does not equate abortions and menstrual regulations, the inclusion of Bangladesh in the table would be inappropriate.

Moreover, Population Council’s report entitled “Menstrual Regulation Impact on reproductive Health in Bangladesh - A literature Review”58 presents clearly the history of the MR (menstrual regulation) in Bangladesh:

“The first five year plan of the government (1973-78) observed the following regarding abortion: “Legalization of abortion has been known as probably the best and most effective method for control of population growth. It should be seriously considered how this method can be adopted to control the population growth in Bangladesh.” Using this premise, the government cautiously began its MR program in 1974 in selected urban clinics. The clear objective was “birth control”. While Menstrual Regulation (MR) was not positioned as a family planning method, it was used as a back-up to a contraceptive failure. In 1978, the Pathfinder Fund (with USAID funds) began a training and service program for MR in seven medical colleges and two government district hospitals. This was the start of what was to become the Menstrual Regulation Training and Services Program (MRTSP).

Today most MRs are provided through government service points and providers, though a limited number of NGOs are also involved in service provision. Support for the MR program is provided by Swedish aid (SIDA), with technical assistance from the International Women’s Health Coalition (IWHC). The majority of MRs reported to the government are performed in government or one of three NGO service points: the Bangladesh Association for the Prevention of Septic Abortion (BAPSA); the Bangladesh Women’s Health Coalition (BWHC), and the Menstrual Regulation Training and Services Program (MRTSP) (Ross and Chowdhury, 1997). In addition, MRs are provided in NGO clinics: BRAC, Marie Stopes Clinic Society and others funded by BPHC. However, SIDA voiced a concern that

55 Id.
"These NGOs do not necessarily report their performance to the government and it is difficult to assess the total quantity of their services" (SIDA, 1996). (...)The researchers’ suggestion that family planning and safe abortion services like MR, had to work together to save the lives of mothers corresponded to international thinking of the day. Potts et al. (1977) warned that: "Organized family planning services have an important contribution to make in accelerating the switch from induced abortion to contraceptive practice but two limitations have to be recognized. First, the reversible methods of contraception at present available are not sufficiently predictable, even when well and consistently used, to control fertility over a lifetime and meet the goals of family size set in modern industrialized nations, and therefore in the foreseeable future the resort to abortion cannot be eliminated."^59

b. Legality of ‘Menstrual Regulation’

In Bangladesh, abortion is still governed by the Penal Code of 1860 and is clearly illegal except to save the life of the mother^60. Rather than challenging this law by trying to make abortion universally legal, Bangladesh has chosen to provide first trimester MR. "This practice has its legal basis in an interpretation of the Bangladesh Institute of Law and International Affairs that the procedure was ‘an interim method to establish nonpregnancy’ thereby effectively removing it from the purview of the Penal Code when pregnancy is not established."^61 Furthermore, “MR is a means of ensuring that a woman at risk of pregnancy is not actually pregnant. As such, MR is not affected by laws restricting abortion, and government officials at the highest levels recognize MR as a life-saving intervention and an important health service for women"^62

MR is often praised for its usefulness in circumventing the law. Even though a 10-week fetus is readily recognizable as human (see Appendix 11), the process of sucking it through the cannula either so disfigures the fetus as to be unrecognizable or it is quickly and quietly discarded (see again Appendix 10, Warning: graphic nature). That means that in countries like Bangladesh where the Penal Code requires physical evidence that an abortion has occurred, the perpetrators can avoid punishment by making it virtually impossible for the prosecutor to obtain proof. Additionally, earlier in the pregnancy often the fetus is so small that it would require a microscopic inspection of the bloody material in order to conclusively prove a pregnancy.

