



## **FEMM's Contribution to the Right to Health for Women in the EU**

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## Preface

Thank you, Isabel Düsterhöft for your supervision.  
Anna and Gabrielle, many thanks for giving me this wonderful assignment.  
Thank you FEMM for making a big difference in the lives of many women.

A very special thanks goes to my best maatjie Albert.  
Your love, silliness, jokes and patience helped me to see everything in the right perspective.

Above all, a great thanks to the God of this universe.  
He inspires me to live wise and make the most of every opportunity.

I am a blessed woman

## Executive Summary

This summary provides an overview of research conducted on FEMM and its contribution to the right to health for women in the EU. FEMM is a non-governmental organisation operating in the field of women's health. Specifically, FEMM uses the indicators of the reproductive system, such as hormonal imbalances, as a starting point to determine and treat the overall health condition of women. Women's health in politics is often only understood in the context of fertility and family planning. This is a limited understanding of women's health. Therefore, this research paper explores how FEMM contributes to the right to health, and not only to women's health. The International Covenant for Economic, Social and Cultural Rights (ICESCR) defines health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations Human Rights, 1966, art.12). The paper also examines the EU's position on women's health, because of FEMM's plans to expand their programmes to Europe.

The paper looks into the legal framework and the pragmatic understanding of the right to health for women in the EU. First of all, human rights, including the right to health, are an obligation for states to abide by. Only states can sign and ratify human rights documents. Non-governmental organisations such as FEMM do not have a direct legal obligation to comply with the right to health. Secondly, the EU institutions have no absolute competence in public health. The decision-making relating to public health is in the hands of the EU Member States. FEMM should therefore target the individual Member States instead of the EU as a whole.

From a pragmatic view, there are a number of findings to highlight. Although FEMM cannot contribute to the right to health from a legal point of view, FEMM supports health principles and adhere to the requirements that are written as guidelines for states. These show means to reach the highest possible standard of health. FEMM provides available, accessible, acceptable and qualified health care to women. These are principles of the ICESCR. Secondly, FEMM provides and promotes health education, encourages individuals to take personal responsibility for their health and eliminates the causes of diseases. These are requirements of the European Social Charter. Thirdly, FEMM provides accessibility to preventive health care. These are Charter of Fundamental Rights of the European Union (EURCFR) requirements.

The legal framework, as shown in the literature review, shows that FEMM cannot contribute to the right to health, but the pragmatic analysis shows that FEMM could contribute to the right to health for women in the EU. It is recommended that FEMM use the health principles and requirements to attain the highest standard of health as a tool to show the individual EU Member States that they can contribute to improving women's health for all European women.

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## List of Abbreviations

ACA	Affordable Care Act
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms
ESC	European Social Charter
EU	European Union
EURCFR	Charter of Fundamental Rights of the European Union
FEMM	Fertility, Education and Medical Management
FWCW	Fourth World Conference on Women
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and development
NGO	Non-Governmental Organization
OHCHR	Office of the High Commissioner of Human Rights
TEU	Treaty on European Union
UDHR	Universal Declaration on Human Rights
UN	United Nations
USA	United States of America
WHO	World Health Organization

## Introduction

### Context of the Paper

In September 2015, the sustainable development goals drafted by the United Nations (UN), an intergovernmental organisation, were launched. The goals aim to end poverty, protect the planet, and ensure prosperity for everyone in the next 15 years (United Nations Department of Economic and Social Affairs). Also women's health is addressed; it is defined by maternity mortality, neonatal mortality, AIDS and access to sexual and reproductive health care services (United Nations Department of Economic and Social Affairs). The origin of the women's health goals are found in documents drafted after the Cairo Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform of Action at the Fourth World Conference on Women (FWCW). These documents define reproductive health by a satisfying safe sex life, the freedom to determine the amount and the spacing of their children, information on family planning methods and access to services to help women through safe pregnancies and childbirth (Programme of Action, 1994, art 7.2; Beijing Declaration and Platform for Action, 1995, p. 94). However, this paper, inspired by Weisman, sociologist and health services researcher at the University of Pennsylvania State University College of Medicine, defines women's health in a broader sense. Weisman states that "women's reproductive health and overall health are inextricably linked" (Weisman, 1997, p. 186). Therefore, this paper looks into women's health in the context of general health.

Meier, Associate Professor of Global Health Policy at the University of North Carolina, explains that health as a definition appeared for the first time in the World Health Organization (WHO) constitution of 1948. It was also the first time that health was defined not only by the absence of disease, but also by complete physical, mental and social wellbeing (Meier, 2010, p. 165). In 1966, the universal right to health was defined in the International Covenant on Economic, Social and Cultural Rights (ICESCR). It states that the right to health is "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations Human Rights, 1966, art.12). The ICESCR is ratified by states. That is to say, the primary obligation to protect and promote the right to health is a state's responsibility (World Health Organization [WHO], Office of the United Nations High Commissioner for Human Rights [OHCHR], 2008, p. 22).

The UN provides interpretations on human rights and monitors how states implement human rights. These tasks are executed by UN committees. Keller and Grover explain the structure of the UN in their book UN human rights treaty bodies. The UN has eight human rights



committees equivalent to the eight UN conventions. Each committee produces non-binding advice, comments and statement in the context of the convention that they monitor. The contributions of the committees provide guidelines to states. However, the UN committees do not have the power to keep the states legally accountable (Keller & Grover, 2012).

Besides states and the UN, also Non-Governmental Organisations (NGOs) shape and human rights. NGOs need to abide by the domestic law they operate under while they promote the universal right to health. However, NGOs can influence international health rights to enhance their goals provided that it does not conflict with domestic law (World Federation of Public Health Association, 1978, p. 4). FEMM, Fertility, Education and Medical management, is one of these NGOs. FEMM's main goal is to improve women's health by changing the way doctors and patients address women's care. FEMM achieves this through three key elements. Key element one focuses on fertility, women's hormonal health can be monitored through the reproductive system biomarkers. Key element two focuses on education. FEMM offers educational programmes to teach women about the functionality of their reproductive system and how to monitor their hormonal signs and patterns. The third and last key element of FEMM is medical management. Through FEMM's medical protocols, FEMM has the capacity to diagnose and treat underlying conditions of the symptoms women typically present for: acne, weight gain, migraines, depression, facial hair, irregular bleeding, pain, polycystic ovarian syndrome, etc., causes of infertility, thyroid dysfunction and menopausal symptoms. FEMM restores health by treating the underlying condition, not simply masking symptoms (FEMM health, 2013).

FEMM is an NGO based in the United States and it was founded in 2012. Its first medical health centre is based in Columbus Ohio. As of autumn 2015, three other health centres are slated to open. One office will be opened in New York; two other health centres will open in Louisiana. In addition to the health centres, FEMM provides three training programmes:

- For medical professionals towards the advanced treatment of women's reproductive health issues;
- For persons to become FEMM teachers;
- Health education classes for women.

These training sessions also take place in Europe. Currently, trainees from the United Kingdom, the Netherlands, Austria, France, Germany, Belgium, Denmark and Croatia are enrolled in the European training programme (FEMM, Personal communication, 2015).

On request of FEMM, this paper presents the conducted research on the right to health for women and the relation to FEMM. FEMM has the desire to educate and bring the best care to all women, as well as to European women. These two elements are combined together in the following research question:

### **How can FEMM contribute to the right to health for women in the EU?**

The main research question has been divided into two parts

1. Can FEMM contribute to the right to health for women in the EU?
2. How would FEMM contribute to the right to health for women in the EU?

Question one focuses on the legal ability of FEMM to contribute to the right to health for women in the EU. The second question leaves the legal obligations behind and focusses on the pragmatic side of the contribution to the right to health for women in the EU.

### **Structure of the Research**

The research addresses several sub topics to answer the research question as presented above. Figure 1 shows the general structure of the paper and the research approach taken. In the introduction, the research question has been presented. The introduction also provided the general context to the research question. It introduced a number of key topics, namely: women's health, the history of the right to health and the definition of the right to health, the UN and its committees, as well as the role of NGOs and specifically FEMM.

After the introduction comes the literature review. In this chapter the right to health and women's health receives attention. This is done through in depth research on the different international conventions and declarations. Also, the views of academics on these topics are presented. The literature review addresses the integration and implementation of the right to health and women's health at a United States of America (USA) and European Union (EU) level. This information establishes the foundation of the research.

Before the presentation of the findings, the methodology chapter explains how and why the findings were obtained through interviews. The findings chapter outlines the results of the interviews and presents the following topics: human dignity, the ideology of women's health, the current approach to women's health in the EU and the USA, and the presentation of the key elements of FEMM. Thereafter, in the analysis, the paper links the legal view with the pragmatic assessment on the right to health for women. The following topics are discussed: women's health and human rights, the EU health policy and the diversity of the EU, and FEMM and its legal duties.

Lastly, FEMMs contribution to the right to health has been assessed against human rights principles and requirements as mentioned in the literature section.

The outcome of the analysis leads to the final conclusion which is addressed in two parts namely: ‘can FEMM contribute to the right to health for women in the EU?’ and ‘how would FEMM contribute to the right to health for women in the EU?’. This ultimately leads into the answer of the main research question. Based on the research findings, a number of recommendations have been provided.

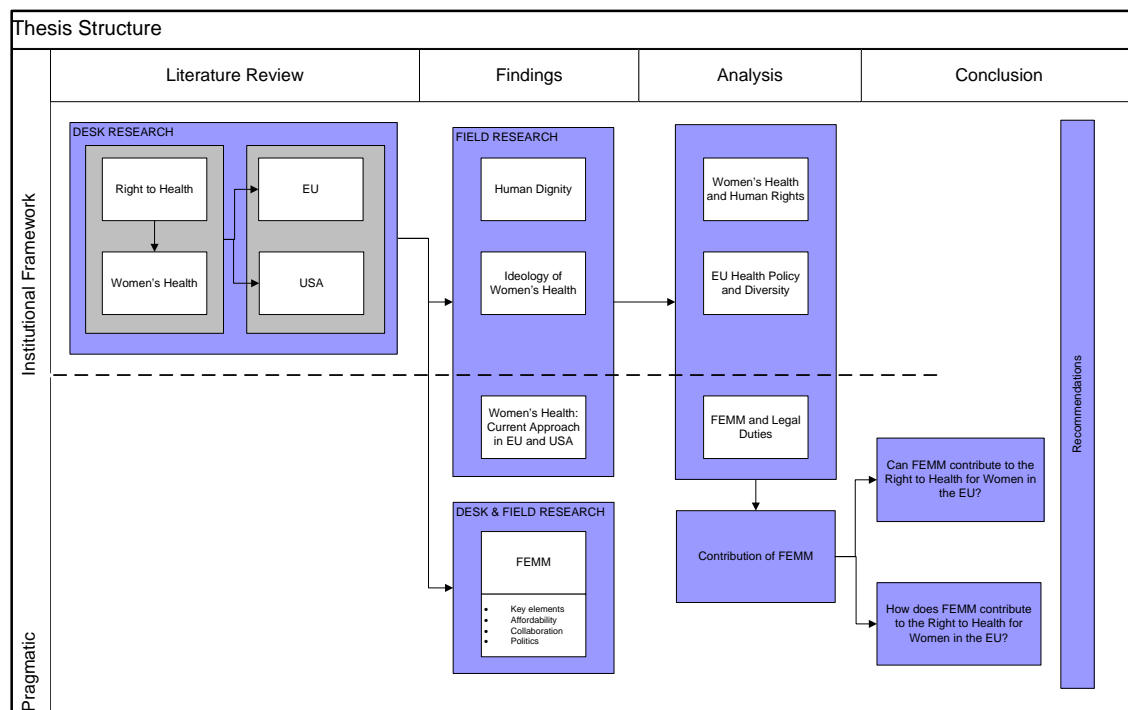


Figure 1 Thesis Structure: Overview

## Literature Review

This chapter reviews the literature on the right to health and women's health (see Figure 2). It also provides an understanding of the legal implications with regard to health rights and the role of the UN, states, and NGOs. The literature review addresses the integration and implementation of the right to health and women's health at the USA and the EU level. Firstly, the legal authority of international documents is reviewed. Secondly, the integration of health in human rights is studied. Thirdly, the implementation of health in human rights shines a light on the actual implementation in the context of states. It also reflects on the implementation of health in human rights, NGOs and the UN. Thereafter, the integration and implementation of women's health is reviewed. It zooms in on the implementation of women's health.