Indeed Malcolm Potts, the creator of the manual vacuum aspirator, praised “menstrual regulation” by declaring, “[T]here will be no proof of pregnancy unless the tissue removed from the uterus is subjected to microscopic examination. The point is of crucial importance in countries where abortion is illegal."^64 Additionally, in A Clinician’s Guide to Medical and Surgical Abortion, the authors praised “menstrual regulation” as a crucial step in order to circumvent pro-life laws, citing Bangladesh as an example of a country where precisely such circumvention was occurring.65

[^60]: id
[^61]: Id
[^62]: Id
Even IPPF acknowledged in a number of its own reports that it is administering “menstrual regulations” at many of its locations in order to circumvent national laws.66 First, in addition to its activities in Bangladesh, IPPF wrote in a report on the role “menstrual regulation” plays in allowing IPPF to evade criminal laws against abortion in South American countries. The report read (translated from Spanish):

“However, in other juridical systems, like those used in the greater part of South America, the proof of pregnancy is a prerequisite in order to establish a cause for abortion. In this situation, it would be much easier to defend the practice of menstrual regulation as a legal procedure for women that ask for help shortly after observing a late period and before pregnancy can be clinically proven.”67

Second, on Commission-funded Project 10867 in Kenya, a country in which abortion is illegal except to preserve the health of the mother,68 IPPF approved the introduction of manual vacuum aspiration machines, first to complete illegal abortions, and then to perform abortions.69 In an IPPF publication, when discussing whether to wait to administer “menstrual regulation” with the manual vacuum aspirators until the Kenyan laws would legalize such a procedure, the report advocated, “Let us not wait for the law to change, let us do what we can even before the law changes.”70

Third, abortion is also illegal in Indonesia, but, according to IPPF, "The Indonesian Planned Parenthood Association (IPPA) has introduced menstrual regulation (MR) services. Although initially only used in cases of contraceptive failure, MR is now being offered for wider indications.”71 IPPA, a member organization of IPPF, now runs 15 clinics in Indonesia that perform thousands of MR abortions annually in contradiction to and clear defiance of the national law.

The very purpose of the “menstrual regulation” procedure is thus to circumvent the law and offer abortion in countries where abortion is illegal.

II.5. Conclusions Drawn from the Reports

Both MSI and IPPF are perpetrating abortion in foreign countries while receiving Commission money intended to aid development in third-world countries. This, in addition to the inclusion of abortion and certainly the inclusion of “menstrual regulation” in both IPPF’s and MSI’s definitions of “sexual and reproductive health,” lead to the conclusion that two NGOs receiving a considerable amount of funding to assist with development are using those funds to finance abortion throughout the world.

Based upon the reports disclosed, the conclusions seem clear. The reports give the strong indication that MSI and IPPF are either perpetrating abortions or training and enabling others to perpetrate them on Commission-funded projects – MSI in Cambodia, South Africa, Bangladesh, and Papua New Guinea and IPPF in Bolivia, Peru, Guatemala, and Bangladesh.

69 Id.
70 Khama Rogo, Int’l Planned Parenthood Fed’n, as quoted in Abortion for All, supra.
III. CONCLUSION

The European Commission, as established by the principles of conferral and subsidiarity, by the position assumed by the Commission itself, and by the requirement of unanimity on foreign policy matters, does not appear to have the legal authority to fund abortions. Still, it seems as though it is doing so under the rubric “sexual and reproductive health” as part of the Health section of the Development Cooperation Instrument. It also seems that the Commission cannot legally award grants to organizations providing “SRH” services if the Commission is unable to prevent the funding of abortion by its contributions. If the Commission is awarding such grants and the funds are being used to perpetrate abortion, as appears to be the case, the Commission would be forcing Member States to pay for abortions. Even if some Member States would consent to such a decision of the Commission, all Member States within the Council have not done so. While there is wide consensus among Member States as well as in society that the EU should provide aid to developing countries, there is no consensus that this aid should include the provision of abortions. Indeed, one is tempted to wonder whether in the current situation the EU’s development policy is not “fighting the poor” rather than “fighting poverty”, or whether development aid should not be directed at providing food, drinking water, health, and education, to children in need, rather than reducing their numbers through abortion.
The following questions then arise:

✓ Is the Commission aware of the services IPPF and MSI are providing with Commission funds – especially Menstrual Regulation, and likewise is it aware of the contents of the reports cited above?
✓ What measures is the Commission taking to prevent the allocation of funds to projects that include abortion or the use of funds to administer abortions?
✓ Where, how, and why might measures taken by the Commission be failing that intend to ensure that SRH programmes are in line with EU law and thus don’t include the supply of abortion?
✓ Does the Commission see a conflict between the legal definition of “sexual and reproductive health” and the allocation of EU funds to organizations such as IPPF and MSI?
✓ Does the Commission intend to continue allocating funds to projects carried out by IPPF or MSI?
✓ Given the ambiguity of the term “sexual and reproductive health”, is the Commission of the opinion that it is reasonable to continue to use this term?
✓ Given the striking conflict between EU’s prohibition to promote or fund abortion and abortion provision being at the core of IPPF’s and MSI’s strategy, would the Commission agree that it would be wiser and safer to allocate the available project funds to organizations that are fully in line with and respect EU’s definition of “sexual and reproductive health”?
✓ Can the Commission explain why there are such big discrepancies between the amounts of EU funds listed in the reports of IPPF and MSI to the Commission and the numbers listed by EuroMapping?
IV. Addendum on European Union Policy and Financial Instruments

A. EU Policy Instruments furthering “Sexual and Reproductive Health” in The World

The development work on the European Union is guided by the ‘European Consensus on Development’ \(^{72}\). It states specifically:

94. The MDGs cannot be attained without progress in achieving the goal of universal sexual and reproductive health and rights as set out in the ICPD Cairo Agenda.

However, a common vision \(^{73}\), shared by both the EU and Member States, affirms that the fundamental goal of EU development cooperation is the eradication of poverty in the context of sustainable development, including pursuit of the Millennium Development Goals (MDGs).

The EU then uses a ‘Policy Coherence for Development’ \(^{74}\) (PCD) approach to ensure that other external policies do not have a negative impact on development work. The EU tends to use PCD as the overall Union approach by establishing a policy framework to better harness other policies and non-ODA financial flows for development objectives.

The EU development policy in the field of sexual and reproductive health is based on the ‘Programme of Action’ of the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 and ‘ICPD +5 key actions for further implementation of the ICPD Programme of Action’ (1999). At its meeting on 23 November 2004, the General Affairs and External Relations Council adopted ‘Cairo/ICPD+10 Council Conclusions’ where it reiterated

“its full and broad support for the entire agenda of the International Conference on Population and Development (ICPD) and the key actions adopted at ICPD+5, as well as the need to achieve its mutually supportive goals” and “reaffirmed the agreement reached to shift towards a rights based approach, which puts the well-being and free choice of the individual at the centre of its concern, and the need for a strong EU leadership in the prompt implementation of the ICPD Program of action in the context of the Millennium Declaration, approved in September 2000.”

The EU policy also reflects the specific targets set in the ‘Millennium Development Goals’ (MDGs) in September 2000. In relation to the Millennium Development Goals and in the run-up to the MDG Summit in 2010, the European Commission produced a Communication entitled ‘A Twelve-Point EU Action Plan in Support of the MDGs’ which outlines how the Commission will support the achievement of the MDGs in the framework of its ‘Europe 2020 Strategy’ in the years ahead. The ‘Agenda for Change’ proposed by European Commission \(^{75}\) make it also clear that tight budgetary times “make it more critical to ensure that aid is spent effectively, delivers the best possible results

\(^{72}\) 2006/C 46/01 Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy: ‘The European Consensus’