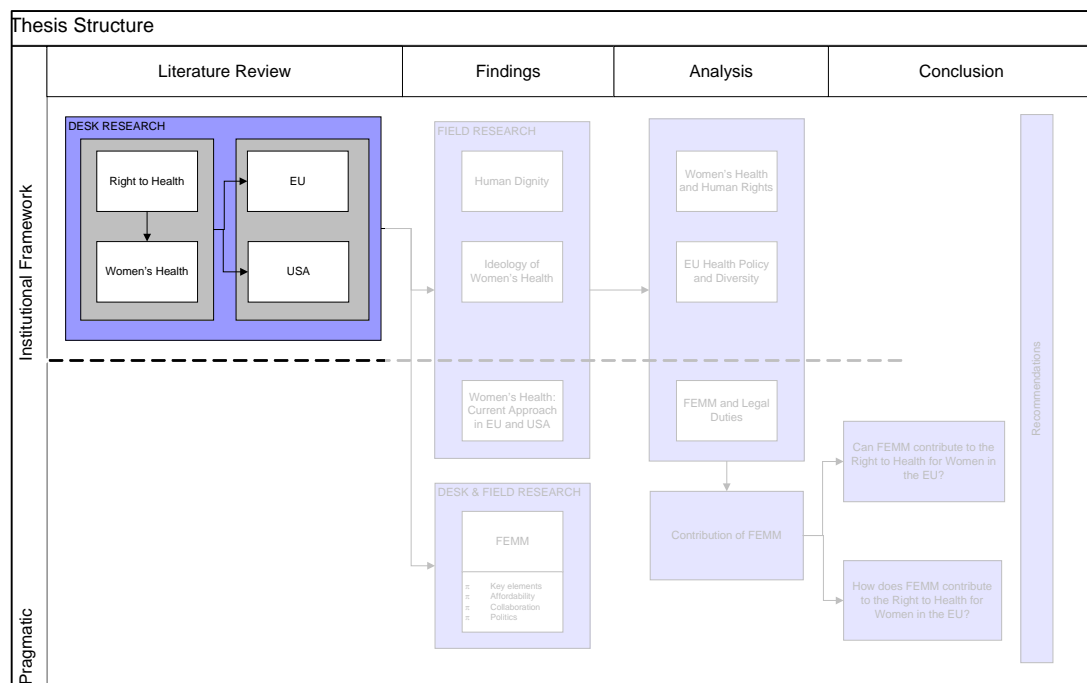


Figure 2 Thesis Structure: Literature Review

## Legal Authority of International Documents

International documents do not all carry the same purpose. International conventions, also known as treaties, are legally binding for states who have ratified the convention. However, other documents such as recommendations, also known as general comments, declarations and programmes of actions are non-binding for states. These are written as an invitation to states to comply with new international norms and principles (United Nations Educational, Scientific and Cultural Organization [UNESCO], n.d.; WHO, 2002, p. 7). Both binding and non-binding documents determine political will. Therefore, both types of documents are reviewed in this paper. Non-

binding documents should not be interpreted as binding documents. Consequently, this chapter explains human rights definitions according to the authority the documents have received from states.

The definition provided in the ICESCR that the right to health is “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (International Convention on Economic, Social and Cultural Rights[ICESCR], 1966, art.12) is a voluntary binding law. The concept of voluntary law and binding law appears to be contradictory; however, Hathaway, professor of international law at Yale Law School, provides a clear explanation of this concept. “The effects of international laws are contingent on who agrees to be bound. Who agrees to be bound is, in turn, contingent on the law's likely effects” (2005, p. 493). In other words, Hathaway (2005) explains that “it is the state that signs or ratifies a treaty, and it is the state that is subject to the treaty's requirements” (p.494). A state can respond to international human rights conventions in several ways. The Vienna Convention on the Law of Treaties explains that states can sign treaties with signatures. This is a symbolic action of the representative. It shows the willingness of the state to ratify the treaty text. The signature becomes definite when it is ratified by the responsible organ of the State. This action is taken prior to ratification (Vienna Convention on the Law of Treaties, 1996, art. 10; art. 12 (2) (b); art. 18). Due to the voluntary character of international human rights law, reservations can be registered. States have the possibility to exclude certain articles to which they do not choose to be bound (Vienna Convention on the Law of Treaties, 1969, art. 2(d)). The next section provides a historic overview of the right to health and its definitions.

### **Integration of Health in Human Rights**

In 1941, in a world scheme where peace and freedom were far from being practiced, the US President Roosevelt envisioned a post-war era based upon four freedoms. Namely the freedom of speech, freedom of religion, freedom from fear and freedom from want (Meier, 2010, p. 165). The years after Roosevelt’s speech, his words continued to resonate in policy makers ears. Roosevelt’s four freedoms were integrated in the UN charter<sup>1</sup> of 1945. Meier (2010) states that “[i]t was the first international legal document to recognize the concept of human rights” (p. 165). Health was not explicitly mentioned in the UN charter. That is not to say that health was irrelevant for the UN. In 1948, the World Health Organisation, a UN specialized agency, provided the first definition on health in their constitution (WHO, OHCHR, 2008, p. 1; Mertus, 2009, p. 165). As Mertus, lecturer in human rights at the American University in Washinton DC, mentions,

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<sup>1</sup> The treaty that established the United Nations (UN,History of the United Nations Charter,(n.d.))

the WHO constitution provided a definition on health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (2009, p. 166). Drawing on the negotiations of the WHO constitution, Health received equal status in the 1948 Universal Declaration of Human Rights (UDHR) in 1948 (Meier, 2010, p. 166). In article 25, the universal right to a standard of living adequate for the health and wellbeing of himself and of his family was acknowledged (United Nations, 1948).

Due to the polarisation between the east and the west during the Cold War, the UDHR never received binding authority. Instead, in 1966, two new human rights treaties, which elaborated on the UDHR, were established. These are the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights (WHO, 2002, p. 7). These treaties were, and still are, credited as binding law on states who ratified them (Universal Declaration on Human Rights [UDHR], 1948, Para 4). Together with the UDHR, the ICESCR and the International Covenant on Civil and Political Rights are referred to as the International Bill of Human Rights (WHO, 2002, p. 12). According to factsheet 31 on the right to health, the ICESCR, “is considered as the central instrument of protection for the right to health” (WHO, OHCHR, 2008, p. 9). More specifically, in article 12 of the ICESCR it recognises that health is “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (ICESCR, 1966, art.12).

The ICESCR, as visible in Figure 3, is ratified by 164 states. Among them are all European Union Member States. Six countries have only signed the ICESCR. Among them is also the USA. 27 states have not taken action with regard to this treaty. All states that ratified the ICESCR have also endorsed ratified article 12 on the right to health without any reservations (OHCHR, 2014). This statement on the right to health is a binding statement for the states that ratified the ICESCR. The next section reviews the role of the State, NGOs and the UN with reference to the right to health.

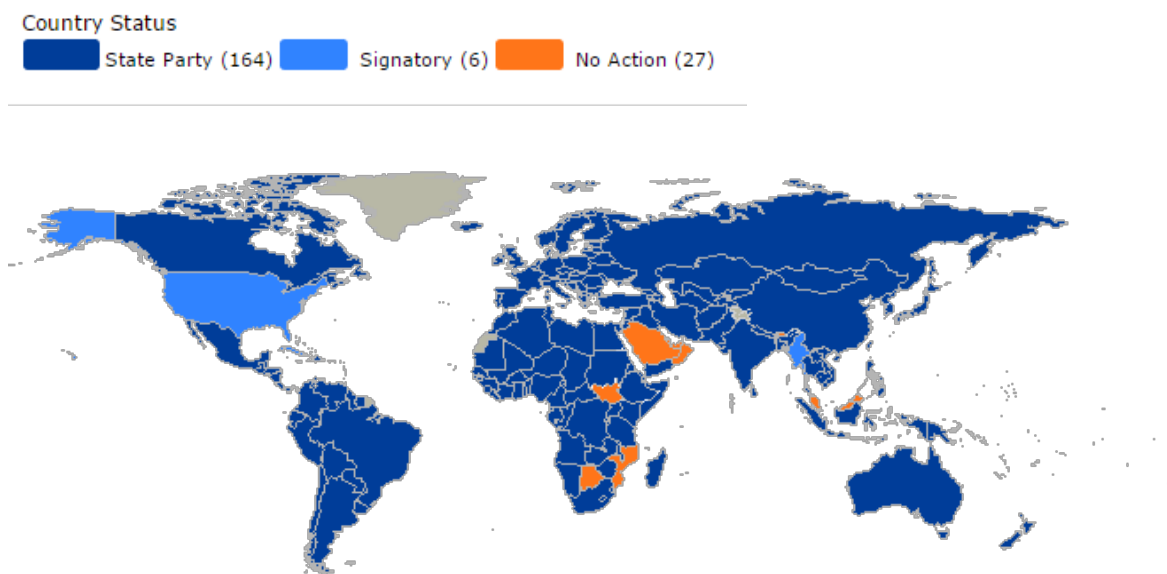


Figure 3 World map of ratification of ICESCR  
Source: Retrieved from [indicators.ohchr.org](http://indicators.ohchr.org) October 2015

## Implementation of Health in Human Rights

### The role of the state.

Hathaway claims that “in most cases, international treaty law applies not to individuals, NGOs, corporations, or other entities, but to states and states alone” (2005, p. 494). The Office of the High Commissioner of Human Rights (OHCHR), outlines the responsibilities of the states towards human rights. “By becoming parties to international treaties, States assume obligations and duties under international law to respect, to protect and to fulfil human rights” (OHCHR, 2015, para. 3). The responsibility to respect means that states cannot interfere or limit the enjoyment of human rights. In other words, governments should not withhold the right to the highest attainable standard of health (ICESCR, 1966, art.12) from their citizens. The responsibility to protect requires states to safeguard their citizens against third parties. Therefore, governments must protect their citizens from third parties, such as companies, organisations and individuals, who violate health rights. The responsibility to fulfill this means that states need to make political, economic and social services, such as health care for their citizens available to all. So that all residents have access to the enjoyment of basic human rights (OHCHR, 2015, para. 3) The next two sections outline health rights in both the USA and the EU.

*Health in the United States of America*

The USA signed the ICESCR in 1977. However, the covenant has never been ratified by the Senate (OHCHR, 2014; MacNaughton, 2011, p. 212). Although the USA has not ratified the right to health, MacNaughton, expert on the right to health, argues that it has human rights obligations. These include social rights. Social rights as MacNaughton states, “derive from the U.N. Charter, the Universal Declaration [UDHR], and international customary law<sup>2</sup>. These obligations are subject to review by the U.N. Charter-based mechanisms, among them the U.N. Special Rapporteurs and the U.N. Human Rights Council” (MacNaughton, 2011, p. 212). The USA statement on social rights has a particular focus on the right to health. This can be found in a public governmental observation. This observation reflects on Fact Sheet No.31. This fact sheet addressed the right to health created by the OHCHR and the WHO in 2008 (United States of America, n.d.; WHO, OHCHR, 2008). Although the USA has not ratified the ICESCR, the Government states that “the issues addressed in the ‘Fact Sheet’ are important to the United States, given its commitment to the protection of human rights and fundamental freedoms and to improving the health of its citizens and people worldwide” (United States of America, n.d., p. 1). The USA Government argues that the WHO and the OHCHR do not recognise the fact that recommendations and declarations are not legally binding. Among states, this can create misunderstanding of health definitions and health implementations. The argument that the USA makes is that the UN committees and other institutions such as the WHO, should challenge states on the right to health as presented in the conventions. However, new interpretations and conclusions that are written as general comments or declarations, should not be presented as binding. The USA Government makes clear that although the fact sheet is not directly addressed to the USA, it still feels obliged to point out the inaccuracy of the WHO and the OHCHR.