\(^{73}\) 2006/C 46/01

\(^{74}\) COM(2009) 458

\(^{75}\) COM (2011) 637
and is used to leverage further financing for development”. With regards to policy priorities of the programmes of aid for population policies and reproductive health care the buck stops with the Directorate General for Development and Cooperation and EuropeAid (DG DEVCO) with its responsible Commissioner Andris Piebalgs. In the new organizational chart of DG DEVCO, a new Directorate for Human and Society Development (DEVCO Section D) has been created, with a thematic unit in charge of Education, Health, Research and Culture (D4). SRH experts are based in this unit. Also DG DEVCO Geographic Directorates have health experts in charge of monitoring health programmes in the EU’s Geographical Programmes. Moreover, Commissioner Catherine Ashton acts in her double role as “High Representative of the Union of Foreign Affairs and Security” Policy heading the European External Action Service (EEAS) and as a Vice-President of the Commission. The European External Action Service (EEAS) is a European Union department that was established following the entry into force of the Treaty of Lisbon on 1 December 2009. It was formally launched on 1 December 2010 and serves as a foreign ministry and diplomatic corps for the EU, implementing the EU’s Common Foreign and Security Policy and other areas of the EU’s external representation. The EEAS has six geographical departments headed by managing directors. EEAS supports EU Sexual and Reproductive Health programmes, such as e.g. a project led by “Catholics for the Right to Decide”.

B. Financial instruments

The legal basis for the commitment of such funds is a Regulation establishing a financial ‘Development Co-operation Instrument’ (DCI) which replaces a range of geographic and thematic instruments created over time and as needs arose. Its aim is to improve development cooperation. The Regulation emphasizes that the Community’s development cooperation policy is guided by the Millennium Development Goals and that the ‘European Consensus on Development’ provides the general framework for action on development matters. It also reaffirms that the objectives of this policy are poverty reduction, sustainable economic and social development and the smooth and gradual integration of developing countries into the world economy. Sexual and Reproductive Health was placed under the DCI’s Thematic Programme “Investing in people” aiming to support actions in the area of human and social development, in particular: education, health, gender equality, social cohesion, employment, childhood and youth, as well as culture.

Based on Article 12 of the EU Regulation establishing the DCI, this is the only thematic programme which covers nearly all Millennium Development Goals. It states:

“The objective of Community assistance under the thematic programme “Investing in People” shall be to support actions in areas which directly affect people’s living standards and well-being defined below and focusing on the poorest and least developed countries and the most disadvantaged sections of the population.”

Article 12,2a Good health for all (ii) defines those actions as:

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76 No 1905/2006
“in line with the principles agreed at the ICPD and ICPD + 5, support actions to improve reproductive and sexual health in developing countries and to secure the right of women, men and adolescents to good reproductive and sexual health and provide financial assistance and appropriate expertise with a view to promoting a holistic approach to, and the recognition of reproductive and sexual health and rights as defined in the ICPD Programme of Action, including safe motherhood and universal access to a comprehensive range of safe and reliable reproductive and sexual health care and services, supplies, education and information, including information on all kinds of family planning methods, including reducing maternal mortality and morbidity rates, with particular reference to the countries and populations where these are highest.”

The current DCI regulation expires on 31 December 2013. New challenges, together with the priorities set out in the Europe 2020 Strategy and the latest EU development policy, have prompted the Commission to make a proposal to review and adapt the DCI Regulation in line with the communication ‘A Budget For Europe 2020’ of 29 June 2011 and with the communication ‘Increasing the Impact of EU Development Policy: An Agenda for Change’ of 13 October 2011.

A Proposal for a new regulation of the European Parliament and of the Council establishing a financing instrument for development cooperation has been presented and is awaiting 1st reading in Parliament. The legal basis of the proposal is Article 209.1 TFEU (Treaty on the Functioning of the European Union).

C. Financial commitments of European Union’s Development Aid to “Sexual and Reproductive Health” policy

The EU remains collectively by far the world’s biggest donor, providing almost 56% of global assistance. EU’s Official Development Assistance (ODA) has almost doubled since the adoption of the MDGs, amounting to €49 billion in 2009. This brings about an increased responsibility towards the developing world. Therefore it is crucial to understand how the EU budgets are allocated and if they are spent in an efficient and goal-oriented manner.

The budget allocated under DCI for the period 2007-2013 is €16.9 billion. Among those, for 2007-2010 €300 million were allocated to the programme “Good Health For All”, which is part of DCI’s thematic programme “Investing in People”. This represents 55% of the total “Investing in People”-budget. For 2011-2013, this budget has been increased to 56% of the total “Investing in People”-budget, i.e. €280 million. This programme supports the improvement of Sexual and Reproductive Health in developing countries. In comparison education obtained only 12% under the same programme.

€86 million of the overall multi-annual (2007-2013) “Good health for all” budget is allocated to the “Implementation of the Cairo Agenda, including provision of Commodities and supporting civil society,” the vast majority of which has been and will be used to promote SHR services throughout the

77 2011/0406
Clearly, there is a large amount of funds available for the encouragement of development and specifically for the promotion of Sexual and Reproductive Health.

“Euromapping 2011” - a study financed by the European Commission under the project of “Euromapping – creating peer pressure among European NGOs decision makers, ODA officials and the media to increase funding for SRHR and development cooperation” – indicates the EU is the 4th largest donor (behind the USA, the Netherlands and the UK) to Reproductive Health with estimated 158.24 Million USD in 2009.  

In EU’s Multiannual Financial Framework (MFF) 2014-2020 the new thematic programme “Global public goods and challenges” will accommodate SRH under Human Development and Health. Article (iii) reads:

“(...) supporting specific initiatives especially at regional and global level, which strengthen health systems and help countries develop and implement sound, evidence-based national health policies, and in priority areas (e.g., maternal health and sexual and reproductive health and rights, access to family planning; global public goods and response to global health threats).”

Indicative financial allocation for the period 2014-2020 for Human Development is 20% or €1,26 million of total € 6.30 billion for “Global public goods and challenges”. At present, it has not been decided how much will be allocated for Health and for SRH specifically. Under the ‘Agenda for Change’ the European Commission proposes that at least 20% of EU aid should be spend on continued support for social inclusion and human development.
## V. APPENDICES

### Appendix 1: List of Documents Withheld by the Commission

**LIST OF DOCUMENTS CONCERNED BY THE REQUEST GESTDEM 2011/841**

<table>
<thead>
<tr>
<th>Doc. No.</th>
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<th>Type</th>
<th>Year</th>
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<th>Sender</th>
<th>Activity/Network</th>
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<td>Type</td>
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<td>16/10/2007</td>
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<td>16</td>
<td>INVITATION TO ADDRESS THE SAFE CONFERENCE ON 09/10/2007 IN BRUSSELS - FOLLOW UP</td>
<td>7/09/2007</td>
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<td>340440</td>
<td>HUBEL MICHAEL</td>
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**LIST OF DOCUMENTS CONCERNED BY THE REQUEST GESDTEM 2011/441**

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<td>LETTER - RECENT CONCERNS IN CROATIA REGARDING THE FAILURE TO ENSURE EVIDENCE-BASED PROGRAMMING IN CROATIAN EDUCATIONAL CURRICULA THAT WILL PROMOTE AND PROTECT THE HEALTH OF CROATIAN YOUTH</td>
<td>19/11/2007</td>
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<td>20/05/2008</td>
<td>A</td>
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<td>25/02/2008</td>
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<td>REMINDER: FINAL REPORT CONCERNING THE PROJECT N° 2003/39</td>
<td>17/04/2008</td>
<td>D</td>
<td>2008</td>
<td>519159</td>
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## LIST OF DOCUMENTS CONCERNED BY THE REQUEST GES DEM 2011/841