As MacNaughton explains, the USA “is well known to spend more money per capita than any other country in the world on health care and yet to achieve worse health outcomes than most, if not all, developed countries” (MacNaughton, 2011, p. 208). Since 2010, the Affordable Care Act (ACA), also known as Obamacare, provides opportunities for its citizens to obtain health insurance through an insurance market place where individuals and businesses can buy the most suitable health insurance plans (Assistant Secretary for Public Affairs, 2014; Obamacarefacts, n.d. para 1). However, not all Americans are pleased with this new health insurance act. Blumenthal, Abrams and Nuzum members of the Commonwealth Fund (2015), have reviewed the ACA over the last 5 years. According to the review, some claim that the ACA threatens the individual freedoms of the citizens of the USA, because the State leaves no choice for the population by

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<sup>2</sup> According to librarian Sahl, “customary international law results from a general and consistent practice of states followed by them from a sense of legal obligation” (Sahl, 2007, para. 3).



removing the option of obtaining insurance or paying a financial penalty. Others claim that the ACA should not be regulated at a federal level, because this threatens the sovereignty of the individual states (p. 2457). Besides the claim that the governmental interference in providing cheaper health care for its citizens is a threat to individual freedom, MacNaughton (2011) explains that “from a human rights perspective ... the main problem [of the ACA] is that it reinforces and subsidizes a system that treats health care as a market commodity to be bought and sold for profit rather than as a human right” (p. 214). Nonetheless, MacNaughton discovered other initiatives in the USA. “[G]rassroots organizations, local governments, and state legislatures are adopting human rights frameworks to guide health care reform” (MacNaughton, 2011, p. 215). MacNaughton provides two examples at a local level. Vermont and King County demonstrate “a ‘principles first’ approach to health care reform, drawing on the human rights principles derived from international human rights instruments to analyze and inform decision making” (MacNaughton, 2011, p. 215). These principles contain, among other things, universality, equity, accountability, transparency, accessibility, affordability and high quality health care (MacNaughton, 2011, p. 215).

### *Health in the European Union*

The EU, in comparison to the USA, is a union rather than one nation. The sovereignty of the individual Member States is highly valued. This is expressed in the Treaty on European Union (TEU), i.e. Maastricht treaty in 1992, by the principles of both subsidiarity and proportionality. Article 5 in the TEU defines subsidiarity as following: “the EU may only intervene if it is able to act more effectively than EU countries at their respective national or local levels” (Art. 5 TEU). Article 5 in the TEU defines proportionality as following: “the action of the EU must be limited to what is necessary to achieve the objectives of the Treaties” (Art. 5 TEU). In terms of health, the Treaty of the Functioning of the EU, i.e. Rome treaty of 1958, states that public health is a shared competence. That is to say “that both the EU and its Member States may adopt legally binding acts in the area concerned. However, the Member States can do so only where the EU has not exercised its competence or has explicitly ceased to do so” (European Commission, 2015, para. 2). The protection and improvement of human health falls under the competence to support, coordinate or supplement actions of the Member States. That is to say that “the EU may not adopt legally binding acts that require the Member States to harmonise their laws and regulations” (European Commission, 2015, para.2).

However, as McHale, researcher in health care law at Birmingham law School argues, this is not to say that the EU does not recognise health as a fundamental right. The EU uses the European Convention on Human Rights (ECHR) and the European Social Charter (ESC), which are

both signed and ratified by all EU Member States, as a starting point to promote health under EU law. Drafted by the Council of Europe, ECHR was the first European human rights treaty in Europe. It came into force in 1950. The ECHR was built on the UDHR. Nonetheless, as Schabas, professor in human rights law at Leiden Law School, and McHale claim, the ECHR excluded social rights such as the right to health (Schabas, 2015, p. 1; McHale, 2010, p. 286). McHale explains that the ECHR can be seen as the basis of the discourse on human rights in Europe. The ECHR does not reflect directly on the right to health, but it can be read into, *inter alia*, the right to life (article 2) and the right to privacy (article 8) (McHale, 2010, p. 286). The ESC, also drafted by the Council of Europe in 1961, addresses health in Article 11. Brillat, Executive Secretary of the European Committee of Social Rights of the Council of Europe, argues that the ESC was built on the ECHR and has become one of the main conventions of the Council of Europe (Brillat, 2005, p. 31). The ESC refers to the right to the protection of health in which states need to enact measures to eliminate the causes of diseases and prevent epidemics and accidents. States are also required to provide and promote health education and encourage individuals to take personal responsibility over their health (McHale, 2010, p. 292; ESC, 1996, art. 11). Further, Hervey, professor of European Union law at the University of Sheffield, confirms that all EU Member States have signed Article 11 (Hervey, 2005, p. 313). In order to respect the diversity of national circumstances and traditions, such as cultural practices or religious or historical traditions the Council of Europe created a margin of appreciation. This means that members of the Council of Europe are allowed to interpret the conventions according to their national circumstances and traditions” (McHale, 2010, p. 289).

The European Commission explains that the European Court of Justice, one of the European institutions, recognises the ECHR and the ESC. Nonetheless, the EU also created its own charter, namely the Charter of Fundamental Rights of the European Union (EURCFR). The European Commission states that the charter was already initiated in 2000. However, it did not receive legal binding effects until the Treaty of Lisbon came into force in December 2009 (European Commission, 2015, para. 3). According to McHale, “the EU Charter draws upon the Treaty of the European Union, the EC Treaty, the ECHR, the European Social Charter and also the case law<sup>3</sup> of the European Court of Justice and the European Court of Human Rights” (McHale,

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<sup>3</sup>Examples of Health case law addressed by the European Court of Justice focus on receiving health care in another Member State. This care is categorised in two categories. Namely: ambulant treatment and hospital care. Examples of cases ‘Kohll and Decker’; ‘Vanbraeckel’, GeraetsSmit’; ‘Peerbooms, Müller-Fauré’; ‘Van Riet, Leichtle’ and the Watts-ruling (Füsser, n.d., p. 3).

Examples of health case law addressed by the European Court of Human Rights (ECHR) are: a lack of access to personal medical records, donor transplantation carried out without consent, liability of health

2010, p. 295). Although the EURCFR addresses health care in article 35, according to Hervey, the right to health as being the “highest attainable standard of physical and mental health” as stated in the ICESCR (1966, art. 12), is not found. Hervey explains that it focusses on “access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices” (Hervey, 2005, p. 315). That is not to say that the EU ignores the definition on the right to health as found in the ICESCR. The European Commission states that, besides the European human rights documents, the EU also recognises other international human rights documents which are signed and ratified by the individual Member States. The Commission states that “[i]n cases where the Charter does not apply, the protection of fundamental rights is guaranteed under the constitutions or constitutional traditions of EU countries and international conventions they have ratified” (European Commission, 2015, para.2). In other words, the EU has its own human rights Charter, which is binding to all Member States. All the other human rights documents to which individual Member States have committed themselves to, should also be applied. The previous sections reviewed the role of the State, with a specific focus on the USA and the EU. The next section reviews the role of NGOs in relation to the right to health.

### The role of NGOs

As stated in section above, human rights are a state responsibility. However, individuals, NGOs, corporations and other entities are not entirely excluded from international human rights law. As Hathaway (2005) explains, “in most states, treaties are binding on entities operating within the state via domestic application of that state's international commitment” (Hathaway, 2005, p. 494). Furthermore, according to Mertus (2009), “without state commitment to the domestic implementation of human rights, the system will fail” (p.4). Thus, the top down approach as visible in Figure 4 shows that states have the power to bind themselves and their citizens to international law through the implementation of international law in domestic law. That is to say, through the appearance of international law in domestic law, citizens and organisations are indirectly connected to international human rights law. In addition to the fact that the state is purely responsible to monitor and the implementation of international human rights, Mertus states that “public authority on human rights practice has now shifted beyond the state to intergovernmental and non-governmental organizations” (Mertus, 2009, p. 5). Hence, even though the traditional top down approach is still in existence, NGOs influence governmental

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professionals because of serious mistakes made by health professionals and discrimination on the ground of health (European Court of Human Rights, 2015).

leaders and UN officials through lobbying. These include, according to Mertus, “private meetings and cooperative information sharing, the provision of concrete policy proposals, and offers of technical assistance” (Mertus, 2009, p. 5) (Figure 4). NGOs are not only executors of domestic

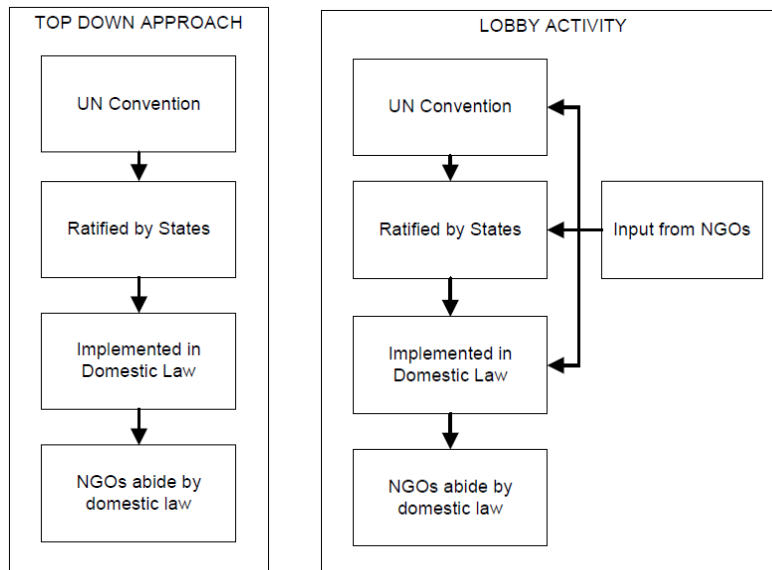


Figure 4 Top Down Approach (left) Lobby Approach (right)

law, they are also involved in the process of drafting international human rights documents and to advise governments to sign and ratify or reject international treaties. Ultimately NGOs can also provide advice on the implementation of the ratified treaty in domestic law. The next section reviews the role of the UN with regard to the right to health.

### The role of the UN

The UN has eight human rights committees to interpret and monitor human rights according to the eight UN treaties. The committee members include independent experts who monitor how the treaties are implemented. The experts review the reports written by the state parties and draft general comments or recommendations for interpretation of the content of the treaties (OHCHR, 2012, pp. 19,21). Mechlem, researcher in public law at Ulster University, adds that the UN committees “serve an instrumental role in promoting global human rights standards; feed into the work of the Charter bodies, regional human rights bodies, and domestic actors; and contribute to the formation of customary international law” (Mechlem, 2009, p. 945). As stated above, committees draft general comments “in which they set out the meaning of human rights and offer options for their realization” (Mechlem, 2009, p. 945). The Committee on Economic, Social and Cultural rights drafted a general comment to the right to health based on the ICESCR. The whole text can be found on the website of the OHCHR. For this paper a summarized version

of the WHO is used. General comment No. 14 recommends that health should meet the following four requirements:

- **Availability:** A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes.
- **Accessibility:** Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions:
  - non-discrimination
  - physical accessibility
  - economical accessibility (affordability)
  - Information accessibility.
- **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.
- **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality. (WHO, 2013, p. 2)

Keller and Grover state that this general comment, just as any other general comment, represents “non-binding norms that interpret and add detail to the rights and obligations contained in the respective human rights treaties” (Keller & Grover, 2012, p. 129). The comment has been created as a practical guideline that states can use to implement the right to health. The general comment can be applied by states as extra guidelines to obtain the “highest attainable standard of health”(ICESCR, 1966, art.12). The right to health, its integration and its implementation have been reviewed. Therefore, the next section studies the integration and implementation of women’s health.

### Integration of Women’s Health in Human Rights

Although women’s health covers all aspects of health, (Weisman, 1997, p. 184) in human rights, women’s health is often referred to as reproductive health. The term ‘reproductive health’ was defined for the first time during the ICPD in Cairo in 1994. Paragraph 7.2 of the Programme of Action, a non-binding document, drafted after the ICPD, agrees with the WHO definition that reproductive health is not only the absence of disease. Reproductive health covers everything that is related to the reproductive system. According to the Programme of Action this includes that couples should be able to have a satisfying safe sex life, the freedom to determine the amount and the spacing of their children, accurate information on family planning methods and

to be able to choose safe, effective, affordable and acceptable family planning methods which comply with the national regulations. It also includes access to services to help women through safe pregnancies and childbirth and to support couples to have the best chance of having a healthy baby (Programme of Action, 1994).