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<td>INVITATION - LAUNCH OF PROGRESS OF THE WORLD'S WOMEN - 29 APRIL</td>
<td>704/2009</td>
<td>A</td>
<td>2009</td>
<td>5889</td>
<td>MARES STOPES INTERNATIONAL</td>
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<td>6773</td>
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<td>PROJECT SAFE II AT151122 PUBLIC PROGRAMME ALONG WITH 14 ASSOCIATED PARTNERS FROM OUR NETWORK</td>
<td>22/10/2009</td>
<td>A</td>
<td>2009</td>
<td>17108</td>
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<td>16/02/2010</td>
<td>D</td>
<td>2010</td>
<td>1008</td>
<td>DE LA MATA ISABEL</td>
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<td>REFUSAL Article 4.2 (1st)</td>
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Article 4.1 (b) – protection of privacy and integrity of the individual
Article 4.2 1st indent – protection of the commercial interests of a natural or legal person
Appendix 2: MSI Cambodia Project 119302

Table 1: Overall Project Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Total</th>
</tr>
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<tr>
<td># client visits</td>
<td>27,883</td>
<td>27,994*</td>
<td>39,770</td>
<td>95,647</td>
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<tr>
<td>Safe abortion</td>
<td>1,642</td>
<td>1,844</td>
<td>3,321</td>
<td>6,807</td>
</tr>
<tr>
<td>IUD</td>
<td>303*</td>
<td>1,329</td>
<td>4,050</td>
<td>5,682</td>
</tr>
<tr>
<td>MSL</td>
<td>2,155*</td>
<td>1,330</td>
<td>3,524</td>
<td>7,009</td>
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<tr>
<td>Vasectomy</td>
<td>0</td>
<td>0</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>CYPs</td>
<td>32,210*</td>
<td>28,019*</td>
<td>75,315</td>
<td>135,544</td>
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</table>

* These figures are different from the figures in the evaluation report. This is either due to different sources of data collection or that the data in this report covers the full year of 2009, whereas the evaluation report includes actual data up to September 2010 only.


Appendix 3: MSI South Africa Project 104975

“MSSA are well above target in HIV VCT, and STI screening and management. MSSA is slightly below target for CYP services (family planning (FP) and termination of pregnancy (TOP)) and has achieved 70% of the target for overall client visits. This is primarily due to the way the services are counted: MSSA has only counted services that are directly funded by the EC through this project. So, all VCT services provided in MSSA’s 30 clinics are counted and presented in this report because VCT is directly funded by the EC in all 30 clinics. For FP and TOP services, only services provided in the six EC funded clinics are counted because these are the only FP and TOP services directly funded by the EC.”
<table>
<thead>
<tr>
<th>Service</th>
<th>08-Aug</th>
<th>08-Sep</th>
<th>08-Oct</th>
<th>08-Nov</th>
<th>08-Dec</th>
<th>09-Jan</th>
<th>09-Feb</th>
<th>09-Mar</th>
<th>09-Apr</th>
<th>Totals (Aug 08 to Apr 09)</th>
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<tbody>
<tr>
<td>Pap smears for cervical cancer</td>
<td>55</td>
<td>72</td>
<td>157</td>
<td>132</td>
<td>95</td>
<td>184</td>
<td>124</td>
<td>146</td>
<td>133</td>
<td>1098</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>90</td>
<td>73</td>
<td>144</td>
<td>137</td>
<td>172</td>
<td>223</td>
<td>241</td>
<td>217</td>
<td>227</td>
<td>1521</td>
</tr>
<tr>
<td>Distribution of male condoms</td>
<td>2624</td>
<td>2738</td>
<td>1118</td>
<td>4726</td>
<td>3687</td>
<td>5392</td>
<td>5124</td>
<td>4020</td>
<td>3528</td>
<td>32,957</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>66</td>
<td>120</td>
<td>146</td>
<td>124</td>
<td>166</td>
<td>213</td>
<td>287</td>
<td>331</td>
<td>239</td>
<td>1692</td>
</tr>
<tr>
<td>Termination of pregnancy</td>
<td>317</td>
<td>290</td>
<td>342</td>
<td>441</td>
<td>427</td>
<td>460</td>
<td>431</td>
<td>445</td>
<td>466</td>
<td>3619</td>
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<tr>
<td>Emergency Contraception</td>
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<td>8</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>8</td>
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<td>11</td>
<td>55</td>
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<tr>
<td>IUCD</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>12</td>
<td>18</td>
<td>40</td>
<td>67</td>
<td>152</td>
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<tr>
<td>Total services</td>
<td>3152</td>
<td>3304</td>
<td>1917</td>
<td>5568</td>
<td>4557</td>
<td>6487</td>
<td>6233</td>
<td>5208</td>
<td>4671</td>
<td>41,094</td>
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### Appendix 4: MSI Bangladesh Project 112170

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<th>Planned target/achievements (Mar '09 - Feb '10)</th>
<th>Progress/Issues</th>
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<td></td>
<td>13,152 clients to receive MR services by the end of the project</td>
<td>As of February 2010, a total of 12,278 clients received MR services since the start of the project which is around 93% of the overall project target.</td>
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<td></td>
<td>3,264 clients to receive MR services during the reporting year.</td>
<td>4,019 clients received MR services from 3 SRH centres during the reporting year, as compared to 3,245 during the previous reporting year.</td>
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</tbody>
</table>

Marie Stopes Int'l, *Improved Access to and Utilization of Affordable, Quality Sexual Reproductive Health (SRH) Services and Information among Underserved and Low Income Women, Men and Young People of the Hard to Reach Areas of Shariatpur, Bhola, and Barisal Districts in Bangladesh*, Annual Report, Commission Contract 112170, 8 (EC).

### Appendix 5: IPPF Bolivia, Peru, and Guatemala Project 100428

- 259,698 medical clinic services provided overall, 74% in sexual and reproductive health, 26% in other medical specialties
- 165,659 young people received medical clinic services
- 164,553 young people received educational services (including skills training and partner counselling)
- 712,273 male condoms distributed, 1,581 female condoms and 1,102 emergency contraception units distributed
- An average of 300 peer educators consistently participating in community activities
- The following institutional commitments were established:
  - Continue with advocacy and technical assistance for the development of public policies promoting capacity building and social mobilization target group, within the communities where the project operates;
  - Continue to provide subsidized services, with a focus on non-discrimination and specialized care for young people aimed at reducing risk and harm;
  - Incorporating youth participation as the core of the model;
  - Maintain educational work through the usual youth program of the organization and continue the strengthening of partnerships for referrals and reduced costs of intervention.

Appendix 6: IPPF Bangladesh Project 80420

1.8. Community education activities to disseminate accurate maternal health and SRH messages. Capacity building of 67 Community Development Centre Organisers

The project conducted a range of community education sessions to disseminate accurate SRH and safe motherhood messages. The quality of educational sessions was substantially improved with the introduction of BCC tools and availability of updated resource material related to sexual and reproductive health at community level.

A total of 21,173 SRH sessions were held. These sessions covered areas such as contraceptive choices including Emergency Contraceptive Pills (ECP), Menstrual Regulation (MR), adolescent health, maternal health, and nutrition, Reproductive Tract Infection (RTI), Sexually Transmitted Infection (STI) and HIV&AIDS. It is expected that the outcome of these sessions will have a snowball effect within the community, which will provide support to the women who are seeking safe motherhood services. It is important to note that the community has made substantial in-kind contributions for the implementation of project activities such as use of building, provision of refreshment, transportation and furniture. Generally there are two types of educational sessions organised by the project:

- SRH education session held with adolescent girls and boys, both in schools and out of school settings
- SRH education session for male and female adults. These sessions are attended by women of reproductive age (including pregnant women) and their families.

Appendix 7: Manual Vacuum Aspirator
Appendix 8: Process of Manual Vacuum Aspiration

A. A speculum is placed in the vagina, a tenaculum is clamped to the lip of the cervix and a cannula is inserted into the uterus.

Appendix 9: Illustration of the Difficulty in identifying a 10-week aborted fetus
Appendix 10: MSI Percentage of Abortions Provided in Selected Countries


Appendix 11: Feet of a 10-week aborted fetus