Another internationally well recognized conference hosted by the UN was the FWCW which was held in Beijing in 1995. After this conference, a document called the Beijing Platform of Action, stated the exact same definition on reproductive health as the ICPD Programme of Action on Reproductive health (Beijing Declaration and Platform for Action, 1995, p. 94).

Both documents have been signed and ratified by the international community. However, these documents have a so called 'call to action' authority. This means that the documents are non-binding. In other words, the definition of reproductive health has no binding obligations in international law. Therefore, states are not obliged to implement reproductive health into their national policies. This section reviewed the integration of women's health as a part of the right to health. The next section addresses the implementation of women's health in the USA and the EU.

### Implementation of Women's Health

The data and information report on women's health in the EU looked into different aspects of women's health. It was found that there are diseases that occur in both men and women but need different treatment. There are also specific diseases that are unique, more common or more serious in women. For example, breast cancer, mental health and fertility (Thümmeler, Britton, & Kirch, 2009, pp. 18,35,42,47). Toebe, associate professor of law at the University of Groningen, with interests in health and human rights, explains that a distinction between general, and women's health, is made due to women's "specific health needs in relation to their sexual and reproductive function, [because] women often require more healthcare services than men" (Toebe, 2010, p. 124). Both sources show that women's health covers all aspects of health and that women's health should not only be interpreted in relation to sexual and reproductive health. Although women's health is often understood through separating reproductive and non-reproductive services without provisions for coordination of total care (Weisman, 1997, p. 184), it is important to understand that women's health is part of general health. Therefore, this paper views reproductive health as one of the aspects of women's health which is part of general health.

### The United States of America

The USA Government has made a clear statement on the presentation of women's health in international documents. The public governmental observation, as referred to above, reflects to the definitions of 'reproductive health', 'the right to sexual and reproductive health' and

‘reproductive health services’ (United States of America, pp. 5-6). The USA Government claims that reproductive rights can only be seen “in the context of explicit references to coercive population control policies. In that context, the phrase [reproductive rights] refers to a couple’s freedom to determine the number and spacing of their children” (United States of America, para.22). At a UN level, abortion has never been agreed upon as a right. “‘Reproductive health,’ ‘sexual and reproductive health,’ and ‘reproductive health care’ cannot be interpreted to constitute support, endorsement, or promotion of abortion” (United States of America, para. 21). That is to say, the USA believes that the UN should only promote the freedom of couples to decide how many children they will have and when they have children. All other issues, such as abortion, are outside the authority of the UN and is a state’s competence.

### The European Union

Health rights for European women can indirectly be found under several articles of the ECHR. McHale offers several examples: article 2, the right to life, “has been used in claims concerning the status of the fetus and abortion, resource allocation in health care systems and the ‘right to die’” (McHale, 2010, p. 286). Article 8 and 12, the right to privacy and the right to marry and found a family, have been used in claims with regard to reproductive rights (McHale, 2010, p. 286). Nevertheless, as explained previously, the EU has no absolute decision-making power when it comes to health, this includes women’s health. The shared competence of the EU allows Member States to create and implement health as they wish, according to their interpretation of how to comply with the right to health. Moreover, Member States also respond to the implementation according to their national policies. In the EU, Member States have different opinions about the legality of abortion. For instance, Feikert-Ahalt, a senior foreign law specialist states that the Republic of Ireland has a highly restrictive approach to abortion. Abortion is only allowed in limited circumstances when women’s lives are threatened (The Law Library of Congress, 2015, p. 19). Whilst, as explained by Zeldin, senior legal research analyst, in the Netherlands abortions are available on request until 22 weeks (The Law Library of Congress, 2015, p. 25). According to a barometer of the International Planned Parenthood Federation conducted in January 2015, Denmark scores 100% in empowering women through ‘Access to Modern Contraceptive Choice’. Conversely, the Czech Republic, Italy and Romania only score 18% (International Planned Parenthood Federation European Network, 2015, p. 26). Despite the fact that the EU is one union, a distinction in the reproductive health approaches is visible. The shared competence of the EU leaves space for all Member States to have their own policies on reproductive health. It shows that EU Member States are not aligned on how to provide the highest attainable health standard for women.

## Conclusion

To conclude, the right to health has been part of human rights since the foundation of human rights. States who have ratified human rights treaties and conventions are voluntarily bound to respect, protect and fulfil these rights. According to the ICESCR, which has received the credits to be the instrument to protect the right to health, the right to health means that everyone has the right to the “highest attainable standard of health” (ICESCR, 1966, art.12). The UN has provided general comment no.14 to help states to achieve the highest attainable standard of health. It states that health must be available, accessible, acceptable and qualified. This comment is an advice and non-binding. Also the EURCFR gives a binding right to all EU citizens. The EU needs to provide access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. The ESC refers to the right to the protection of health in which states need to undertake measures to eliminate the causes of diseases and prevent epidemics and accidents. States are also required to provide and to promote health education and to encourage individuals to take personal responsibility over their individual health.

The USA has not ratified human rights treaties in which health rights are mentioned. Nevertheless, it committed itself to protect human rights, the fundamental freedoms and to improve the health of its citizens and people worldwide. The EU promotes health among its Member States, but it cannot take binding decisions on health. The responsibility of health can only be taken at Member State level.

NGOs do not have a legal responsibility to the right to health. However, the literature shows that NGOs are obliged to human rights which are included in domestic law. Also it shows that some businesses and organisations base their mandate on the right to health. This can stimulate governments to set health standards according to the right to health.

There is limited information available on women’s health under human rights. It was found that international non-binding documents address women’s health under reproductive health. However, reproductive health does not include all factors of women’s health. It includes a satisfying safe sex life, the freedom to determine the amount and the spacing of their children, information on family planning methods and access to services to help women through safe pregnancies and childbirth. An explanation for this limited amount of information on women’s health is addressed in the findings chapter of this paper. The USA Government maintains that states have no legal obligation to respect, protect and fulfil reproductive health. The EU has not made such a statement. Each Member State addresses women’s health according to their national health policies. The EU has no power to rule over national health policies.



The literature review provided a legal view on the integration of the right to health and women's health. The next chapter, methodology, explains how the interviews were conducted to provide a pragmatic view on the right to health for women in the EU.

## Methodology

The goal of this paper is to research how FEMM can contribute to the right to health for women in the EU. The first chapter reviewed the legal framework of the right to health and women's health at an intergovernmental level and a state level. Besides the legal context, the research aims to provide a pragmatic understanding on the right to health for women in the EU. Together with the legal context, as described in the literature review, the pragmatic view on the right to health for women provides the ultimate conclusion whether FEMM contributes to the right to health for women in the EU. The following sections explain which methods are used to conduct the research on the pragmatic assessment of FEMM's contribution to the right to health for women in the EU.

### Desk Research

The first research method, desk research, was found in the literature review and the findings chapter. With regard to the legal review, the secondary qualitative approach allowed the researcher to review the legal background of the right to health and women's health as well as the interpretations of other scholars on this topic. Confirmed by Gilbert (2008), author of the book 'researching social life', "a qualitative research often describes scenes, gathers data through interviews or analyses the meaning of documents" (p. 35). For the literature review the analysis of documents was used. These documents included journals and (e)books which covered the legal aspects of the right to health. This created a framework to understand women's health under the right to health, and the implementation of the right to health under USA law and EU law. FEMM is introduced in the findings chapter. The secondary sources, such as the white paper on the FEMM approach and the website of FEMM, supported the primary data which was conducted through an interview with FEMM.

Articles, books and websites were selected through the combinations of the following keywords: 'UN', 'human rights', 'the right to health', 'social rights', 'EU', 'reproductive health', 'women's' health' 'UN conventions' and US conventions. Exclusions to the search terms were also used. The key words 'abortion' and 'contraceptive' were filtered out. The exclusion of these keywords from the search results, provided women's health articles in which women's health was discussed in a broader context than only abortion and contraceptive use. To sustain the credibility of sources, websites without a reference to well-known organisations such as the UN were avoided.

### Field Research

The second method is based on primary qualitative research and the results can be found in the findings chapter. Due to the limited available data on the implementation to the right to health

for women in developed regions, qualitative interviews were conducted. The interviews created a pragmatic view on the right to health for women in Europe and the current activities of FEMM. Conducting in depth qualitative interviews allowed the researcher to acquire pragmatic information that could not be obtained through the desk research method. The following sections explain how the interviews were planned and conducted.

### Identification of the interviewees

The in depth qualitative interviews were conducted over Skype. First of all, a qualitative interview with Gabrielle Jastrebski, Programme Manager of FEMM, provided data on the FEMM activities at the USA level. Secondly, the director of advocacy of World Youth Alliance, Antoine Mellado, was approached to provide information on the EU and the right to health for women. Thirdly, a total of seven EU associations of Obstetrics & Gynaecology were approached to participate in an interview. Ofra Balaban, chair of CHEN Fertility association in Israel, and deputy executive committee member to Fertility Europe, responded.

### Interview structure

Semi structured interviews were selected for all interviews. The purpose of semi structured interviews, as the researcher agrees with Brinkmann (2013), professor in psychology and co-director of the centre for qualitative studies at the University of Aalborg, Denmark, was to obtain “descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena” (p.21). This interview method provided pragmatic data which the researcher could only obtain if the interview was semi-structured. Inspired by Brinkmann (2013), the interviewee was encouraged to decide how answer the question and what topics they preferred to discuss. The researcher asked relatively few questions and many of those were open in their style. The questions continued to follow up on the points that the interviewees made (p. 21, p. 31) Although the researcher remained in the background and only interjected when needed, (Brinkmann, 2013, p. 37) open interview questions were designed prior to the interviews. These questions were either used as a guidance for the researcher if the interviewee remained silent for a couple of seconds, or when the interviewee drifted away from the topics of human rights, the right to health and women’s health.

One-on-one interviews were selected. The primary reason for this is that it meets the above discussed criteria. As Brinkmann (2013) explains; “[i]t is often easier for the interviewer in one-on-one interviews to lead the conversation in a direction that is useful in relation to the interviewer’s research interests” (Brinkmann, 2013, p. 27). Secondly, the interviewees were experts in different fields. An one-on-one interview enabled the researcher to focus entirely on the interviewee and listen exclusively to their information. For this paper it was desirable that the

interviewees would not interact, influence or inspire each other. The provided data that was unique and comparable while addressing the data in a later stage of the paper. For this reason, the interviews were conducted individually, i.e. the interview consisted of the researcher/interviewer and the interviewee.

### Media

For qualitative interviews, face-to-face interviews are most desirable. Brinkmann(2013) states that “people are present not only as conversing minds, but as flesh and blood creatures that may laugh, cry, smile, tremble, and otherwise give away much information in terms of gestures, body language, and facial expressions” (p.28). However, due to the fact that all interviewees are not based in the Netherlands, interviews took place over Skype. The researcher is aware that this technique is not the same as face-to face interviews in which the interviewee and interviewer are in the same room. But, as Brinkmann (2013) argues, “[t]here is no universally correct medium that will always guarantee success” (p.30). Nonetheless, to simulate a face-to-face interview through Skype, the body language, facial expressions and other gestures are still noticeable. As explained by Saumure and Given, interviews via Skype have several benefits. It is inexpensive, it is geographically flexible, it is user-friendly and easy to install. Using Skype as an interview technique also has challenges. A delay in the conversation and the connection can fail which results in data loss or rescheduling of the Skype interview could appear (Using Skype as a Research Tool, p. 2). To prevent data loss issues, an external recording device and a recording programme on the computer was used. When delay’s in conversations were noticed during the interview, a repetition of the answer was requested.

### Ethics

The primary data collection, i.e. interviews, required ethical consideration. All interviewees received an email invite to the interview. It stated the purpose of the interview. They were asked for their consent with regard to an audio recording. Recordings were only accessible for the researcher, and were destroyed once the paper had been graded. All interviewees gave permission for the use of their full names. The interviewees were informed about these conditions through the consent form. The content of the form was inspired by the ES4 Guide for Final Project and Dissertation. The consent form was handed out prior to the interview. A signed copy can be found in the appendix. The researcher was aware of the APA Ethics code and wrote and signed the student ethics form prior to the interviews. These are also to be found in the appendix.

The secondary sources required accurate citing and referencing according to the APA guidelines. Through carefully citing and rephrasing ideas of scholars, the researcher avoided plagiarism.

### Processing of the interviews

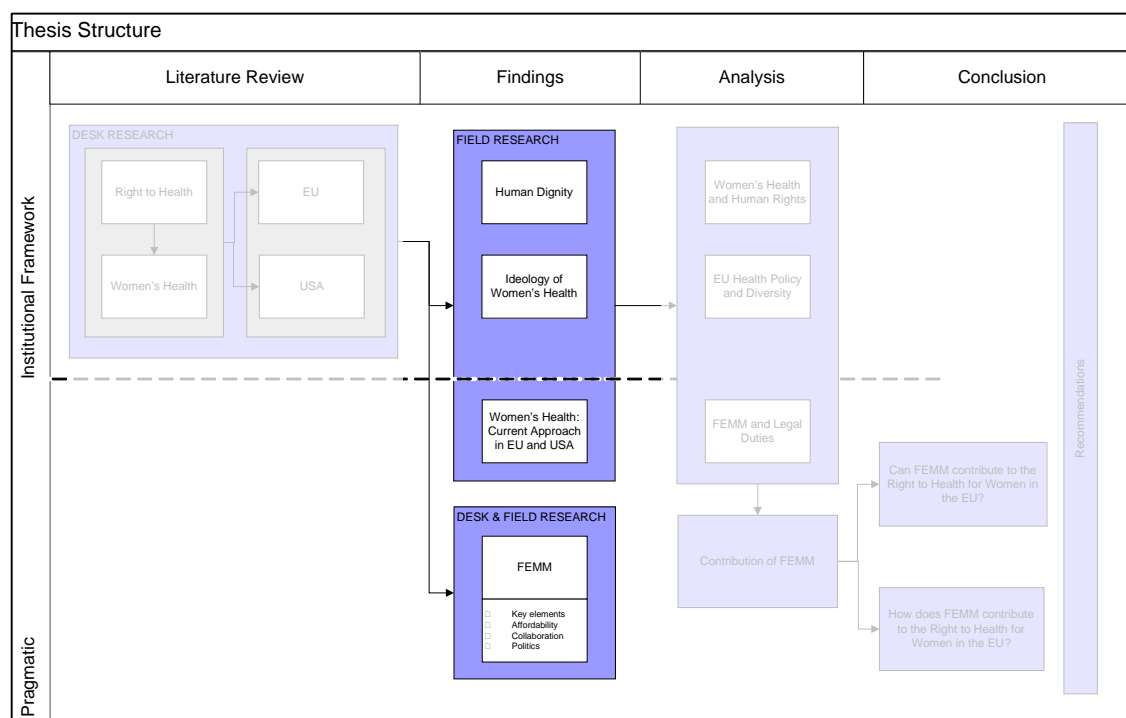
After conducting the interviews, the data were processed. The interviews represented three different experts in different fields. Therefore, to be able to create connections, comparisons and interpretations among the interviews and the literature, transcripts of all interviews were created. As suggested by Brinkman, the transcriptions were written within a couple of days after the interviews. For the presentation of the interviews in the next chapter, as explained in the book *Doing Your Undergraduate Social Science Dissertation* by Smith, Todd and Waldman (2009), the transcripts received coding, after which they were categorised and divided into themes. First, the interviews were processed in Microsoft Word Office. Secondly, the transcripts were transferred to Excel in which each sentence of the transcript received an individual 'row'. One or two themes were attached to each sentence. This created an overview of overlapping themes in the three independent interviews. The themes are visible in the sub headings of the next chapter. The technique of labelling themes was selected to help the researcher to analyse the findings and start a discussion (p.123). The Microsoft Word Office transcripts are included in the appendix

### General Limitations

Both discussed methods have limitations. The desk research method requires secondary sources. The large amount of secondary sources available on the right to health challenged the researcher to divide and select relevant sources. Another significant limitation was the little amount of information available on women's health without debating abortion and contraceptives. This caused a limitation for the researcher to provide a profound literature review on this topic. As for the field research method, the researcher neither had control over the responsiveness of the interviewees, nor the answers that the interviewees provided. Also a withdrawal of the interviewees, before, during or after the interview took place was at risk. Two of the interviewees and the researcher, are not native English speakers. This fact led to a higher risk of misunderstanding of the interviewee. Also the time frame in which the paper had to be delivered limited the researcher in the amount of interviews they were able to conduct. Regardless of the limitations, the findings are presented in the next chapter.

## Findings

The literature review provided a legal context for international human rights documents and their relation to the right to health and women's health. The ICESCR, has been recognized as the instrument to protect the right to health. It states that the right to health is "the highest attainable standard of health for women" (ICESCR, 1966, art 12). Several other documents, namely the general comment no.14, the ECS and the EURCFR, supported this definition by adding specific conditions under the right to health or to provide guidance in the implementation of the right to health. Also the authority of the documents was reviewed and it became clear that the right to health is a state's responsibility. NGOs and the UN can provide advice and support the implementation of the right to health. Women's health, an aspect of the right to health, has been reviewed. Women's health in legal terms is understood as reproductive health. However, it also became clear that women's health contains other aspects of health as well. The provided legal context asked for a more pragmatic view on the right to health for women. The results of three interviews present the following themes as shown in Figure 5: Human dignity, the ideology of women's health, the current approach to women's health in the USA and the EU. Lastly, FEMM, its key elements, affordability, collaboration with other organisations and politics are presented.



**Figure 5 Thesis Structure: Findings**

## Human Dignity

Antoine Mellado, director of advocacy for the World Youth Alliance Europe in Brussel, emphasises that human rights are created to promote the human dignity of each person. This can also be found in the preamble of the UDHR (UDHR, 1948). Therefore, Mellado states that “human dignity is the source of human rights” (Mellado, personal communication, 9 November). Besides, according to Mellado, human rights as stated in the UDHR are “universal and have to be considered... in every circumstance” (Mellado, personal communication, 9 November). Through this comment, Mellado denies the argument that the UDHR is influenced by neo-colonialism. By this he refers to the claims of African and Asian nations that human rights are an invention of the western world. However, Mellado states that the UDHR is universal, because it has been drafted and voted for by representatives from all over the world, the African and Asian nations included. Mellado believes that human rights are open to constant development. In other words, human rights need to strive to meet every culture and philosophy. Nevertheless, Mellado lays a strong emphasis on the fact that development of human rights can only take place when based on the initial intention of the UDHR, namely, human dignity (Mellado, personal communication, 9 November).

Mellado also states that human dignity is reflected in the right to health. However, Mellado underlines that the right to health is interdependent on other rights. The right to health relates to the right of informed choices, the right to education and the right to freedom of thought, conscience and religion. Mellado demonstrates that the highest attainable standard of health goes hand in hand with being informed about medical action and giving consent for treatment based on this informed consent. Mellado also explains that health education is necessary to understand health. For example, to prevent sickness, children need to be taught to clean their hands before dinner. Lastly, Mellado gave an example from an acquaintance. A family who has based their lifestyle on ecological principles decided to give birth at home with the assistance of a nurse. Child birth at a hospital does not meet their standard of living. Although Mellado believes that the right to freedom of conscience should be respected, it should not endanger the highest attainable standard for health (Mellado, personal communication, 9 November).

## The EU promotion of health

Mellado acknowledges that the EU strives for the best care possible, but he also carefully states that a lack of financial resources might be a reason why there is not an EU wide health care policy. In fact, he views the economic crisis of 2008 as the source of the lost focus upon human dignity within the field of health care. Payments for general doctor appointments, as present in

Belgium, create an obstacle for poor citizens to visit their doctor. A lack of financial resources can also determine political decisions on health care. Mellado uses a statement of a Lithuanian minister, “euthanasia is a good solution for poor people”. However, according to Mellado euthanasia should not be considered as a cheaper economical option (Mellado, personal communication, 9 November).

Besides the limited role that the EU has in the regulation of health care, the EU is active in the promotion of health care within its borders. Since women’s health falls under health care, Mellado assumes that there might be opportunities under EU regulation for women’s health to be promoted. These include Good practices among the EU Member States, pilot projects and available budget for research about women’s health. Besides, the EU supports public, as well as private initiatives (Mellado, personal communication, 9 November). Ofra Balaban, chair of CHEN Fertility association in Israel, and deputy Executive committee member to Fertility Europe, a European umbrella association, emphasises on the impact of EU health recommendations. EU recommendations shape national policies on health. These recommendations have a longer duration than the average time a minister of health sits in government, which is mostly four years. Balaban believes that EU recommendations encourage research into the field of women’s health. Also NGOs should play a role in advising the health commissioner on these recommendations (Balaban, Personal communication, 10 November 2015). The next section addresses a reason why women’s health development is hindered through politicians own ideological stances.

### **Ideology of Women’s Health**

The European Parliament addresses women’s health under the right to health as well. Although, according to Mellado the discourse focusses more on the concepts of women’s health than the actual implementation. The reason for this phenomenon is, according to Mellado, that within European politics women’s health is an ideological issue. By this Mellado means that topics, such as family and population control, shape the political discourse on women’s health. Moreover, Mellado believes that the different ideologies represented by politicians contradict each other in women’s health approaches. This limits the development of women’s health. In other words, among all the represented ideologies, the EU has not been able yet to create consensus on the women’s health debate (Mellado, personal communication, 9 November). Hereafter, the pragmatic approach of women’s health is presented.

### **Women’s Health and its Current Approach in the EU and the USA**

The following quote from Gabrielle Jastrebski, Programme Manager of FEMM, identifies why women’s health needs to be addressed. Jastrebski states “[w]hile women are unique in and of



themselves, we are all women and there is a universality in that as well” (Jastrebski, Personal communication, 16 November 2015). The fact that all women across the world face the same health issues, each in its own unique way, shows that women’s health is relevant for approximately half of all world citizens. Jastrebski, explains that women’s health in both America and the EU focusses “primarily on pregnancy prevention and symptom relief through hormonal suppression” (Jastrebski, Personal communication, 16 November 2015). Mellado confirms this statement by outlining women’s health and the relation to family in terms of child birth and pregnancy (Mellado, personal communication, 9 November). Nonetheless, Jastrebski and Balaban both add that women’s health must encompass more than pregnancy prevention and symptom relief. Mellado agrees that women have different health needs due to the hormonal life that men do not have (Mellado, personal communication, 9 November, Balaban, Personal communication, 10 November 2015, Jastrebski, Personal communication, 16 November 2015). Balaban states that although it is known that women are in need of different care compared to men, doctors are conservative in their approaches to treatment. However, she also foresees that doctors will change their attitude towards new treatments if it is based on credible research (Balaban, Personal communication, 10 November 2015). The next section presents FEMM and its key elements, affordability, collaboration with other organisations and politics are presented.

## FEMM

### Key elements

Jastrebski argues that “FEMM is a women's health programme that is revolutionising the way doctors and patients alike address women's care”(Jastrebski, Personal communication, 16 November 2015). This new approach is reflected in FEMM’s three key elements of their women’s health programme. These are based on the name of FEMM, which stands for Fertility, Education and Medical Management. The first key element is therefore fertility, it represents a fundamental shift in the approach to women’s health, focusing on hormonal health and restoring health by treating underlying hormonal conditions. The second element focuses on educating women to know and understand their hormonal patterns and signs. The third and last element concentrates on training medical professionals in FEMM Medical Management, to give them the capacity to diagnose and treat underlying conditions.

### Fertility

Although fertility is the first key element of FEMM, Jastrebski clarifies that “with FEMM we want to move as far away from fertility as we can and first and foremost focus on health” (Jastrebski, Personal communication, 16 November 2015). FEMM is a comprehensive women’s health programme that focuses on women’s hormonal health. Jastrebski states that, “the vast majority of

women's reproductive health issues have hormonal disorders as an underlying cause, so it makes sense that hormonal analysis is the foundation and standard for women's healthcare" (Jastrebski, Personal communication, 16 November 2015). This approach to women's health is unlike the average woman and physician's clinician's approach. As Jastrebski explains, most women and their physicians only consider their reproductive health in the context of their fertility when achieving, or avoiding pregnancy or when they encounter symptoms of hormonal imbalance. This is inadequate. FEMM recognises that women's reproductive health conditions indicate their overall health. Therefore, it is crucial for women to monitor their reproductive health in relation to their general health and not only to achieve their fertility goal (Jastrebski, Personal communication, 16 November 2015). This is also confirmed by Barron, as cited in the FEMM white paper, "fertility literacy is important for improving reproductive health, pregnancy outcomes, and chronic disease prevention" (FEMM health, 2013, p. 46). According to FEMM, the lack of ovulation, which is a sign of fertility, indicates that women face health problems. FEMM claims that "every woman should understand how ovulation works, what the signs of ovulation are and that ovulation is a sign of health" (FEMM health, 2013, p. 43). Irregularities in a woman's cycle can be used as an indicator of several health dysfunctions. Among other things, thyroid disorders, tumours, sexually transmitted infections, a premenstrual syndrome, endometriosis and infertility (FEMM health, 2013, p. 9-16). Therefore, fertility should be seen in light of women's overall health.

### **Education**

The second key element of FEMM is to educate women about the functioning of their bodies. Jastrebski states that education "efforts must be directed towards comprehensive hormonal education for women" (Jastrebski, Personal communication, 16 November 2015). As explained by FEMM:

Empowering a woman to take care of her hormonal health is multifaceted. It entails educating her to observe events throughout her cycle and to note any irregularities that require health care consultation. Without knowledge about the hormonal interplay of her cycle, a woman's ability to make empowered, informed sexual and reproductive decisions is hindered, as it renders her own health and fertility confusing. (FEMM health, 2013, p. 42)

Research conducted in 2012 in Melbourne, Australia shows that 87,3% out of 204 women who attempted to become pregnant had difficulties to understand their fertile window, even though

about 86,8% had consulted the internet, books and general practitioners to increase their fertility awareness (FEMM health, 2013, p. 43). This study shows why FEMM sees the need to provide fertility education to all women. The study includes women from developed regions. FEMM has the objective to teach women of all ages. FEMM teaches children from age 11 – through a TEEN FEMM programme – all the way through to menopause. Next to the education, FEMM also provides an integrated smart phone application with the aim to give women information about their bodies. Ideally the application directs women to a full education course. It has been downloaded by over more than 10,000 women. These women mainly live in the USA, although there are also international users from Europe, Latin America, Africa and the Philippines (Jastrebski, Personal communication, 16 November 2015).

### *Medical Management*

As Jastrebski points out, “once women are aware of the hormonal basis of their cycle and understand their signs of health, they will desire healthcare that takes this into account educated women create a demand for medical care that is able to diagnose and treat what they are seeing” (Jastrebski, Personal communication, 16 November 2015). Both Mellado and Jastrebski state that doctors give women the best treatment they know, but “[e]uropean doctors are using treatments which are not accurate enough to solve women’s problems” (Mellado, personal communication, 9 November, Jastrebski, Personal communication, 16 November 2015). Also Balaban states repeatedly that doctors are open to new education as long as it is credible and accessible. However, she believes that it will take 10 to 20 years before a new curriculum with a focus on women’s health is integrated in medical studies. (Balaban, Personal communication, 10 November 2015). Comments made by all participants lead to the acknowledgement that there is a need for medical improvement in the field of women’s health.

At the same time, FEMM provides Medical Management training for medical professionals. Jastrebski explains that the medical training offers physicians the following treatment approach:

The ability to reach a sensitive diagnosis of underlying hormonal imbalances in order to provide better patient outcomes. FEMM partners with the Reproductive Health Research Institute, headed by one of the foremost reproductive endocrinologists “to develop the science and research of the medical protocols; research and science that is very reputable to physicians all over the world. FEMM and the medical protocols are all based on the latest research

and science” (Jastrebski, Personal communication, 16 November 2015).

Jastrebski, describes that physicians who have received the medical protocols are better equipped to treat their patients. They are eager to use these protocols in their medical treatment. The medical protocols are applicable, either in established medical practices or within FEMM clinic treatment settings. Doctors can therefore implement the protocols within their own practices (Jastrebski, Personal communication, 16 November 2015).

### Affordability

Jastrebski explains that the affordability of the medical care of FEMM depends on the structure of clinics or established medical practices. FEMM medical care can be billed like any other care, it is simply a more advanced way to diagnose and treat their health problems. Patients who visit doctors that use the FEMM medical protocol and whose medical treatment is covered by private and State insurance companies, will receive coverage in the same manner as the other health care (Jastrebski, Personal communication, 16 November 2015). As FEMM explains, FEMM education and medical care can allow for early diagnosis and proper treatment, often mitigating larger health issues in the long-term, thereby, lessening overall costs (Jastrebski, Personal communication, 16 November 2015).

### Collaboration with other organisations

Jastrebski gives an example of collaboration among three different women’s health clinics on a university campus in Columbus, Ohio. Together the pilot health clinic of FEMM, the International Planned Parenthood Federation and a crisis pregnancy centre serve the same population. FEMM has noticed that both the International Planned Parenthood Federation and the crisis pregnancy centre have referred young women to the FEMM health clinic, as these organisations could not offer the care that these women need. Although, at the moment this only happens on a small scale, Jastrebski is delighted about this development: “It is exciting to see when organizations from two very different ends of the spectrum are able to see that FEMM is filling a gap that is really substantial right now in terms of women’s health care” (Jastrebski, Personal communication, 16 November 2015). For the future, she hopes to see that all organisations work together provide the best health for women.

### Politics

FEMM is, besides the educational and medical focus, also aware of the role of politics in the field of women’s health. FEMM contributes to women’s health, therefore, it is desired that political

institutions promote FEMM in their health policy programmes. Recently FEMM received consultative status at the UN. This enables FEMM “to bring in their topics directly to the representatives of the UN” and to work along with other organisations (Jastrebski, Personal communication, 16 November 2015). In terms of responses of other organisations who work in the same field, Jastrebski assumes she will see competition. However, as stated before, FEMM strives to put emphasis on the best care of women and not on competition (Jastrebski, Personal communication, 16 November 2015).

At an EU level, Mellado believes that FEMM could be successful. This is mainly as FEMM represents all ideologies that are alive among Europeans. Mellado hopes that FEMM will be received positively within European politics. Politicians might suppress FEMM if they see FEMM as a threat to their ideology. Mellado observes that through FEMM, women receive accurate information and education. All women will become able to make informed choices. Instead of ideology exclusion, FEMM includes every ideology. Above all, Mellado hopes “that politicians see that FEMM is encouraging human rights with a focus on the right to health, the right to education, the right to informed choice, the right to the freedom of belief and opinion. Mellado also briefly points out that a successful launch of FEMM in Europe might cause a “spill over effect to other nations. Also to developing nations, since basic educational programmes can be taught easily without huge expenses (Mellado, personal communication, 9 November).

## Conclusion

To conclude, first of all, Mellado states that human rights are grounded in the concept to promote human dignity. Furthermore, the right to health can only be achieved if the right to informed choice, education and the freedom of thought, conscience and religion are taken into account. Secondly, Mellado outlines the willingness of the EU to promote health within its borders. However, a lack of financial resources constrain the good practices the EU wants to promote. Thirdly, Balaban agrees that the EU involvement in health through recommendations offers great added value for other countries. It helps states to base their health policy on a long term and European-wide health policy. Then, Mellado explained that the different represented ideologies in the European Parliament prevent pragmatic discussion on women’s health. It is mainly discussed based on concepts and not on actual implementation. Furthermore, Women’s health is universal and it should not only be seen in light of pregnancy prevention and symptom relief. Moreover, women’s health is part of general health. Currently, doctors are still conservative in new women’s health approaches. However, credible research could change the perspective of medical professionals. Further, fertility, education and medical management are the key elements FEMM focusses on. Fertility is explained in light of general health. Education

programmes teach women from puberty through menopause how to monitor their general health. The medical management offers health care for women and it also includes training for medical professionals so that they can work with FEMM medical protocols. FEMM is adaptable to health care systems since doctors can use the medical protocols in established practice. This makes FEMM affordable for everyone. A pilot FEMM project showed that other similar organisations work together with FEMM to provide the best care for women. In terms of politics, through the consultative status in the UN, FEMM can start to advocate their programme at an international political level. These were the presented findings. The next chapter analyses the results.

## Analysis

In this chapter, the information from the interviews is discussed within the context of the literature review. It links the legal view on the right to health for women with the pragmatic view on the right to health for women. The analysis is divided into four parts in order to deliberate the over all aspects of FEMM and the right to health for women in the EU (see Figure 6). First of all, women's health and human rights are discussed. Secondly, the EU health policy and cultural diversity are discussed. Thirdly, the paper continues to discuss FEMM's legal duties in the contribution to the right to health for women. Lastly, independent from the outcome of the first and second part, the definition of the right to health as given by the ICESCR and general comment no.14 of the committee of the ICESCR are used to examine FEMM's contribution to the right to health for women.

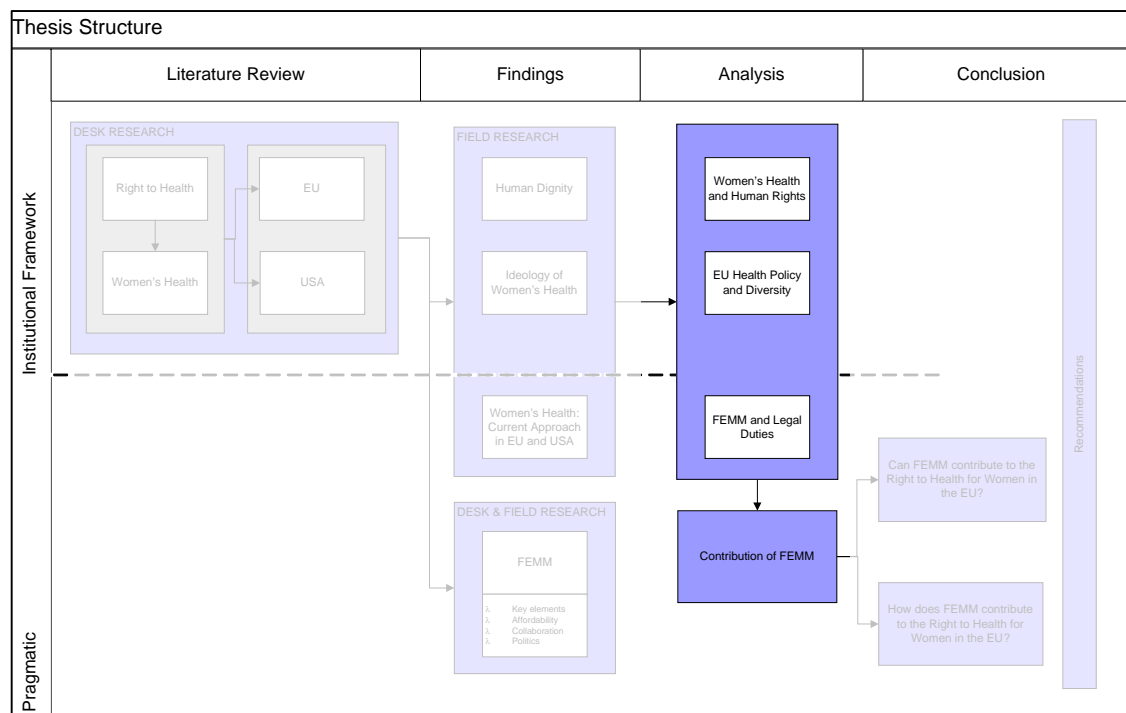


Figure 6 Thesis Structure: Analysis

## Women's Health and Human Rights

First of all, the right to health and women's health are inextricably linked. Health for women, similar to health for men, is part of the right to health. In international documents, such as the Cairo and Beijing declarations, women's health is often understood as reproductive health. Although these documents show political will and cannot not bind states to implement these statements into their health policies, this unilateral approach constrains women's health development. Scholars have stated that women's health contains all aspects of health.

Nonetheless, the political debates do not go beyond reproductive health. Reproductive health addresses ideologies such as family structures, family planning, abortion and contraception. Political leaders defend their own ideologies. The protection of their own ideology blinds them for new advancing knowledge in women's health. In other words, the different ideologies stagnate the process of the improvement of women's health. FEMM provides an objective women's health programme which engages all ideologies. Besides the right to health, women's health is also related to other rights. It is also related to the right to make informed choices, the right to education and the right to freedom of thought, conscience and religion.

### **The EU Health Policy and Diversity.**

Secondly, as reviewed in the literature review of this paper, human rights, and therefore the right to health, are a state's responsibility. The EU is not a State, but consists of individual Member States. Also, the EURCFR in article 35 points towards the responsibility of Member States concerning health care and the limited power of the EU. In terms of public health, the EU has a shared responsibility regarding public health. In relation to the protection of human health, the EU can support, coordinate or supplement actions of the Member States, but cannot create binding laws. The EU supports good health practices, invests in health research and funds pilot projects. A reason why the EU should not have the power to make overarching health related decisions could be linked to limited financial resources. A more likely reason is to be found in the highly diverse approaches that the individual EU Member States take in addressing women's health. These viewpoints prevent the EU to have one health policy. This can be seen as EU countries are not aligned on the implementation of women's health. To show one of the extremes, some EU Member States only allow abortion when women's lives are in danger, whilst other Member States have legalised abortion under any circumstances up until 22 weeks. Both nations are Members of the EU. However, these Members are difficult to align on this topic. The difficult alignment is rooted in the different ideologies that delegates represent. The motto of the EU states that the EU is united in diversity (European Union, 2015). Therefore, the EU will respect Member States views and health policies. It demonstrates the sovereignty of the EU Member State.

### **FEMM and its Legal Duties**

Thirdly, due to the fact that FEMM is an NGO, FEMM is not obliged to respect, protect and fulfil the right to health for women. As stated above, this role rests with national governments. It does not automatically mean that the right to health is irrelevant for FEMM. NGOs are required to comply with the implementation of the right to health in domestic law. Moreover, as is visible in some States in the USA, NGOs and businesses use the international principles of the right to



health to achieve the highest attainable standard of health, which are above the health requirements given by the domestic law. That is to say that, besides the fact that high health standards of FEMM increase women's personal health, it also helps FEMM to influence new standards for national law. Through this 'top down' approach, it is hoped that all health institutions will act according to the new health standards.

### **FEMM's contribution to the right to health for women**

As stated in the ICESCR, the right to health is the "highest attainable standard of mental and physical health" (ICESCR, 1966, art.12). Although this right is a voluntary binding law, it does not provide criteria to measure the highest attainable standard of health. The committee of the ICESCR, however, provided health principles through a general comment which will help to measure the highest attainable standard of health. Also the ESC states requirements to protect health. These principles are written as guidance for states and are not legally binding. Legally, FEMM does not have the mandate to fulfil the right to health. Neither does it need to follow the general comment of the UN. However, these principles help to examine FEMM's contribution to the right to health for women. Women's health is different from men's health, however, it should not be excluded from general health. Women's health, is part of the right to health and can be analysed according to the general comment the ESC and the EURCFR.

### **General comment on the right to health**

The general comment states that health must be available, accessible, acceptable and qualified. The first principle, health availability, requires a "*sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes*" (WHO, 2013, p. 2). FEMM provides medical protocols for medical professionals. These protocols are used in FEMM clinics, but doctors and nurses can also implement these medical protocols in established practices. The fact that medical protocols can be implemented in already established practices ensures that FEMM's medical management is widely available. Besides the support that FEMM provides for medical professionals, FEMM also provides services to women. FEMM's mobile phone application is a service from FEMM to help women understand their reproductive health. More than 10,000 downloads, including those from outside of the USA, show that FEMM reaches women throughout the world. The aim of the application is to direct app-users to enrol for a FEMM course in order to become more educated about their reproductive health.

This links to the second principle: health accessibility. Accessibility has been divided in the following sub-principles; non-discrimination, physical accessibility, affordability and information accessibility (WHO, 2013, p. 2). One of FEMM's key elements is to teach and inform women about their reproductive health. This information enables women to make informed choices with regard

to their health. FEMM teachers and medical professionals who work within the FEMM protocols are physically present to support women in understanding and restoring their health. Women receive a face-to-face FEMM course, and FEMM clinics are available if women want to see a doctor who works according to the FEMM protocols. A side note here is that FEMM is still expanding their clinics. FEMM clinics do not reach all women in the USA, and at the moment of writing, no FEMM clinics exist in Europe. In the USA, affordability of FEMM health depends on the health care system that the medical professional operates under. FEMM health is covered if the medical professional is acknowledged by private or State health insurance companies. The term non-discrimination finds its roots in equality. The UDHR states that “[a]ll human beings are born free and equal in dignity and rights” (UDHR, 1948, art.1). FEMM has an inclusive character. Women from different demographics, cultures, religions and ideologies have at least one thing in common, namely the fact that women are women. Irrespective of the background that women have, FEMM provides information and teaches them to understand their hormonal health. Through education, women are enabled to make free and informed choices regarding their health.

The third principle addresses health acceptability. The principle requires that *“[a]ll health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements”* (WHO, 2013, p. 2). FEMM offers an inclusive service for all women, irrespective of their culture, beliefs or ideologies and in all phases of their hormonal health. These include teenagers when they enter puberty, young women, pregnant women and women going through their menopause. Through the FEMM medical protocols, FEMM is indirectly related to medical ethics. FEMM provides medical protocols to accredited medical professionals. In their established practices, physicians are required to work according to medical ethics. These protocols are scientifically and medically qualified, as required under health qualification. That is to say FEMM’s information is credible. The Reproductive Health Research Institute and FEMM works closely together on the development of the medical protocols. This meets the fourth and last health principle: Quality.

### European Social Charter

The ESC provides three requirements for the protection of health. The first requirement includes the provision and promotion of health education. The second requirement contains encouragement of individuals to take personal responsibility over their health. The third requirement is to eliminate the causes of diseases and prevent epidemics and accidents (ESC, 1996, art.11).

FEMM meets the requirements of the promotion and provision of health education. FEMM offers several educational programmes. FEMM offers training for medical professionals towards the advanced treatment of women's reproductive health issues. FEMM also offers training to persons to become FEMM teachers and provide health education classes for women. The educational programmes have two purposes. Firstly, it enables women to take personal responsibility over the health. The educational classes provide information to women how to monitor their everyday hormonal health. Women are encouraged to monitor their everyday health so that irregularities can be detected in early stages. That leads to the second purpose of the educational programmes: the medical training. Medical professionals who work according to the FEMM medical protocols are able to trace, cure or eliminate a disease based on underlying hormonal issues. Therefore, according to the health requirements of the ESC as described in article 11, FEMM contributes to the protection of health.

### **Charter of Fundamental Rights of the European Union**

The EURCFR emphasises both the accessibility to preventive health care and the right to benefit from medical treatment under national conditions. As explained in the analysis of the ESC, FEMM teaches women how to take personal responsibility for their health in order to monitor their own health. The teaching approach of FEMM can fall under preventive health care. FEMM teaches women to understand their normal healthy hormonal health. All observed events that deviate from a normal hormonal health pattern require health care consultation. The monitoring of hormonal health can lead to the identification of hormonal malfunctions. These malfunctions can be the effect of a more serious underlying health problem, such as thyroid disorders, tumours, sexually transmitted infections, a premenstrual syndrome, endometriosis and infertility. When the source of a health disruption is identified, women can be treated accordingly. Empowering women to understand their own reproductive system can lead to early detection of health disorders. The right to benefit from medical treatment under national conditions is a state's responsibility. It is a right between citizens and the State. FEMM cannot fulfil this right.

### **Conclusion**

To conclude, from a legal perspective, FEMM is an NGO and does not have to comply with human rights. However, from a pragmatic view, it has been shown that FEMM's contribution can be measured according to the right to health principles and health requirements. Also, as shown through desk and field research, women's health includes different ideologies. This hinders women's health development. The diversity of the EU Member States shows that a single health policy brings challenges. To impact the EU as a whole, FEMM should approach each Member

State individually and show that FEMM represents all ideologies. A full conclusion on the research question can be found in the conclusion chapter.

## Conclusion and recommendations

This paper analysed the right to health for women in the EU through a legal review and in depth semi structured interviews. These approaches were used to answer the main research question of this paper. *“How can FEMM contribute to the right to health for women in the EU?”*

The paper was divided in different chapters. These all had their unique purpose to support the answer to the research question.

The literature review focussed on the legal aspects of the right to health for women. Also the role of organisations and states with regard to health rights were reviewed. The literature review was followed by the methodology. The methodology outlined how, after the literature study, in depth semi structured interviews supported the research with a pragmatic assessment on the right to health for women. The findings chapter presented the outcome of the in depth semi-structured interviews and the organisation FEMM was introduced. The analysis followed after the findings were presented. The pragmatic views on the right to health and women's health in the EU were combined with the legal obligations to the right to health for women which were also analysed. All chapters led to the conclusion which will be presented below.

The conclusion to the research question will be given in two parts. First of all, the main research question will be split in two questions.

1. Can FEMM contribute to the right to health for women in the EU?
2. How would FEMM contribute to the right to health for women in the EU?

Question one focused on the legal ability of FEMM to contribute to the right to health for women in the EU. First of all FEMM is an NGO and NGOs do not have the legal responsibility to respect, protect and fulfil the right to health. It is the state's obligation to respond to, respect, protect and fulfil the right to health. Therefore, FEMM cannot contribute to the right to health for women. Secondly, following the first part of the conclusion, all 28 EU Member States carry this responsibility. However, the EU institutions only have a shared competency concerning health. That is to say, the Member States have the power to make decisions on health. The EU can only promote good practices throughout the EU, invest in health research and subsidise health related pilot projects. For this reason, a legal contribution to health for women can only be made at an EU Member State level. Therefore, the first question is answered with: FEMM cannot contribute to the right to health for women in the EU.

The second question left the legal obligations behind and focussed on the pragmatic view of the contribution to the right to health for women in the EU. FEMM is an NGO, therefore,

FEMM has no obligation towards the right to health. However, this does not mean that FEMM is excluded from the contribution to the right to health. Moreover, the paper has shown that FEMM complies to health principles and requirements, such as the health principles of general comment no. 14, which was written by the Committee of the Economic, Social and Cultural Rights and the health requirements as stated in article 11 of the ESC and article 35 of the EURCFR. First of all, this has a direct result of attaining the highest standard of health for women's personal health. Secondly, high health standards of FEMM might in the future also shape national policies. Indirectly, FEMM can be the catalyst for national policy change on health. Therefore, FEMM contributes to the right to health for women in the EU through the compliance with international health principles and rights.

To conclude, the entire research question *"How can FEMM contribute to the right to health for women in the EU?"* is answered as follows: FEMM cannot legally contribute to the right to health for women in the EU. It is a Member States obligation. However, by following health rights and health principles that the international community agreed upon, Member States may respond and embrace FEMM's health approach and change national health policy accordingly. When this occurs, FEMM indirectly contributes to the right to health for women in the EU.

### Recommendations

Further study on women's health implementations in EU Member States is recommended. The EU has limited competence in the field of health, because Member States have the decision-making power. Although all 28 Member States have ratified the ICESCR and are subjected to the EURCFR, this paper showed that there are significant differences among the EU Member States in women's health approaches. Therefore, an analysis on women's health of the individual 28 Member States is recommended.

It is recommended that the EU support FEMM through all possible available means. FEMM can offer affordable health services to all women in the EU. Through the promotion of the good practices that FEMM conducts, supporting future FEMM pilot projects and investment in research conducted by FEMM, the EU can improve health for European women. Eventually, the promotion of FEMM by the EU could also lead to the improvement of development aid programmes coordinated by the EU.

FEMM is recommended to increase its accessibility by providing more medical professionals with the FEMM medical protocols and opening new health clinics in the USA as well as in Europe.

FEMM is recommended to continue to strive for the highest attainable standard of health for women through following the health principles of general comment no. 14 and the health

requirements of the ESC and the EURCFR. These legal definitions of health assist FEMM to communicate health in the same language that political leaders use. This increases international and national political credibility. This might lead to a political change in the perspective of women's health. Which in turn contributes to the highest attainable standard of health for all women.

Besides the relation between FEMM and the right to health, it is recommended to conduct further research on the link between FEMM's objectives and other human rights. These are, among others, the right to informed choice, the right to education and right to freedom of thought, conscience and religion

For FEMM to be recognised in all Member States, and to be included in the national health plans, not only a comprehensive understanding of the diversity of the Member States on women's health is essential, also advocacy work is necessary. In other words, it is recommended that FEMM examines each Member State individually on the existing ideologies on women's health. FEMM is adaptable to all women's health ideologies, but it should be communicated to the Member States. The outcome of these Member States examinations help FEMM to associate with each Member State based on the ideologies that delegates represent. This may help FEMM to achieve the highest possible accessibility for women in the EU.

## References

- Assistant Secretary for Public Affairs. (2014, November 18). *Key Features of the Affordable Care Act*. Retrieved October 26, 2015, from [www.hhs.gov](http://www.hhs.gov):  
<http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca/index.html>
- Blumenthal, D., Abrams, M., & Nuzum, R. (2015, June 18). The Affordable Care Act at 5 Years. *The New England Journal of Medicine*, 2451-2458.
- Brillat, R. (2005). The Supervisory Machinery of the European Social Charter: Recent Developments and their Impact. In G. De Burca, & B. De Witte, *Social Rights in Europe* (pp. 31-45). Oxford: Oxford University Press.
- Brinkmann, S. (2013). *Qualitative interviewing, understanding qualitative research*. Oxford: Oxford University Press.
- Council of Europe. (1996). *European Social Charter (revised)*. Retrieved September 8, 2015, from [www.conventions.coe.int](http://www.conventions.coe.int): <http://conventions.coe.int/Treaty/EN/Treaties/Html/163.htm>
- European Commission. (2015, September 13). *EU Charter of Fundamental Rights*. Retrieved October 27, 2015, from <http://ec.europa.eu>: [http://ec.europa.eu/justice/fundamental-rights/charter/index\\_en.htm](http://ec.europa.eu/justice/fundamental-rights/charter/index_en.htm)
- European Commission. (2015, August 6). *EU Competences*. Retrieved October 27, 2015, from <http://ec.europa.eu>: <http://ec.europa.eu/citizens-initiative/public/competences/faq?lg=en>
- European Court of Human Rights. (2015, October). *factsheet - Health*. Retrieved November 2015, 16, from [www.echr.coe.int](http://www.echr.coe.int): [http://www.echr.coe.int/Documents/FS\\_Health\\_ENG.pdf](http://www.echr.coe.int/Documents/FS_Health_ENG.pdf)
- European Union. (2012, October 26). *Consolidated version of the Treaty on European Union*. Retrieved November 3, 2015, from <http://eur-lex.europa.eu/>: <http://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX:12012M/TXT>
- European Union. (2012, October 26). *Consolidated version of the Treaty on the Functioning of the European Union*. Retrieved November 3, 2015, from <http://eur-lex.europa.eu/>: <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012E%2FTXT>
- European Union. (2015, August 24). *The EU motto*. Retrieved December 7, 2015, from <http://europa.eu>: [http://europa.eu/about-eu/basic-information/symbols/motto/index\\_en.htm](http://europa.eu/about-eu/basic-information/symbols/motto/index_en.htm)
- FEMM health. (2013, October). *The Case For FEMM, White paper*. Retrieved May 12, 2015, from [www.femmhealth.org](http://www.femmhealth.org):  
[https://femmhealth.org/sites/all/files/whitepaper/femm\\_white\\_paper\\_2015.pdf](https://femmhealth.org/sites/all/files/whitepaper/femm_white_paper_2015.pdf)



- Füsser, K. (n.d.). *European Court of Justice decisions on healthcare policy*. Retrieved December 10, 2015, from <http://www.fuesser.de/>:  
[http://www.fuesser.de/fileadmin/dateien/publikationen/manuskripte/vortrag\\_healthcare\\_portugal.pdf](http://www.fuesser.de/fileadmin/dateien/publikationen/manuskripte/vortrag_healthcare_portugal.pdf)
- Gilbert, N. (2008). *Researching Social Life* (3rd ed.). London: SAGE Publications.
- Hathaway, O. A. (2005). Between Power and Principle: An Integrated Theory of International Law". *Faculty Scholarship Series*, 469-536.
- Hervey, T. (2005). The 'Right to Health' in the EU charter and the ESC. In g. De Burca, & B. De Witte, *Social Rights in Europe* (pp. 305-339). Oxford: Oxford University Press.
- How to Use Your State's Health Insurance Marketplace to Buy "Affordable" Health Insurance*. (n.d.). Retrieved October 26, 2015, from <http://obamacarefacts.com/>:  
<http://obamacarefacts.com/insurance-exchange/health-insurance-marketplace/>
- International Planned Parenthood Federation European Network. (2015, January). *Barometer of Women's access to modern contraceptive choice in 16 EU countries*. Retrieved November 16, 2015, from [www.ippfen.org](http://www.ippfen.org/):  
[http://www.ippfen.org/sites/default/files/Barometer\\_final%20version%20for%20web%20\(2\)\\_0.pdf](http://www.ippfen.org/sites/default/files/Barometer_final%20version%20for%20web%20(2)_0.pdf)
- Keller, H., & Grover, L. (2012). UN Human Rights Treaty Bodies Law and Legitimacy General Comments of the Human Rights Committee and their legitimacy. In H. Keller, & G. Ulfstein, *UN Human Rights Treaty Bodies Law and Legitimacy* (pp. 116-198). Cambridge: Cambridge University Press.
- MacNaughton, G. (2011, September 30). The Human Right to Health Care in the United States. *Journal of Poverty Law and Policy*, 208-216.
- McHale, J. (2010). Fundamental rights and health care. In E. Mossialos, T. K. Hervey, & G. e. Permanand, *Health Systems Governance in Europe, The Role of European Union Law and Policy* (pp. 282-314). Cambridge: Cambridge University Press.
- Mechlem, K. (2009). Treaty Bodies and the Interpretation of Human Rights. *Vanderbilt Journal of Transnational Law*, 42, 905-947.
- Meier, B. M. (2010). The World Health Organization, the evolution of human rights, and the failure to achieve Health for All. In J. Harrington, & M. Stuttaford, *Global Health and Human Rights* (pp. 163-190). Oxon: Routledge.
- Mertus, J. A. (2009). *The United Nations and Human Rights, a guide for a new era* (2nd ed.). Oxon: Routledge.

- Office of the United Nations High Commissioner for Human Rights. (2012). *The United Nations Human Rights Treaty System, Factsheet 30*. Retrieved September 1, 2015, from [www.ohchr.org: http://www.ohchr.org/Document/Publications/FactSheet30Rev1.pdf](http://www.ohchr.org/Document/Publications/FactSheet30Rev1.pdf)
- Office of the United Nations High Commissioner for Human Rights. (2014). *Status of Ratification Interactive Dashboard*. Retrieved from [indicators.ohchr.org: http://indicators.ohchr.org/](http://indicators.ohchr.org/)
- Office of the United Nations High Commissioner for Human Rights. (2015). *International Human Rights Law*. Retrieved October 26, 2015, from <http://www.ohchr.org/>: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>
- Sahl, S. (2007, June/July). *Researching Customary International Law, State Practice and the Pronouncements of States regarding International Law*. Retrieved December 2010, 2015, from Hauser Global Law School Program: [http://www.nyulawglobal.org/globalex/Customary\\_International\\_Law.html#\\_edn1](http://www.nyulawglobal.org/globalex/Customary_International_Law.html#_edn1)
- Saumure, K., & Given, L. M. (n.d.). *Using Skype as a Research Tool*. Retrieved September 15, 2015, from [http://lrsv.umd.edu/abstracts/Saumure\\_Given.pdf](http://lrsv.umd.edu/abstracts/Saumure_Given.pdf): [http://lrsv.umd.edu/abstracts/Saumure\\_Given.pdf](http://lrsv.umd.edu/abstracts/Saumure_Given.pdf)
- Schabas, W. A. (2015). *The European Convention on Human Rights*. Oxford: Oxford University Press.
- Smith, K., Todd, M., & Waldman, J. (2009). *Doing Your Undergraduate Social Science Dissertation*. Oxon: Routledge.
- The Law Library of Congress. (2015, January). *Abortion legislation in Europe*. Retrieved November 16, 2015, from [//www.loc.gov: http://www.loc.gov/law/help/reports/pdf/2015-011789%20FINAL%20REPORT%20%20with%20maps.pdf](http://www.loc.gov/law/help/reports/pdf/2015-011789%20FINAL%20REPORT%20%20with%20maps.pdf)
- Thümmel, K., Britton, A., & Kirch, W. (2009). *Data and Information on Women's Health in the European Union*. Technische Universität Dresden. Dresden: Directorate-General for Health and Consumers.
- Toebe, B. (2010). Human Rights and Health Sector Corruption. In J. Harrington, & M. Stuttford, *Global Health and Human Rights, Legal and Philosophical Perspectives* (pp. 102-134). Oxon: Routledge.
- United Nations. (1948). *Universal Declaration of Human Rights*. Retrieved August 21, 2015, from [www.un.org: http://www.un.org/en/documents/udhr/](http://www.un.org/en/documents/udhr/)
- United Nations. (1969, May 23). *Vienna Convention on the Law of Treaties*. Retrieved October 2015, 2015, from [www.treaties.un.org](http://www.treaties.un.org/): <https://treaties.un.org/doc/Publication/UNTS/Volume%201155/volume-1155-I-18232-English.pdf>

- United Nations. (1994, September 5-13). *Report of the ICPD*. Retrieved September 1, 2015, from <http://www.unfpa.org/>: [http://www.unfpa.org/sites/default/files/pub-pdf/programme\\_of\\_action\\_Web%20ENGLISH.pdf](http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf)
- United Nations. (1995, September 4-15). *Beijing Declaration and Platform for Action*. Retrieved September 1, 2015, from [www.un.org](http://www.un.org/): <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>
- United Nations Department of Economic and Social Affairs. (n.d.). *Sustainable Development Goals*. Retrieved September 23, 2015, from <https://sustainabledevelopment.un.org/>: <https://sustainabledevelopment.un.org/?menu=1300>
- United Nations Educational, Scientific and Cultural Organization. (n.d.). *General introduction to the standard-setting instruments of UNESCO*. Retrieved November 16, 2015, from [www.unesco.org](http://portal.unesco.org/en/ev.php-URL_ID=23772&URL_DO=DO_TOPIC&URL_SECTION=201.html): [http://portal.unesco.org/en/ev.php-URL\\_ID=23772&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=23772&URL_DO=DO_TOPIC&URL_SECTION=201.html)
- United Nations Human Rights. (1966, December 16). *International Covenant on Economic, Social and Cultural Rights*. Retrieved September 1, 2015, from [www.ohchr.org](http://www.ohchr.org/): <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>
- United States of America. (n.d.). *Observations by the United States of America on "The Right to Health, Fact Sheet No. 31"*. Retrieved October 22, 2015, from <http://www.state.gov/>: <http://www.state.gov/documents/organization/138850.pdf>
- Weisman, C. S. (1997). Changing Definition of Women's Health: Implications for Health Care and Policy. *Maternal and Child health journal*, 1(3), 179-189.
- World Federation of Public Health Association. (1978). *Non-Governmental Organizations and Primary Health Care*. Position Paper.
- World Health Organization. (2002, July). *25 Questions. Answers on Health and Human Rights*. Retrieved September 23, 2015, from [www.who.int](http://www.who.int/): <http://www.who.int/hhr/information/25%20Questions%20and%20Answers%20on%20Health%20and%20Human%20Rights.pdf>
- World Health Organization. (2013, November). *The right to health, Fact sheet N°323*. Retrieved August 21, 2015, from [www.who.int](http://www.who.int/): <http://www.who.int/mediacentre/factsheets/fs323/en/#>
- World Health Organization, Office of the United Nations High Commissioner for Human Rights. (2008, June). *The Right to Health, Factsheet 31*. Retrieved August 21, 2015, from [www.ohchr.org](http://www.ohchr.org/): <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>